Social worker: Samuel Addo
Registration number: SW117505
Fitness to Practise
Final Hearing

Dates of hearing: 24 November 2025 to 02 December 2025

Hearing venue: Remote hearing

Hearing outcome:
Fitness to practise impaired, suspension order (10 months)

Interim order:
Interim suspension order (18 months)

Introduction and attendees:

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

2. Mr Addo attended and was not represented.

3. Social Work England was represented by Ms Louisa Atkin, Counsel instructed by Capsticks LLP.

4. The panel of adjudicators conducting this hearing (the "panel") and the other people involved in it were as follows:

Adjudicators	**Role**
Adrian Smith	Chair
Suzanna Jacoby	Social worker adjudicator

Hearings team/Legal adviser	**Role**
Jenna Keats/Hannah McKendrick	Hearings officer
Chiugo Eze	Hearings support officer
Neville Sorab	Legal adviser

Allegations:

5. Mr Addo faces the following allegation:

Whilst registered as a social worker and employed with Kent County Council:

1. *You did not complete 'RAG' ratings with respect to one or more of the service users identified in Schedule 1 in an appropriate and/or timely way;*

2. *You created inaccurate records with respect to one or more of the service users identified in Schedule 2 in or around May 2020;*

3. *You did not complete sufficient visits to, or alternatively ensure that you had an appropriate level of contact with, one or more of the service users identified in Schedule 3;*

4. *You did not complete assessments and/or reviews, either adequately or at all, with respect to one or more of the service users identified in Schedule 4*

5. *You did not take appropriate and/or timely action in response to concerns with respect to one or more of the service users identified in Schedule 5*

6. *You did not handle confidential information sensitively on one or more occasions in or around June or July 2020.* **ADMITTED**

The matters outlined at paragraphs 1 – 5 amount to the statutory grounds of misconduct and/or lack of competence.

The matter outlined at paragraph 6 amounts to the statutory ground of misconduct.

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

Schedule 1

i. *Service User A;* **ADMITTED**

ii. *Service User B;* **ADMITTED**

iii. *Service User C;* **PROVED**

iv. *Service User D;* **ADMITTED**

v. *Service User E;* **ADMITTED**

vi. *Service User F;* **PROVED**

vii. *Service User G;* **PROVED**

viii. *Service User H;* **ADMITTED**

ix. *Service User I;* **PROVED**

x. *Service User J;* **PROVED**

xi. *Service User K;* **PROVED**

xii. *Service User L;* **ADMITTED**

xiii. *Service User M;* **PROVED**

xiv. *Service User N;* **PROVED**

xv. *Service User O;* **ADMITTED**

xvi. *Service User P;* **PROVED**

xvii. *Service User Q;* **PROVED**

xviii. *Service User R;* **ADMITTED**

xix. *Service User S.* **PROVED**

Schedule 2

i. *Service User A;* **ADMITTED**

ii. *Service User R;* **ADMITTED**

iii. *Service User M;* **ADMITTED**

iv. *Service User B;* **ADMITTED**

v. *Service User N;* **ADMITTED**

vi. *Service User P;* **ADMITTED**

vii. *Service User H;* **ADMITTED**

viii. *Service User G;* **ADMITTED**

ix. *Service User F;* **ADMITTED**

x. *Service User S;* **ADMITTED**

xi. *Service User J;* **ADMITTED**

xii. *Service User D;* **ADMITTED**

xiii. *Service User E;* **ADMITTED**

xiv. *Service User I;* **ADMITTED**

xv. *Service User O;* **ADMITTED**

xvi. *Service User C*. **ADMITTED**

Schedule 3

i. *Service User A;* **PROVED**

ii. *Service User B;* **PROVED**

iii. *Service User C;* **PROVED**

iv. *Service User D;* **PROVED**

v. *Service User E;* **PROVED**

vi. *Service User F;* **PROVED**

vii. *Service User G;* **ADMITTED**

viii. *Service User H;* **PROVED**

ix. *Service User I;* **PROVED**

x. *Service User J;* **PROVED**

xi. *Service User L;* **ADMITTED**

xii. *Service User M;* **PROVED**

xiii. *Service User N;* **ADMITTED**

xiv. *Service User O.* **ADMITTED**

Schedule 4

i. *Service User A;* **PROVED**

ii. *Service User B;* **PROVED**

iii. *Service User C;* **ADMITTED**

iv. *Service User D;* **PROVED**

v. *Service User E;* **PROVED**

vi. *Service User K;* **PROVED**

vii. *Service User N;* **PROVED**

viii. *Service User O;* **ADMITTED**

ix. *Service User T;* **ADMITTED**

x. *Service User U;* **ADMITTED**

xi. *Service User S.* **ADMITTED**

Schedule 5

i. *Service User S;* **ADMITTED**

ii. *Service User U;* **NOT PROVED**

iii. *Service User R.* **ADMITTED**

Preliminary matters – Panel composition:

6. The panel composed of two panel members, as there was no lay member for this hearing. The panel accepted the legal advice provided by the legal adviser that Rule 34 of the Fitness to Practise Rules 2019 (as amended) (the "Rules") sets out:

> *(a) Where a case is to be considered under these Rules by the adjudicators or the case examiners, the regulator must appoint at least one lay person and at least one registrant.*

(b) Where a case is to be considered by the regulator under these Rules, the person or persons appointed to determine the case must include at least one lay person.

(c) The chair of any hearing or meeting must be a lay person.

7. The panel noted that even without the lay adjudicator, the panel had a lay member, the Chair, and a registrant member, the Social Worker panel member. The panel considered it to be in the interests of justice, and judicially efficient, to proceed with only the Chair and the social worker panel member as a two-member panel.

Admissions:

8. Rule 32c(i)(aa) states:

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

9. Following the reading of the allegations the panel Chair asked Mr Addo whether he admits any of the allegations or facts and whether he admits that his fitness to practise is currently impaired.

10. Mr Addo informed the panel that he admitted allegations as set out above in the allegations section. The panel therefore found those allegations proved by way of Mr Addo's admissions.

Background:

11. Mr Addo was employed within the West Kent Disabled Young People's Team at Kent County Council ("the Council") from around May 2018 and completed his Assessed and Supported Year in Employment ("ASYE") with them.

12. From around October 2019, Mr Addo was supervised by Ms Louisa Rogers, who was a Senior Social Worker at the time.

13. In her capacity as Mr Addo's supervisor, Ms Rogers began to have concerns in relation to Mr Addo's practice over time. This included concerns that Mr Addo had:

    a. "RAG-rated" service users on his caseload in response to the COVID-19 pandemic, without having any, or any significant contact with them;

    b. Created inaccurate case recordings;

    c. Not completed visits and/or assessments as required; and

    d. Not taken appropriate action in response to safeguarding concerns.

14. On 27 July 2020, Mr Addo was suspended pending an investigation. Mr David Doe was appointed as the Council's Investigating Officer and completed an investigation into the concerns.

15. Whilst reviewing Mr Addo's emails during his investigation, Mr Doe identified a further concern, namely that Mr Addo had used external email addresses to send information regarding one or more service users to his Council email address.

16. On 18 September 2020, the Council referred Mr Addo to Social Work England.

17. Mr Addo's employment with the Council came to an end with effect from 23 February 2021.

Allegation 1

18. The Covid RAG rating was established when COVID began so the Council could keep track of the higher risk cases and help it determine which cases needed more intervention. The RAG (Red; Amber; Green) rating would establish the cases of concern and highlight any young people who the Council was concerned about the impact COVID was having on them or if there were concerns about their care needs being met or concerns about safeguarding as the children were not in school. The RAG rating would establish a high-risk group where the Council would need to conduct further contact with them. All the RAG ratings were meant to be done at the start of the pandemic and then should have been reviewed regularly.

19. Social workers were asked to RAG rate all their cases from red to green in terms of whether more contact was needed more frequently due to the pandemic or not. To do this, a social worker was required to speak to the families on the phone.

20. In an email sent to Mr Addo on 2 July 2020, Ms Price, Team Manager for the West Kent Disabled Young People's Team at the Council, commented that "[t]*here has been a lot of emphasis since lockdown started that all staff should contact all of their clients in order to complete the RAG rating and agree a contact timescale and conclude on the RAG rating accordingly.*". Mr Addo's response to Ms Price's email on the following day suggests that he understood that contact should be made to inform the RAG rating, as he stated that he had "*ensured they were seen in line with the directives following the lockdown.*"

21. Ms Rogers explains that she was "*concerned about lack of progress as [Mr Addo] was not promptly RAG rating each of his cases*" and comments that "*I had to ask him to complete the RAG ratings several times.*"

22. Ms Rogers sent a further email to Mr Addo on 17 April 2020 asking him to "*ensure every one of your cases has a case note summary with a Covid 19 updated (highlight this in bold and red) to say their rag rating*" and asking him to "*put how often the family need contact so for your red rag rated cases you'd say weekly, or every other day contact required.*" Ms Rogers advised Mr Addo that "[t]*hese need to be completed today.*"

23. Mr Addo was also sent an email by Ms Price on 17 April 2020, which contained a list of his "LAS" cases which required Mr Addo to update the case summaries and include the RAG rating. Mr Addo responded to Ms Price's email and advised that he was "*currently updating the case summaries as mentioned*."

24. On 20 April 2020, Ms Rogers sent a further email to Mr Addo. Mr Addo acknowledged that he had "*made a start*" on the case note summaries, but that it had not been completed. Ms Rogers advised that this needed to be completed urgently and provided a list of 12 service users where there was "*no case note summary with sufficient covid 19 update*."

25. Ms Rogers states that, when she subsequently checked Mr Addo's cases after he had completed the RAG ratings, she found that he had not done what he had been asked, in that he had not made direct contact with families, and appeared to have submitted "green" RAG ratings without evidence of how he reached the decision.

26. During the Council's investigation, Mr Addo was asked whether he had sought support in relation to RAG ratings. He informed Mr Doe that he had not because he had updated all the records with a RAG rating. Mr Addo was asked about 12 cases which were still outstanding as at 24 April 2020, and said that "*to the best of his knowledge and ability he had added the RAG rating on all his cases and updated appropriately. The only ones missing were those where he had not managed to speak with the client, or those that had been contacted via email*."

Service User A

27. Ms Price's email to Mr Addo on 3 July 2020 raised a concern that Mr Addo had RAG-rated Service User A "*without any contact to determine how their situation is impacted by lockdown*." The case notes in relation to Service User A indicate that Mr Addo completed a case summary on 17 April 2020, which gave Service User A a "green" RAG-rating. Neither the case summary, nor the surrounding case notes, indicate that Mr Addo had had any kind of contact with Service User A around this time. The last entry into the case notes prior to the case summary on 17 April 2020 suggests that Mr Addo made a call to Service User A's accommodation on 13 February 2020 in order to try and arrange a visit, but was unsuccessful in doing so. Following the case summary being entered into the case notes, Mr Addo recorded further unsuccessful attempts to arrange a visit on 21 May 2020, 29 May 2020 and 1 June 2020.

Service User B

28. Ms Rogers comments that "[o]*n 20 April 2020, Mr Addo updated the RAG rating for Service User B but did not speak with Service User B or the family to determine this RAG rating*." The case notes in relation to Service User B indicate that Mr Addo completed a case summary on 20 April 2020, which gave Service User B a "green" RAG-rating. The case summary indicates that Mr Addo had not had any contact with Service User B or his family at the point of making this entry, as it states "*Telephone made to* [Service User B] *and support network re: update following the outbreak and restrictions*.

Awaiting response." Neither the case summary, nor the surrounding case notes, indicate that Mr Addo had had any kind of contact with Service User B (or his family) since December 2019. Following the case summary being entered into the case notes, Service User B's mother sent an email to Mr Addo on 7 May 2020 to report that the family was doing well. Mr Addo does not then appear to have made any attempt to have contact with Service User B until 9 June 2020 when he asks whether they can arrange a face time chat.

Service User D

29. With respect to Service User D, Ms Rogers comments that "[t]*he RAG rating was completed on 20 April 2020 and a green rating was allocated without speaking to the family"*. She goes on to say that "*[Mr Addo] has recorded that he has attempted to call but was unable to speak to the family and only left a voicemail.*" The case notes in relation to Service User D indicate that Mr Addo completed a case summary on 20 April 2020, which gave Service User D a "green" RAG-rating. As noted by Ms Rogers, the case summary confirms that Mr Addo had not had any contact with Service User D or his family at the point of making this entry, as it states "*I attempted to call* [Service User D] *and support network following the outbreak to get an update on their current circumstances, but was unable to speak to the family, however I left a VM requesting a callback from the family"*. Neither the case summary, nor the surrounding case notes, indicate that Mr Addo had had any kind of contact with Service User D (or his family) since February 2020. Following the case summary being entered into the case notes, Mr Addo sent Service User D's parents a copy of an assessment for their comments on 26 May 2020, but has not recorded any direct contact with Service User D until 22 July 2020.

Service User E

30. With respect to Service User E, Ms Rogers commented that "*[Mr Addo] updated the RAG rating on 20 April 2020 without speaking to the family*". She goes on to say that "*[Mr Addo] did not face time the family until 23 June 2020.*" The case notes in relation to Service User E indicate that Mr Addo completed a case summary on 20 April 2020, which gave Service User E an "amber" RAG-rating. The case summary confirms that Mr Addo had not had any contact with Service User E or his family at the point of making this entry, as it states "*I have attempted severally contacting* [Service User E] *and support network without success for an update on their situation and if the family will need any support following the COVID outbreak and the restrictions"*. Neither the case summary, nor the surrounding case notes, indicate that Mr Addo had had any kind of contact with Service User E (or his family) since February 2020. Following the case summary being entered into the case notes, Mr Addo has not recorded any contact with Service User E until 23 June 2020.

Service User H

31. Ms Rogers comments that "*[Mr Addo] updated the RAG rating on 20 April 2020 without contact with* [Service User H] *or the family*". She goes on to say that "*[Mr Addo] did not*

have a video call with H until 1 June 2020", and notes that he "*should have been in constant contact with the family throughout lockdown and should not have added the RAG rating before speaking to them.*" The case notes in relation to Service User H indicate that Mr Addo completed a case summary on 20 April 2020, which gave Service User H a "green" RAG-rating. The case summary confirms that Mr Addo had not had any contact with Service User H or his family at the point of making this entry, as it states "*Telephone call made to* [Service User H] *and support network re: update following the outbreak and restrictions. Awaiting response."* Neither the case summary, nor the surrounding case notes, indicate that Mr Addo had any kind of contact with Service User H (or his family) since March 2020 when there was an email exchange regarding direct payments. Following the case summary being entered into the case notes, Mr Addo has not recorded any contact with Service User H until 1 June 2020.

Service User L

32. The case notes in relation to Service User L indicate that Mr Addo completed a case summary on 17 April 2020 which gave Service User L a "green" RAG-rating. The case summary confirms that Mr Addo had not had any contact with Service User L or her family at the point of making this entry, as it states "*I attempted severally to contact* [Service User L] *on* [redacted] *following the restrictions for an update on her situation without success. I was unable to leave a message for the family to make contact. No facility on the phone to leave a message."* Neither the case summary, nor the surrounding case notes, indicate that Mr Addo had had any direct contact with Service User L (or her family) since December 2019. Following the case summary being entered into the case notes, Mr Addo has not recorded any contact with Service User L until 3 July 2020 when he visited her at home.

Service User O

33. Ms Rogers comments that "*[Mr Addo] reported to myself that he had been trying to get in touch with [Service User O] but had not had any luck.*" The case notes in relation to Service User O confirm that Mr Addo did not have any successful contact with Service User O at any point prior to 6 July 2020. The notes do not include a RAG rating.

Service User R

34. The case notes in relation to Service User R indicate that Mr Addo completed a case summary on 17 April 2020 which gave Service User R a "green" RAG-rating. The case summary indicates that Mr Addo had had contact with Service User R via email.

Other service users

35. With respect to service users C, F, G, J, K, M, N, P, Q, S, Mr Addo has commented that contact was made either with the respective service user, or with their support network, or both. With respect to Service User I, Mr Addo cannot remember whether he completed a RAG rating in an appropriate and/or timely way.

Allegation 2

36. Any contact which takes place on a case (i.e. email, call, visits in person and virtual visits) must be recorded on Liquid Logic ("LAS"), the Council's recording system. When a visit is conducted with a young person, this is recorded on the system as "*contact with a young person*." In order to constitute contact, a visit must take place in person face to face or virtually online via video call.

37. Ms Rogers mentioned to Mr Addo during supervision on 24 April 2020 that all his contacts were in red (i.e. had not been seen), and that she asked him to rectify this. The notes of the supervision on 24 April 2020 indicate that Mr Addo had been advised that "*the TOD* [Team Operational Dashboard] *has changed and now has an adult due to be seen section, which are largely red, advised on how to do this*."

38. In an email sent to Mr Addo on 19 May 2020, Ms Rogers stated "*I note that you Tod is green for all adult seen visits, however this isn't case you can not record attempted phone calls as contact with YP only home visits face to face with YP or successful video calls where you physically see them. Some of your notes you've dated May 2020 when you saw them in July 2019, so this looks like they have been seen when they haven't* [sic]."

39. Ms Rogers commented that "[i]*t was essential that these records were removed from the file. They were wholly inaccurate as some were just a repeat of historic contact with the service that were recorded as occurring recently. Other case notes were just completely wrong and said the Social Worker had 'seen' the service user when they had not.*" Ms Rogers arranged for the records where Mr Addo had incorrectly recorded contact with service users to be deleted. She produced a report generated by the Council's IT Team which shows which records were deleted in accordance with her instructions on 20 May 2020. This shows that Mr Addo had recorded contact or virtual contact with 16 service users (namely service users A, R, M, B, N, P, H, G, F, S, J, D, E, I, O and C) when he had not actually seen and/or spoken to them, and/or had not had recent contact with them. For example, with respect to:

    a. Service User A, the case note text refers to Service User A being seen on a previous occasion, namely "*during the last review.*"

    b. Service User R, the case note text refers to a meeting with professionals, which based on Service User R's case notes appears to reflect a meeting which had taken place in January 2020.

    c. Service users including M, N, H, G, J, E and C, the case note text indicate that Mr Addo had made telephone calls rather than having face to face or virtual contact, and in some instances suggest that he had only spoken to parents of the service users, rather than the service users themselves.

    d. Service User B, the case note text indicates that the entry related to a home visit on 12 August 2019, rather than recent contact.

e. Service User P, the case note text refers to seeing Service User P following a "CHC" assessment, which based on Service User P's case notes appears to have taken place in January 2020.

f. Service User F, the case note text indicates that Mr Addo had emailed, rather than have face to face contact.

g. Service users including D, I and O, the case note text indicates that Mr Addo had made unsuccessful attempts to contact the service users / their families via telephone.

h. Service User S, the case note text indicates that the most recent contact with Service User S was on 5 February 2020.

Allegation 3

40. During her investigation meeting with Mr Doe, Ms Price commented that "[u]*sually there is a minimum six-monthly visiting schedule however during this lockdown period there was an expectation that the contact would be much more frequent and mostly across the teams this was two weekly / monthly.*" Mr Price goes on to say that "[w]*hen looking at* [the Social Worker's] *case load it looked as though he hadn't had contact with some of his families for several months over lockdown. This was raised with him and he claimed said that he had made contact however Power BI wasn't reflecting what he said he'd done – there was a discrepancy in what he said he'd done and what's recorded.*"

41. Within her statement, Ms Rogers explains that "[p]*rior to lockdown social workers were required to conduct visits to service users at least every six months for both adults and children*", but that visits would sometimes be required more frequently, if for example a child was subject to child protection procedures or was a child in need. She goes on to say that "[d]*uring the COVID lockdown, depending on the RAG rating of clients, video calls were permitted for a period of time before face to face visits recommenced.*" She confirms that "*not all visiting requirements were the same, but all service users should have been visited every 6 months.*"

Service User G

42. Ms Rogers explains that Mr Addo was allocated to Service User G on 13 November 2018. The case notes for Service User G indicate that Mr Addo asked when it would be convenient for him to visit on 6 February 2019, but he did not make arrangements for a visit until almost 6 months' later on 5 August 2019. A record of the visit was entered on 8 August 2019. Subsequent entries indicate that there was an annual review in relation to Service User G organised by SEN Kent on 12 November 2019, however it is not clear whether Mr Addo and/or Service User G attended this. There is no evidence that Mr Addo visited (or saw) Service User G at any time between 5 August 2019 and 3 July 2020.

Service User L

43. Ms Rogers explains that Mr Addo was allocated to Service User L on 29 December 2019. She indicates that visits needed to be conducted every six months. The case notes for

Service User L indicate that Mr Addo completed an introductory visit on 18 December 2019. Although the case records indicate that Mr Addo subsequently made enquiries about visiting Service User L in College in or around February 2020, there is no evidence that he did so. There is no evidence that Mr Addo visited (or saw) Service User L at any time between 18 December 2019 and 3 July 2020, and no evidence that he had any alternative form of direct contact with her or her family between these dates.

44. Ms Rogers states that she raised with Mr Addo in supervision that he had not spoken to Service User L since December 2019, and advised him to book a visit as soon as possible. Ms Rogers produces a supervision note dated 2 July 2020 which confirms that she "*advised* [Mr Addo] *to call college and book to see her there and ask college if they have any up to date number* [...] *advised to book a visit asap tomorrow*." The case notes indicate that Service User L had not been attending College due to her health needs, and that Mr Addo only became aware of this as a result of making enquiries about a visit on 3 July 2020.

Service User N

45. Ms Rogers explained that Mr Addo was allocated to Service User N on 30 October 2018. She goes on to say that Service User N "*required* [...] *visits be conducted six monthly*." The case notes for Service User N suggest that a virtual visit / video call which took place on 26 May 2020 was more than a month overdue, as there is no evidence to suggest that Mr Addo had seen Service User N between 18 October 2019 and 26 May 2020. There are no entries of any kind recorded in the case notes in the six-month period between 18 October 2019 and 17 April 2020.

Service User O

46. Ms Rogers explained that Mr Addo was allocated to Service User O on 6 March 2020. Ms Rogers says that Mr Addo advised her during a supervision meeting on 2 July 2020 that "*he had been trying to get in touch with AH but has not had any luck*", and that she "*advised the [Mr Addo] to visit AH as soon as possible as we have not spoken to him at all for months*". She comments that Mr Addo "*should have conducted a visit upon allocation.*"

47. The earliest entry in the case notes for Service User O is dated 1 April 2020 and records an unsuccessful attempt at telephone contact. The subsequent entries indicate that Mr Addo made some further unsuccessful attempts to contact Service User O or his support network on 17 April, 13 May, 20 May, 27 May, 1 June and 26 June 2020. The records also include an entry which confirms that Mr Addo attempted to visit on 3 July 2020 (in accordance with the instructions given by Ms Rogers in supervision on 2 July 2020), but found out (via a call to Ms Rogers), that Service User AH had "*moved to supported accommodation about a month ago.*"

48. Ms Rogers confirms that she made a call on 3 July 2020 which was answered by Service User O's brother, and was informed that Service User O had moved to supported living. She comments that "[d]*ue to [Mr Addo] not completing the action necessary on this*

case, we did not know where AH was and his family thought he did not have a social worker."

Other service users

49. With respect to Service Users A, C, D, E, F, I and M, Mr Addo cannot remember whether he completed sufficient visits to them, or alternatively had an appropriate level of contact with them. With respect to Service User B, Mr Addo acknowledges that he initially had some challenges establishing contact with the service user, but states that he continued to make attempts and was eventually able to engage them successfully. With respect to Service Users H and J, Mr Addo states that contact was made with their support network.

Allegation 4

50. Part of Mr Addo's role was to complete assessments, which included Child and Family Assessments, and Care Act Assessments. Both these assessments had to be completed within 40 days of receiving the referral. Guidance was provided to the Team to help with completing assessments. Ms Rogers stated that "*[Mr Addo's] assessments often lacked information and did not reflect current information for the Service Users.*"

Service User C

51. Ms Rogers explains that Mr Addo was allocated to Service User C on 3 June 2018. She states that Service User C required a Care Act Assessment, and indicates that this had not been completed despite the referral being received on 1 January 2017. The case notes for Service User C suggest that Mr Addo liaised with the family to arrange a visit on 11 February 2020. However, it is not clear whether this was completed. Within emails recorded in an entry dated 16 April 2020, Mr Addo is asked "*When was his last review and when was the last assessment update*", however he does not appear to have responded to this query.

52. The supervision notes produced by Ms Rogers indicate that part of the "*Actions for next week*" which were discussed with Mr Addo on 24 April 2020 was for him to complete a needs assessment with respect to Service User C by 11 May 2020. However, the case notes indicate that Service User C was not seen by the Social Worker following this. Ms Rogers states that Mr Addo sent an assessment for review on 12 May 2020, but comments that it was "*not adequate and was returned for further comments*". She goes on to say that "[s]*everal bits of information were missing from the assessment including health information, GPS, health diagnosis and identity*" and that the "*assessment did not contain key information about C's behaviour, mental health and the concerns around this.*"

53. Within his investigation report, Mr Doe indicates that he had been provided with email evidence from Ms Rogers and Ms Price "*regarding the quality of assessments and assessments that were overdue or needed returning for amendments*," and states that this is "*evidenced in emails sent to* [Mr Addo] *in Appendix A.*" Appendix A contains an email dated 12 May 2020 from Ms Rogers in relation to Service User C which states:

"*I've reassigned [Service User C] to you, only for a few points:*

Can you complete on the (I think its first or second page) the bits where it asked whether he can make any decisions (for example his diagnosis impacts on him being able to understand or make decisions in complex cases). Also add his GP (for example, if he needed urgent respite, GP is important information they would require).

I know of [Service User C] when I worked in CDT, (not very well) but he did express challenging behaviours? If he still does, this does need to be evidenced in the behaviour section, how does he express, how is this managed, (I did read he expresses them at school.. do they have a behavioural support plan?)

It states in identity about activities to meet his health needs, but I'm not sure what his health needs are?

Finances, he is over 20 and parents manage his money, do they have deputyship.. as this is something they would need to go for.

When they leave him on his own, does [Service User C] understand what to do in an emergencies?

Hope this is okay, ring me if you need to. With these details whoever reads it will have a clearer picture of [Service User C]"

Service User O

54. Although Ms Rogers states that she is "*unsure when the Care Act Needs Assessment needed to be completed in respect to [Service User O]*", the record of supervision with Mr Addo on 29 May 2020 indicates that Ms Rogers had asked for the assessment in relation to Service User O to be completed by 29 May 2020. The assessment was not completed in accordance with this request as the notes of the subsequent supervision on 2 July 2020 state that the Social Worker has not been able to speak to Service User O. Ms Rogers confirms that "[i]*n our supervision meeting on 2 July 2020, [Mr Addo] reported to myself that he had been trying to get in touch with [Service User O] but has not had any luck.*"

55. The case notes for Service User O indicate that Mr Addo was aware of the requirement to complete an assessment with respect to Service User O, as the case summary entered on 17 April 2020 states that Mr Addo left a message "*to enable me to arrange a visit and complete an assessment following the case allocation.*" There is no evidence to suggest that Mr Addo ever completed the necessary Care Act Assessment.

Service User T

56. Ms Rogers explains that Mr Addo completed a Care Act Assessment for Service User T on 21 April 2020, but states that this was "*returned to [Mr Addo] for further amends as it was not sufficient*." She goes on to say that Mr Addo said that Service User T "*did not*

meet the criteria for support from our team and did not meet the eligibility assessment when he did.". She says that Mr Addo "*amended the assessment but again this was lacking in information*", although she is unable to recall specifically what information was lacking.

57. Ms Rogers goes on to say that Service User O "*was scored as low on the Deprivation of Liberty Safeguards ("DOLS") assessment criteria, when they were in fact high".* She explains that "*DOLS are used when a young person has restrictions in their care plan which they do not have capacity to consent to*." She states that Mr Addo had stated that "*as [Service User T] was under 18 and still lived at home an assessment was not needed. However this is not the case and as the Social Worker would have been informed at the DOLS training, we do DOLS for those living at home from 16 plus*". Ms Rogers comments that "[t]*he risk factor here was that [Service User T] was at risk of unlawful deprivation of liberty*." The notes of Ms Rogers' supervision with Mr Addo on 24 April 2020 refer to this concern. Ms Rogers states that Mr Addo would have had access to a DOLS screening tool form, and comments that there was also an allocated DOLS worker who was available for consultations.

Service User U

58. Ms Rogers explained that "[a] *Child and Family Assessment was required for Service User U as an update from the previous Children and Family Assessment which was completed by the previous social worker. [Mr Addo] sent this assessment for review on 1 May 2020. [Mr Addo] had left the previous social worker's details in the assessment and had just copied all of the information over and it the previous social workers name throughout which had not been changed.*" Ms Rogers goes on to say that "[t]*here was no report of the concerns regarding the incident which led to the Domestic Abuse Notification ("DAN") on 01 December within the assessment which was sent for review by [Mr Addo] on 1 May 2020*". She states that Mr Addo "*had not highlighted the risks within the assessment as he should have done*", and comments that "[t]*he assessment has to be returned three times to [Mr Addo] due to him not mentioning the risks with the assessment before it was completed.*"

59. Within his investigation report, Mr Doe indicates that he had been provided with email evidence from Ms Rogers and Ms Price "*regarding the quality of assessments and assessments that were overdue or needed returning for amendments*," and states that this is "*evidenced in emails sent to* [Mr Addo] *in Appendix A*". Appendix A contains an email dated 6 May 2020 from Ms Rogers in relation to Service User U which states "*I sent [Service User U] back to you for further amendments. In the scaling question bit there is still CB name. I also think it would be good to highlight the concerns we have had for [Service User U] at home in relation to his mothers relationships and how this could have impacted him.*" Appendix A contains a further email dated 12 May 2020 from Ms Rogers in relation to Service User U which states "*I have sent [Service User U] assessment back to you, there a few typos* [sic] *and I think that it needs to be mentioned in the harm and analysis about mums relationships and the impact this could have had on [Service User U]. We need to make it very clear that we are doing*

increased visits due to the concerns and this also needs to be mentioned in the parenting capacity as it doesn't read like we have concerns for [Service User U] in his mothers care, and we do." It is noted that the assessment was signed off "*after several returns but I did add in things within the worries as these were not recorded.*"

Service User S

60. Ms Rogers explains that "*Jane Price had to send a Care Act assessment back to [Mr Addo] on this case as he had not mentioned the concerns or education within the assessment and it had misleading information within it, such as '[Service User S] does not require an MCA' then referring to it regarding education.*"

61. Both Ms Rogers and Ms Price exhibit an email from Ms Price to Mr Addo dated 9 July 2020 which raises concerns in relation to the assessment. The email notes that there are factual errors within the assessment, and lists examples of these as follows:

> **"***1. In the first section you have selected that an MCA is not necessary, but you then refer to the MCA regarding education in the assessment. Therefore, please amend the first section and refer to your assessment (MCA).*
>
> *2. Accommodation details: Please change from Lives rent free to claiming Housing Benefit (which I assume is the case as he lives in supported living)*
>
> *3. As above, you have stated he lives with family, which should be living in supported living*
>
> *4. Education status: This was left blank*
>
> *5. Re Education, please add an update on what the education status is going forward. i.e. have they agreed* [Name of Provider] *placement in principle? Also, please add in your professional opinion the advantages/ disadvantages of the residential placement that is being requested in comparison to a supported living placement. Also explain that you will be taking this to the decision making panel, as they will need to approve the plan.*
>
> *6. How I feel and behave: Please add into the worries section the risk of placement breakdown and the impact his behaviour is having on other residents, such as safeguarding being raised for them due to* [JT2]*'s behaviour.*
>
> *7. In the meeting it was raised that* [JT2] *is likely to be better suited to a placement where other residents have less severe needs than him. I don't think this was reflected in the assessment."*

Other service users

62. With respect to Service Users A, B, D, E, K and N, Mr Addo cannot remember whether he failed to complete assessments and/or reviews, either adequately or at all.

<u>Allegation 5</u>

Service User S

63. Ms Rogers explains that she had provided assistance to find a supported living placement for Service User S, following concerns that he was physically and emotionally abusing his mother who was his primary carer. Ms Rogers indicates that, at the point of her becoming involved, both Service User S's mother, and his school, had raised safeguarding concerns which they felt had not been listened to.

64. The case notes include an email exchange between Mr Addo and Service User S's Mother in relation to his support plan in September 2019. Service User S's Mother commented that "[t]*here is nothing in there regarding our need for residential*" and raises concerns about the delay in organising respite.

65. Ms Rogers states that "[o]*n 17 December 2019 I completed a joint home visit with [Mr Addo]*", where "*[Service User S's] mum expressed that she felt that [Mr Addo] had ignored all of her cries for help and she felt let down and was very emotional*."

66. Ms Rogers states that Mr Addo "*did not respond appropriately to the concerns raised and the family and professionals felt unheard*". She comments that "*[Mr Addo] should have taken steps to safeguard the family by increasing the care package to include more respite and supported living could have been considered*". She goes on to say that Mr Addo "*could have also raised concerns with team managers and safeguarding leads to ascertain what next steps to take.*"

67. Ms Rogers says that, after Service User S had moved placement, "*myself and Jane Price had several case discussions with [Mr Addo] about [Service User S] and how he was doing. [Mr Addo] reported to myself and Jane Price that [Service User S] was happy and settled and that there were no issues*". The notes of Ms Rogers' supervision with Mr Addo on 29 May 2020 corroborate this, as it is noted that "*[Service User S] moved to supported living in January and this has been going well.*"

68. Ms Price indicates that she had concerns around Mr Addo not taking appropriate action in the time required, and refers to Service User S's case as an example of this. She states that "[Mr Addo] *was feeding back to me that everything was fine with this placement when it was not*", and that she "*found out that the placement was at risk of breaking down from another worker who had been informed by someone in the placement that things were not fine and they then raised those concerns with me.*"

69. Within his investigation report Mr Doe states that he "*found 13 reports from [Service User S's] provider (Appendix P) that had been emailed to [Mr Addo] with numerous concerns about [Service User S's] placement.*" He goes on to say that, having been given access to Mr Addo's email account, he "*noted that a number of these emails were unread at this point*". He sets out a list of the concerns raised, which include incidents of Service User S displaying threatening behaviour on occasions prior to June 2020. Mr Doe appended the reports in relation to Service User S to his report. These include a number of reports which refer to incidents which pre-date the assurance given by Mr Addo in supervision on 29 May 2020 (that the placement had been going well), namely:

a. An incident on 5 January 2020 where Service User S repeatedly ran away from staff;

b. An incident on 25 April 2020 where Service User S shouted, swore, caused damage and targeted other service users;

c. An incident on 30 April 2020 where Service User S displayed aggressive behaviours;

d. An incident on 1 May 2020 where Service User S targeted another service user and made threats;

e. An incident on 4 May 2020 where Service User S targeted another service user.

70. Ms Rogers explains that "*the provider informed me on 18 June 2020 that they were struggling to meet [Service User S's] needs*", and that they had been "*advised by [Mr Addo] that [Service User S] would only be in placement till September 2020.*"

71. Ms Rogers exhibits an email exchange between herself, Mr Addo and Ms Price dated 18 June 2020. The first email is from Ms Rogers to Mr Addo and Ms Price, and states:

> "*I have just returned from visiting my 2 young people at* [Placement], *where* [Service User S] *lives. Staff informed me they cant meet* [Service User S]*'s needs and cope with his extreme behaviours, they said they have sent you a number of behaviour logs. They were under the impression he was leaving in September for St Johns college, they said they cant meet his needs much longer and that he is targeting the other 2 people who live there. I would suggest you call them ASAP and book in a meeting and a date to see* [Service User S]*, as they seemed to be really struggling.* [sic]"

Within a response to the above email, Ms Price comments that "[t]*his is really concerning information, particularly as we have been discussing this a lot recently and the concerns were never raised.*"

72. During his investigation meeting with Mr Doe, Mr Addo stated that there had been "*no significant concerns*" raised with regards to [Service User S]'s placement, and that he had looked at the behaviour logs and responded "*but did not feel these were of any significance.*"

73. Ms Price explains that Service User S's placement was at risk of breaking down as he was "*in crisis*". She states that "[Mr Addo] *did not take the action required to strengthen the placement and did not identify a new placement*." She comments that "[t]*he expectation in such circumstances would usually be to assess what was negatively impacting on placement stability (i.e. behaviours) and whether anything could be done to reduce these, i.e. support from behaviour specialists*." She also comments that "[t]*he starting point would usually be to convene a meeting with those involved in providing care to agree an action plan*," and considers that Mr Addo "*should have asked*

for guidance from a supervisor, other senior or team manager in order to respond to any concerns about placement breakdown."

74. During her investigation meeting with Mr Doe, Ms Price referred to a concern regarding Mr Addo's delay in providing a decision-making panel request form, which she says was not provided until during the meeting. Within an email sent to Mr Doe on 9 November 2020, Ms Price explained that the request for Mr Addo to present to the panel was made on 24 June 2020. She refers to her subsequent email of 9 July 2020, which provided feedback on Service User S's assessment and asked Mr Addo to "*please request a slot at the Decision making panel and be prepared to share your professional opinion over which placement is required…*" Ms Price confirms that whilst Mr Addo sent her an incident report regarding Service User S on 16 July, "[n]*o reference was made regarding the panel report*". She went on to say that she emailed Mr Addo on 23 July 2020 "*about the parent complaining about the length of time it has taken to present this case at panel and that as a result of the delay in Sam sending this through, I have sought Area Manager agreement to present this case on Sam's behalf, despite the deadline having been missed*". Ms Price's email to Mr Addo dated 23 July 2020, confirms that Mr Addo had "*missed the deadline for this panel referral deadline*."

75. Ms Price went on to explain, in response to Mr Doe asking what was the "*issue in him submitting the report during the meeting*," that "[t]*he request was for the case to be discussed at panel prior to the follow up review, in order for the new information to then be shared. In order to achieve this, [Mr Addo] had to submit the report to panel within timescales to be heard.*" She additionally noted that there "*had been significant delay of several months for the decision about the placement to be made,"* and says "[t]*he placement was breaking down and this could have significant implications for the YP who had no placement agreed to move on to*." She states that "[s]*ubmitting the report during the meeting indicated to me that he was reminded of his task to do so by me asking and he was then focussed on writing the report, rather than on the discussion during the meeting*."

Service User R

76. Ms Rogers states that Mr Addo was allocated to Service User R on 17 July 2019. She states that "[a]*n updated Care Act Assessment was required for Service User R due to Service User R moving to his girlfriend's home and leaving education*", and goes on to say that "[t]*he assessment needed to be completed when Service User R left the family home.*"

77. Ms Rogers states that "[a] *Kent Adult Safeguarding Concern Form ("KASAF") should have also been completed as Service User R raised concerns that his girlfriend's sister was bullying him and hurting his girlfriend.*" She explains that the KASAF "*is a form which identifies concerns and then involves consulting with Ruth Headley (safeguarding lead for immediate safeguarding planning).*" Ms Rogers explains that Service User R reported via email to Mr Addo on 27 June 2020 "*that he was being bullied by his*

girlfriend's brother whom he lived with and that the brother had also assaulted his girlfriend." Ms Price also refers to this, and explains:

> "*On 27 June 2020 [Service User R] emailed [Mr Addo] stating that his girlfriend's brother was bullying him and strangled [Service User R]'s girlfriend with a rolling pin. On 30 June 2020 [Mr Addo] responded by email asking if there is anything he can do to help. [Service User R] responded the same day stating that [Mr Addo] does not appear to be saying anything about what he had told him. On 7 July 2020 [Mr Addo] emailed [Service User R] again, asking whether he is well and to give him a call. [Service User R] responded by email on 8 July 2020 stating he is fed up with [Mr Addo's] slow replies when he tells him something and he no longer needs a social worker.*"

78. Ms Price comments that "[Mr Addo] *responded to the young person casually and did not recognise the young person had highlighted risk.*" She goes on to say that "[t]*here is no written guidance on how [Mr Addo] should deal with such a situation, but these types of scenarios are discussed in safeguarding training.*" She says that "[w]*hen the Service User raised concerns around bullying, [Mr Addo] should have raised that email with me, a supervisor or a safeguarding lead as soon as possible. Contact then should have been made with the Service User to speak with him to get his wishes to see if he wanted to move placements and support him with his choice. If contact could not be established, a welfare visit should have been conducted. However, as this was not done, the Service User did not feel heard and we lost our trust to work with him*."

79. Ms Rogers adds that "[Mr Addo] *forwarded [Service User R]'s email to the safeguarding team but with subject as "hey" and [Mr Addo] did not follow this up with a call or in any way. Safeguarding did not see this for a while as the subject was "hey" and so it was not prioritised and it was not followed up by [Mr Addo].*" Ms Rogers says that Mr Addo "*should have called the safeguarding lead immediately when [Service User R] raised concerns*", and "*should have also raised a KASAF as there were clear risk indicators as [Service User R] himself and school had both raised concerns and [Mr Addo] had failed to take necessary actions to safeguard [Service User R] as a result of the concerns raised.*"

Service User U

80. With respect to Service User U, Mr Addo cannot remember whether he failed to take appropriate or timely action in response to concerns.

Allegation 6

81. Mr Doe was given access to Mr Addo's email account for the purposes of his investigation. He explains that, whilst sifting through the Mr Addo's emails for evidence, he found evidence that Mr Addo had forwarded emails from his work email address at the Council, and from an NHS email address to his personal email address.

82. Mr Addo acknowledged that "[t]*he forwarding of [...] case notes from the NHS email to my personal email and onto the @kent email was a grave mistake on my part and a poor*

error of judgment. I was trying to catch up on my work in the early hours of the morning. My actions were entirely work related and the motive was to try and catch up with my work. I accept my actions were wholly improper, given KCC ICT user policy and standards." He also acknowledged, with respect to the further email, that "*my action was a grave error and I exercised a very poor sense of judgment. I can however, assure everyone one there was no other motive than to accomplish my tasks. This will never happen again.*"

Summary of evidence:

83. Ms Rogers provided the following evidence:

    a. She did not have any direct work with Mr Addo until she started supervising him in October 2019. She conducted personal supervision and case supervision with Mr Addo on a monthly basis but we would also have ad hoc supervision if this was needed on cases.

    b. All case supervision would have been recorded on the individual case files. Mr Addo had between 27-30 cases at the time. Everyone in the team generally had around 30 cases at any one time but this could sometimes go up and down a couple.

    c. The concerns regarding Mr Addo started at the beginning of the Covid-19 lockdown in March 2020. The team was asked to RAG rate all of its cases from red to green in terms of whether contact was needed more frequently due to the pandemic or not. The RAG ratings were to highlight cases which needed extra support throughout lockdown. If there were no concerns about a family then they would be green but if they have had for example, a previous safeguarding concern, an unstable care package or if they had health concerns, then they would be rated as red.

    d. There were several meetings when lockdown first happened where the importance of RAG rating was raised. The RAG rating was needed on every case so the Council could identify all vulnerable people and could then have increased contact with them. On 16 March 2020, she sent the first email to the whole team asking that they complete the RAG rating as had been instructed by the Assistant Director, Sharon Howard. Ms Howard also sent an email to the whole team on 02 April 2020 outlining how to record Red RAG rating and what was required.

    e. Where a social worker could not access a service user in person or via videolink, attempts should be made to telephone call them, and failing that, an unannounced home visit.

    f. She was concerned about lack of progress as Mr Addo was not promptly RAG rating each of his cases. She had to ask him to complete the RAG ratings

several times. On 17 April 2020, she sent a further email to Mr Addo to request that his RAG ratings were completed. Ms Price also emailed Mr Addo on 17 April 2020 asking that the RAG ratings were updated urgently. Ms Rogers then sent a follow up email on 20 April 2020 in which she stressed that her request in her email on 17 April had not been actioned and needed addressing urgently. She asked that these were completed today and if they were not, that Mr Addo should contact her. The importance of RAG ratings was also mentioned regularly within all the team meetings.

g. When Mr Addo had completed the RAG ratings, she checked his and he had not done what he had been asked to do. In order to assess the RAG rating direct contact had to be made with the families via the telephone and Mr Addo had not done this. Mr Addo had RAG rated each case but had not spoken to the families on the phone, as was required. This was across all of his cases. Mr Addo knew this needed to be done as it was mentioned regularly in team meetings. In an email from Jane Price to Mr Addo on 2 July 2020, she highlighted concerns that Mr Addo had RAG rated without seeing or speaking to the families. She raised concerns that Mr Addo had appeared to have submitted "Green" RAG ratings without evidence of how he reached the decisions.

h. There was an audit regarding incomplete RAG ratings that was sent to managers. All of Mr Addo's cases were on the spreadsheet. She was part of the audit. She asked Mr Addo to update the RAG ratings by the following day but this was not completed as requested.

i. There was guidance on what to consider when completing the RAG rating and this guidance was sent around to the team:

    i. Who the Service User was living with, where they were living, and then their circumstances for lockdown were to be considered (i.e. school is closed so the young person is now being supported by their family full time).

    ii. The history of the young person and if there had been any previous concerns (i.e. parent's ability to manage this).

    iii. Young person's health needs to see if there was any risk if they caught Covid-19.

Contact was required to ascertain a RAG rating. A social worker had to speak to each family to see what their arrangements were and to check if there was anything they were worried about. A phone call had to be made on every case to obtain this information. If this phone call and initial enquiry was not made this was serious as the Council would not know their circumstances or if the young person is safe and well. The Council would not be aware of who was caring for them in the absence of the normal services (i.e. school) and what

impact the loss of the normal services was having on them and their family. The RAG rating for each case should have been recorded on the case file in the case note summary. The RAG rating was to be added there and highlighted so it was the first thing people saw when they went onto a case file.

j. Prior to lockdown, social workers were required to conduct visits to service users at least every six months for both adults and children. During the COVID lockdown, depending on the RAG rating of clients, video calls were permitted for a period of time before face-to-face visits recommenced.

k. Any contact which takes place on a case (i.e. email, call, visits in person and virtual visits) must be recorded on Liquid Logic, which is the platform / system used by the Council to record information. Mr Addo was aware of this requirement as she discussed this with him in supervision on 24 April 2020.

l. She mentioned to Mr Addo in supervision on 24 April 2020 that all of his Contacts were red i.e. had not been seen and asked him to rectify this.

m. She realised that Mr Addo had recorded "Contact with Young Person" but it was just an attempted phone call which had taken place, rather than a face to face, or virtual visit so it should not have been recorded as a Contact on the system. It therefore appeared as though Mr Addo had recorded contact with service users which did not take place. She emailed Mr Addo on 19 May 2020 to explain that he had recorded the visits incorrectly, and that this needed rectifying, as soon as possible. She explained to Mr Addo that it currently looks as though the young people on his case load had been seen when they have not and that this could be very problematic and dangerous should anything happen. Mr Addo would have been aware of how to record different types of contact with a young person, depending on what type of contact it was as it was regularly mentioned in team meetings, and she discussed this with him in supervision on 24 April 2020 and 29 May 2020.

n. Having realised that Mr Addo had inaccurately recorded contact with Service Users, she called IT on 20 May 2020 to rectify these mistakes. She believes that all of Mr Addo's records that were deleted were created on 19 May 2020. Unfortunately, deleting the records was the only option as they could not be amended once they had been submitted. It was essential that these records were removed from the file. They were wholly inaccurate as some were just a repeat of historic contact with the service user that were recorded as occurring recently. Other case notes were just completely wrong and said that Mr Addo had "seen" the Service User when he had not. If someone were to audit the file they would be presented with completely incorrect information which could jeopardise planning and provision of care moving forward. It was not necessary to remove all records that were poor quality;

just the ones that would have caused serious issues if someone were to audit the file.

o. As part of Mr Addo's role, he had to complete assessments. These assessments included Child and Family Assessments and Care Act Assessments. Both of these assessments have to be completed within 40 days of receiving the referral. Mr Addo's assessments often lacked information and did not reflect current information for the Service Users.

p. Service User A:

    i. Allocated to Mr Addo on 2 July 2018.

    ii. Open to social services due to her disabilities which required a care package.

    iii. Required a Care Act Assessment, an annual review and a care and support plan, and should have been visited every six months.

    iv. Mr Addo only did one home visit on 20 August 2018.

    v. Mr Addo was asked to do another visit in June 2020.

    vi. There is no plan or review on Service User A's file.

    vii. The first case note summary recorded by Mr Addo on Service User A's case was on 17 April 2020. However, Mr Addo only spoke to Service User A's support worker on this date and did not speak to Service User A directly.

    viii. In May 2020, Mr Addo added a contact that Service User A had been seen when they had not seen Service User A. The case notes were not of visits but of attempted phone calls.

    ix. On this case the RAG rating was added on 17 April 2020, and again on 28 May 2020 and 16 June 2020. This was supposed to be done in March 2020. Mr Addo had not spoken with Service User A prior to completing the RAG rating.

    x. Mr Addo would have been aware of the requirement to complete an assessment due to the training he completed, and through team meetings and emails received from managers. Mr Addo should have had meaningful visits and reviewed Service User A's needs and their care package. Mr Addo did not perform any meaningful visits or reviews of Service User A so he could update her needs and the care package offered.

q. Service User B:

    i. Allocated to Mr Addo on 22 May 2018.

ii. Disabled young person and had eligible needs under the Care Act.

iii. Required annual reviews, six monthly visits, a care and support plan and annual assessments.

iv. There is no contact recorded with the family upon allocation in May 2018.

v. On 20 April 2020, Mr Addo updated the RAG rating for Service User B but did not speak with them or their family to determine this RAG rating.

vi. Mr Addo should have had contact with Service User B at the start of Covid-19 to check their circumstances.

vii. The case notes do show attempts made by Mr Addo to arrange a visit in December 2019. Mr Addo attempted to call the family when adding a case summary on 20 April 2020, however there was no answer and the family did not respond until 7 May 2020.

viii. Mr Addo did not complete a review, a plan or an assessment for Service User B.

ix. Mr Addo was asked to complete the needs assessment for Service User B for 24 April 2020.

x. A visit was conducted to Service User B on 9 January 2019 in regards to an unexplained injury. However, the visit does not record any actions (i.e. follow up with safeguarding).

r. Service User C:

i. Allocated to Mr Addo on 3 June 2018.

ii. Disabled young person and had eligible needs under the Care Act.

iii. Service User C's case notes show minimal evidence of direct work with Service User C and there is no evidence of any telephone calls, emails, visits or virtual calls with them.

iv. The RAG rating was added by Mr Addo on 23 April 2020 without any contact with Service User C or their family.

v. A Care Act Assessment was required for Service User GS. The referral was received on 01 January 2017 so the assessment would have been due 40 days after this.

vi. Mr Addo sent the assessment for review on 12 May 2020 but it was not adequate and was returned for further comments. Several bits of information were missing from the assessment including health information, GPS, health diagnosis, behaviour and identity.

vii. Mr Addo recorded CV19 Virtual Contact which requires that he sees the Service User virtually via video link. However, the case note text suggests that this was a telephone call following up on an email. This should have been recorded as a "Telephone call out".

s. Service User D:

i. Allocated to Mr Addo on 29 October 2019.

ii. Disabled young person and had eligible needs under the Care Act and a care package.

iii. The first case record that Mr Addo recorded on this file was from 07 February 2020.

iv. The RAG rating was completed on 20 April 2020 and a green rating was allocated without speaking to the family. Mr Addo recorded that he has attempted to call but was unable to speak to the family and only left a voicemail.

v. There is minimal information recorded for this case. Young people are usually seen six monthly but when a new worker is allocated there should be an introduction visit. No visit or introduction was made by Mr Addo and no visit was carried out until 3 July 2020. According to the case note, Mr Addo did not actually see Service User D on 3 July 2020 as he had gone out.

vi. Mr Addo was advised that he needed to visit the family and did so on 22 July 2020.

vii. There was no review on file for Service User D and no assessment/care plan.

viii. On 22 May 2020, the Social Worker submitted an incomplete assessment and said that Service User D had agreed with the assessment despite never seeing him or speaking to him. Ms Rogers therefore sent the assessment back to Mr Addo via email on 22 May 2020 and asked him to complete the assessment and to call Service User D and his support network to get further information. This was not completed so in supervision on 29 May 2020, Ms Rogers asked Mr Addo to complete the assessment by the end of the same day, 29 May 2020.

t. Service User E:

i. Allocated to Mr Addo on 22 August 2018.

ii. Disabled young person and had eligible needs under the Care Act.

iii. The case records show that Mr Addo carried out an introductory visit on 1 October 2018, and subsequent home visits on 28 June 2019 and 17 September 2019. Mr Addo also recorded on virtual visit with Service User E on 23 June 2020 which was shown on the system. Service User E needed to be visited every 6 months.

iv. Mr Addo had the case from August 2018 until he left the team in July 2020 and a review was not completed in that period. No reviews can be seen on file.

v. Mr Addo updated the RAG rating on 20 April 2020 without speaking to the family. Mr Addo did not FaceTime the family until 23 June 2020.

vi. Mr Addo has recorded CV19 Virtual Contact when in fact he had not seen Service User E and their support network via video link. The case note text shows that this was a phone call and therefore needed to be recorded as Telephone Call Out.

u. Service User F:

i. Allocated to Mr Addo on 11 June 2018.

ii. Disabled young person.

iii. The case notes show that Mr Addo recorded no successful visits to Service User F's family. On 12 June 2018, Mr Addo called the family to arrange a visit but there was no answer. He also appeared to have attempted an unannounced home visit on 25 September 2019 which was recorded as a successful visit but the notes clearly state that it was not. Mr Addo was required to visit Service User F every six months.

iv. The RAG rating was updated on 20 April 2020 without speaking to the family.

v. Mr Addo exchanged an email with Service User F on 13 May 2020 but did not have contact via video call or face to face.

vi. In May 2020, Mr Addo also added a "*contact young person*" seen when he had not seen them.

v. Service User G:

i. Allocated to Mr Addo on 13 November 2018.

ii. Disabled young person and had eligible needs under the Care Act.

iii. The case notes referred to CV19 Virtual Contact (via video link). However, the case note text clearly stated that this is a telephone call.

w. Service User H:

i. Allocated to Mr Addo on 30 January 2019.

ii. Disabled young person and had eligible needs under the Care Act.

iii. There were no visits recorded on the file by Mr Addo, who was required to visit Serviced User H every six months.

iv. Mr Addo updated the RAG rating on 20 April 2020 without contacting Service User H or their family. Mr Addo did not have a video call with MK until 1 June 2020.

x. Service User I:

i. Allocated to Mr Addo on 31 January 2019.

ii. Young lady with complex needs including autism and learning disabilities.

iii. The earliest record on file for Mr Addo is 06 February 2020.

iv. Mr Addo updated the RAG rating to green on 20 April 2020 without speaking to the family or Service User I.

v. Mr Addo had no telephone or video contact with the family during Covid-19.

vi. Mr Addo has recorded that he had performed a welfare check to determine Service User I's RAG rating.

vii. Mr Addo allocated a CV19 Virtual Contact to the case note to confirm that he had had virtual contact with Service User I. However, it states in the case note text that he is "awaiting response" after making a telephone call.

y. Service User J:

i. Mr Addo recorded a telephone call with Service User J's mother as "Contact with Young Person" in the case notes, when this was not the correct designation.

z. Service User K:

i. Mr Addo recorded visits on 30 January 2020 (recorded on 5 February 2020) and July 2020 (as a "communication").

ii. Mr Addo recorded a RAG Rating as Green on 13 May 2020. The record states that Mr Addo attempted to call the family and Service User K's support network on 11 May 2020. However, he was unable to get through so left a voicemail.

iii. A Child and Family Assessment was to be completed by Mr Addo on this case as Service User K was a child with disabilities who had

moved from France to Kent. A translator was required to complete the assessment as the family's primary language was French. The translator never received the invitation to attend the meeting as Mr Addo sent the email to the incorrect email address. Consequently, the meeting had to be rearranged.

iv. Child and Family Assessments should be completed within 40 days of receiving the referral and the child should be seen within 10 days of the referral. The referral for Service User K was received on 6 December 2019. However, the assessment was not completed by Mr Addo at all and so was done by a manager on 18 September 2020 meaning the assessment was seven months out of timescale.

v. Mr Addo sent the family a blank assessment via email for them to complete. Mr Addo should have completed the assessment and then sent it for review internally to a team manager as they reviewed all of the assessments.

vi. She emailed Mr Addo on 11 May 2020 to outline the discussion they had in regards to this family and the actions he needed to take.

aa. Service User M:

i. Allocated to Mr Addo on 7 August 2018.

ii. On 20 August 2018, Mr Addo recorded an introductory Home Visit which had taken place on 17 August 2018. Mr Addo did not then visit Service User M until 8 June 2020, when Ms Rogers asked him to make contact.

iii. Mr Addo recorded two visits as virtual during the Covid-19 pandemic as virtual visits, when they were telephone calls.

bb. Service User N:

i. Allocated to Mr Addo on 30 October 2018.

ii. Mr Addo conducted an introductory home visit on 21 November 2018.

iii. Mr Addo failed to complete an assessment or PP1. There is no evidence of Mr Addo working directly with Service User N to gather his views, wishes and feelings.

iv. A record was deleted as it inaccurately recorded virtual contact with Service User N when the case note clearly states that it was a telephone call with "mum and [Service User N]".

cc. Service User P:

i. Allocated to Mr Addo on 22 May 2018.

ii. Had complex health and social care needs.

iii. No plan on file which had been completed by Mr Addo.

dd. Service User Q:

i. Allocated to Mr Addo on 23 May 2018.

ii. There is no review completed by Mr Addo on file which should have taken place annually. There is no evidence of any meaningful direct work with RG. Mr Addo should have had contacted Service User Q to gather their views, discuss any concerns they had and ensure their wishes and feelings are at the centre of the review process.

ee. Service User S:

i. Mr Addo had recorded that Service User S had been seen on 05 February 2020, as part of the RAG rating determination. However, this visit was too far ahead of the COVID-19 RAG rating to be considered as part of that activity.

ii. Mr Addo should have prioritised this case and had frequent visits to Service User S and his family to consider supported living, an increase in the care package, considered a Coordinated Community Response and involved the multi-disciplinary team around the issues with Service User S. This was required as Service User S was being violent towards his family who were his primary carers and they felt unsafe and unsupported.

iii. Ms Price had to send a Care Act assessment back to Mr Addo as he had not mentioned the concerns or education within the assessment and it had misleading information within it, such as "[Service User A] does not require an MCA" but then refers to it regarding education in the assessment.

iv. Mr Addo also failed to update Service User S's record to reflect that he no longer resided at home but in a placement.

ff. Service User U:

i. On a Child in Need plan due to disabilities.

ii. Witnessed domestic violence.

iii. There was an urgent request for Mr Addo to contact Service User U's mother on 6 February 2019. However, there is no evidence that this was followed up by Mr Addo until 12 February 2019.

iv. A Domestic Abuse Notification ("DAN") had been received on 01 December 2019 from the Police. There was no evidence of Mr Addo having a conversation with Service User U's mother around the

incident and offering any support such as Domestic Abuse Volunteer Support Services ("DAVS"). Mr Addo failed to recognise the risk of the situation and did not take the necessary action to safeguard Service User U or his mother.

v. Further to the DAN received on this matter, on 11 December 2019, Service User U spoke to Mr Addo about wanting to poison himself. On 13 December 2019, Service User U ran in front of cars saying he wished to die. Service User U had also told Mr Addo about this incident. However, there was no evidence of any follow up on these two incidents by Mr Addo.

84. Ms Price provided the following evidence:

a. She had been a part time Team Manager for the West Kent Disabled Young People's Team at the Council from October 2019 until January 2023. Prior to October 2019, she was a Senior Practitioner in the same team. She was never Mr Addo's supervisor.

b. During team meetings, they would discuss Covid related things such as the requirement of completing regular contact with children, updating the Covid risk RAG rating on the case note summaries and any case direction raised by management would be passed down to the workers. During the meeting, the management would also ask the workers how they were getting on with their work and it was a space for them to raise any worries or issues they had in regards to the current working circumstances. It was a way of keeping in touch with each other during COVID. She does not recall Mr Addo raising any particular concerns during these meetings.

c. The Covid RAG rating was established when Covid began so the Council could keep track of the higher risk cases and help determine which cases needed more intervention. The RAG rating would establish the cases of concern and highlight any young people who the Council was concerned about, including the impact Covid was having on them, if there were concerns about their care needs being met, or concerns about safeguarding as the children were not in school.

d. Concerns regarding Mr Addo came to light when his supervisor at the time, Ms Rogers, completed a QA (quality assurance) of his cases.

85. Mr David Doe provided evidence that during the time of these concerns, Mr Doe was a Service Manager in the Community and Adult Short Break team at the Council. He was in this role when he undertook the disciplinary investigation into Mr Addo.

86. Mr Addo provided the following evidence:

a. During his time with the Council, he worked with dedication and commitment to supporting vulnerable service users. He consistently aimed to uphold the values and expectations of the social work profession. He acknowledged that during the relevant period leading to these proceedings, there were areas of his practice that did not meet the expected standards. The allegations relate to:

    i. delays in completing visits;

    ii. breach of confidentiality;

    iii. incomplete assessments;

    iv. incomplete RAG ratings; and

    v. concerns raised by some service users.

    He recognises the seriousness of these concerns and has reflected deeply on the circumstances surrounding them.

b. This period was marked by exceptional system pressures, including:

    i. Impact of COVID-19

        1. There were sudden changes in service delivery models.

        2. Communication from management was often unclear, inconsistent, or delayed due to the rapid pace of change.

        3. Remote working created gaps in supervision, oversight, and clarity about expectations.

        4. Caseloads were high, and risk prioritisation processes changed frequently.

        These factors significantly affected his ability to meet deadlines and complete documentation to the expected standard.

    ii. [PRIVATE]

c. He acknowledges that some service users raised complaints regarding:

    i. delays in communication;

    ii. late visits; and

    iii. incomplete actions.

    He takes these concerns seriously and has reflected carefully on how his actions may have affected them. He accepts that service users should not bear the burden of organisational pressures or personal challenges. He remains committed to learning from this feedback.

d. He fully recognises that elements of his practice during this period did not align with Social Work England's professional standards, including:

    i. maintaining clear, accurate, and timely records;

    ii. effective communication;

    iii. managing risk appropriately;

    iv. upholding confidentiality; and

    v. ensuring service user wellbeing remains central.

e. He takes responsibility for these shortcomings. Since the allegations were raised, he has undertaken significant training and reflective work to improve his practice, including:

    i. Safeguarding;

    ii. risk assessment;

    iii. confidentiality;

    iv. RAG rating;

    v. DoLS;

    vi. reflective practice;

    vii. record-keeping;

    viii. communication and time management; and

    ix. professional standards refreshers.

f. He has obtained character references and engaged in ongoing reflective exercises to build insight.

g. He has taken proactive steps to strengthen his practice and ensure these issues do not recur. His learning includes:

    i. improved understanding of priority setting and workload management;

    ii. clearer appreciation of the importance of timely documentation;

    iii. deeper insight into the impact of delays on service users;

    iv. enhanced knowledge of safeguarding thresholds and risk assessment; and

    v. strengthened professional boundaries and confidentiality awareness.

h. He is now more confident in identifying support needs early and communicating difficulties more transparently to management.

i. He is committed to upholding the values, ethics, and standards of the social work profession. He has learnt deeply from this experience. He remains willing, motivated, and capable of practising safely, ethically, and effectively.

j. His actions since the allegations demonstrate:

    i. Reflection;

    ii. Insight;

    iii. Accountability;

    iv. Learning; and

    v. a strong desire for improvement.

k. He completed the ASYE at the Council. He accepted that the ASYE is intended to support him to reach the intended standards for social workers, by instilling the right skills and knowledge.

l. He understood the responsibility to keep accurate records of work.

m. He accepted and knew that he had to visit all service users under his responsibility. He knew that he had to document all of these visits.

n. He accepts that some of the visits may not have been documented properly as he was referring to another form of communication, but made a note that these were via a videocall.

o. He had frequent supervision.

p. Although he felt he was managing his case load well, he could have obtained further help from supervisors.

q. He accepts that he did not complete RAG ratings for a number of service users. He struggled to complete some given delays in getting hold of service users through a videocall.

<u>In relation to Allegation 1:</u>

r. Service User C:

    i. There was no RAG rating completed for Service User C in March 2020.

    ii. The RAG rating was completed on 23 April 2020. This was a green entry despite not having spoken to Service User C or their family. Although, he did speak to Service User C's mother later on 23 April 2020.

    iii. He did not complete a RAG rating as asked by Ms Rogers on 17 April 2020.

iv. He accepts that he did not complete the RAG rating in a timely manner. However, he was unsure given the continually changing requirements for recording interactions with service users.

s. Service User F:

i. There was no RAG rating completed for Service User F in March 2020. He cannot recall when he last dealt with Service User F.

ii. The RAG rating was completed on 20 April 2020. This was a green entry despite not having spoken to Service User F or their family.

iii. He did not complete a RAG rating as asked by Ms Rogers on 17 April 2020.

iv. Some of his recordings were deleted which would explain why there was no RAG rating for Service User F.

v. He accepts that he did not complete the RAG rating in a timely manner. However, he was unsure given the continually changing requirements for recording interactions with service users. He gave a green RAG rating based on Service User F's history.

vi. He sent an email to check on Service User F on 13 May 2020. Service User F responded on 14 May 2020.

t. Service User G:

i. There are no case notes from 27 February 2020 to 20 April 2020.

ii. There was no RAG rating completed for Service User G in March 2020.

iii. The RAG rating was completed on 20 April 2020.

iv. He did not complete a RAG rating as asked by Ms Rogers on 17 April 2020.

v. He accepts that he did not complete the RAG rating in a timely manner. However, he made all reasonable efforts to speak with Service User G and it was never his intention to refuse to complete RAG ratings.

u. Service User I:

i. There are no case notes from 26 February 2020 to 20 April 2020.

ii. There was no RAG rating completed for Service User I in March 2020.

iii. The RAG rating was completed on 20 April 2020. This was a green entry despite not having spoken to Service User I or their family. He only had contact with Service User I's family in June 2020.

iv. He did not complete a RAG rating as asked by Ms Rogers on 17 April 2020.

v. He accepts that he did not complete the RAG rating in a timely manner. However, he cannot remember when he got information in relation to Service User I during the Covid-19 pandemic.

v. Service User J:

i. There are no case notes from 17 January 2020 to 20 April 2020.

ii. There was no RAG rating completed for Service User J in March 2020.

iii. The RAG rating was completed on 20 April 2020. This was a green entry.

iv. He did not complete a RAG rating as asked by Ms Rogers on 17 April 2020.

v. He accepts that he did not complete the RAG rating in a timely manner.

w. Service User K:

i. There was no RAG rating completed for Service User K in March 2020.

ii. The RAG rating was completed on 13 May 2020. This was a green entry despite not having spoken to Service User K or their family. He made several attempts to speak with Service User K's mother between February and May 2020, but these were unsuccessful. He managed to engage in an email exchange with Service User K's mother between 11-12 May 2020, but Service User K's mother did not respond to Mr Addo's question about how Service User K was doing.

iii. He did not complete a RAG rating as asked by Ms Rogers on 17 April 2020.

iv. He accepts that he did not complete the RAG rating in a timely manner.

x. Service User M:

i. There are no case notes from 23 March 2020 to 17 April 2020.

ii. There was no RAG rating completed for Service User M in March 2020.

iii. The RAG rating was completed on 17 April 2020 following Ms Rogers' instruction. This was a green entry.

iv. He accepts that he did not complete the RAG rating in a timely manner.

y. Service User N:

i. There are no case notes from 18 October 2019 to 17 April 2020.

ii. There was no RAG rating completed for Service User N in March 2020.

iii. The RAG rating was completed on 17 April 2020 following Ms Rogers' instruction.

iv. He accepts that he did not complete the RAG rating in a timely manner.

z. Service User P:

i. There are no case notes from 27 March 2020 to 17 April 2020.

ii. There was no RAG rating completed for Service User P in March 2020.

iii. The RAG rating was completed on 17 April 2020 following Ms Rogers' instruction. This was an amber entry. There is no indication that Mr Addo spoke to Service User P or their support network prior to completing the RAG rating. After completing the RAG rating, Mr Addo received an update concerning Service User P.

iv. He accepts that he did not complete the RAG rating in a timely manner.

aa. Service User Q:

i. There was no RAG rating completed for Service User Q in March 2020.

ii. The RAG rating was completed on 17 April 2020 following Ms Rogers' instruction.

iii. He accepts that he did not complete the RAG rating in a timely manner.

bb. Service User S:

i. There was no RAG rating completed for Service User S in March 2020.

ii. The RAG rating was completed on 21 April 2020 following Ms Rogers' instruction.

iii. He accepts that he did not complete the RAG rating in a timely manner.

iv. He accepts that he did not complete the RAG rating in an appropriate manner on 17 April 2020.

<u>In relation to Allegation 3:</u>

cc. He was aware of the requirement to visit service users every six months.

dd. He was aware that during the Covid-19 pandemic, there was no need for face-to-face visits, but that service users still needed to be seen every six months.

ee. He knew that there was an expectation that there needed to be regular contact with service users and their families.

ff. Mr Addo said that he would record completed visits.

gg. Service User A:

i. In his written submissions, he could not remember whether he completed sufficient visits to this service user.

ii. He made a home visit on 20 August 2018.

iii. Prior to 17 April 2020, some unsuccessful visits were attempted by Mr Addo with Service User A. But there was no contact since 20 August 2018.

iv. There is an email on 18 November 2019 suggesting that a visit would take place in November 2019. However, there is nothing in the notes to suggest that a visit took place.

v. Contact was made with Service User A on 26 June 2020.

vi. Although this was a service user that Mr Addo stated that he visited quite frequently, it looks like from the notes that Service User was not visited for approximately two years.

vii. He accepts that there was not an appropriate level of contact with this service user.

hh. Service User B:

i. The case was allocated to Mr Addo on 25 May 2018.

ii. He made a home visit on 14 August 2018; approximately three months after the case was allocated to him.

iii. He met the service user and their support network on 5 November 2018.

iv. He was present at a joint visit on 9 January 2019.

v. The next entry in the case notes is a home visit on 12 August 2019; more than six months later.

vi. There is no further evidence of a visit until 22 June 2020, although he made contact with the family in May 2020.

vii. The service users notes set out that contact during covid-19 should be every two weeks.

viii. He accepts that there was not an appropriate level of contact with this service user and their family.

ii. Service User C:

i. In his written submissions, he could not remember whether he completed sufficient visits to this service user.

ii. There appear to be a few case note entries suggesting that Mr Addo planned to visit between July and November 2018. However, no visits were recorded between November 2018 and February 2020.

iii. Between 11 February 2020 and 6 April 2020, there was no contact with the service user's family. There is a case note of one telephone call after that.

iv. He considers it more likely than not that he did not complete a visit to the service user every six months.

v. He accepts that there was not an appropriate level of contact with this service user.

jj. Service User D:

i. In his written submissions, he could not remember whether he completed sufficient visits to this service user.

ii. He was allocated this service user on 23 October 2019.

iii. The only notes of Mr Addo visiting this service user are in July 2020. Although he did send an email to the family on 26 May 2020.

iv. He considers it more likely than not that he did not complete a visit to the service user every six months.

v. He accepts that there was not an appropriate level of contact with this service user.

kk. Service User E:

i. In his written submissions, he could not remember whether he completed sufficient visits to this service user.

ii. He was allocated this service user on 3 June 2018.

iii. He arranged his first visit with the service user on 4 September 2018; almost three months after the case was allocated to him. This visit was cancelled. The actual first visit took place on 1 October 2018; almost four months after the case was allocated to Mr Addo.

iv. A planned visit on 4 February 2019 was cancelled. The next successful visit in the case notes was in June 2019; almost nine months following the previous visit.

v. He arranged visits, but these were cancelled by Service User E's mother. He struggled to get in touch with Service User E and their support network.

vi. He completed a further visit on 17 September 2019.

vii. He arranged a visit on 2 March 2020, which was postponed to 11 March 2020, but the case notes state that the visit in March did not go ahead.

viii. Although he tried to contact Service User E and his support network on many occasions, these attempts had been unsuccessful.

ix. The next successful visit was on 24 June 2020.

x. He considers it more likely than not that he did not complete a visit to the service user every six months.

xi. He accepts that there was not an appropriate level of contact with this service user.

ll. Service User F:

i. In his written submissions, he could not remember whether he completed sufficient visits to this service user.

ii. The case was allocated to Mr Addo in June 2018.

iii. The case notes show that Mr Addo did not conduct any visits to Service User F or their family until 30 June 2020.

iv. A visit on 12 November 2018 was cancelled by Mr Addo due to work commitments.

v. The service user's notes set out that contact during covid-19 should be twice a month by email and telephone.

vi. On 30 June 2020, Mr Addo saw Service User F in a joint videocall.

vii. He considers it more likely than not that he did not complete a visit to the service user every six months.

viii. He accepts that there was not an appropriate level of contact with this service user.

mm. Service User H:

i. The case was allocated to Mr Addo on 30 January 2019.

ii. The case notes show that Mr Addo did not conduct any visits to Service User H or their family until 1 June 2020. Although a visit was discussed in November 2019 to take place on 6 December 2019, there is no evidence to suggest that this went ahead.

iii. The service user's notes set out that contact during covid-19 should be every two weeks.

iv. He considers it more likely than not that he did not complete a visit to the service user every six months.

v. He accepts that there was not an appropriate level of contact with this service user.

nn. Service User I:

i. In his written submissions, he could not remember whether he completed sufficient visits to this service user.

ii. The case was allocated to Mr Addo on 31 January 2019.

iii. The earliest case notes for Service User I was 6 February 2020; over a year after the case was allocated to Mr Addo.

iv. The service user's notes set out that contact during covid-19 should be every two weeks.

v. He considers it more likely than not that he did not complete a visit to the service user every six months.

vi. He accepts that there was not an appropriate level of contact with this service user.

oo. Service User J:

i. The earliest case notes for Service User J was 7 October 2019.

ii. The first telephone call was on 20 April 2020. This was recorded incorrectly on the case notes as a videocall.

iii. There were no attempts to visit Service User J from October 2019 to July 2020.

iv. The service user's notes set out that contact during covid-19 should be twice a month.

v. He considers it more likely than not that he did not complete a visit to the service user every six months.

vi. He accepts that there was not an appropriate level of contact with this service user.

pp. Service User M:

i. In his written submissions, he could not remember whether he completed sufficient visits to this service user.

ii. He completed an introductory meeting on 17 August 2018.

iii. His next meeting with Service User M was on 8 June 2020.

iv. He considers it more likely than not that he did not complete a visit to the service user every six months.

v. He accepts that there was not an appropriate level of contact with this service user.

In relation to Allegation 4:

qq. For a number of service users, he cannot remember why there was no review on file.

rr. Service User A:

i. He cannot remember whether he completed an adequate review.

ii. On 29 May 2020, there is a note for Mr Addo to book a date and time for a PP2 review. Mr Addo was aware that he needed to complete a review.

iii. On 13 June 2020, a further supervision note sets out that the review of Service User A needs to be completed.

iv. It is likely that he did not complete the review.

ss. Service User B:

i. He cannot remember whether he completed an adequate assessment.

ii. Mr Addo was aware that he needed to complete an assessment for Service User B by 11 May 2020. Further, he was aware that he needed to speak to Service User B before he completed the assessment.

iii. Mr Addo had not completed the assessment by 9 June 2020. It was only on 22 June 2020 that Mr Addo had a WhatsApp videocall with Service User B.

iv. It is likely that he did not complete the assessment.

tt. Service User D:

i. He cannot remember whether he completed an adequate assessment.

ii. On 22 May 2020, the case notes set out that Mr Addo submitted an incomplete assessment as he had not spoken to the Service User

prior to completing the assessment. Mr Addo provided evidence that he would never complete an assessment without speaking to a service user. This has never been part of his practice and comes as a shock to him.

iii. He managed to get hold of Service User D after initially struggling to do so.

iv. Ms Rogers asked for a completed assessment by 29 May 2020.

v. There are no case note entries between 29 May 2020 and 3 July 2020.

uu. Service User E:

i. He cannot remember whether he completed an adequate review.

ii. Reviews for Service User E should have been completed annually.

iii. Mr Addo did not complete a review for Service User E between August 2018 and July 2020.

iv. On 28 October 2019, he was aware that Service User E's care package was to be reviewed.

v. On 16 April 2020, it was noted that Service User E's care package still needed to be reviewed.

vi. On 23 June 2020, he made virtual contact with Service User E.

vii. It is likely that he did not complete an adequate review.

vv. Service User K:

i. He cannot remember whether he completed an assessment.

ii. A Child and Family assessment was needed for Service User K.

iii. Service User K was to be seen within ten days of being referred to Mr Addo, which was 6 December 2019. This visit took place on 30 January 2020. At this visit, he said he would arrange a meeting to complete the assessment, which needed to be completed within 40 days.

iv. Mr Addo made several unsuccessful attempts to call the family, whose first language was not English.

v. On 11 May 2020, Ms Rogers sent an email to Mr Addo asking about the assessment. By this date, the assessment would have been overdue.

vi. As Mr Addo was struggling with this family, Ms Rogers suggested alternative options.

vii. On 12 May 2020, Mr Addo sent an email to Service User K's mother, to which a response was received on the same day.

viii. Mr Addo followed up with the family on19 May 2020 and 27 May 2020.

ix. Mr Addo only raised the issue of translation needed with the family on 24 June 2020.

x. On 6 July 2020, Mr Addo attended the home of Service User K and their family, but there was no translator available.

xi. It is more likely that not that Mr Addo did not complete an assessment.

ww. Service User N:

i. On 24 April 2020, Mr Addo knew that an assessment for Service User N needed to be completed.

ii. There was not assessment on file by 26 May 2020.

iii. It is more likely than not that Mr Addo did not complete an adequate assessment.

In relation to Allegation 5:

xx. Service User U:

i. He cannot remember whether he took appropriate or timely action.

ii. Mr Addo did not receive the DAN and has never seen this document, so he cannot comment on it.

iii. He cannot recall or remember whether Service User U told him that he wanted to poison himself or run in front of cars and die.

iv. If this did happen, he would have contacted the Safeguarding Lead and told Ms Rogers. He would have ensured that Service User U was safe and protected.

v. If he was aware of this, he would have followed procedures and guidance. He would be surprised if he had not taken any action.

Finding and reasons on contested facts:

87. The panel accepted the advice of the Legal Adviser.

Allegation 1 – You did not complete "RAG" ratings with respect to one or more of the service users identified in Schedule 1 in an appropriate and/or timely way:

88. The panel refers to paragraphs 18-26 set out above.

Service User C:

89. Having taken into account the case notes, the oral evidence of all the witnesses and Mr Addo, the panel considers that:

    a. There was no RAG rating completed for Service User C in March 2020 when COVID began, and therefore was required.

    b. The RAG rating was completed by Mr Addo on 23 April 2020. This was a green entry despite him not having spoken to Service User C or their family. Although, he spoke to Service User C's mother later in the day on 23 April 2020, the RAG rating should have been completed after Mr Addo spoke to Service User C or their family.

    c. In oral evidence, Mr Addo accepted that he did not complete the RAG rating in a timely manner.

90. Consequently, on the balance of probabilities, the panel finds that Mr Addo did not complete "RAG" ratings with respect to Service User C in an appropriate and timely way.

    Found Proved

    Service User F:

91. Having taken into account the case notes, the oral evidence of all the witnesses and Mr Addo, the panel considers that:

    a. There was no RAG rating completed for Service User F in March 2020 when COVID began, and therefore was required.

    b. The RAG rating was completed by Mr Addo on 20 April 2020. This was a green entry despite him not having spoken to Service User F or their family. Although, he exchanged emails with Service User F on 13/14 May 2020, the RAG rating should have been completed after Mr Addo spoke to Service User F or their family.

    c. Neither the case summary, nor the surrounding case notes, indicate that Mr Addo had had any kind of contact with Service User F (or their family) over the preceding six months.

    d. In oral evidence, Mr Addo accepted that he did not complete the RAG rating in a timely manner.

92. Consequently, on the balance of probabilities, the panel finds that Mr Addo did not complete "RAG" ratings with respect to Service User F in an appropriate and timely way.

    Found Proved

Service User G:

93. Having taken into account the case notes, the oral evidence of all the witnesses and Mr Addo, the panel considers that:

    a. There was no RAG rating completed for Service User G in March 2020 when COVID began, and therefore was required.

    b. The RAG rating was completed by Mr Addo on 20 April 2020. This was a green entry written after Mr Addo spoke to Service User G's mother by telephone.

    c. There are no case notes from 27 February 2020 to 20 April 2020. This does not support Mr Addo's assertion that he made all reasonable efforts to speak with Service User G.

    d. In oral evidence, Mr Addo accepted that he did not complete the RAG rating in a timely manner.

94. Consequently, on the balance of probabilities, the panel finds that Mr Addo did not complete "RAG" ratings with respect to Service User G in a timely way.

Found Proved

Service User I:

95. Having taken into account the case notes, the oral evidence of all the witnesses and Mr Addo, the panel considers that:

    a. There was no RAG rating completed for Service User I in March 2020 when COVID began, and therefore was required.

    b. The RAG rating was completed by Mr Addo on 20 April 2020. This was a green entry despite him not having spoken to Service User I or their family. Although, he had contact with Service User I's family in June 2020, the RAG rating should have been completed after Mr Addo spoke to Service User I or their family.

    c. In oral evidence, Mr Addo accepted that he did not complete the RAG rating in a timely manner.

96. Consequently, on the balance of probabilities, the panel finds that Mr Addo did not complete "RAG" ratings with respect to Service User G in an appropriate and timely way.

Found Proved

Service User J:

97. Having taken into account the case notes, the oral evidence of all the witnesses and Mr Addo, the panel considers that:

    a. There was no RAG rating completed for Service User J in March 2020 when COVID began, and therefore was required.

    b. The RAG rating was completed by Mr Addo on 20 April 2020. This was a green entry after Mr Addo spoke to Service User J's mother by telephone.

    c. In oral evidence, Mr Addo accepted that he did not complete the RAG rating in a timely manner.

98. Consequently, on the balance of probabilities, the panel finds that Mr Addo did not complete "RAG" ratings with respect to Service User J in a timely way.

Found Proved

Service User K:

99. Having taken into account the case notes, the oral evidence of all the witnesses and Mr Addo, the panel considers that:

    a. There was no RAG rating completed for Service User K in March 2020 when COVID began, and therefore was required.

    b. The RAG rating was completed by Mr Addo on 13 May 2020. This was a green entry despite him not having spoken to Service User K or their family. Mr Addo made several attempts to speak with Service User K's mother between February and May 2020, but these were unsuccessful. He managed to engage in an email exchange with Service User K's mother between 11-12 May 2020, but Service User K's mother did not respond to Mr Addo's question about how Service User K was doing. The RAG rating should have been completed after Mr Addo spoke to Service User K or their family.

    c. In oral evidence, Mr Addo accepted that he did not complete the RAG rating in a timely manner.

100. Consequently, on the balance of probabilities, the panel finds that Mr Addo did not complete "RAG" ratings with respect to Service User K in an appropriate and timely way.

Found Proved

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Service User M:

101. Having taken into account the case notes, the oral evidence of all the witnesses and Mr Addo, the panel considers that:

a. There was no RAG rating completed for Service User M in March 2020 when COVID began, and therefore was required.

b. The RAG rating was completed by Mr Addo on 17 April 2020. This was a green entry written after Mr Addo spoke to Service User M's mother by telephone.

c. In oral evidence, Mr Addo accepted that he did not complete the RAG rating in a timely manner.

102. Consequently, on the balance of probabilities, the panel finds that Mr Addo did not complete "RAG" ratings with respect to Service User M in a timely way.

Found Proved

Service User N:

103. Having taken into account the case notes, the oral evidence of all the witnesses and Mr Addo, the panel considers that:

a. There was no RAG rating completed for Service User N in March 2020 when COVID began, and therefore was required.

b. The RAG rating was completed by Mr Addo on 17 April 2020. This was a green entry written after Mr Addo spoke to Service User N and their mother by telephone.

c. In oral evidence, Mr Addo accepted that he did not complete the RAG rating in a timely manner.

104. Consequently, on the balance of probabilities, the panel finds that Mr Addo did not complete "RAG" ratings with respect to Service User N in a timely way.

Found Proved

Service User P:

105. Having taken into account the case notes, the oral evidence of all the witnesses and Mr Addo, the panel considers that:

a. There was no RAG rating completed for Service User P in March 2020 when COVID began, and therefore was required.

b. The RAG rating was completed by Mr Addo on 17 April 2020. This was an amber entry despite him not having spoken to Service User P or their family. Although, he received an update concerning Service User P later on 17 April 2020, the RAG rating should have been completed after Mr Addo spoke to Service User P or their family.

c. In oral evidence, Mr Addo accepted that he did not complete the RAG rating in a timely manner.

106. Consequently, on the balance of probabilities, the panel finds that Mr Addo did not complete "RAG" ratings with respect to Service User P in an appropriate and timely way.

Found Proved

Service User Q:

107. Having taken into account the case notes, the oral evidence of all the witnesses and Mr Addo, the panel considers that:

a. There was no RAG rating completed for Service User Q in March 2020 when COVID began, and therefore was required.

b. The RAG rating was completed by Mr Addo on 17 April 2020. This was a green entry written after Mr Addo spoke to Service User Q's parents about the impact of the pandemic/restrictions.

c. In oral evidence, Mr Addo accepted that he did not complete the RAG rating in a timely manner.

108. Consequently, on the balance of probabilities, the panel finds that Mr Addo did not complete "RAG" ratings with respect to Service User Q in a timely way.

Found Proved

Service User S:

109. Having taken into account the case notes, the oral evidence of all the witnesses and Mr Addo, the panel considers that:

a. There was no RAG rating completed for Service User S in March 2020 when COVID began, and therefore was required.

b. The RAG rating was completed by Mr Addo on 21 April 2020. This was a green entry written after Mr Addo communicated with Service User S's mother by email.

c. In oral evidence, Mr Addo accepted that he did not complete the RAG rating in a timely manner.

110. Consequently, on the balance of probabilities, the panel finds that Mr Addo did not complete "RAG" ratings with respect to Service User S in a timely way.

Found Proved

Allegation 3 – You did not complete sufficient visits to, or alternatively ensure that you had an appropriate level of contact with, one or more of the service users identified in Schedule 3:

111. The panel refers to paragraphs 40-41 set out above. Furthermore, Mr Addo:

a. was aware of the requirement to visit service users every six months.

b. was aware that during the Covid-19 pandemic, there was no need for face-to-face visits, but that service users still needed to be seen every six months.

c. knew that there was an expectation that there needed to be regular contact with service users and their families.

d. would record completed visits on the case notes.

Service User A:

112. Having taken into account the case notes, the oral evidence of all the witnesses and Mr Addo, the panel considers that:

a. Mr Addo made a home visit on 20 August 2018.

b. Some unsuccessful visits were attempted by Mr Addo with Service User A. The case notes suggest that Mr Addo made a call to Service User A's accommodation on 13 February 2020 in order to try and arrange a visit, but was unsuccessful in doing so. Mr Addo recorded further unsuccessful attempts to arrange a visit on 21 May 2020, 29 May 2020, and 1 June 2020.

c. The next successful visit took place on 26 June 2020; approximately two years after the previous visit.

d. In his written submissions, Mr Addo could not remember whether he completed sufficient visits to this service user. In oral evidence, Mr Addo accepted that there was not an appropriate level of contact with this service user.

113. Consequently, on the balance of probabilities, the panel finds that Mr Addo did not complete sufficient visits to Service User A.

Found Proved

Service User B:

114. Having taken into account the case notes, the oral evidence of all the witnesses and Mr Addo, the panel considers that:

a. The case was allocated to Mr Addo on 25 May 2018.

b. Mr Addo made a home visit on 14 August 2018; approximately three months after the case was allocated to him.

c. Mr Addo met Service User B and their support network on 5 November 2018.

d. Mr Addo was present at a joint visit on 9 January 2019.

e. The next entry in the case notes is a home visit on 12 August 2019; more than six months later.

f. There is no further evidence of a visit until 22 June 2020 (approximately ten months later), although Mr Addo made contact with the family in May 2020 (approximately nine months later). The case notes show that Mr Addo attempted to arrange a visit in December 2019, and attempted to call the family on 20 April 2020, but these were unsuccessful.

g. The service user's notes set out that contact during covid-19 should be every two weeks.

h. In oral evidence, Mr Addo accepted that there was not an appropriate level of contact with this service user.

115. Consequently, on the balance of probabilities, the panel finds that Mr Addo did not complete sufficient visits to Service User B.

Found Proved

Service User C:

116. Having taken into account the case notes, the oral evidence of all the witnesses and Mr Addo, the panel considers that:

a. The case was allocated to Mr Addo on 3 June 2018.

b. There appear to be a few case note entries suggesting that Mr Addo planned to visit between July and November 2018. However, no visits were recorded between November 2018 and February 2020.

c. Between 11 February 2020 and 6 April 2020, there was no contact with the service user's family. There is a case note of one telephone call after that.

d. In his written submissions, Mr Addo could not remember whether he completed sufficient visits to this service user. In oral evidence, Mr Addo considered it more likely than not that he did not complete a visit to the service user every six months. Further, Mr Addo accepted that there was not an appropriate level of contact with this service user.

117. Consequently, on the balance of probabilities, the panel finds that Mr Addo did not complete sufficient visits to Service User C.

Found Proved

Service User D:

118. Having taken into account the case notes, the oral evidence of all the witnesses and Mr Addo, the panel considers that:

    a. The case was allocated to Mr Addo on 29 October 2019.

    b. The only notes of Mr Addo visiting this service user are in July 2020. Although he did send an email to the family on 26 May 2020.

    c. In his written submissions, Mr Addo could not remember whether he completed sufficient visits to this service user. In oral evidence, Mr Addo considered it more likely than not that he did not complete a visit to the service user every six months. Further, Mr Addo accepted that there was not an appropriate level of contact with this service user.

119. Consequently, on the balance of probabilities, the panel finds that Mr Addo did not complete sufficient visits to Service User D.

Found Proved

Service User E:

120. Having taken into account the case notes, the oral evidence of all the witnesses and Mr Addo, the panel considers that:

    a. The case was allocated to Mr Addo on 3 June 2018.

    b. Mr Addo arranged his first visit with the service user on 4 September 2018; almost three months after the case was allocated to him. This visit was cancelled. The actual first visit took place on 1 October 2018; almost four months after the case was allocated to Mr Addo.

    c. A planned visit on 4 February 2019 was cancelled. The next successful visit in the case notes was on 28 June 2019; almost nine months following the previous visit.

    d. Mr Addo arranged visits, but these were cancelled by Service User E's mother. He struggled to get in touch with Service User E and their support network.

    e. Mr Addo completed a further visit on 17 September 2019.

f. Mr Addo arranged a visit on 2 March 2020, which got postponed to 11 March 2020, but the case notes state that the visit in March 2020 did not go ahead.

g. Although he tried to contact Service User E and his support network on many occasions, these attempts had been unsuccessful.

h. The next successful visit was on 24 June 2020; approximately nine months from the previous visit.

i. In his written submissions, Mr Addo could not remember whether he completed sufficient visits to this service user. In oral evidence, Mr Addo considered it more likely than not that he did not complete a visit to the service user every six months. Further, Mr Addo accepted that there was not an appropriate level of contact with this service user.

121. Consequently, on the balance of probabilities, the panel finds that Mr Addo did not complete sufficient visits to Service User E.

Found Proved

Service User F:

122. Having taken into account the case notes, the oral evidence of all the witnesses and Mr Addo, the panel considers that:

a. The case was allocated to Mr Addo on 11 June 2018.

b. The case notes indicate that Mr Addo tried to arrange a visit on 12 June 2018, but the case notes do not confirm whether this went ahead.

c. A visit on 12 November 2018 was cancelled by Mr Addo due to work commitments.

d. An entry completed on 15 April 2019 states that Service User F had last been seen on 13 July 2019, but this is an error given it is a date in the future.

e. Mr Addo subsequently made a request to visit Service User F in July 2019, but the case notes do not confirm whether a visit actually went ahead.

f. Mr Addo recorded an unsuccessful home visit on 25 September 2019.

g. There is no evidence to suggest that Mr Addo visited (or saw) Service User F at any time between 27 September 2019 and 30 June 2020.

h. The service user's notes set out that contact during covid-19 should be twice a month by email and telephone.

i. On 30 June 2020, Mr Addo saw Service User F in a joint videocall.

j. In his written submissions, Mr Addo could not remember whether he completed sufficient visits to this service user. In oral evidence, Mr Addo

considered it more likely than not that he did not complete a visit to the service user every six months. Further, Mr Addo accepted that there was not an appropriate level of contact with this service user.

123. Consequently, on the balance of probabilities, the panel finds that Mr Addo did not complete sufficient visits to Service User F.

Found Proved

Service User H:

124. Having taken into account the case notes, the oral evidence of all the witnesses and Mr Addo, the panel considers that:

    a. The case was allocated to Mr Addo on 30 January 2019.

    b. The case notes show that Mr Addo did not conduct any visits to Service User H or their family until 1 June 2020. Although a visit was discussed in November 2019 to take place on 6 December 2019, there is no evidence to suggest that this went ahead.

    c. The service user's notes set out that contact during covid-19 should be every two weeks.

    d. In oral evidence, Mr Addo considered it more likely than not that he did not complete a visit to the service user every six months. Further, Mr Addo accepted that there was not an appropriate level of contact with this service user.

125. Consequently, on the balance of probabilities, the panel finds that Mr Addo did not complete sufficient visits to Service User H.

Found Proved

Service User I:

126. Having taken into account the case notes, the oral evidence of all the witnesses and Mr Addo, the panel considers that:

    a. The case was allocated to Mr Addo on 31 January 2019.

    b. The earliest case notes for Service User I was 6 February 2020; over a year after the case was allocated to Mr Addo.

    c. The case notes indicate that the only contact between Mr Addo and Service User I (or their family), in the period between mid-March 2020 and 2 June 2020, was an email sent by Mr Addo on 1 May 2020, to which there was no response.

d. The service user's notes set out that contact during covid-19 should be every two weeks.

e. In his written submissions, Mr Addo could not remember whether he completed sufficient visits to this service user. In oral evidence, Mr Addo considered it more likely than not that he did not complete a visit to the service user every six months. Further, Mr Addo accepted that there was not an appropriate level of contact with this service user.

127. Consequently, on the balance of probabilities, the panel finds that Mr Addo did not complete sufficient visits to Service User I.

Found Proved

Service User J:

128. Having taken into account the case notes, the oral evidence of all the witnesses and Mr Addo, the panel considers that:

a. The earliest case notes for Service User J was 7 October 2019.

b. The first telephone call recorded on the case notes was on 20 April 2020. This was recorded incorrectly on the case notes as a videocall.

c. There were no attempts to visit Service User J from 7 October 2019 to 23 July 2020.

d. The service user's notes set out that contact during covid-19 should be twice a month. There was no contact between Mr Addo and Service User J between 20 April 2020 and 9 July 2020.

e. In oral evidence, Mr Addo considered it more likely than not that he did not complete a visit to the service user every six months. Further, Mr Addo accepted that there was not an appropriate level of contact with this service user.

129. Consequently, on the balance of probabilities, the panel finds that Mr Addo did not complete sufficient visits to Service User J.

Found Proved

Service User M:

130. Having taken into account the case notes, the oral evidence of all the witnesses and Mr Addo, the panel considers that:

a. The case was allocated to Mr Addo on 7 August 2018.

b. Mr Addo completed an introductory meeting on 17 August 2018.

c. Mr Addo made enquiries about a further meeting with Service User M in September 2019, over a year later, but there is no confirmation whether this took place.

d. The entry on 17 April 2020 indicates that Mr Addo spoke to Service User M's mother on 17 April 2020, but did not see or speak to Service User M.

e. Mr Addo next visited Service User M on 8 June 2020, when he was asked to by Ms Rogers.

f. In his written submissions, Mr Addo could not remember whether he completed sufficient visits to this service user. In oral evidence, Mr Addo considered it more likely than not that he did not complete a visit to the service user every six months. Further, Mr Addo accepted that there was not an appropriate level of contact with this service user.

131. Consequently, on the balance of probabilities, the panel finds that Mr Addo did not complete sufficient visits to Service User M.

Found Proved

Allegation 4 – You did not complete assessments and/or reviews, either adequately or at all, with respect to one or more of the service users identified in Schedule 4:

132. The panel refers to paragraph 50 set out above. Furthermore, for a number of service users, Mr Addo cannot remember why there was no review on file.

Service User A:

133. Having taken into account the case notes, the oral evidence of all the witnesses and Mr Addo, the panel considers that:

a. Service User A was allocated to Mr Addo on 2 July 2018.

b. On 29 May 2020, there is a note for Mr Addo to book a date and time for a PP2 review. Mr Addo was aware that he needed to complete a review by 13 June 2020.

c. A case note entry on 16 June 2020 indicates that the review was still outstanding.

d. In his written submissions, Mr Addo could not remember whether he completed an adequate review. In oral evidence, Mr Addo accepted that it is likely that he did not complete the review.

134. Consequently, on the balance of probabilities, the panel finds that Mr Addo did not complete a review with respect to Service User A.

Found Proved

Service User B:

135. Having taken into account the case notes, the oral evidence of all the witnesses and Mr Addo, the panel considers that:

    a. Service User B was allocated to Mr Addo on 22 May 2018.

    b. On 24 April 2020, Mr Addo was aware that he needed to complete an assessment for Service User B by 11 May 2020. Further, he was aware that he needed to speak to Service User B before he completed the assessment.

    c. Mr Addo had not completed the assessment by 9 June 2020. Mr Addo had no contact with Service User B between 24 April 2020 and 22 June 2020. Only on 22 June 2020, did Mr Addo have a WhatsApp videocall with Service User B.

    d. In his written submissions, Mr Addo could not remember whether he completed an adequate assessment. In oral evidence, Mr Addo accepted that it is likely that he did not complete the assessment.

136. Consequently, on the balance of probabilities, the panel finds that Mr Addo did not complete an assessment with respect to Service User B.

Found Proved

Service User D:

137. Having taken into account the case notes, the oral evidence of all the witnesses and Mr Addo, the panel considers that:

    a. Service User D was allocated to Mr Addo on 29 October 2019.

    b. On 22 May 2020, the case notes set out that Mr Addo submitted an incomplete assessment as he had not spoken to Service User D prior to completing the assessment.

    c. Although Mr Addo provided evidence that he would never complete an assessment without speaking to a service user and that this has never been part of his practice and comes as a shock to him:

        i. Ms Rogers provided evidence that Mr Addo "*said that [Service User D] agreed with the assessment despite never seeing him or speaking to him*".

        ii. The assessment was still incomplete as at 29 May 2020. The case notes suggest that there was no contact between Mr Addo and

Service User D (or his family) in the period between 29 May 2020 and 3 July 2020.

d. In his written submissions, Mr Addo could not remember whether he completed an adequate assessment. In oral evidence, Mr Addo accepted that it is likely that he did not complete an adequate assessment.

138. Consequently, on the balance of probabilities, the panel finds that Mr Addo did not complete an adequate assessment with respect to Service User D.

Found Proved

Service User E:

139. Having taken into account the case notes, the oral evidence of all the witnesses and Mr Addo, the panel considers that:

a. Service User E was allocated to Mr Addo on 22 August 2018.

b. Reviews for Service User E should have been completed annually. Mr Addo did not complete a review for Service User E between August 2018 and July 2020.

c. On 28 October 2019, he was aware that Service User E's care package was to be reviewed. On 16 April 2020, it was noted that Service User E's care package still needed to be reviewed. Only on 23 June 2020, did Mr Addo make virtual contact with Service User E.

d. In his written submissions, Mr Addo could not remember whether he completed an adequate review. In oral evidence, Mr Addo accepted that it is likely that he did not complete the review.

140. Consequently, on the balance of probabilities, the panel finds that Mr Addo did not complete a review with respect to Service User E.

Found Proved

Service User K:

141. Having taken into account the case notes, the oral evidence of all the witnesses and Mr Addo, the panel considers that:

a. Service User K was to be seen within ten days of being referred to Mr Addo, which was 6 December 2019. This visit took place on 30 January 2020. At this visit, he said he would arrange a meeting to complete the assessment, which needed to be completed within 40 days.

b. Mr Addo made several unsuccessful attempts to call the family, whose first language was not English.

c. On 11 May 2020, Ms Rogers sent an email to Mr Addo asking about the assessment. By this date, the assessment would have been overdue.

d. As Mr Addo was struggling with this family, Ms Rogers suggested alternative options.

e. On 12 May 2020, Mr Addo sent an email to Service User K's mum, to which a response was received on the same day.

f. Mr Addo followed up with the family on 19 May 2020 and 27 May 2020.

g. Mr Addo only raised the issue of translation needed with the family on 24 June 2020.

h. On 6 July 2020, Mr Addo attended the home of Service User K and their family, but there was no translator available.

i. Ms Rogers provided evidence that the assessment was ultimately "*done by a manager on 18 September 2020 meaning the assessment was seven months out of timescale*".

j. In his written submissions, Mr Addo could not remember whether he completed an adequate assessment. In oral evidence, Mr Addo accepted that it is likely that he did not complete the assessment.

142. Consequently, on the balance of probabilities, the panel finds that Mr Addo did not complete an assessment with respect to Service User K.

Found Proved

Service User N:

143. Having taken into account the case notes, the oral evidence of all the witnesses and Mr Addo, the panel considers that:

a. Service User N was allocated to Mr Addo on 30 October 2019.

b. On 24 April 2020, Mr Addo knew that an assessment for Service User N needed to be completed. There was no assessment on file by 26 May 2020.

c. Ms Rogers provided evidence that "[t]*he Social Worker did not do the assessment or PP1*".

d. In oral evidence, Mr Addo accepted that it is likely that he did not complete an adequate assessment.

144. Consequently, on the balance of probabilities, the panel finds that Mr Addo did not complete an assessment with respect to Service User N.

Found Proved

Allegation 5 – You did not take appropriate and/or timely action in response to concerns with respect to one or more of the service users identified in Schedule 5:

Service User U:

145. Having taken into account the case notes, the oral evidence of all the witnesses and Mr Addo, the panel considers that:

    a. Ms Rogers states that an incident report was received from BJL's school on 6 February 2019, and an urgent request was made by the duty worker to contact BJL's mother. She comments that "[t]*here is no evidence that this was followed up by the Social Worker until 12 February 2019*".

    b. Ms Rogers states that, on 1 December 2019, a Domestic Abuse Notification was received.

    c. Mr Addo provided evidence that:

        i. he did not receive the DAN and has never seen this document.

        ii. he cannot recall or remember whether Service User U told him that he wanted to poison himself or run in front of cars and die. If this did happen, he would have contacted the safeguarding team and told Ms Rogers. He would have ensured that Service User U was safe and protected.

    d. The panel does not have access to the case records for Service User U. Furthermore, the panel does not have evidence that Mr Addo received the DAN or was informed about the issues with Service User U.

    e. The panel noted that Supervision notes dated 2 July 2020 were exhibited by Ms Rogers and indicate that she discussed the safeguarding concerns with Mr Addo. However, these are not signed by Mr Addo. Consequently, the panel has treated these notes with caution.

    f. Mr Addo has been forthcoming otherwise with respect of his actions. The panel does not consider there to be any motive why he would not be forthcoming for this allegation concerning Service User U.

146. Consequently, on the balance of probabilities, the panel finds insufficient evidence to prove that that Mr Addo did not take appropriate and/or timely action in response to concerns with respect to Service User U.

Not Found Proved

Submissions on grounds:

147. Concerning misconduct and lack of competence or capability, on behalf of Social Work England, Ms Atkin set out that the failures can be properly characterised as misconduct. She outlined the HCPC and Social Work England standards that she considered that Mr Addo had breached. She submitted:

    a. Social Work England considers that Mr Addo failed to carry out a number of the basic and fundamental requirements of his role as a social worker, namely by failing to complete assessments of risk and/or need appropriately, failing to keep accurate records, failing to visit and/or alternatively have contact with service users, failing to take appropriate action in response to risk indicators / safeguarding concerns, and/or failing to handle confidential information sensitively. Social Work England considers that Mr Addo's failings in relation to these requirements meet the threshold for a finding of misconduct given he was aware of relevant requirements (such as knowing that contact should be made) and was able to adhere to some of the requirements.

    b. Although there is no evidence of actual harm, there is evidence of the circumstances of service users changing as a result of COVID and the subsequent lockdown. Mr Addo's lack of contact had an impact on some service users who requested that Mr Addo was no longer their social worker.

    c. Mr Addo gave the impression that some service users were being seen, when this was not the case. This not only put these service users at risk of harm, but is indicative that Mr Addo knew the requirements that he needed to meet.

    d. Mr Addo's caseload at the relevant time was said to be around 27-30 cases, in line with the average number of cases held by members of the team at the time. Ms Rogers stated that she did not experience the same issues with other social workers who had the same workload.

    e. Further or alternatively, Social Work England considers that Mr Addo's failings with respect to paragraphs 1-5 of the allegations could additionally and/or alternatively meet the threshold for a finding of lack of competence or capability. The evidence indicates that Mr Addo failed to complete work which was required either adequately or at all with respect to approximately half of the service users on his caseload. Social Work England consider that it would be reasonable to conclude, based on the evidence in this case, that Mr Addo demonstrated a standard of performance which was unacceptably low across a substantial period with respect to a significant proportion of the service users he was allocated to work with.

148. Concerning misconduct and lack of competence or capability, Mr Addo submitted:

    a. His actions were not intentional, dishonest, reckless, or motivated by any disregard for service user safety. They were unintentional issues that

occurred in a challenging and pressured working environment, at the time of the COVID pandemic.

b. He fully understands the impact of the concerns and has demonstrated insight through reflective practice, supervision, and learning. This is inconsistent with someone who lacks competence or professionalism.

c. With the training, leaming, and insight he has gained, the risk of repetition is low. This demonstrates competence, responsibility and professional growth – not misconduct.

Finding and reasons on grounds:

149. The panel accepted the legal advice and applied the following definition of "*misconduct*":

> "*...some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a practitioner in the particular circumstances. The misconduct is qualified in two respects. First, it is qualified by the word 'professional' which links the misconduct to the profession. Secondly, the misconduct is qualified by the word 'serious'. It is not any professional misconduct which will qualify. The professional misconduct must be serious.*"

150. The panel also took into account the observation of Collins J in *Nandi v GMC [2004] EWHC 2317 (Admin)* that: "*The adjective 'serious' must be given its proper weight and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners.*"

151. The panel considered the difference between deficient performance and serious misconduct by reference to the case of *Calhaem v GMC [2007] EWHC 2606 (Admin)* which set out:

a. Mere negligence does not constitute "*misconduct*". Nevertheless, and depending upon the circumstances, negligent acts or omissions which are particularly serious may amount to "*misconduct*".

b. A single negligent act or omission is less likely to cross the threshold of "*misconduct*" than multiple acts or omissions. Nevertheless, and depending upon the circumstances, a single negligent act or omission if particularly grave, could be characterised as "*misconduct*".

c. "*Deficient professional performance*" is conceptually separate both from negligence and from misconduct. It connotes a standard of professional performance which is unacceptably low and which (save in exceptional

circumstances) has been demonstrated by reference to a fair sample of the practitioner's work.

d. A single instance of negligent treatment, unless very serious indeed, would be unlikely to constitute "*deficient professional performance*".

e. It is neither necessary nor appropriate to extend the interpretation of "*deficient professional performance*" in order to encompass matters which constitute "*misconduct*".

152. The panel considered that by committing the proven conduct, Mr Addo fell short of what would be proper in the circumstances. Mr Addo's proven conduct amounts to serious professional misconduct. In particular:

a. Mr Addo failed to carry out a number of the basic and fundamental requirements of a social worker. He failed to:

i. complete risk assessments appropriately or at all;

ii. keep accurate records;

iii. visit and/or have contact with service users;

iv. complete assessments and/or reviews, either adequately or at all;

v. take appropriate action in response to safeguarding concerns; and

vi. handle confidential information sensitively.

b. Mr Addo's lack of contact had an impact on some service users, which was especially important given the circumstances of service users' needs changing as a result of COVID and the subsequent lockdown.

c. Mr Addo gave the impression that some service users were being seen, when this was not the case. This not only put these service users at risk of harm, but is indicative that Mr Addo knew the requirements that he needed to meet.

d. Mr Addo failed to adhere to the following HCPC Standards of Conduct, Performance and Ethics:

i. <u>1. Promote and protect the interests of service users and carers.</u>

1.2. You must work in partnership with service users and carers, involving them, where appropriate, in decisions about the care, treatment or other services to be provided.

ii. <u>2. Communicate appropriately and effectively.</u>

2.2 You must listen to service users and carers and take account of their needs and wishes.

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

iii. 5. Respect confidentiality.

5.1 You must treat information about service users as confidential.

iv. 6. Manage risk and identify and minimise risk.

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

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

v. 7. Report concerns about safety.

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

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

vi. 10. Keep records of your work.

10.1 You must keep full, clear and accurate records for everyone you care for, treat, or provide other services to.

e. The conduct also puts Mr Addo in breach of the following HCPC Standards of Proficiency:

i. 1. Be able to practise safely and effectively within their scope of practice.

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

1.3 Be able to undertake an assessment of risk, need and capacity and respond appropriately.

1.5 Be able to recognise signs of harm, abuse and neglect and know how to respond appropriately, including recognising situations which require immediate action.

ii. 3. Be able to maintain fitness to practise.

3.1 Understand the need to maintain high standards of personal and professional conduct.

iii. 4. Be able to practise as an autonomous professional, exercising their own professional judgement.

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.

4.3 Recognise that they are personally responsible for, and must be able to justify, their decisions and recommendations.

iv. 7. Understand the importance of and be able to maintain confidentiality.

7.3 understand the principles of information governance and be aware of the safe and effective use of health and social care information

v. 8. Be able to communicate effectively.

8.4 understand how communication skills affect the assessment of and engagement with service users and carers.

8.10 be able to listen actively to service users and carers and others.

vi. 9. Be able to work appropriately with others.

9.1 understand the need to build and sustain professional relationships with service users, carers and colleagues as both an autonomous practitioner and collaboratively with others.

9.2 be able to work with service users and carers to enable them to assess and make informed decisions about their needs, circumstances, risks, preferred options and resources.

vii. 10. Be able to maintain records appropriately.

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

viii. 14. Be able to draw on appropriate knowledge and skills to inform practice.

14.1 be able to gather, analyse, critically evaluate and use information and knowledge to make recommendations or modify their practice.

14.2 Be able to select and use appropriate assessment tools.

14.3 Be able to prepare, implement, review, evaluate, revise and conclude plans to meet needs and circumstances in conjunction with service users and carers.

f. The conduct also puts Mr Addo in breach of the following Social Work England Professional standards:

i. 1. Promoting the rights, strengths and wellbeing of people, families and communities.

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

ii. 2. Establishing and maintaining the trust and confidence of people.

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

iii. 3. Being accountable for the quality of my practice and the decisions I make.

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

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

3.3 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.

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

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

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

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

153. The panel considers that Mr Addo's failings in relation to these requirements amount to misconduct rather than a lack of competence or capability given:

a. he was aware of relevant requirements, such as:

    i. the requirement to visit service users every six months.

    ii. during the Covid-19 pandemic, there was no need for face-to-face visits, but that service users still needed to be seen every six months by video calls.

    iii. there was an expectation that there needed to be regular contact with service users and their families.

b. he was able to adhere to some of the requirements.

154. Further, such actions damage public confidence in the profession, as it would convey a degree of opprobrium to the ordinary intelligent citizen (*Shaw v General Osteopathic Council [2015] EWHC 2721 (Admin)*).

Submissions on impairment:

155. On behalf of Social Work England, Ms Atkin submitted that Mr Addo's fitness to practise is currently impaired:

a. Social Work England is mindful that Mr Addo failed to fulfil essential requirements of his role across a two-year period, and in some instances failed to carry out specific tasks despite clear reminders/instructions to do so.

b. Mr Addo's responses during Social Work England's investigation suggested that he believed that the concerns had been raised maliciously, and that he had been discriminated against, however Social Work England considers that there is clear evidence that Mr Addo did not undertake tasks required of him in an appropriate and timely way.

c. Any concessions that Mr Addo has made are as a result of his answers during cross examination rather than any self-reflection.

d. Although Mr Addo has now made admissions with respect to the concerns, these were not full admissions.

e. Social Work England does not consider, in any event, that Mr Addo has, to date, sufficiently reflected on the serious nature of the concerns, and the potential risks to service users resulting from them.

f. Social Work England considers that Mr Addo continues to lack insight, and, that in light of that, and the repeated nature of the concerns, consider there is a significant risk of repetition.

g. Whilst Mr Addo has now made admissions with respect to the concerns, his characterisation of these as "*lapses in practice during a challenging period*"

indicates that Mr Addo has not, to date, sufficiently reflected on the serious nature of the concerns, and the potential risks to service users resulting from them.

h. Whilst Mr Addo has provided some evidence of general reflection on the areas of concern, and evidence of further training he has undertaken, Social Work England does not consider that this is sufficient evidence to demonstrate that the concerns have been successfully remediated. There is a lack of independent evidence that the concerns in relation to Mr Addo's practice have been addressed.

i. Whilst Mr Addo has provided some professional references, Social Work England considers that these do not address the concerns raised about Mr Addo's practice.

j. Social Work England considers that there remains a risk of repetition and that Mr Addo's fitness to practise remains impaired.

k. Social Work England also considers, given the serious and widespread nature of the failings identified, that a finding of current impairment should be made to maintain public confidence in the profession and to promote and maintain proper professional standards for social workers in England.

156. Mr Addo submitted that his fitness to practise is no longer impaired given:

a. Since the concerns arose, he has taken extensive and meaningful steps to remediate the issues identified. He has completed relevant training in safeguarding, risk assessment, RAG rating, confidentiality, record-keeping, and professional standards, and has engaged in sustained reflective learning to fully understand the impact of his past shortcomings.

b. He now has clear insight into what went wrong, why it happened, and how to prevent any recurrence. The concerns occurred several years ago during a period of high workload, the unprecedented pressures of COVID-19, and poor supervision. **[PRIVATE]** There have been no further issues since.

c. He said that, where there is incomplete reporting, his actions impacted service users as they might be missing out on support and the family of service users may not be getting sufficient respite.

d. He said that his actions would have had a negative impact upon the social work profession as people would not have respect for social work professionals where they considered them to be undertaking poor recordkeeping.

e. He said that the risk of not visiting service users is that they are vulnerable and would not have appropriate and immediate support.

f. He regrets using his personal email address for his social work. This was due to being in a pressurised environment and he was trying to get on top of his work.

g. The evidence of his remediation, insight, and commitment to safe practice demonstrates that the risk of repetition is low.

h. If a safeguarding issue was before him now, Mr Addo would bring the concern to his manager (so that they are fully informed), contact the service user (to ensure that they are fully safeguarded), inform the safeguarding lead, and raise the matter as a high priority.

i. He would now ensure that regular contact is made with service users to ensure correct RAG ratings.

j. He will continue to address these issues satisfactorily and that his current fitness to practise is not impaired.

k. Since the time of the allegations, he has been working as an NHS support worker and as a registered nurse. He has not worked as a social worker since the time of the allegations. If given the opportunity, he would like to practise as a social worker again. He would prefer to be a social worker rather than a nurse. He can fit into any type of social work.

l. He qualified as a nurse over a year ago and is registered with the Nursing and Midwifery Council. It took him three years to qualify as a nurse. He currently works as a mental health nurse for NHS Professionals.

m. He gave an example that in his current practice as a nurse, there was a patient refusing to take their medication. This resulted in a risk of dehydration and a risk of poor food intake. He reported this and the patient was taken to A&E and was closely monitored. This put the patient in a position where his intake and bowel movement was stabilised. Furthermore, another patient threatened to commit suicide. Mr Addo ensured this patient was closely monitored for their safety.

Finding and reasons on current impairment:

157. The panel accepted the advice of the legal adviser that when considering impairment, the panel should consider whether Mr Addo fitness to practise is currently impaired in relation to the misconduct. The panel was asked by the legal adviser to consider:

a. whether Mr Addo has acted in the past and/or is liable in the future to act so as to put a service user at unwarranted risk of harm;

b. whether Mr Addo has in the past and/or is liable in the future to bring the social work profession into disrepute;

c. whether Mr Addo has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the social work profession; and

d. whether Mr Addo has in the past acted dishonestly and/or is liable to act dishonestly in the future.

158. When considering the question of impairment, the panel took into account Social Work England's "*Impairment and Sanctions Guidance*".

159. At the outset, the panel considered Mr Addo's insight and remediation.

160. The panel considers that Mr Addo has shown some insight, given:

a. His partial admissions to the allegations.

b. His willingness to engage in the proceedings, including providing his account to explain the concerns.

161. However, the panel considers that Mr Addo's insight is limited, given:

a. The panel does not consider that Mr Addo has provided an in-depth analysis of his actions. For example, he has cited some mitigation that he was working in a pressurised environment, had family issues, had a high workload and received poor supervision, but these appear to focus upon external factors rather than a reflection of his conduct and practice.

b. There is limited insight from Mr Addo on the effect of his actions on service users and on the social work profession, and this was only provided after prompting from the panel. Consequently, the panel considers that Mr Addo has not fully appreciated the gravity of the admitted/proven allegations.

162. The panel considered that Mr Addo has remediated his practice on a limited basis, given:

a. He has cited some practice examples as a mental health nurse where he has taken action following safeguarding concerns. This helped the panel form a view of what he would do should a safeguarding concern would arise: prioritise the patient/service user's welfare, and inform the relevant people to ensure the patient/service user is safeguarded. However, there is no independent verification before the panel of such practice.

b. Mr Addo has provided some references, but these do not relate to his role as a social worker.

c. Mr Addo has undertaken some training, but he has not evidenced how he has put his learning into practice in a comprehensive way, in any professional setting.

<u>Whether Mr Addo has acted in the past and/or is liable in the future to act so as to put a service user at unwarranted risk of harm</u>

163. Mr Addo's (in)actions in the proven allegations demonstrate that he has acted in the past so as to put service users at unwarranted risk of harm. Mr Addo did not:

    a. complete risk assessments appropriately or at all;

    b. keep accurate records;

    c. visit and/or have contact with service users;

    d. complete assessments and/or reviews, either adequately or at all;

    e. take appropriate action in response to safeguarding concerns; and

    f. handle confidential information sensitively.

    This meant that service users were being put at risk by the Council being unaware of their needs, or their needs not being met. This was exacerbated as it took place during the COVID lockdown.

164. Given the limited insight and limited remediation from Mr Addo as set out in paragraphs 160-162 above, the panel considers that Mr Addo is liable in the future to act so as to put a service user at unwarranted risk of harm.

    Whether Mr Addo has in the past and/or is liable in the future to bring the social work profession into disrepute

165. As a result of the (in)actions set out in paragraph 163 above, the panel considers that Mr Addo has in the past brought the social work profession into disrepute.

166. Given the limited insight and limited remediation from Mr Addo as set out in paragraphs 160-162 above, the panel considers that Mr Addo is liable in the future to bring the social work profession into disrepute.

    Whether Mr Addo has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the social work profession

167. As a result of the (in)actions set out in paragraph 163 above, the panel considers that Mr Addo has breached a fundamental tenet of the social work profession, namely the requirement to safeguard service users, especially vulnerable service users.

168. Given the limited insight and limited remediation from Mr Addo as set out in paragraphs 160-162 above, the panel considers that Mr Addo is liable in the future to breach a fundamental tenet of the social work profession.

    Whether Mr Addo has in the past acted dishonestly and/or is liable to act dishonestly in the future

169. The panel does not consider Mr Addo's honesty has been brought into question during these proceedings. Mr Addo has not in the past acted dishonestly and/or is not liable to act dishonestly in the future.

    Panel's conclusion on impairment

170. In light of the above, the panel considered Mr Addo's fitness to practise to be currently impaired on the personal element.

171. Further, members of the public would be concerned to learn about Mr Addo's misconduct, stemming from the admitted/proven allegations. Mr Addo has shown limited insight and limited remediation, as set out in paragraphs 160-162 above, which runs the risk that Mr Addo may repeat the actions that resulted in the finding of misconduct. Consequently, the panel considered Mr Addo's fitness to practise to be impaired on the wider public interest element, namely maintaining public confidence in social workers in England and maintaining proper professional standards for social workers in England.

Submissions on sanction:

172. On behalf of Social Work England, Ms Atkin submitted:

a. Mitigating factors for Mr Addo are:

i. Mr Addo has engaged with the fitness to practise process.

ii. Mr Addo has successfully completed educational courses.

iii. During the relevant period, Mr Addo was suffering with personal issues.

iv. Mr Addo has provided character references and testimonials.

b. Aggravating factors for Mr Addo are:

i. During the period of the allegations, Mr Addo received an adequate level of support.

ii. Mr Addo has demonstrated an insufficient level of remorse despite having significant time to reflect.

iii. There has been a lack of remediation on the part of Mr Addo.

iv. Mr Addo's proven misconduct gave rise to the risk of harm to service users.

c. Taking no action, giving advice or a warning is not appropriate in the circumstances given:

i. Mr Addo's limited insight;

ii. There is no evidence that Mr Addo has put any of his training into practice;

iii. Mr Addo's (in)actions put service users at unwarranted risk of harm; and

iv. Mr Addo brought the social work profession into disrepute.

d. Conditions of practice would be insufficient to manage the risk posed by Mr Addo given:

i. The serious and wide-ranging concerns set out in the proven/admitted allegations;

ii. Mr Addo's inadequate insight;

iii. Mr Addo has not engaged in social work practice since he was dismissed by the Council following these allegations. It would not be reasonable for an employer to provide the support that is needed for Mr Addo's return to practice; and

iv. Mr Addo did not follow guidance from colleagues, which would call into question the effectiveness of conditions of practice.

e. Ms Atkin further submitted that removal is the only appropriate and proportionate outcome given the serious and widespread concerns. Mr Addo understood the seriousness of his actions and the subsequent consequences. Any insight from Mr Addo has been as a result of questioning at this Final Hearing rather than through any independent reflection. This calls into question whether there is any realistic prospect of Mr Addo developing insight, especially given the significant time elapsed since the allegations.

173. Mr Addo provided the panel with the following written submissions:

"*I accept the seriousness of the concerns raised and I do not minimise my actions in any way. I take full responsibility for the delays and recording shortcomings identified. My aim is to demonstrate genuine insight, remediation, and my ongoing commitment to safe and effective practice.*

Applying the Social Work England Sanctions Guidance, I respectfully submit that a sanction at the lower end of the scale—such as No Action, a Warning Order, or if necessary, a Conditions of Practice Order—is the most appropriate and proportionate response. A Removal Order would not be justified under the guidance.

1. NO ACTION (SWE Guidance -, full insight, low risk)

The Sanctions Guidance states that No Action may be appropriate where:

- *The social worker has shown clear insight*
- *Effective remediation has already taken place*

- *There is no current or future risk*

These criteria apply to my case:

- *I have completed substantial remediation*
- *I have demonstrated genuine insight into how delays and*
- *recording can impact service users*
- *There has been no repetition*

2. WARNING ORDER (SWE Guidance - remediable concerns, low risk)

A Warning is suitable when:

- *Conduct fell below expected standards*
- *But is not fundamentally incompatible with continued registration*
- *Insight is present*
- *Remediation is complete*
- *The risk of repetition is low*

This accurately reflects my situation.

My delays and recording issues were the result of workload pressures, ***[PRIVATE]*** *and a period of personal difficulty.*

They were not:

- *deliberate*
- *dishonest*
- *exploitative*
- *or harmful by intention*

A Warning Order would reinforce professional standards and maintain public confidence while recognising the learning I have undertaken.

3. CONDITIONS OF PRACTICE ORDER (SWE Guidance — competence-related concerns)

Conditions are appropriate where:

- *Issues relate to competence, organisation or practice under pressure*
- *The social worker has shown they can improve*

- *The social worker is willing and able to comply*
- *Public protection can be achieved without removing the person from practice*

If the Panel believes additional structured support is needed, I would welcome a 12-24 month Conditions of Practice Order. Conditions would protect the public while supporting my continued rehabilitation in line with the guidance.

4. SUSPENSION ORDER (SWE Guidance — serious but remediable)

Suspension is used where concerns are serious, but:

- *Insight is present*
- *Remediation is possible*
- *Removal would be disproportionate*

Given that I have already been on interim suspension for an extended period and have completed extensive training and reflection, further suspension may not be necessary.

However, if imposed, I respectfully request that it be time-limited and aligned with clear developmental aims.

5. REMOVAL ORDER (SWE Guidance - NOT justified)

According to the Sanctions Guidance, Removal is only for conduct that is:

- *fundamentally incompatible with social work practice*
- *intentionally harmful*
- *exploitative*
- *seriously dishonest*
- *abusive*
- *or where there is no meaningful insight or no prospect of remediation*

None of these apply to my case.

<u>a. No dishonesty, no abuse, no exploitation</u>

The concerns relate to delays and documentation — not behaviour that undermines trust in the profession at its core.

<u>b. Significant personal mitigation</u>

*At the relevant time, I was dealing with the emotional impact **[PRIVATE]** which affected my resilience and capacity. The guidance allows panels to consider major personal life events that affect performance.*

c. Workload and resource pressures

The practice failures occurred in a period of:

- *high caseloads*
- *staff shortages*
- *competing priorities*
- *organisational pressure*
- *the level of my experience at the time*

These environmental factors contributed significantly to the delays.

d. Full insight and sincere understanding of impact

I now fully understand that delays and recording issues can:

- *cause stress and uncertainty for service users*
- *slow the delivery of support*
- *affect of care*
- *hinder colleagues picking up cases*

I apologise for this impact and have reflected deeply on how to prevent such issues in future.

e. Extensive remediation already completed

I have undertaken significant CPD and training, including:

- *safeguarding*
- *risk assessment*
- *case recording*
- *RAG rating*
- *workload prioritisation*
- *reflective practice*
- *Engagement with the process*
- *early admission of the facts*
- *apologies to service users involved*

My learning is genuine and sustained.

f. No risk of repetition

There have been no further concerns for several years. The issues were situational, not character-based

g. Removal would exceed what is needed to protect the public

The guidance emphasises the least restrictive sanction that still protects the public. Removal is an extreme sanction reserved for cases far more serious than mine.

6. CONCLUSION

Based on the Social Work England Sanctions Guidance, the following points support a sanction short of removal:

- *The concerns are historic*
- *I have genuine, developed insight*
- *I have fully remediated the issues*
- *There has been no repetition*
- ***[PRIVATE]***
- *The issues arose in a context of high workload and service pressures*
- *A lesser sanction can protect the public*
- *Removal would be disproportionate and contrary to guidance*

For these reasons, I respectfully submit that the most proportionate outcome would be:

No Action, a Warning Order, or—if the Panel believes it necessary—a Conditions of Practice Order."

Decision on sanction:

174. The panel accepted the advice of the legal adviser that it must pursue the overarching objective when exercising its functions. The purpose of a sanction is not to be punitive although a sanction imposed may have a punitive effect. The panel considered the least restrictive sanction first and then moved up the sanctions ladder as appropriate. The panel had regard to the Sanctions Guidance.

175. The panel considered the following factors to be mitigating:

    a. Mr Addo has admitted to some of the allegations.

b. Mr Addo appears to have developed some understanding about the actions to take to safeguard others whilst in practice as a mental health nurse.

c. Mr Addo has fully engaged with the fitness to practise process.

d. Mr Addo suffered from pressures within the work environment, during the height of the COVID-19 pandemic.

e. Mr Addo was a relatively inexperienced social worker, having only completed an ASYE the previous year.

f. Mr Addo has successfully completed educational courses.

g. During the relevant period, Mr Addo was suffering with personal issues, **[PRIVATE]**.

h. Mr Addo has provided character references and testimonials.

176. The panel considered the following factors to be aggravating:

a. The misconduct was wide-ranging and repetitious, covering a number of service users.

b. Mr Addo's proven misconduct gave rise to the risk of harm to service users.

c. During the period of the allegations, Mr Addo received an adequate level of support.

177. The panel finds that taking no action or issuing advice or a warning would not be sufficient to protect the public, maintain public confidence in the profession and uphold proper standards of conduct and behaviour, given:

a. Mr Addo's misconduct put service users at unwarranted risk of harm;

b. Mr Addo's limited insight and limited remediation;

c. Mr Addo brought the social work profession into disrepute; and

d. Mr Addo's misconduct breached a fundamental tenet of social work.

178. The panel next considered whether a conditions of practice order would be proportionate and appropriate in the circumstances. The panel considered that a conditions of practice order would not be proportionate and appropriate to protect the public or be in the wider public interest given:

a. The serious and wide-ranging concerns set out in the proven/admitted allegations;

b. Mr Addo's limited insight, in particular to understand what went wrong and an-depth evaluation of why;

c. Mr Addo has not engaged in social work practice since he was dismissed by the Council following these allegations. Any supervision required would have to be so restrictive as to be tantamount to suspension; and

d. Mr Addo did not follow guidance from his superiors at the time, which would call into question the effectiveness of conditions of practice.

179. The panel next considered whether it was appropriate to impose a suspension order. The panel had regard to paragraphs 136 and 137 of the Sanctions Guidance:

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

- *the decision makers cannot formulate workable conditions to protect the public or the wider public interest*
- *the case falls short of requiring removal from the register (or where removal is not an option)*

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"*

180. The panel considered a suspension order to be appropriate given:

a. The panel cannot formulate workable conditions to protect the public or the wider public interest.

b. The case falls short of requiring removal from the register given that Mr Addo has demonstrated some insight (albeit limited).

c. A suspension order would provide Mr Addo with the time and opportunity to develop further insight and remediate his practice.

d. Mr Addo has expressed a wish to return to social work and a preference of social work over nursing. The panel consider this to be a willingness on the part of Mr Addo to resolve and remediate his failings.

e. Mr Addo appears to have developed some understanding, and therefore remediation, regarding the actions to take to safeguard patients whilst in practice as a mental health nurse.

f. A suspension order would protect the public.

g. A suspension order would mark the seriousness of the misconduct.

h. A suspension order would maintain public confidence in the social work profession and uphold professional standards.

181. In the particular circumstances, the panel considers that a removal order is disproportionate given that a suspension order would be sufficient to mark the misconduct, protect the public, and meet the wider public interest to maintain public confidence in the social work profession and uphold professional standards. The panel also had regard to Social Work England Sanctions Guidance that "*decision makers should not use a sanction to further punish a social worker for an offence.*" Mr Addo has demonstrated a commitment to further develop his insight and to remediate his practice, and the panel considers that Mr Addo is capable of further insight and remediation. He has engaged positively with this hearing.

182. The panel considered that the following would assist any future reviewing panel:

    a. A reflective piece from Mr Addo reflecting:

        i. the findings of this adjudication panel;

        ii. the reasons for his actions that led to the proven/admitted allegations;

        iii. the impact of his actions on service users; and

        iv. the impact of his actions on the wider profession.

    b. Evidence of further CPD and training relevant to the proven misconduct, and evidence of how he would put that into practice in social work and how he has put it into practice in a professional environment.

    c. Up-to-date testimonials from current employer(s) or voluntary work, especially in relation to safeguarding.

    d. Mr Addo's attendance at a future review hearing.

183. The panel considered that a suspension order of ten months would mark the seriousness of the misconduct, to allow Mr Addo to develop further insight, remediate his practice, and prepare for any future review hearing by complying with the recommendations set out in paragraph 182 above.

Interim order:

184. In light of its findings on sanction, the panel next considered an application by Ms Atkin for an interim suspension order for eighteen months to cover the appeal period before the final order becomes effective. Ms Atkin submitted that an interim suspension order would be consistent with the panel's previous findings and, in particular, the finding that Mr Addo still poses a risk to service users. Mr Addo did not comment on the application.

185. The panel next considered whether to impose an interim order. It was mindful of its earlier findings and decided that it would be wholly incompatible with those earlier

findings and the imposition of a suspension order to conclude that an interim suspension order was not necessary for the protection of the public for the appeal period.

186. Accordingly, the panel concluded that an interim suspension order is necessary for the protection of the public. It determined that it is appropriate that the Interim Suspension Order be imposed for a period of 18 months to cover the appeal period. When the appeal period expires, this interim order will come to an end unless an appeal has been filed with the High Court.

187. In light of the findings of the panel, the interim order previously imposed under paragraph 8(2) of Schedule 2 of the Regulations is revoked as Mr Addo was in attendance and consented to the interim order being revoked.

Right of appeal:

188. 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.

189. 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.

190. 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.

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

Review of final orders:

192. 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

193. 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:

194. 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.