Social worker: Amoge Okweri
Registration number: SW97999
Fitness to Practise Final Hearing:

Dates of hearing: 13 January 2025 to 17 January 2025

- 27 January 2025 to 7 February 2025 and
- 2 June 2025 to 6 June 2025 and
- 17 June 2025 to 20 June 2025
- 21 July 2025 to 23 July 2025
- 26 August 2025
- 28 to 29 August 2025
- 3 September 2025

Hearing venue: Remote

Facts proved: 1a,1c,2,3,4a,4b,5a,5b,6a,6b,7,8a-8h,9,10a,10b,10c,10d,10f,11,12,13a-13d,14,15,16,18a-18c,19,20,21,22a,22b,23a 23e,25,26a,26b,26c,26e,27,30,31(b)(i),31(b)(ii),31d,31f,31h,32a,32d,33a,33b,33c.

Facts found not proved: 1b,10e,17a,17b,24a,24b,26d,28,29,31a,31c,31e,31g

Hearing Outcome: Suspension Order of 2 years

Interim Order: Interim Suspension Order 18 Months

Introduction and attendees:

1. This is a hearing held under Part 5 of The Social Workers Regulations 2018 (as amended) (the regulations").
2. Ms Okweri was present and was not represented.
3. Social Work England was represented by Mr Smith, instructed by Capsticks LLP.

Adjudicators	**Role**
Debbie Hill	Chair
Joanna Bowes	Social worker adjudicator
Simon Jones	Lay adjudicator

Jenna Keats / Titlee Pandey	Hearings officer
Robyn Watts / Molly-Rose Brown	Hearings support officer
Ruksana Kosser	Legal adviser

Preliminary matters:

4. At the outset, the Panel sought clarification from Mr Smith in respect of two issues regarding the Statement of Case submitted by Social Work England. The first being reference to service user 11 in allegation 27 and if this was correct or whether it should read service user 10. The second was in respect of paragraph 139 in the statement of case where reference was made to paragraph 28 (d)-(h). The Panel noted that they could not find any reference to a paragraph 28 (d)-(h) in the schedule of allegations.
5. [PRIVATE].
6. [PRIVATE].
7. Mr Smith on behalf of Social Work England did not oppose these applications. The Panel accepted the advice of the legal adviser and had regard to the fitness to practice rules 2019 (amended) (the Rules) Rule 32(a).
8. The Panel noted that it has a wide discretion as to the management of the hearing in accordance with rule 32 (a), which states that adjudicators or the regulator may regulate their own procedures and must conduct the hearing in the manner they consider fair. Both applications were granted to allow Ms Okweri to fully participate and engage in these proceedings and assist her in giving her best evidence.

Application to hear part of hearing in private:

9. Mr Smith made an application on behalf of Social Work England to have part of the hearing heard in private. Mr Smith told the Panel that some of the evidence provided in the bundles relates to Ms Okweri's health matters. Mr Smith submitted that in accordance with the Rules, any submission or evidence relating to Ms Okweri's health must be heard in private. However, Mr Smith went on to submit that the remainder of the hearing should be heard in public because most of the allegations do not relate to her health [PRIVATE].

10. Ms Okweri did express her concern with the proceedings being held in public and submitted that the whole proceedings should be held in private due to the immense [PRIVATE]. Furthermore, that proceedings being held in private would make it easier for her and assist her in engaging in the proceedings.

11. The Panel heard and accepted the advice of the legal adviser and had regard to rules 37 and 38 of the Rules.

12. The legal adviser advised the Panel that there is a general presumption under rule 37 of the Rules that hearings will be held in public. However, rule 38 states that the hearing or part of the hearing must be in private where there is mention of physical or mental health and that the Panel must have regard to the vulnerability, interest and welfare of Ms Okweri, balancing that with the effective pursuit of the regulator's overarching objective of public protection.

13. The Panel agreed with Mr Smith that matters relating to Ms Okweri's health shall be held in private session in accordance with rule 38. The Panel concluded that all other parts of the hearing shall be held in public in accordance with rule 37. In reaching this decision the Panel considered the vulnerability, interests and welfare of Ms Okweri, [PRIVATE].

Hearsay:

14. Mr Smith informed the Panel that on 4 October 2024 and 6 December 2024 Social Work England made a hearsay application to rely on the documentary evidence of M and K. These applications were granted as follows:

    - Application on 4 October 2024 the Panel admitted the following evidence from K and provided directions for Social Work England in respect of further steps required in relation to M's attendance:
    - Appendix 3- Support and Action Plans (SAP) March 2020,
    - Appendix 15- Reflective Guidance Exercise following DSL meeting,
    - Appendix 20- Supervision Notes 10 & 11 April 2019,

- Appendix 21- K Email to AO with working from home tasks.
- Application on 6 December 2024- Social Work England had complied with the directions set by the first panel. The second panel admitted the following evidence from M:
- The Capability Report,
- Appendix 4- Minutes from weekly call 22 July 2020,
- Appendix 5- Minutes from weekly call 05 August 2020,
- Appendix 6- Supervision record- 27 August 2020,
- Appendix 7- Minutes from meeting on 10 December 2020,
- Appendix 8- SAP Meeting 16 December 2020,
- Appendix 9- SAP Review 4 February 2021,
- Appendix 10- SAP Review 25 February 2021,
- Appendix 11- SAP Review February 2021,
- Appendix 14- SAP Client Safeguarding review and Reflecting Practice Guidance- 04 March 2021,
- Appendix 16- SAP Review- 10 March 2021,
- Appendix 17- SAP Review 01 April 2021,
- Appendix 18- SAP Review 08 April 2021,
- Appendix 19- SAP Review 15 April 2021,
- Appendix 23- Email from M Recovery re Amoge Okweri training progress,
- Appendix 24- Email to all PTR staff regards completing Naloxone training,
- Appendix 27- SAP 16/12/2020- 05 February 2021,
- Appendix 28- Reduced SAP- 25 February 2021.

Application to adjourn:

15. On the fourth day of the hearing Ms Okweri made an application to adjourn the hearing for a short period, via an email sent to Social Work England. In her email sent on the evening of 15 January 2025, Ms Okweri expressed that she had found the hearing profoundly distressing and emotionally overwhelming, referring to the evidence given by L. Ms Okweri stated that although she had had some time to compose herself at home, she remained significantly affected and therefore felt she was not in a suitable frame of mind to effectively participate or continue with the hearing. Ms Okweri went onto state that she felt confident that with a short period of adjournment, she would be able to fully engage with the process and contribute meaningfully.

16. Ms Okweri was contacted via email and spoken to via telephone by the hearings officer, to inform her of the hearing time so the application could be heard in her presence. However, Ms Okweri expressed that she did not feel well enough to attend and requested the matter be dealt with based on the information sent in her email. The Panel gave Ms Okweri until 11am to see if she would attend. The hearing

reconvened at 11am but Ms Okweri did not attend. The Panel therefore first considered whether to proceed in her absence.

17. Mr Smith submitted that Ms Okweri was aware of the start time, as she was contacted by the hearings officer who informed her of what time the application would be heard and therefore it could be concluded that Ms Okweri had voluntarily absented herself. Mr Smith cited the leading case of Adeogba v GMC [2016] EWCA Civ (Admin) and the factors to be considered when determining whether to proceed in absence, namely the nature and circumstances of Ms Okweri absenting herself, the length of any adjournment and the extent of any disadvantage of proceeding in her absence. Mr Smith submitted that Ms Okweri made it abundantly clear that she was content for application to be considered on the contents of her email and therefore the Panel should proceed in her absence to consider the application. That there was no disadvantage because Ms Okweri had made representations within the email that were available for the Panel to view.

18. In respect of the application to adjourn Mr Smith submitted that on behalf of Social Work England that he would be opposing such an application. Mr Smith pointed out that under rule 32 (a) of the Rules that the Panel had a wide discretion to regulate its own procedures if they were fair and in the public interest. Mr Smith submitted that the reasons put forward by Ms Okweri to adjourn were due to the stress caused because of the hearing process itself.

19. Mr Smith referred the Panel to the guidance on adjournments and postponements by Social Work England and a specific section on stress related illness. Mr Smith stated that the Guidance states that at some point during the hearings process a social worker may have stress related illness and may use this to delay the process. Mr Smith submitted that in his view this application amounts to Ms Okweri attempting to use the stress caused to her, to delay the hearings process.

20. Mr Smith stated that the guidance goes onto state that stress caused solely by the hearings process will not usually be enough to support an application to adjourn and more importantly the stress is likely to reoccur when the hearing resumes. Therefore, any adjournment is unlikely to serve any useful purpose. Mr Smith submitted that instead, the Panel should consider what reasonable adjustments could be made to support engagement. Mr Smith stated that the Panel had already made reasonable adjustments to assist Ms Okweri to engage in the hearings process, by allowing regular breaks. Mr Smith said that whether the hearing commenced later in the day or on 27 January 2025, Ms Okweri is still likely to experience the same level of stress.

21. Mr Smith cited the leading case of DPP v Picton [2006] EWHC 1008 3 which is a criminal case but nonetheless sets out considerations when considering an application to adjourn. Mr Smith outlined these to the Panel referring to paragraph 9 of the judgement. In determining the application to adjourn, Mr Smith submitted that the Panel should bear in mind:

- The public interest in ensuring the hearing is dealt with expeditiously.
- The reasons for the adjournment.
- The likely length of any adjournment and the risk of the case going part heard.
- The impact any adjournment will have on the ability of Ms Okweri to present her defence.

22. Mr Smith submitted that there were other considerations including the history of the case and the fault of any party but the pertinent question for the Panel to ask was whether Ms Okweri could fairly present her case/defence. Mr Smith submitted that with the reasonable adjustments already in place and consideration of further adjustments by assisting Ms Okweri by asking her to write down questions for the witnesses and the possibility of asking the questions on her behalf that Ms Okweri could continue the proceedings today without the need for an adjournment. On the basis that a short adjournment would serve no useful purpose, Mr Smith submitted respectfully that the application be refused.

23. The legal adviser concurred with the legal considerations put forward by Mr Smith when determining both applications. The legal adviser referred to Rule 43 and advised the Panel that they must be satisfied that Ms Okweri is aware of the hearing and/or all reasonable steps have been taken to notify her. Furthermore, that they needed to consider the impact of any delay and the reasons for non-attendance when determining whether to proceed in absence.

24. The Panel received advice from the legal adviser that Social Work England's overarching objective to protect the public, is best served through the efficient, fair and effective determination of the fitness to practice concerns. This includes concluding cases as quickly as possible. Any decision to delay the proceedings must balance the interest of Ms Okweri with that of Social Work England.

25. The Panel were advised that in determining whether to grant an adjournment, the Panel should have regard to the following factors, derived from the decision of DPP v Picton [2006] EWHC 1008 3, namely the general need for expedition in the conduct of proceedings; where an adjournment is sought by the social worker, if not granted, whether they will be able to fully present their case and, if not, the degree to which the ability to do so is compromised; the likely consequences of the proposed adjournment, in particular its likely length and the need to decide the facts while recollections are fresh and the reason for the adjournment.

26. The Panel accepted the advice of legal adviser.

Panel's decision on adjournment:

27. The Panel first considered whether to proceed in the absence of Ms Okweri when determining the application to adjourn. The Panel noted that Ms Okweri had attended

throughout the hearing process and only absented herself on the fourth day of the hearing for the reasons outlined in her email. Furthermore, that efforts had been made to engage Ms Okweri to attend so that this application could be heard in her presence.

28. The Panel was satisfied that Ms Okweri was fully aware of the hearing, had voluntarily absented herself and therefore were minded to deal with the application to adjourn in her absence.

29. Turning to Ms Okweri's application to adjourn the Panel considered all the circumstances of the case, including the reasons put forward by Ms Okweri, namely that she found the hearing profoundly distressing and emotionally overwhelming and needed a short time to recover and compose herself before continuing. The Panel further noted Ms Okweri's participation in the hearing to date. The panel also considered this alongside the need to deal with matters expeditiously.

30. The Panel determined, based on the submissions advanced, that Ms Okweri was not able to continue with the hearing, In making this determination the Panel noted that Ms Okweri had fully participated throughout the fitness to practice process and had expressed her willingness to continue to do so, but with the support of reasonable adjustments, considering the enormity of the proceedings and the fact that Ms Okweri is unrepresented. The Panel also noted that Ms Okweri only required a short adjournment. The Panel accepted that even a short adjournment may impact on whether the hearing is concluded within the timescale set but felt that this was out weighed by the need to consider Ms Okweri's wellbeing and ability to participate effectively in the hearing.

31. The Panel determined that if an adjournment was not granted, Ms Okweri would not be able to fully present her case and may even withdraw altogether because of the enormity of the circumstances impacting on her emotional wellbeing to cope with the stress and anxiety of these proceedings. The Panel therefore agreed to adjourn the case until 27 January 2025 at 9.15am.

32. However, the Panel did express that no further adjournments would be granted for the same reasons. The Panel took into account the facts that reasonable adjustments were already in place to support Ms Okweri and that all efforts should be made to conclude these proceedings to fulfil the overarching objective of public protection whilst at the same time affording Ms Okweri the opportunity to present her case.

Allegations:

Whilst registered as a social worker, between April 2019 and April 2021, whilst employed by Change Grow Live ("CGL") as a Family Support Worker:

1. *You produced an in-cell pack on or around 30 July 2020 which was inappropriate for use in that it:*
    a. *Included content plagiarised from various internet sources;*
    b. *Did not provide references for the sources of information in line with best practice;*
    c. *Included reference to the American penal system.*

2. *On or around April 2021, you informed Colleague 1 that you had completed the entirety of 'Module 1- Getting SMART' training, when this was not the case.*

3. *You did not complete training in a timely manner in that you were requested to complete Naloxone training on 30 June 2020, but did not complete the training until on or around 19 February 2021.*

4. *You made inaccurate statements about work you had undertaken whilst working from home, in that;*
    a. *On 16 July 2020, when you provided details of your working from home tasks for 16 July 2020 to Colleague 1, you said you had: "checked some more updates on CriiS for ideas on what is going on with clients", when you had not accessed client records on that date;*

    b. *On 7 August 2020, when you provided details of your working from home tasks for 7 August 2020 to Colleague 1, you said you: "went through the list of [your] current clients. Studying [your] clients update in preparation for reviews', when you had not accessed client records on that date.*

5. *You did not take adequate steps to resolve issues with your access to key systems as directed by your manager, Colleague 1, including;*

    a. *OASYS, and/or*
    b. *Systm1*

6. *As a result of your lack of access to OASYS and/or SYSTM-1, you did not consider all relevant information when assessing risk and making professional decisions for:*

    a. *Service User 1*
    b. *Service User 2*

In relation to Service User 1:

7. *Your Initial Family Service Assessment dated 26 January 2021 was inaccurate, in that you:*

a. *Stated within the assessment that Service User 1 was yet to find out if they had a mental health issue despite Service User 1 telling you they had a diagnosis of psychosis and depression which they were receiving treatment for.*

8. *In relation to Service User 1:*

a. *As part of your assessment on 26 January 2021, you did not conduct checks to determine if Service User 1 was diagnosed with psychosis and/or depression*

b. *As part of your assessment on 26 January 2021, you did not sufficiently explore Service User 1's statement that: "they hear voices in their head telling them to do something bad".*

c. *Your assessment of Service User 1 took place on or around 26 January 2021, but by 15 April 2021 you had not taken adequate action in relation to Service User 1's safeguarding.*

d. *You recorded in your assessment on 26 January 2021 that Service User 1 was expecting a baby and you did not share this information with social services, despite Colleague 1 informing you on 8 April 2021 that this needed to be done.*

e. *In your assessment on 26 January 2021, you recorded that their partner had a restraining order against them but you did not take steps to ascertain the nature of the restrictions, including whether they related to Service User 1's child.*

f. *On 4 February 2021, you recorded a potential risk to Service User 1's pregnant partner in the safeguarding module but did not take any further steps to share this information with the appropriate professionals.*

g. *You concluded that there were no safeguarding concerns when this was not the case in light of the information disclosed by Service User 1.*

h. *In discussion with Colleague 1 on 15 April 2021 you indicated that as Service User 1 was still in prison you did not have to take any safeguarding action at that point.*

9. *You did not raise a safeguarding concern for Service User 1 in a timely manner despite identifying risk factors in your assessment of 26 January 2021.*

In relation to Service User 2:

10. *In your Safeguarding Review of 20 January 2021:*

a. *The only risk management step you identified was advising Service User 2 not to breach a restraining order.*

b. *You suggested that the risks relating to Service User 2 were managed whilst Service User 2 was in custody.*

c. *You recorded that "systems were checked for info" but did not record what systems had been checked and/or what information had been checked.*

d. *You recorded that Service User 2's children were at potential risk of harm but did not identify which of Service User 2's [PRIVATE] children were at risk.*

e. *You noted that Service User 2 would be at risk if they breached the Restraining Order, but did not identify the nature of that risk*

f. *You did not inform the appropriate agencies regarding safeguarding to establish whether any other agencies were involved with, or needed to be involved with Service User 2, such as MARAC, MAPPA, or Social Care.*

11. *In your assessment of 22 December 2020, you did not include any information about who the breaches of the Restraining Order or Service User 2's convictions for Grievous Bodily Harm related to.*

12. *You did not complete the outstanding safeguarding actions identified by Colleague 2 on or around 4 March 2021 in a timely manner, or at all.*

In relation to Service User 3:

13. *Your safeguarding assessment dated 9 April 2021:*

a. *Did not provide a sufficiently detailed analysis of the risks involved in Service User 3's case.*
b. *Did not provide the details of any other professionals involved with Service User 3.*

c. *Did not list the key risks identified for Service User 3 and/or what is being done to mitigate those risks.*

d. *Did not include information recording your professional assessment of the level of risk.*

14. *You did not take any steps to contact Social Services to find out if they were involved with Service User 3's ex-partner and/or children despite this being an action identified in the assessment of 9 April 2021*

In relation to Service User 4:

15. *You did not obtain sufficient detail of Service User 4's interest in young girls as expressed to you during a 1:1 session on 8 April 2021*.

16. *You did not share information with any relevant professional relating to Service User 4's interest in young girls as expressed to you during a 1:1 session on 8 April 2021*.

In relation to Service User 5:

17. *Your case recordings were not accurate and/or timely in that:*

    a. *Your assessment for Service User 5 was completed on 25 January 2021 but the case note was not written until 29 January 2021*.

    b. *The contact date was recorded as 28 January 2021 when it should have been recorded as 25 January 2021*.

18. *Your case recordings were not sufficiently detailed in that:*

    a. *On 22 January 2021, you recorded that "Client information updates was accessed for prior knowledge of client previous and current situation" but did not record any information about what systems were checked, why, or what was relevant within each system*.

    b. *On 28 January 2021, you did not record adequate detail of any advice you gave Service User 5 during the assessment*.

    c. *Your assessment on 28 January 2021 does not provide a full assessment of the Service User's strengths and vulnerabilities*.

In relation to Service User 6:

19. *Your case recordings were not accurate in that your assessment took place on 3 March 2021, but you recorded the date of contact with Service User 6 for the assessment as 10 March despite Service User 6 having been transferred to a different prison on 8 March 2021*.

20. *On or around 8 March 2021, you did not update the Family Service Spreadsheet with Service User 6's release date and/or close Service User 6 from the spreadsheet following their transfer in a timely manner, or at all.*

In relation to Service User 7:

21. *On or around 6 April 2021, you did not update the Family Service Spreadsheet with Service User 7's release date and/or close Service User 7 from the spreadsheet following their release in a timely manner, or at all.*

In relation to Service User 8:

22. *Your case management was inadequate, in that;*

    a. *You did not action a referral for Service User 8 to the Learning and Disability Team in a timely manner, with the referral being actioned on or around 8 April 2021;*

    b. *Your referral to the Learning and Disability Team was inappropriate as it was made after Service User 8 had been released from prison, which you knew, or ought to have known.*

In relation to Service User 9

23. *Your assessment dated 7 April 2021 was inadequate in that it:*

    a. *Was too descriptive.*

    b. *Did not note Service User 9's strengths and/or weaknesses.*

    c. *Did not detail what support Service User 9 was currently receiving.*

    d. *Did not identify areas where Service User 9 needed further support.*

    e. *Did not identify any other professionals Service User 9 was currently working with and/or how they were assisting Service User 9.*

24. *The action plan you created for Service User 9 on 7 April 2021 was inadequate in that it:*

    a. *Did not contain actions around other family members.*

    b. *Did not contain actions to assist Service User 9 with community support.*

25. *You did not complete the actions listed in the action plan you created for Service User 9 on 7 April 2021 and/or did not record the outcome of any actions taken against the action plan.*

In relation to Service User 10:

26. *Your assessment dated 03 March 2021 was inadequate in that it:*
    a. *Was too descriptive.*

    b. *Did not note Service User 10's strengths and/or weaknesses.*

    c. *Did not detail what support Service User 10 was currently receiving.*

    d. *Did not identify areas where Service User 10 needed further support.*

    e. *Did not identify any other professionals Service User 10 was currently working with and/or how they were assisting Service User 10.*

27. *Following your assessment dated 03 March 2021, you did not complete and/or record the identified action of referring Service User 10 to the Learning Difficulties team.*

28. *Following your assessment dated 03 March 2021, you did not take timely action in providing Service User 10 with the in-cell packs identified in the action plan.*

29. *On or around between March and April 2021, you did not record a contact with Service User 10 in CRiiS after providing in-cell materials.*

30. *On or around 12 and/or 18 March 2021, you made contact with Service User 10's family without conducting and/or recording any checks on whether there were restrictions preventing Service User 10 from having contact with his family.*

In relation to Service User 11:

31. *Your assessment dated 6 February 2020 was inadequate in that it:*

    a. *Contained sentences which did not make sense, making the entry unclear.*
    b. *Contained the following inappropriate language:*
        i. *You described suicide as "selfish".*
        ii. *You said Service User 11 "throws support back in peoples' faces".*

    c. *Did not demonstrate empathy towards Service User 11.*

    d. *Did not identify Service User 11's strengths.*

e. *Did not identify Service User 11's presenting issues.*

f. *Did not identify what support Service User 11 was currently receiving.*

g. *Did not identify appropriate next steps in order to support Service User 11.*

h. *Did not contain sufficient detail to enable other professionals to effectively manage risk.*

In relation to Service User 12:

32. *Your assessment dated 8 April 2021 was inadequate in that:*

a. *You did not explore and/or record why Service User 12 was working with the mental health team despite his account of having no mental health issues.*

b. *It does not contain sufficient detail regarding your conversation with Service User 12 during the assessment.*

c. *You did not obtain sufficient detail about Service User 12's previous convictions.*

d. *You did not assess Service User 12's level of risk.*

33. *Your conduct at paragraph 2, and/or 4a, and/or 4b, was dishonest, in that:*

a. *In respect of paragraph 2, you knew that you had not completed Module 1- Getting SMART, yet told Colleague 1 that this was the case.*

b. *In respect of 4a, you knew you had not accessed client records on 16 July 2020.*

c. *In respect of 4b, you knew you had not accessed client records on 7 August 2020.*

Your conduct at paragraphs 2, 4a, 4b, and 33 amounts to the statutory ground of misconduct.

Your conduct at paragraph 1, 3, and 5 to 32 constitutes lack of competence.
Your fitness to practise is impaired by reason of your misconduct and/or lack of competence.

Admissions:

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

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

35. Following the reading of the allegations the Panel Chair asked Ms Okweri whether she admits any of the allegations and whether she admits that her fitness to practise is currently impaired.

36. Ms Okweri informed the Panel that she admitted allegations 1(a),1(c),2,3,6(a),10(b),10(d),11,18(a),21,26(b) and 31(b)(ii).

37. The Panel therefore found the allegations above proved by way of Ms Okweri's admissions.

38. The Panel noted that Ms Okweri denied the remainder of the allegations.

Background

39. On 29 July 2021, Social Work England received a referral from the Social Worker's former employer, Change Grow Live ("CGL") regarding the Respondent social worker, Amoge Okweri.

40. Ms Okweri was not working as a social worker at the time of the concerns and instead was employed as a Family Support Worker at HMP [PRIVATE], [PRIVATE] prison. Ms Okweri was employed at CGL from 12 September 2018. Ms Okweri resigned from her employment with immediate effect on 8 June 2021. Ms Okweri's day-to-day duties are contained in her job description and are outlined in the witness statement of B. The Social Worker's role required her to interact with [PRVIATE] (prisoners) at HMP [PRIVATE]. CGL raised concerns that Ms Okweri had been made subject to a capability action plan and was unable to meet the required standards. The referral set out that disciplinary proceedings commenced in April 2021 and Ms Okweri resigned from the role prior to the conclusion of those proceedings.

41. A number of issues were identified in Ms Okweri 's work by CGL. In summary, the concerns related to poor standards of record-keeping and inadequate assessment of clients, not referring clients for treatment or support, not following safeguarding processes and procedures, not identifying risks, and not following up appropriately on disclosures by clients which indicate a potential high risk to themselves and/or the public.

42. The information provided by CGL was that CGL put in place a number of support measures for Ms Okweri, including a series of Support and Action Plans ("SAP"), a series of training courses, and a reduced case load. CGL alleged there was insufficient improvement in Ms Okweri's performance despite the support given. It was also alleged that the records relating to Ms Okweri's access to an IT system maintained by CGL suggested that Ms Okweri had not accessed records, contrary to an email sent by Ms Okweri to her manager stating she had accessed the casework system.

Summary of evidence:

43. The Panel noted all the documentation presented in support of the Final hearing, namely:

- Appendix outlining the allegations
- Final Statement of Case
- Social worker response bundle
- Exhibits bundle
- Witness bundle
- Service and supplementary bundle
- ID Key bundle
- Written closing submissions

44. The Panel also noted the additional pieces of evidence that were presented during the hearing process.

45. Social Work England relied upon the evidence and exhibits of the following witnesses:

- R– a registered Social Worker since 2019. Worked as a Family Support Worker at CGL alongside Ms Okweri .
- L - employed as HR Regional Manager at CGL since 2015.
- C – employed as a Data Business Partner at CGL since March 2014.
- L – employed as a Software Developer at CGL between January 2015 and July 2023
- B- current Head of Social Work at CGL
- C – employed by Capsticks Solicitors LLP as an Associate Solicitor. Worked on and had conduct of the Post-case Examiner investigation relating to Ms Okweri.
- M –Ms Okweri's Manager at CGL- admitted as hearsay.

- K - Ms Okweri's Manager at CGL- admitted as hearsay.

46. Mr Smith called Ms R, L, C, L and Ms B to give evidence. The five witnesses gave evidence under [PRIVATE] and adopted the contents of their witness statements. The written statement of C was submitted to the Panel.

47. In respect of the evidence of M and K, this consisted of documents including the Capability Report and various SAPs.

Opening Submissions:

48. Mr Smith opened his submissions by addressing the two issues raised by the Panel in respect of the evidence bundle. Mr Smith thanked the Panel for bringing it to his attention. As regards allegation 27, Mr Smith confirmed that it should read as service user (SU) 10 and not 11. In respect of the second issue Mr Smith informed the Panel that reference to paragraph 28 (d)-(h) was incorrect and that it should read paragraph 31 (d)-(h) and that this was on oversight and requested the that the errors be amended. The Panel agreed for the amendments to be made.

49. Mr Smith then took the Panel through the evidence on which Social Work England will rely upon to prove the allegations. Mr Smith stated that the Statement of Case provided a summary of each allegation and should be used as a route map for each allegation with reference to the various exhibits in the bundle.

50. Mr Smith stated that throughout Ms Okweri's employment at Change Grow Live, she was managed by three people. A from September 2018 through to March 2019. K between March 2019 and May 2020. And M between May 2020 and April 2021. It was K and M who were the primary managers during the Support Action Plan being in place. Both have now left the organisation.

51. Mr Smith submitted that although the entirety of their evidence has been submitted as hearsay, M and K had firsthand knowledge of Ms Okweri, as her line managers and were therefore, best placed to comment on any action or inaction. Mr Smith conceded that their evidence will be untested and appreciated that the weight attached to that evidence must be addressed with caution.

52. Mr Smith continued by giving a brief breakdown of the other witnesses' evidence. In respect of C, Mr Smith stated that she will not be giving live evidence because her evidence does not give opinion or insight, but rather a production statement and therefore is of limited value.

53. In respect of B, who is the current Head of Social Work at Change Grow Live, Mr Smith stated that she was not working at the time Ms Okweri worked there and therefore she

will not comment on Ms Okweri other than through the records that have been produced by M and K.

54. R (previously R) is a qualified social worker and worked as a Family Support Worker at the same time as Ms Okweri. Although Ms R no longer works for Change Grow Live, she assisted Ms Okweri in training when they worked together. Her evidence will relate to the working practices at the time and her interaction with Ms Okweri.

55. In respect of L, Mr Smith stated that she was the Human Resources (HR) manager at Change Grow Live during the time Ms Okweri worked there and her evidence will relate to the HR procedures and policies that were in place at the time.

56. Mr Smith stated that the remaining two witnesses, C and L will assist in giving evidence in respect of the IT queries and explain whether Ms Okweri was able to undertake reviews without IT access.

57. Mr Smith submitted that the allegations were wide ranging and due to a deterioration of Ms Okweri's performance and concerns, Ms Okweri was made subject to a capability plan which set out the areas Ms Okweri needed to improve in. An initial support and action plan (SAP) was due to start on the 12 March 2020. This was paused due to a breakdown in relationship between Ms Okweri and K and with COVID lockdown. M took line management responsibility from May 2020.

58. Mr Smith submitted that the first SAP review took place on 4 February 2021. During the review it was established that the targets set out in the SAP were not achieved. It was conceded that there were too many elements and too much required. Therefore, a reduced SAP was created with a reduced workload.

59. Mr Smith submitted that a further SAP review took place on 25 February 2021. At the end of the review period, it was concluded that Ms Okweri had not reached the level of performance to meet the requirements of the SAP. It was at this stage that it was decided to commence a capability report. Before the official disciplinary proceedings could conclude, Ms Okweri resigned from her post on 8 June 2021.

60. Mr Smith concluded his opening submissions by outlining the burden of proof being on Social Work England to produce evidence to support each individual allegation to the civil standard, by persuading the Panel that each allegation is more likely than not to have happened.

<u>Evidence of Ms R</u>

61. The Panel had a written statement from Ms R dated 5 September 2023 In addition to Minutes of the meeting between R and Ms Okweri on 2 March 2021 and the Case records for SU 11.

62. Ms R stated that she was employed as a Family Support Worker at CGL between June 2018 and July 2021. This involved the case management of clients who were under the recovery service, so were involved in drugs and alcohol. The recovery service would refer clients if they had any family issues, issues managing their feelings or emotions or there were safeguarding concerns. Ms R confirmed that Ms Okweri was her colleague and for most of the time that they worked together they were the only two Family Support Workers in the team. Ms R described her caseload at any given time to be between 20-30 cases but this would not dip below 20. Ms R recalled that Ms Okweri's caseload was between 5-15 but noted that Ms Okweri worked part time whereas she worked full time. Ms R could not recall which days of the week Ms Okweri worked. Ms R stated that she never had to work out of hours or weekends.

63. Ms R described the role of a Family Support Worker, which included completing Family Service Assessments. These were completed once a referral was received from Recovery Workers on the in-house case management system (CRiiS). Sometimes they would email the referral, but it could be accessed on CRiiS. Ms R recalled that there was guidance on what should be covered in an assessment, which was saved in the family service folder which everyone in the team had access to.

64. Ms R stated that the Family Service Assessment involved going to meet the prisoner (also referred to as a client/SU), discussing their presenting concerns and the reason for the referral. Ms R detailed the importance of gathering as much, background information as possible, for example the client's childhood circumstances, family details including restrictions on 'no child contact' or existing non-molestation orders. Ms R stated that it was important that these facts were noted and that NOMIS (prison system) was monitored or updated so staff would know who they and the client were allowed to contact.

65. Ms R stated that during the COVID-19 pandemic staff were asked to work from home. Ms R recalls collecting her laptop from [PRIVATE] Prison with other colleagues. Ms R could not recall if Ms Okweri was one of the colleagues who collected them. Ms R explained that this allowed her and colleagues to work from home as they were able to access the family service folder to undertake work as well as training through the pathways to recovery folder. This included online training which could be accessed via the training portal.

66. Ms R described the various IT systems in place which she had access to and used as part of her job as a Family Support Worker. These included CRiiS, SYSTM1, NOMIS and OASYS. Ms R described the first two as very important tools to be able to carry out her work because CRiiS was where referrals were made and SYSTM1 was the place to locate and share vital information with other stakeholders. NOMIS was the prison system so was important to monitor for updates. OASYS was used but not so much as this was more for probation staff.

67. Ms R stated that when Ms Okweri first started, she was asked by her then manager AL to show Ms Okweri how to use CRiiS and the Family Service spreadsheet. Ms R went on to say that she could not recall the exact dates, but Ms Okweri shadowed on at least two Family Support assessments, the first being within two weeks of Ms Okweri's start date and was included in her induction period. This was the 'CGL' induction morning, followed by assessment on houseblocks, which is a unit in which the cells are located.

68. Ms R stated that she showed Ms Okweri what is expected from the point of referral to typing up the assessment, making referrals, assessing the client and actioning anything further. Ms R recalls explaining processes to Ms Okweri during the assessments and Ms Okweri acknowledging but can't recall if any questions were asked. In respect of the Family Support spreadsheet Ms R stated that she regularly showed Ms Okweri how to complete this as it was often not updated or had incorrect information.

69. Ms R stated that after the initial induction training, there were several more occasions where she showed Ms Okweri how to use the systems particularly CRiiS. Ms R recalls being consistently being asked by the team manager to support Ms Okweri with this. Ms R went on to say that during team meetings Ms Okweri would say that she was never shown how to use the systems and that it was preventing her from being able to do her job. Ms R stated that this resulted in having to sit down with Ms Okweri and show it again to her on at least 5 to 6 occasions and eventually Ms R expressed her frustration to her manager in having to repeat it only to be told to do it again. Ms R stated that it was then agreed that a meeting with Ms Okweri would be minuted to record what support was given.

70. Ms R referred to the minutes of the meeting on 2 March 2021, stating that during the meeting she explained to Ms Okweri the process of a case from the point of referral in front of a computer, how this is added to the system, how to update a referral once an assessment had been completed, progress notes, how to open a safeguarding page step by step. During the meeting Ms R stated that she also talked through how to complete the Family Support spreadsheet and the importance of keeping it up to date. Ms R stated that she recalled Ms Okweri taking notes but that she did not raise any concerns during the meeting. Ms Okweri did say that she would approach Ms R if she wanted to go over anything.

71. After the meeting Ms R stated that she created a word document with all the steps that they had gone through and sent the document to Ms Okweri by email a few times as she denied receiving it.

72. Ms R was asked to refer to her exhibits in respect of allegation 31. This involved a conversation that Ms Okweri had with SU 11 on 6 February 2020. Ms R explained that Ms Okweri had recorded the content of her conversation where Ms Okweri spoke candidly to SU 11, concerning suicidal intent and telling him that he was selfish. Ms R

stated that on 21 January 2020 she had planned to make a visit to see SU 11 but this could not be achieved because SU 11 had self-harmed. This was recorded and therefore Ms Okweri, before making her visit to SU 11 on 6 February 2020 should have accessed SU 11 records and should have made herself aware of this incident. Ms R stated that in her opinion the conversation between Ms Okweri and SU 11 on 6 February 2020 was not appropriate as it showed no empathy or understanding, or that Ms Okweri had not read her previous entry from 21 January 2020.

73. Ms R was asked about her knowledge of in-cell packs. Ms R stated that her understanding of an in-cell pack was that it was a comprehensive document developed as an activity pack to explore a particular theme. Ms R said that there was no template available to assist in creating one, that she had created one herself which was then checked by her manager for approval before use. Ms R recalls Ms Okweri forwarding her an in-cell pack that she had created on 'Fatherhood'. Ms R commented on this document as not relevant or helpful to clients because Ms Okweri had used the American Penal system as opposed to the English legal system which was more appropriate to prisoners in the UK. Ms R further commented on the content, as some of the information Ms Okweri used had been copied and pasted, which was inappropriate because it was someone else's work and opinion and furthermore it was not properly referenced. Ms R stated that she would not do that and that she just knew from her university days that you have to source the material used and correctly reference it.

74. During cross examination Ms R stated that when K first started as their new manager, there was a disruption to the flow of work because K implemented new procedures which did "rub colleagues up the wrong way". Ms R stated that she did take time off for personal reasons but did meet with K and sorted out any issues between them. Ms R went onto say that she was not close to K personally, only as work colleagues. Ms R confirmed that she did share an office with K and could not comment on why Ms Okweri was seated separately.

75. Ms R was asked whether there was any specific training that took place on Mondays or Tuesdays with the team (Ms Okweri's non working days). Ms R stated that there was no specific team training but there was safeguarding training that was done individually that might have fallen on these days. Ms R stated that she was aware that there were issues between Ms Okweri and K but she did not witness them. Ms R was asked how many times she witnessed Ms Okweri break down, to which she responded that that she could not recall but remembers Ms Okweri being upset and crying. Ms R was asked if the team worked together to create in-cell packs. Ms R stated that she created her own by herself and not with the team.

76. Ms R was asked by the Panel how the staff remained in contact during COVID. Ms R stated that contact was maintained through Teams, phone calls, emails and there were some meetings and that any updates would be given by mangers to workers. Ms

R confirmed that only CGL applications and CRiiS could be accessed remotely from personal devices but SYSTM1 could not.

Evidence of L

77. The Panel had a written statement dated 12 August 2024 with 45 documents exhibited.

78. L stated that there was an overlap between her employment and that of Ms Okweri. L recalled that she did interact with Ms Okweri, M and potentially K as well but could not recall if she spoke to K personally.

79. L stated that she is employed as a HR Manager at CGL and has held this position since 1 January 2024. That prior to this she was employed as a Regional HR Advisor with L. L described C as a national charity, which covers the whole country. L described her role as HR Manager to advise on HR policies by providing support to employers and managers to support employees. L stated her involvement in the fitness to practice case to date had been to collate information requested by Capsticks L. L stated that it had been difficult to provide some of the documents requested because HMP [PRIVATE] contract was transferred to another organisation in 2023, and because of this C no longer have access to some information. In addition, some of the staff previously employed no longer work for C.

80. L confirmed that she shared the Capability Report dated 21 April 2021 and the Appendices to the Capability Report with Social Work England. That these documents were held in the HR employee folder. L also confirmed that she obtained various case recordings exhibited in excel spreadsheet format. L explained that the information contained in this spreadsheet recorded 'contact date/time' when Ms Okweri recorded her contact with the SU. That some of the information is populated automatically and some is input by the staff member.

81. L stated that she also exhibited Ms Okweri's training record which was obtained from C Learning and development department. L stated that she did not have specific knowledge of the training, as to what was mandatory or not. L stated that she would have to check with the Learning and Development department to confirm the type of training. L also exhibited details of the time taken to complete training sessions and Ms Okweri's induction Programme. L confirmed that she exhibited all the SAP reviews which would have been stored on the HR employee folder as well as the managers folder. L stated that she no longer has access to M's folder as he had left. In respect of the SAP reviews, L's understanding was that once the SAP review is completed it is sent to the employee to read and confirm if correct. L stated that HR was not copied into these emails.

82. L stated that the SAP reviews do not have to be signed but must be confirmed via email for the content by the employee. A lack of signature does not suggest that it has

not been received. L went onto to say that if an employee wanted to make any amendments, then it should be raised with the manager. If the amendments were still not made after this, then she would expect the employee to raise this issue with senior management or HR to intervene and resolve.

83. L gave an overview of the capability process as steps to be taken if an employee is underperforming. L would initially expect a one-to-one supervision between the manager and employee to discuss concerns and possible solutions to improve. The manager should give support, set reviews and follow up on progress. If no changes or progress are made, then the manager should look at implementing a SAP together with the employee so the employee understands and contributes. This should last between 6-8 weeks. If at the final SAP review, there are no changes or improvement then the next step is to look at a capability report leading to disciplinary hearing. At this stage a file is put together by the manager with all supporting documents. This is then bundled and sent to the employee along with a letter to attend a scheduled disciplinary hearing. L stated that at a disciplinary hearing the following would be in attendance: the employee, HR representative, employee's union representative and an independent member who makes the assessment. When asked by Mr Smith if she had any concerns about the capability report, L stated that she did not, and believed that the correct process was followed.

84. In cross examination L was asked whose responsibility it was to ensure an employee has the correct tools and facilities to carry out their role. L responded that it is generally the manager's responsibility to ensure the employee had the correct tools to be able to perform their duties. L went on to state that this would also depend on the circumstances, such as an employee having additional needs, in which case additional support would have to be provided by the employer/manager. When asked if there was a duty of care by the employer with regards to ensuring they had the correct tools and facilities and whose responsibility that was, L responded by stating it was both the employer's and employee's duty.

85. [PRIVATE]

86. When asked why Ms Okweri's laptop was only delivered one month before returning to work despite raising it numerous times, L stated that this was an operational decision, and she was not involved in this and therefore could not comment.

87. Ms Okweri put it to L that she raised the issue of being discriminated against by her manager K and that she had raised it with L on several occasions and asked why nothing was done about it. L responded that she did not recall any conversation about discrimination otherwise she would have followed it through. L stated that from memory she recalls having a conversation about Ms Okweri's [PRIVATE] and the relationship breakdown between Ms Okweri and K. It was put to L that she was contacted so many times by Ms Okweri to get help and raise these issues, but nothing was done to assist her. Furthermore, that Ms Okweri contacted L to raise the issue of

the SAP review minutes which Ms Okweri believed were re-phrased and did not reflect the review that took place but again nothing was done. L stated that she does not recall this.

88. At this point in L'S evidence an adjournment was granted (see para 15 above).

Monday 27 January 2025 – hearing re-convened.

89. To assist Ms Okweri, it was agreed to allow Ms Okweri to write down her questions and for the Legal Adviser to ask the questions of the witnesses on her behalf. A total of 15 questions were put to L. Many of the questions related to the legal duty of care owed to Ms Okweri by her employer C, and whether L thought C had breached this. Mr Smith objected to these questions being asked and stated that they were not relevant to L's evidence and more appropriate for an employment tribunal. The Panel agreed and this was explained to Ms Okweri.

90. In re-examination L explained the procedure to be followed if a laptop was not received to allow an employee to work from home. L stated that the employee should raise it with their manager who could chase it up for them, but they could also chase it up themselves directly with procurement team as the contact information was easily accessible on the intranet. L recalled Ms Okweri raising the issue of not having a work laptop on one occasion.

91. When asked what tasks could be completed by an employee who had to work from a mobile phone, L stated that an employee could check emails, answer phone calls and attend a virtual training course where only attendance was required. Furthermore, that those who were expected to come into work were prioritised with equipment and therefore those working from home who did not have equipment were not expected to do any work from home. L was asked to comment on the timescale between lockdown which happened on 24 March 2020 and an email that was sent by K dated 8 April 2020 to IT to order the laptop for Ms Okweri. L stated that in her view that was an appropriate timescale.

92. L stated that M, as Ms Okweri's manager would not have direct access to her training record and would have to request it from the Learning and Development department but could not be sure. L stated that she could not recall if any assistance was offered by [PRIVATE], and if so, whether this was refused by Ms Okweri. L was asked to comment on the reasonableness of the time Ms Okweri had to wait for a laptop from when it was requested in April 2020 to receiving it on 22 July 2020. L stated that this was very difficult to answer because although it was a long time, C was not operating under normal circumstances because of the pandemic and a lot of equipment had to be distributed due to the size of the company. L was asked whether she thought the SAP was used as an oppressive tool as put to her by Ms Okweri. L stated that she did not.

93. It was put to L that Ms Okweri contacted her multiple times to raise issues, one issue being the rephrasing of the SAP minutes by K and M. L responded by stating that she was not sent any amended version of minutes by K or M. L now recalled advising Ms Okweri to contact M with the amendments. L stated at this point that she may still have access to Ms Okweri's HR file and may be able to access it.

94. At this stage a short adjournment was requested by Mr Smith because of relevant disclosure made in L's evidence where there was reference to a possibility of emails existing between HR and Ms Okweri. Mr Smith sought permission from the Panel to allow L to speak to Capsticks to see if these emails existed. The Panel granted the request.

95. After the short adjournment it was confirmed by Mr Smith that as a result of further enquiries two documents were found, of which one is disclosable – a COVID risk assessment was conducted by Ms Okweri and M. This was exhibited with an additional statement by L and added to the bundle. L stated the COVID risk assessment was completed on 4 July 2020 and reviewed and updated on 4 September 2020.

96. When asked what steps were taken to check in on Ms Okweri's wellbeing and follow up on the complaints, L stated that any information she had, had been passed on to the operational managers, also the service manager and head of prison but she could not say if that was followed through as M and K have left the organisation.

97. L stated that there were some workplace policies and procedures to ensure employees had the proper tools to be able to carry out their role. However, due to the global pandemic, C was working outside of certain policies as they were trying to establish how they could best support the SU's based on what the government was telling them. When asked whether there was an active difference in management applied by the organisation towards Ms Okweri as opposed to other employees, L stated that she was not aware of this.

98. [PRIVATE]

99. [PRIVATE]

100. L stated that the minutes of SAP reviews are usually sent to the employee by the manger to sign and then sent to both the HR employee file and the manager's file. However in this case, they were not sent to HR. L stated that she could not say why Ms Okweri was not provided with final versions of meeting notes or reviews before they were shared with HR.

101. L stated that she was not involved in Ms Okweri's recruitment. L described the culture at CGL as a compassionate company, supporting SU's back into recovery and the community. L described C as an open, honest and compassionate place to work. L exhibited the job description for the Family Support Worker dated 2018, but she stated that she had no responsibility for its compilation.

102. L stated that she was aware of the breakdown of relationship between Ms Okweri and K which resulted in the change of manager for Ms Okweri but she was not involved in the process itself.

103. L was asked to comment on the outcome of the grievance process. She was referred to a letter dated 30 March 2021 advising Ms Okweri of the outcome of her appeal. It was noted by the Panel within that document that it recorded that the outcome did not uphold bullying/harassment, however it did acknowledge that the behaviour K was not appropriate. Therefore, L stated that they understood there were learning and development needs for staff resulting from this grievance.

104. L stated that she was not aware of what the Bite Size Learning package was, but she believed Ms Okweri would have had access to this. L stated that if an employee raised an issue of discrimination, then there was a specific process that would be followed namely, either the Bullying and Harassment or the Grievance process.

Evidence of C

105. The Panel were provided with an written statement dated 08 July 2023.

106. C stated that he has worked for C as a Data Business Partner since March 2014. C stated that as part of the fitness to practice investigation, he was asked to provide specific information regarding CRiiS, namely whether it would be possible to study client records in preparation for review, without accessing client records and that his statement primarily related to this. C stated that he had had no direct involvement with other systems such as NOMIS or SYSTM1 which are held within the prisons as they are available for staff directly working in prisons, which he was not.

107. C was asked by Mr Smith if he was familiar with the platform Connect Skills and whether this system could be accessed remotely, away from work premises. C responded by confirming that it could be accessed if an employee had a C IT account (username email and password), as this enabled them to plug into the staff intranet, the internal C system including the training platform. An employee could log onto the system remotely, from any web browser including on a personal device, using the allocated username and password. Furthermore, even during COVID employees could access shared folders, if there was a service site within the intranet site. C stated that Microsoft Teams was implemented towards the end of 2019, into early 2020 as the preferred platform. C stated that his involvement in the changes that needed to happen to allow people to work from home was limited.

108. When asked about the CRiiS system, C explained that CRiiS is a secure, web-based case management system that supports the collection, recording and reporting of agreed data points of people accessing the services that C are commissioned to deliver. One of the main functions of CRiiS was to provide a record of interactions staff in services had with people who access those services. C stated that CRiiS has

a background user activity log system with associated reports, that it logs which user of CRiiS has accessed which client records, with the date and time this took place. When asked by Mr Smith if CRiiS could be accessed remotely on personal devices C confirmed that it could as long as an employee had a valid log-in and IP address. In 2020 C and CRiiS had separate log ins, but in 2020 a single login was adopted.

109. C explained that when a user logs into CRiiS, they are able to see a list of clients who have ever engaged with the service, but the only details that are visible are the client ID, their name, date of birth, the current allocated worker and some high level information that appears when the mouse is hovered over the client's name. C went on to explain that to study client records in preparation for review by accessing case notes within the client records, the user would need to go into the client record on CRiiS and this would show up in the CRiiS user activity logs. In respect of checking for updates on CRiiS the user would need to go into each client record and that upon auditing this would show up in the CRiiS activity logs.

110. C explained that whenever a user gives CRiiS a command such as entering information and saving it, not only does that information appear to the user, a parallel footprint is made in the background which captures all of the user's commands and activity. The programme creating this footprint was implemented around 2016/2017, prior to that a very basic one was in place.

111. In response to a question put to C by the Panel, he stated that when he was asked to assist in this investigation the question posed to him was 'in order to access the case notes in a client records, would that show up in the audit programme in preparation for review'. C's understanding was that it was necessary that a user must go into the client record on CRiiS for this to be done and it would show on the audit programme and have a digital footprint.

112. C was not aware of any additional training offered during COVID but stated that there was a focus on getting employees to work from home on personal devices but in a limited way, with GDPR principles reiterated and only accessing things that were absolutely necessary. C explained that if an employee was having problems logging onto the system during the first lockdown, it was an immensely busy period, but issues were addressed by the IT team through a ticket system and were dealt with within an appropriate response time.

<u>Evidence of L</u>

113. The Panel had a written statement with one exhibit dated 24 March 2023. L stated that he was employed as a software engineer between January 2015 to July 2021 by CGL.

114. Mr Smith referred L to his exhibit which contained the Capability Report. L confirmed that this was an email he sent to M on 26 August 2020 at 9.52am at his request.

However, due to the length of time that had passed he could not recall why he was asked to provide this information or what it was in relation to. L confirmed that the content of the email included a table generated from CRiiS to show Ms Okweri's activity on the system.

115. L described the document which recorded that Ms Okweri has viewed a particular page and seen the basic client details. L stated that the last column showed the date and time the record was accessed. L clarified that this does not show how long the user was in the file, only when they accessed it. L's recollection was that if another user logged into CRiiS then only the last action of the previous user would show by default and would not log all the actions over a period of time. L stated that it had worked this way since its inception and cannot recall when the changes were implemented in its ability to record all actions.

116. L stated that he could not comment on the accuracy of the software functions in relation to the spreadsheet report produced in the email he sent to M. It had been four years since he left CGL but from his recollection logging in to the system authenticated access. L stated that the report only showed events that had been recorded, and that there may be events that have not been recorded. In response to a question by the Panel L stated that column 2 of the document displayed that the client records were viewed. When asked to clarify by Mr Smith if client records were accessed L replied no. This evidence was noted to be contradictory.

Evidence of Ms B

117. The Panel was provided with a written statement from Ms B dated 9 July 2024. Ms B exhibited 41 documents.

118. Ms B stated that she is a qualified social worker and has been employed as the Head of Social Work at CGL since November 2023. She commenced her employment after Ms Okweri left so did not have any personal or direct professional knowledge of her. Ms B stated that her statement was based upon her review of the documents that she had exhibited and her own knowledge and experience as a registered social worker.

119. Ms B explained in her statement that she gained her knowledge of the Family Support Worker role by studying the job description.

120. During the hearing Ms B was asked for her understanding of the capability report process. Ms B explained that it was a tool to manage an employee's performance and record their progress. Ms B confirmed that she had not used the tool whilst at CGL. Ms B confirmed that the report was drafted by M, Ms Okweri's manager and she would expect the report to be given to the employee and line manager.

121. Ms B confirmed that a capability plan was created on 16 December 2020. Ms B considered it to be appropriate, although she thought it would benefit from having the dates of future reviews and being more supportive by phrasing it more positively. Ms B expected it to be signed and dated by both manager and employee. However, Ms B stated that as it was during COVID this may have impacted the production of signed documents. Ms B's view of the frequency of any plan was that it should be four weekly.

122. Ms B was referred to a supervision record from 27 August 2020 between M and Ms Okweri where it was discussed that the (SAP) was due to be implemented before COVID as a support measure. Ms B agreed the primary purpose of a SAP was as a support measure to improve the quality of work produced by an employee and focused on how an employee can be supported. Ms B agreed that if an employee raised concerns about management, it should be recorded.

123. Ms B was asked to comment on the appropriateness of Ms Okweri's return to the office after COVID. Ms B stated that it depended on Ms Okweri's circumstances at the time and that although three weeks seemed sufficient, she could understand it feeling rushed if one is vulnerable.

124. Ms B was asked to comment on the meeting notes dated 10 December 2020, between Ms Okweri and M where her case load was discussed. Ms B explained a case load of 5 appeared to be low but it would depend on its complexity.

125. The SAP review from 4 February 2021 was referred to, where M realised on reflection that the SAP action plan was too challenging and not met, thus resulting in a much-reduced SAP being implemented. Ms B agreed that this was an appropriate step to allow the employee to have another opportunity to meet the required standard.

126. Ms B confirmed that CRiiS was still in use at CGL. Ms B stated that she does have knowledge of CRiiS but does not have access to CRiiS as she does not have direct line management of social workers. Ms B agreed that if someone started a job in 2018 that they should be expected to have access to all systems by 2020 to enable them to carry out their role and the responsibility for that would be with the line manager during the induction period.

127. Ms B stated that she has no knowledge of in-cell packs and the information that she had gathered was from others. Mr Smith showed an example of an in-cell pack exhibited by C in her statement and the one produced by Ms Okweri. Ms B commented that Ms Okweri's in-cell pack contained information from an American website and that in her opinion that would be inappropriate for a UK prison population. Ms B stated that there are American words and phrases that are used which the UK prison population may not fully understand. Ms B stated that this could result in the risk that SU's do not get the support they need or may become disillusioned. Ms B was also clear that if the pack cited material then this should be referenced.

128. Ms B described a recovery coordinator as someone who worked with a person who had drug/alcohol dependency and helped them prepare for release from prison and directed them to other appropriate services. Ms B went on to state that it was the Family Support Worker's responsibility to assess the risk level by checking all the relevant systems available to them. Ms B would have expected notes to be uploaded on to the appropriate systems.

SERVICE USER 1

129. Ms B was asked to comment on Ms Okweri's assessment of SU 1 from 26 January 2021. Ms Okweri stated that 'he is yet to find out if he has a mental health issue'. Ms B stated that in her view if this was raised then Ms Okweri should have explored further to minimise risk, to try to understand the person and help them. Ms B went onto say that she would have expected this information to be recorded on the Action Plan and flagged with a manager. Although Ms Okweri did contact the mental health team on 24 February 2021, in Ms B's opinion it should have been done sooner. Ms Okweri should have contacted other professionals to check the mental health diagnosis raised by SU 1. Further, that Ms Okweri should have recorded the details of the person she spoke to and what was discussed on the CriiS system.

130. In respect of the risk posed by SU 1 to his unborn child, Ms B stated that she would have expected Ms Okweri to have accessed all the systems to find out information and raise it as a safeguarding concern. Any safeguarding concern should be opened within 24 hours of the risk being identified and recorded on CriiS. Despite being told by her colleague on the 8 April 2021 to contact social services Ms Okweri did not do so until the 15 April 2021, which in Ms B's view was not acceptable.

131. Ms B stated that family assessment undertaken on 26 January 2021 was not complete because Ms Okweri had not indicated whether she had checked other applications to verify what SU 1 was telling her. In addition, Ms Okweri failed to record accurate information and she should have shared this information with other professionals.

SERVICE USER 2

132. In respect of SU 2 who was subject to a restraining order, Ms B commented that by not accessing OASYS and SYSTM1 Ms Okweri had failed to take adequate steps to ascertain the nature of the risk associated with the restraining order. Ms B said she would have expected Ms Okweri to make contact with the multiagency risk assessment conference, probation, social care and prison resettlement team. In

respect of the action plan she would have expected them to be written in a SMART format, which is Specific, Measurable, Achievable, Realistic and Timely. Even though SU 2 was still in custody and the risk was not imminent Ms B would have expected Ms Okweri to fully explain the consequences of breaching the order to him SU 2 to check his understanding. The recorded assessment lacked sufficient information to be able to identify which children were at risk.

SERVICE USER 3

133. Ms B was asked to comment on the assessment of SU 3 from 9 April 2021. Ms B stated that in her opinion the assessment recorded by Ms Okweri was too descriptive in nature with little analysis in identifying the level of risk. It would appear that Ms Okweri had recorded an analysis of the whole situation rather than the salient points, to highlight the key risks identified and what was being done to mitigate those risks in her professional judgement.

SERVICE USER 4

134. In respect of a one-to-one session between SU 4 and Ms Okweri on 8 April 2021 where SU 4 disclosed that he followed young girls in the shopping centre, Ms B stated that she would have expected Ms Okweri to explore this comment further by asking what he meant by that and how that led to his arrest. The purpose of one-to-one sessions is to have a conversation with the SU to explore their understanding of why they are in custody and offending behaviour, to assist the social worker to formulate a risk assessment and plan. In Ms B's opinion this information should have been shared with other agencies to formulate a safety plan on release from prison.

SERVICE USER 5

135. Ms B stated that whenever any safeguarding risk is identified then that should be uploaded within 24 hours, or if in the case of Ms Okweri who worked part time then it should be recorded as soon as possible. If a significant risk was identified and could not be recorded promptly then the employee could make a phone call to inform a colleague or manager. In respect of SU 5, the assessment was completed on 25 January 2021 and was not recorded until 29 January 2021, which in Ms B's opinion was too long.

SERVICE USER 6

136. Ms B stated that Ms Okweri's case recordings were not accurate in that the assessment took place on 3 March 2021, but the recorded date of contact states 10 March 2021, despite SU 6 having been transferred to a different prison on 8 March 2021.

137. Ms B stated that the SAP review from 15 April 2021 contained input from M which demonstrated that the Family Service spreadsheet had not been updated for SU 6 to record that he had been transferred to a different prison 5 weeks earlier.

SERVICE USER 8

138. Ms B confirmed that Ms Okweri had not been expeditious in referring SU 8 to the learning disability team. The action was dated 11 March 2021but this was not carried out until 7 April 2021. SU 8 was released on 21 March 2021. There should have been some urgency in her referral knowing SU 8 release was imminent.

SERVICE USER 9

139. Ms B stated that in her opinion the Family Service assessment of SU 9 was inadequate because it failed to address SU 9's strengths, the support offered, the areas needing further support and listing clear actions to address them. If these points were not addressed in the assessment, then there was potential for an impact upon the support that a SU could be given.

SERVICE USER 10

140. Ms B stated that in respect the Family Assessment conducted on 3 March 2021, Ms Okweri failed to record actions that had been followed up on the CriiS system. Furthermore, that it would have been prudent for Ms Okweri to have checked if there were any restrictions on contact prior to speaking with SU 10's family.

SERVICE USER 11

141. In respect of SU 11 the assessment carried out by Ms Okweri on 6 February 2020 was inadequate because it was not clearly recorded and some of the sentences did not make sense. This could result in key information being missed or misunderstood.

SERVICE USER 12

142. In respect of SU 12 Ms B stated that the assessment carried out by Ms Okweri was inadequate because it did not record SU 12's mental health issues, his previous convictions and did not contain sufficient information regarding conversations that took place with SU 12. The level of risk that SU 12 posed was not sufficiently assessed and therefore it was not possible to safeguard effectively.

143. In cross examination Ms B was asked whether she had worked in a [PRIVATE] prison and if so, the distinct differences from a community-based approach. Ms B said she had not and therefore could not describe the differences.

144. Ms B was asked based on her expertise and understanding of work place dynamics, whether she agreed that discrimination, stress, bullying, institutional discrimination, micromanagement, a lack of duty of care, or undue pressure could negatively impact on an individual's performance at work. Ms B replied absolutely.

145. Following on from that question Ms B was asked how these factors might manifest and affect an employee's contributions and well-being, specifically in relation to Ms Okweri's grievance with her manager K. Ms B responded that hypothetically it would affect people in lots of different ways.

146. The Panel asked Ms B how long she would expect a family support worker, working in a prison to spend with a SU in a one-to-one situation whilst undertaking an assessment. Ms B replied that in her opinion about an hour to hour was appropriate.

147. Mr Smith asked Ms B if Ms Okweri had conducted an assessment and recorded it on to the CriiS system, would another user be able to alter the record. Ms B stated that she was not sure because she does not have access to CriiS but normally in a case recording system once a person records and saves it then it is locked so people cannot edit it.

148. In re examination Ms Okweri put it to Ms B that she did not have the relevant training in in-cell packs and was not able to access any support despite raising this. Ms Okweri asked Ms B what she would have done in this situation. Ms B responded that she would probably have asked for support from her line manager and if that was not forthcoming she would escalate it higher.

149. Ms B was asked to comment on the SMART online training that Ms Okweri was asked to complete and is alleged to have been dishonest about. It was put to Ms B that SMART UK had informed Ms Okweri that she had completed 40% of the training and that when Ms Okweri was informed of this, she went onto complete the remainder of it the next day. Ms B stated that based on this information then there was nothing more Ms Okweri could do. If she had thought she had completed it and then been alerted to the fact that she had not, to have done so the next day was reasonable. Ms B could not comment on the dishonesty element.

150. In respect of the Naloxone training, it was put to Ms B that the reason why Ms Okweri did not complete it in a timely manner was because of the challenges that she was facing, including the [PRIVATE], bullying and lack of equipment.

Evidence of Ms Okweri

151. Ms Okweri provided several statements throughout to the Panel.

152. Ms Okweri started by thanking everyone for their support and help and appreciated that she was accommodated throughout the hearing. Ms Okweri stated that it was problems and difficulties that she experienced in her life in [PRIVATE] which gave her the passion to help people and pursue a career in social work. Ms Okweri stated that this has been a very challenging period in her life, that she has been under a lot of pressure which had affected her personally and professionally. The proceedings were an extremely daunting experience, a situation beyond her control but she felt she was doing the right thing to do by defending herself.

153. Allegation 1b. Mr Smith asked Ms Okweri her recollection regarding in-cell packs and confirmed that Ms Okweri had addressed this allegation in her written responses. Ms Okweri stated that the Programme Team had been initially tasked with creating them but after COVID, the family service team were asked to assist with the creation of the packs. Ms Okweri stated that she was asked to create them on her own whilst the rest of her team were working together and she received no support.

154. In examination regarding the in-cell packs Ms Okweri was reminded that she had been directed to seek assistance from Ms R. Ms Okweri disputed the level of help Ms B provided. Ms Okweri had noted that other colleagues were working together on in-cell packs whilst in the office. Ms Okweri stated that she had to work on her own and whilst at home on the work phone. It was put to Ms Okweri that from her supervision record from 27 August 2020, when asked by MJ why it was taking her so long that she said it was because of other work. Ms Okweri responded by stating that she did raise the fact she was struggling in supervision, but M had omitted it from the minutes.

155. Ms Okweri accepted that she made reference to the American Penal System and using sources obtained from the internet. It was put to Ms Okweri by Mr Smith that she did not reference the information that she used to create the in-cell packs. Ms Okweri responded by stating that she thought at the end of the in-cell pack she had put details of the references. Ms Okweri stated that she had studied at University in [PRIVATE] and was taught how to reference and understood if information is used that it needs to be referenced. Ms Okweri reiterated that under the circumstances she thought she had referenced to the best of her ability. Furthermore, that the unexpected challenges that she was facing at the time including COVID, working from home, not having the correct IT equipment, not being trained in creating in-cell packs and not receiving the support or help meant that she felt isolated and did not

feel part of the team. Under the circumstances she tried her best. That the minutes from her supervision could not be relied upon because they did not reflect accurately what was said as M had omitted the conversation that actually took place.

156. Allegation 2. It was put to Ms Okweri that she was instructed with completing the SMART recovery training on 15 December 2020 but in April 2021 she still had not completed this fully despite telling M that she had. Ms Okweri responded by stating that she initially had access problems and that she had so much online training to do that she got confused and thought she had done it initially. However, that once she was notified by UK SMART that she had not completed it, she completed it on 31 March 2021. Ms Okweri stated that when she was asked by M if she had completed it, she honestly thought that she had.

157. [PRIVATE]

158. Allegation 4a Mr Smith reminded Ms Okweri that this allegation related to the email that she sent to MJ on 16 July 2020 saying that she had accessed CRiiS for updates on clients and that evidence had been heard from C and L in relation to what access she had on CRiiS. Ms Okweri was asked if she could recall how the CRiiS system operated. Ms Okweri stated that she could not recall exactly how it worked. Mr Smith put to Ms Okweri that the evidence provided by C and L shows that it was not possible to review information on CRiiS for clients without clicking into their records and therefore, the email that she sent on 16 July 2020 stating that she had accessed those records was false. Ms Okweri responded by stating that she could not recall the exact events of that day because it was so long ago and the stress that she was under at the time.

159. Mr Smith suggested to Ms Okweri that it was quite convenient now that she could not recall these nuances of the CRiiS system yet was able to recall details of other events at the time. Ms Okweri responded by stating that she was not picking and choosing what she could recall and was not lying. She just could not remember what happened.

160. Allegation 4b Mr Smith stated that the same process applied to this allegation relating to an email sent to MJ by Ms Okweri on 7 August 2020, where Ms Okweri stated that she had gone through the list of her current clients but evidence by C and L showed that she did not access their records. Ms Okweri responded that she could not recall the exact events of that date and that if the description in her email was inaccurate it was an honest mistake.

161. [PRIVATE]

162. Mr Smith asked Ms Okweri why, if her [PRIVATE] was causing such difficulties, did she not ask to withdraw from visiting clients. Ms Okweri answered that she did make a request to stay off work, but it was not granted and instead was threatened over and over again with disciplinary action. Ms Okweri went on to state that it was at this

time that she contacted HR to seek help and guidance, but despite her cry for help nobody assisted her. Ms Okweri stated that it was a very difficult and challenging period and one that she does not want to keep remembering because it was traumatising.

163. Mr Smith asked Ms Okweri how M threatened her with disciplinary action. Ms Okweri stated he made these threats verbally but this was never reflected in the minutes of their meetings. Ms Okweri went on to state that when she corrected the minutes to reflect this it was ignored and not changed. She realised that M was not sending the correct minutes of their meetings when he was speaking to HR.

164. Allegation 5 Mr Smith reminded Ms Okweri that this allegation relates to the steps she did or did not take to resolve issues with her access to OASYS and Systm1. Mr Smith referred to the capability report in which it is noted that on 5 August 2020 Ms Okweri was tasked with obtaining access to these two systems and by 28 April 2021, it was noted that Ms Okweri still had not obtained access by this date. Ms Okweri responded by stating that she sent all the information and took all the necessary steps to resolve it. Ms Okweri referred to an extract from her work diary dated 22 April 2021 that she exhibited which refers to an entry where she had made a note to contact the relevant individual within the IT department. Mr Smith asked whether this was a to do list or completed list to which Ms Okweri replied it was a to do list to help her plan her workday. Under examination Ms Okeri confirmed that she had underlined the diary entry dated 22 April 2021, concerning the need to contact J regarding OASYS access at the point of disclosing her diary to the Panel.

165. Mr Smith made reference to notes from a meeting on 5 August 2020 where Ms Okweri was asked to reset her OASYS password and therefore Mr Smith suggested that the issue was with Ms Okweri forgetting her password. Ms Okweri stated that this was not the case and that the main issue was that she did not have access to the systems and despite asking for help and support from management she did not receive it.

166. In reference to the minutes from 5 August 2020 Ms Okweri stated that these were inaccurate and did not reflect the conversations that took place with M. They omitted to mention the issues Ms Okweri was having and the help that was being requested. Ms Okweri stated that this was constantly raised with M and H but to no avail. Ms Okweri stated that she felt like she was being overly scrutinised and micro-managed.

167. Mr Smith referred to the notes of the SAP review of 4 February 2021 where he pointed out that Ms Okweri had raised concerns about M taking direction from K, M responded stating that any email communication comes from him not K and that he has extensive management experience and does not need to run everything by K. Further that M believed that his communication accurately represented what was said in the meetings. Ms Okweri responded by stating that the notes were incorrect and did not reflect what was said.

168. Mr Smith suggested to Ms Okweri that her claim that all these notes were inaccurate is simply to cover the fact that she was not doing her job to a satisfactorily standard at that point. Ms Okweri denied this.

169. Mr Smith referred to the SAP reviews of 4 February 2021, 25 February 2021 and 8 April 2021 where Ms Okweri was instructed to contact IT to resolve her access issues by MJ. Mr Smith asked Ms Okweri how many times she chased IT to resolve her issues. Ms Okweri stated that she cannot recall the exact number, but she was constantly chasing it up.

170. Allegation 6b Ms Smith outlined that this allegation was as a result of not having access to OASYS and/or Systm1, that Ms Okweri did not consider all relevant information when assessing risk and making professional decisions for SU 2. Ms Okweri agreed that in order to fully assess risk that she would need access to both systems but the reason why she could not, was because she did not have access to these systems despite repeated attempts to do so. Access was only obtained a few weeks before Ms Okweri left CGL.

171. Ms Okweri stated that she had no reason to delay getting access and in fact it was to the contrary and caused her immense stress. She stated that she did everything to gain access.

172. Allegation 7. Mr Smith stated that this related to an assessment from 26 January 2021 of SU 1. Ms Okweri accepted that she may not have completed all of the action plan but that she did write 'he is yet to find out'. Ms Okweri stated that she did refer to mental health services, but they kept referring her back to Systm1. Ms Okweri did not have access to this, and as a consequence she stated she was going round in circles and this made her feel "handicapped". Mr Smith put it to Ms Okweri that what she was saying today was not recorded anywhere in the notes. Ms Okweri agreed that this was not recorded but she had contacted mental health services on 24 February 2021 and did everything she could immediately after the assessment before putting the intelligence report in.

173. Allegation 8a-h. Mr Smith stated that this allegation related to the assessment undertaken on 26 January 2021 where it was alleged that Ms Okweri did not conduct checks to determine if SU 1 was diagnosed with psychosis and/or depression and did not follow that up with the healthcare team. Mr Smith referred to the safeguarding reports of 24 February 2021 and 15 April 2021 where the risks were outlined but there were no notes to say what action Ms Okweri had taken to contact the safeguarding team despite M asking Ms Okweri for updates. Ms Okweri responded by stating that she did speak to the safeguarding team but could not record it because she did not have access to CRiiS.

174. Ms Okweri agreed that she did not notify social services regarding the fact that SU 1's partner was expecting a baby because she did not believe there was an imminent risk as SU 1 was in prison and not due for immediate release, despite being told to do so

by M. Furthermore, Ms Okweri stated that the whereabouts of the partner was unknown and therefore she believed the risk was low.

175. In respect of the restraining order that SU 1 was subject to, Ms Okweri stated that she did not actually see the terms of this and worked from limited information that she had access to, hence the reason why she did not record it.

176. Allegation 9. Ms Okweri in response to this allegation Ms Okweri stated that she believed she did raise the safeguarding concern in relation to SU 1 in a timely manner.

177. Allegation 10a,c,e,f. Ms Okweri stated that she advised SU2 to seek legal advice which would enable him to take the right steps to mitigate any risk. Ms Okweri agreed that systems were checked but conceded that her assessment did not mention which systems were checked. Ms Okweri stated that she did identify the risks and advised SU2 of the risks of breaching the restraining order including domestic abuse/violence but accepted that it was not recorded. As regards not informing the appropriate agencies regarding safeguarding, Ms Okweri stated that she believed it would depend on the circumstances when steps should be taken but usually it should be 24 hours. Ms Okweri stated that she could not recall the exact circumstances but may have been delayed in passing on the information because she was sick, or working part time.

178. Allegation 12. Mr Smith stated that this related to Ms Okweri not completing outstanding safeguarding actions identified by K on or around 4 March 2021.

179. Ms Okweri stated that she was waiting for help and assistance, waiting for change but instead received threats of being reported to Social Work England. These threats were made verbally but never recorded in the minutes of meetings. Ms Okweri continued that she amended the minutes to reflect what was actually said back to MJ, but he did not pass them onto HR.

180. Mr Smith put it to Ms Okweri that she did not carry out the actions identified by K as instructed. Ms Okweri responded that due to what she was going through, her [PRIVATE] circumstances, she did not follow the instructions, but that it was not deliberate.

181. Allegation 13a-d. Mr Smith stated that this related to a safeguarding assessment from 9 April 2021. Ms Okweri stated that she only had limited information to work from and when she requested further information regarding a partner, the SU would not release it to her. She added that if the assessment did not provide sufficient details of risk, it was not because of a lack of trying, care or commitment but because she had limited information to work from and limited access to systems.

182. Allegation 14. This related to Ms Okweri failing to contact social services to find out if they were involved with SU 3's ex-partner and children despite this being an action identified in an assessment of 9 April 2021. Ms Okweri stated that SU 3 would not tell

her the location of the ex-partner and that is why she did not contact the Social Services department.

183. Allegation 15 and 16. As these were related to SU 4 Mr Smith addressed these together. Allegation 15 related to Ms Okweri not obtaining sufficient detail of SU4's interest in young girls as expressed in a one-to-one session on 8 April 2021. Allegation 16 related to Ms Okweri not sharing information with any relevant professional. In response to these two allegations Ms Okweri stated that SU 4 was a vulnerable young adult who was in prison because he had entered a shopping centre where he was not allowed whilst following some girls. Therefore Ms Okweri maintained that her record of this incident was not misleading since SU4 had not indicated to her that he had a "negative interest" in young girls. Ms Okweri stated that she had discussed it with the safeguarding lead and there was no risk.

184. Allegation 17 concerned Ms Okweri's case recordings not being accurate and timely in relation to SU 5. Specifically SU5's assessment was undertaken on 25 January 2021 but was not written up until 29 January 2021. The contact date was recorded as 28 January 2021 when it should have been recorded as 25 January 2021. Ms Okweri stated that this was incorrect because she did not work Mondays, which 25 January 2021 was, so this assessment could not have been conducted by her on that date. Ms Okweri confirmed to the Panel that M was aware of her working pattern. Ms Okweri stated that this was an example of inaccurate information and that shewould not have recorded it.

185. Allegation 18b, c. These related to Ms Okweri not recording adequate detail of any advice she gave to SU 5 during the assessment on 28 January 2021. Ms Okweri stated that these were not her entries and she therefore did not accept these allegations.

186. Allegation 19. This related to Ms Okweri not recording accurate case recordings in relation to an assessment of SU 6 stating that it took place on 3 March 2021 but the recorded date input by Ms Okweri was 10 March 2021 despite SU 6 having been transferred out of prison on 8 March 2021. Ms Okweri stated that she could not comment on this because she could not have seen SU 6 on that date, if he was no longer in prison. Similarly to SU 5, Ms Okweri felt that this raised the issue of the credibility of some of the allegations against her.

187. Allegation 20. This related to Ms Okweri not updating the family service spreadsheet in relation to SU 6's release date and/or not closing SU 6's file on the spreadsheet in a timely manner. Ms Okweri stated that in relation to SU 6 she really did not know what to say, because the records concerning him were not correct, and she asserted that most of the entries on CRiiS were inaccurate.

188. Allegation 22. This related to inadequate case management in relation to SU 8 in that Ms Okweri did not action a referral to the learning and disability team in a timely manner. Mr Smith stated that according to Ms Okweri's notes the safeguarding review was carried out on 11 March 2021, but the referral was not actioned until 8

April 2021. Ms Okweri stated that she could not recall what happened at the time but that the referral might have been delayed because of the time it took to undertake referrals and also because she had limited access to Systm1 and other services.

189. Allegation 23. This related to the quality of the assessment from 7 April 2021 of SU 9 and the detail within it. Ms Okweri stated that she could not recall anything about the entries referred to.

190. Allegation 24. This related to the action plan created for SU 9 on 7 April 2021 being inadequate and not containing action around family members. Ms Okweri stated that she could not recall much about SU 9.

191. Allegation 25. This related to SU 9 and Ms Okweri not completing any of the action plans that were created. Ms Okweri reiterated that she could not recall anything about this matter.

192. Allegation 26a, c,d, e. This related to an assessment of SU 10 being inadequate. Ms Okweri stated that she could not recall the assessment but in her email of 5 February 2025 she stated that her usual process was hampered by limitations in accessing crucial information.

193. Allegation 27. This related to an assessment on 3 March 2021 in relation to SU10 where Ms Okweri had not completed the outstanding actions. Ms Okweri stated that she could not recall.

194. Allegation 28. This related to Ms Okweri not providing in-cell packs in a timely manner in relation to SU 10. Ms Okweri stated that she could not recall.

195. Allegation 29. This related to Ms Okweri not recording contact with SU 10 on CRiiS after providing in-cell packs. Ms Okweri stated that she could not recall.

196. Allegation 30. This related to Ms Okweri making contact with SU 10's family without conducting and/or recording any checks as to whether there were any restrictions that would prevent service from SU 10 having contact with said family members. Ms Okweri reiterated that she could not recall anything about SU 10.

197. Allegation 31a, b. This related to Ms Okweri's assessment of SU 11 being inadequate, including the use of inappropriate language around SU11's suicidal ideation. Mr Smith asked whether Ms Okweri agreed that the way the record had been written was unclear and that some parts did not make sense. Ms Okweri said that she could see that. In relation to allegation 31b Ms Okweri stated that to someone reading her assessment it could come across as troublesome, but that she was only trying to get SU 11 to see that there was a lot of help and support he could access . She added that she would never trivialise someone trying to take their life.

198. Allegation 32a-d. This related to Ms Okweri's assessment of SU12 being inadequate. Ms Okweri stated that she could not recall anything relating to SU 12.

199. Allegation 33. This related to Ms Okweri being dishonest in relation the allegation 2, 4a and 4b. Ms Okweri categorically denied being dishonest.

200. The Panel asked Ms Okweri in relation to her access to systems when working at CGL, whether her lack of access was ever raised as an issue before August 2020. Ms Okweri stated that she could not recall exactly, but beleived that it was never raised before. Prior to that time her role mainly involved group work and for this she did not need access to the systems to the best of her recollection.

Social Work England's Closing Submissions on Facts

201. It was submitted by Mr Smith that throughout this hearing Ms Okweri had been evasive and noncommittal. He asserted that where questions became difficult, Ms Okweri stated she could not remember. Mr Smith added that at certain points Ms Okweri started to question the accuracy of the records to which she had been referred to throughout the hearing; these were records she herself had created. At all times Ms Okweri's responses reverted to questioning the level of support she received or stating that the SAPs were entirely inaccurate. None of this was corroborated by Social Work England's witnesses. It was submitted that Ms Okweri was not a credible or reliable witness.

202. Mr Smith confirmed that each of Social Work England's witnesses approached their evidence in a clear and helpful manner. Mr Smith stated that each was willing to accept when they did not know an answer or could not recall a specific point. He also asserted that witnesses (in particular Ms L) were willing to concede points where it was in Ms Okweri's interest. Mr Smith added that there was no impression of bias or of an attempt to be 'out to get' Ms Okweri. He submitted that all the witnesses presented their evidence in a way which meant the Panel could rely on them as credible and reliable. Mr Smith invited the Panel to prefer the evidence of Social Work England's witnesses to that of Ms Okweri.

203. During Mr Smith's closing submissions, he raised with the Panel the issue of allegation 17. He submitted that the Panel's decision on this allegation would depend on whether it accepted Ms Okweri's evidence of her working pattern. Social Work England was not in a position to provide evidence from CGL of what Ms Okweri's working arrangements were. Mr Smith added that if the Panel determined that Ms Okweri did not work on a Monday, this would mean that it would not have been possible for Ms Okweri to have conducted a visit on 25 January 2021. This would make the body of the entry inaccurate, but the 'contact date' potentially correct.

204. Mr Smith invited caution from the Panel regarding the above point. It was put to Ms Okweri that she stated she did not work on Monday 25 January 2021 because it was one of her non working days. Mr Smith added that if it was not possible for Social

Work England to gainsay this answer, given the lack of attendance records from CGL, it was the case that the record from the SAP with M did not record the fact this visit took place on a Monday as an error. It was submitted that where the dates of entry were being directly criticised by M, this would have been precisely the time for Ms Okweri to raise the issue that this was not her working day. Mr Smith asserted that if the visit did take place on 28 January 2021, there would have been little criticism of the timeliness of the entry. Mr Smith elaborated that this SAP Review occurred during the week following the disputed dates, meaning it was less likely that Ms Okweri would not remember when the visit had taken place.

205. Mr Smith submitted that Ms Okweri's mistake was in creating the contact date as 28 January 2021 and that in fact the visit did take place on 25 January 2021 as recorded.

206. Mr Smith submitted that if the Panel were to disagree with the above point and find that Ms Okweri did not ever work on a Monday and therefore did not conduct the visit on 25 January 2021, the record should still be considered inaccurate. Mr Smith invited the Panel to consider the case of PSA v HCPC and Doree [2017] EWCA Civ 319. This case states at paragraph 54 that *"A professional disciplinary committee is entitled to make amendments to the allegations before it, so as to avoid "undercharging". Mr Smith submitted that it would be important for the Panel to consider whether finding this allegation 'not proved' would in fact amount to under charging, thereby having- a potential impact on a finding of impairment or on any final sanction to be imposed. It was further stated in the case of Doree by counsel for HCPC (and accepted by L) that, "it would be possible for [the Panel] at that stage to canvass the possibility of amendments being made to the allegations to match their relevant findings of fact, and, if satisfied that such amendments could be made without unfairness, to proceed on the basis of the allegations amended"*.

207. Mr Smith reminded the Panel that the basis of the allegation as drafted was that the record was not accurate. As the allegations stand it alleged that the record was not accurate because the visit was dated as having taken place on 28 January 2021 when in fact it took place on 25 January 2021. Mr Smith submitted that if the Panel were to accept Ms Okweri's submissions regarding working patterns, then the timeliness component of allegation 17a would fail based on the evidence of Ms B. However, Mr Smith asserted that the record would still remain inaccurate. Mr Smith noted that it was not possible to amend the allegation as currently worded by simply changing the date.

208. In the event of the Panel accepting Ms Okweri's submission that she could not have undertaken the visit on 25 January 2021 since it was a non-working day, Mr Smith suggested the Panel take the following approach:

    a. Find allegation 17(a) not proved.

b. Amend allegation 17(b) to read: *Your case recordings were not accurate in that your assessment for Service User 5 indicates it was completed on 25 January 2021 when that was not the case.*

209. It was submitted by Mr Smith that no unfairness would result as the stem of the allegation (inaccuracy of records) would remain the same. It was submitted that the amendment would ensure that the allegation properly reflected the evidence, which was important for the next stage of the proceedings (should it be reached). It was submitted that an amendment would also ensure that there was no undercharging. It was submitted that the greater the number of errors regarding inaccurate reports, , the more likely that current impairment may be found.

210. Mr Smith submitted that this matter would ultimately rest with the Panel, who would need to consider whether it would be unfair to Ms Okweri to make this amendment at this stage of the proceedings. It was further submitted that if the Panel were not to find this allegation proved in its entirety, whether that would in fact make a difference to a finding of impairment given there are other allegations of a more serious nature for the Panel to consider.

211. In respect of allegation 33 a Mr Smith submitted that;

212. It was necessary for the Panel to work backwards through the evidence. The email from Mr F demonstrated that Ms Okweri had only completed 40% of SMART training by 19 April 2021. The SAP from 1 April 2021 stated that Ms Okweri had been made aware she had not completed the training which was at odds with what she had stated in her e mail to M on 31 March 2021.

    a. Given that by 19 April 2021 Ms Okweri was only 40% of the way through the module, her knowledge would have been that she had not completed the training when she spoke to M on 1 April 2021. It therefore could not have been an honestly held belief that she had completed it. The fact was that Ms Okweri knew she had not completed the trainingit. It was submitted that Ms Okweri lied to M.

    b. The ordinary person would view this behaviour as dishonest.

213. Ms Okweri's account in oral evidence was that she could not remember what happened. It was submitted this was a convenient excuse so that the Ms Okweri did not have to accept she lied to M. It was submitted that Ms Okweri lied to cover up the lack of work undertaken by her. Mr Smith also noted that M had repeatedly requested Ms Okweri to complete the training over a four month period.

214. In respect of *33*(b) and (c) Mr Smith submitted that;

a. Given the nature of the evidence relating to CRiiS, these submissions could be taken together (although they must be assessed independently).

b. Again, the Panel was invited to start by looking backwards through the evidence. C and L had stated that CRiiS created an audit trail when SU records were accessed. This audit trail did not exist until the user clicked into the SU record. Without clicking into the record, only 'high level information' was available.

c. L provided the CRiiS log information to M on 26 August 2020.This log recorded that Ms Okweri did not enter any SU records on either the 16 July 2020 or 7 August 2020.

d. The email from Ms Okweri to M stated the following, *"On Thursday 16th July 2020. Checked some more updates on CRiiS, for ideas on what is going on with clients"*. Clearly this email denoted that the Ms Okweri was claiming that this was work done on 16 July 2020. However, the evidence from C was that Ms Okweri would not have been able to tell what was *"going on with clients"* unless she clicked into the SU records, which would have created a similar footprint and would have been picked up in the audit trail.

e. This email was sent to M on the same day as the work is said to have been completed. There can be no confusion as to when Ms Okweri undertook this work (for example on 15 July 2020). As a consequence, when Ms Okweri sent the email to M, she knew she had not accessed the client records on that date. It was submitted that the reason why Ms Okweri claimed this work had been carried out was to make M think she had done more work than she had. It was submitted that Ms Okweri had not completed any other meaningful work on 16 July 2020.

f. The email from Ms Okweri to M sent on 7 August 2020 detailed work undertaken on the same day. It was again claimed by Mr Smith that there could be no confusion as to the date. Item 4 on the e mail recorded the following, *"Went through the list of my current clients on CRiiS. Studying*

my clients update in preparation for reviews". As before, the evidence of C is that it would not have been possible to study the client updates in preparation for review without clicking into their records. Mr Smith reminded the Panel that there was no audit trail because no activity had taken place.

g. It is submitted that the reason behind the alleged dishonesty was for the same reason as per the alleged earlier matter on the 16 July 2020, namely to cover up Ms Okweri's lack of work.

h. Mr Smith asserted that an ordinary person looking at this conduct would find that Ms Okweri had acted dishonestly.

215. It was submitted that when applying the *Ivey test,* Ms Okweri's actions were clearly dishonest. Ms Okweri knew what she was saying was false, and the ordinary member of the public would view her actions as dishonest.

Conclusion

216. Mr Smith submitted that he had presented, on behalf of Social Work England, compelling evidence against each of the alleged concerns. Social Worker England's witnesses were honest, credible, and reliable. He further asserted that the hearsay evidence relied upon remained accurate and reliable. It was submitted Ms Okweri's account, by contrast, was confused and evasive. Mr Smith invited the Panel to consider the evidence as outlined by the witnesses and to find each of the allegations proved on the balance of probabilities.

Social Worker's Closing Submissions on Facts

217. Ms Okweri submitted that her induction was poorly coordinated and, in her view, largely absent. She submitted she did not receive essential IT equipment in a timely manner to enable her to work remotely and she considered that [PRIVATE] was not taken into account in a meaningful and supportive way. Ms Okweri felt that she experienced a pattern of indifference and discriminatory treatment whilst working at CGL.

218. Ms Okweri acknowledged that she initially expressed relief when M was assigned as her new manager, as she was hopeful for a fresh start and the professional support she needed. Ms Okweri submitted that her very first supervision with M felt unusually intense and critical. She asserted that the SAP meeting minutes

misrepresented her contributions and undermined her position. She perceived that she was being collectively targeted and that it was an attempt to discredit her.

Reflections and Commitment

219. Ms Okweri acknowledged that the matters covered by the allegations highlighted areas where her practice could have been more robust. She submitted that she had taken time to reflect on both the importance of providing clear, analytical recording and the need to formally evidence all safeguarding checks even where there appeared to be no indication of concern.

220. Ms Okweri went on to state that since the time of the allegations arising, she had improved her own internal processes, including introducing personal checklists to ensure assessments were not only thorough but documented and triangulated with system records and multi-agency contacts.

221. Ms Okweri submitted that she remained committed to learning from this experience and ensuring that her future practice fully aligns with professional standards, particularly in complex or resource-constrained environments. She asked the Panel to consider the context in which these events occurred, and the steps she had taken since to ensure continuous improvement in her practice

222. (Ms Okweri accepted that some of the language used in the documentation regarding SU11 may not have conveyed the empathy she intended, and she sincerely regretted any unintended impact this may have had. She wished to make it unequivocally clear that she would never seek to undermine or invalidate the experience of someone in emotional pain, particularly in relation to thoughts of suicide. Any such interpretation did not align with her character, values or her practice.

223. Ms Okweri submitted that the use of the word "selfish" was not meant as a judgment but rather as part of an effort to help the SU consider the effect of their actions on loved ones. Ms Okweri recognised that this was a poor choice of words and that there were more sensitive and appropriate ways to engage. She stated that she was truly sorry for any distress this may have caused.

224. Ms Okweri submitted that her intention was to encourage reflection and offer hope by gently reminding SU11 of their strengths and existing support networks. In doing so, she hoped to promote resilience, not to cause harm. Ms Okweri acknowledged that language matters deeply, especially when supporting vulnerable individuals and stated that she had sought to act in good faith and with compassion.

225. Ms Okweri understood the need for ongoing reflection and development.

226. Ms Okweri asked the Panel to consider the impact of the time that had passed since the allegations had occurred and the impact on her ability to recall. She stated that any gaps or uncertainties in her responses were not due to a lack of cooperation or intent to mislead, but simply the reality of trying to recall procedural details several years after the fact.

Legal Advice on Finding of Fact:

227. The Panel accepted the legal advice from the legal adviser regarding its role in determining the Findings of Fact. The advice set out key legal principles to be applied in reaching a decision, including the burden and standard of proof, assessment of evidence, the admissibility and weight of hearsay evidence, the assessment of dishonesty and the procedural steps required to ensure a fair and reasoned decision.

228. The Panel was reminded that the burden of proof rests with Social Work England. It is Social Work England's responsibility to prove the alleged facts; on the balance of probabilities. The Panel was advised to assess each allegation separately and base its findings solely on the evidence presented during the hearing. This standard requires the Panel to be satisfied that it is more likely than not that the alleged facts occurred.

229. Hearsay evidence, which is defined under the Civil Evidence Act 1995, refers to statements made outside the current proceedings that are offered to prove the truth of the matter asserted. The Panel were reminded that whilst hearsay evidence is generally admissible, it is crucial that the Panel carefully considers its reliability and relevance.

230. The Panel should weigh the hearsay evidence against the principles laid out in the case of Thorneycroft v Nursing and Midwifery Council - [2014] All ER (D) 161. They are: -

- Whether the statement is the sole and decisive evidence in support of the charges
- The nature and extent of the challenge the contents of the statement.
- Whether there was any suggestion that the witness had reason to fabricate their allegations
- The seriousness of the charge, taking into account the impact which adverse findings might have on the registrants career.
- Whether there was a good reason for the non-attendance of the witness.

- Whether the Regulator had taken reasonable steps to secure the attendance of the witness.

- Whether the registrant did not have prior notice that the witness statement would be read.

231. The Legal Adviser referred to the case of R v Smith [2005] EWCA Crim 1295, where the Court of Appeal emphasised the need for caution when relying on hearsay evidence. The decision underscored that while hearsay evidence can be admitted, its weight should be carefully evaluated particularly concerning the credibility and reliability of the source.

232. The legal adviser reminded the Panel regarding the test for dishonesty as established in the case of Ivey v. Genting Casinos [2017] UKSC 67. This involves assessing whether the registrant's actions can be explained by factors other than dishonesty and considering the registrant's character and previous conduct. Ivey v. Genting Casinos [2017] UKSC 67, establishes a two-step approach:

- Subjective Element: Assess the individual's actual state of mind at the time of the alleged misconduct.

- Objective Element: Determine whether the conduct was dishonest by the standards of ordinary, decent people.

233. The Panel was reminded that they could take Ms Okweri's good character into consideration when assessing Ms Okweri's propensity to act in the manner alleged and her evidence in relation to the circumstances of the allegations.

Finding and reasons on facts:

234. The Panel carefully considered the evidence presented, including the Statement of Case, the live evidence, the Witness Statement Bundle, Exhibits Bundle, Social Worker's Response Bundle, the Final Service and Supplementary Bundle and all the other evidence submitted throughout the hearing process. In reaching its decision, the Panel assessed whether the allegations were proved on the balance of probabilities.

Allegation 1

1. You produced an in-cell pack on or around 30 July 2020 which was inappropriate for use in that it:

   a. Included content plagiarised from various internet sources;

   b. Did not provide references for the sources of information in line with best practice;

   c. Included reference to the American penal system.

235. The panel found allegations 1 (a) and (c) proved by way of admission. .

236. The Panel took note that whilst Ms Okweri was a qualified social worker at the time of the allegations she was not operating in the capacity of a registrant when the events occurred. The Panel accepted that Ms Okweri was tasked to put together an in-cell pack, as evidenced in the Capability Report appendix 4 and recorded in the weekly call dated 22 July 2020. The Panel concluded that Ms Okweri had received some guidance, albeit limited from Ms B about completing the in-cell packs. The lack of references was self-evident from viewing the in-cell pack created by Ms Okweri.

237. However, the Panel found that there was no evidence to show that Ms Okweri received adequate guidance or training on this specific point or that she was challenged about the lack of references when she initially presented the in-cell pack. Furthermore the Panel had no examples before it to show other people's work as a comparison . The only evidence the Panel had before it was the evidence of Ms B who stated, *'that [citing references] is what I would do because I just know how to do it from university'*. Ms B did not state that there had been any specific directive to add references to the in cell packs. The Panel noted that there was nothing in the evidence including the supervision notes, to show that M, as her manager had specifically told Ms Okweri that she had to reference her work.

238. The Panel found that although it was clear that Ms Okweri did not include the references, the burden of proof was not met to the required standard for the reasons stated above. There was no evidence to show that Ms Okweri had been directed to include references and furthermore, Panel had not been presented with any specific policy or guidance relating to best practice in this instance. NOT PROVED.

Allegation 2

2.On or around April 2021, you informed Colleague 1 that you had completed the entirety of 'Module 1- Getting SMART' training, when this was not the case.

239. The Panel found Allegation 2 proved by way of admission.

Allegation 3

3. *You did not complete training in a timely manner in that you were requested to complete Naloxone training on 30 June 2020, but did not complete the training until on or around 19 February 2021.*

240. The Panel found Allegation 2 proved by way of admission.

Allegation 4

4. *You made inaccurate statements about work you had undertaken whilst working from home, in that;*

    a. *On 16 July 2020, when you provided details of your working from home tasks for 16 July 2020 to Colleague 1, you said you had: "checked some more updates on CriiS for ideas on what is going on with clients", when you had not accessed client records on that date;*

    b. *On 7 August 2020, when you provided details of your working from home tasks for 7 August 2020 to Colleague 1, you said you: "went through the list of [your] current clients. Studying [your] clients update in preparation for reviews', when you had not accessed client records on that date.*

241. Allegation 4a.The Panel first considered the email sent by Ms Okweri to M on 16 July 2020 timed at 7.58pm. In that email Ms Okweri set out that she had undertaken the following tasks whilst working from home on 16 July 2020:

    - *Emails and other correspondence.*
    - *Navigate through other relevant work apps.*
    - *Reflective learning on prison domestic abuse Policy*
    - *Checked some more updates on CRiiS, for ideas on what is going on with clients.*

242. The Panel then went on to consider the evidence of C whom they found to be a reliable and impartial witness who gave cogent evidence relating to the digital footprint when accessing client records. The Panel accepted the evidence of C who stated that in order to obtain any significant information about clients a user would need to go into the respective client record on CRiiS and that such activity would show up on the CRiiS activity log and leave a digital footprint. To support this the Panel heard evidence from L who provided a document which contained an extract of the CRiiS activity log for Ms Okweri from 15 July 2020 to 25 August 2020. The evidence presented clearly demonstrated that Ms Okweri did not access client records on CRiiS on 16 July 2020.

243. The Panel then considered the statement of Ms B and her understanding as to how a CRiiS user would access case records for the purposes of undertaking reviews and establishing what '*is going on with clients*.' In Ms B's view she concluded that it was not possible to review anything on CRiiS, or see any information, without logging in.

244. This evidence was not challenged by Ms Okweri. In response to this allegation Ms Okweri in her evidence offered no other explanation other than that a lot of time had passed and she could not recall exactly what happened.

245. The Panel accepted the evidence of C and L, which was unchallenged, and which clearly demonstrated that Ms Okweri made inaccurate statements about the work she had undertaken whilst working from home on 16 July 2020. The Panel found this allegation proved. PROVED.

246. Allegation 4b. The Panel considered the email sent by Ms Okweri to M on 7 August 2020, listing the work she had completed that day. This included the assertion that Ms Okweri had checked CRiiS for the purpose of *"studying my clients update in preparation for reviews"*.

247. The Panel again considered the evidence of C and L regarding the digital footprint that would have been created, had Ms Okweri accessed client records on 7 August 2020. It considered that on order to study client records in preparation for a review, client records would need to be accessed. The Panel again accepted Ms B's evidence that it would not be possible to obtain any meaningful updates regarding a S without this showing up on the activity log as produced by L. The Panel found that there was no evidence to indicate that Ms Okweri accessed client records on CRiiS on 7 August 2020.

248. The Panel found this allegation proved. PROVED.

Allegation 5

5. *You did not take adequate steps to resolve issues with your access to key systems as directed by your manager, Colleague 1, including;*

    a. OASYS, and/or

    b. Systm1

249. The Panel noted that Ms Okweri was first tasked with re-setting her password and resolving access issues on 5 August 2020 as recorded in the minutes of a meeting between M and Ms Okweri. Ms Okweri was reminded to complete this task by M on several further occasions; 27 August 2020, 4 February 2021, 25 February 2021 and 8 April 2021 as evidenced in the SAP meetings. These documents confirmed that Ms Okweri did not have access to either of these two systems for a significant period of time and was consistently instructed to resolve the access issues by M.

250. Ms Okweri maintained throughout her evidence that despite repeated attempts to gain access and requests to management for assistance to gain access to these applications, help was not forthcoming. Ms Okweri produced a document which consisted of a paper diary entry from 22 April 2021 which read *'email to J..OASYS access'*, to demonstrate her efforts to obtain access to the systems. Other than

this, Ms Okweri was unable to provide any further evidence to demonstrate what attempts she had made to resolve her access issues and she suggested that the supervision notes were produced by M were not an accurate reflection of their discussions.

251. The Panel noted that Ms B stated in her evidence that any access/IT issues, once raised, were quickly resolved.

252. The Panel accepted the evidence contained within the SAP review meetings which clearly demonstrated that despite repeated instructions by M to resolve the IT/access issues to OASYS and Systm1, Ms Okweri did not take adequate steps to resolve them. The evidence of Ms B was persuasive in showing that IT issues were dealt with promptly. Ms Okweri on the other hand did not provide sufficient evidence to satisfy the Panel that she made repeated attempts to resolve her access issues, having only presented one diary entry from 22 April 2021. PROVED.

Allegation 6

6. *As a result of your lack of access to OASYS and/or SYSTM-1, you did not consider all relevant information when assessing risk and making professional decisions for:*

    a. *Service User 1*
    b. *Service User 2*

253. Allegation 6a. The Panel found this allegation proved by way of admission.

254. Allegation 6b. The Panel considered the evidence from the SAP review dated 4 February 2021 which demonstrated that Ms Okweri had not accessed OASYS or Systm1 when conducting assessments of SU2. Ms B in her witness statement stated that it was necessary to review all systems when conducting assessments as they contained material which may inform the social worker of important information. In cross examination Ms Okweri accepted that she did not have access to either system.

255. In cross examination Ms Okweri was asked by Mr Smith how, if she did not have access to both systems she could have conducted a full risk assessment of SU2. Ms Okweri responded by stating ‘not only SU2 all my SU’s’.

256. The Panel found that as Ms Okweri did not have access to either of these two systems, it followed that she could not have considered all relevant information when assessing risk and making professional decisions. ,The Panel therefore found this allegation proved. PROVED.

Allegation 7

In relation to Service User 1:

7. Your Initial Family Service Assessment dated 26 January 2021 was inaccurate, in that you:

a. Stated within the assessment that Service User 1 was yet to find out if they had a mental health issue despite Service User 1 telling you they had a diagnosis of psychosis and depression which they were receiving treatment for.

257. Allegation 7. The Panel found that Ms Okweri's response to this allegation was somewhat confused. In her oral testimony Ms Okweri admitted that she understood that psychosis and depression are mental health issues but, in her defence, she went onto to say that she is not a mental health professional and therefore this was beyond the scope of her practice. Despite this, in her assessment Ms Okweri stated that SU1 was yet to find out if he had mental health issues but could not recall why she wrote that. Ms Okweri did not deny SU1 telling her about their diagnosis. Ms Okweri then suggested that the information was entered by M and not herself, that it was inaccurate and she had raised this with HR. When challenged on this point and reminded of the nature of the document, Ms Okweri did concede that she was the author.

258. The Panel found that the assessment recorded in the Family Service Assessment dated 26 January 2021 was inadequate. It considered that any reasonable person in Ms Okweri's position would know that SU1 was suffering from mental health issues having been informed of a psychosis and depression diagnosis and would take appropriate action. The Panel found that this record was poorly drafted and inaccurate and the allegation was therefore proved. PROVED.

Allegation 8

8. In relation to Service User 1:

a) As part of your assessment on 26 January 2021, you did not conduct checks to determine if Service User 1 was diagnosed with psychosis and/or depression

b) As part of your assessment on 26 January 2021, you did not sufficiently explore Service User 1's statement that: "they hear voices in their head telling them to do something bad".

c) Your assessment of Service User 1 took place on or around 26 January 2021, but by 15 April 2021 you had not taken adequate action in relation to Service User 1's safeguarding.

d) *You recorded in your assessment on 26 January 2021 that Service User 1 was expecting a baby and you did not share this information with social services, despite Colleague 1 informing you on 8 April 2021 that this needed to be done.*

e) *In your assessment on 26 January 2021, you recorded that their partner had a restraining order against them but you did not take steps to ascertain the nature of the restrictions, including whether they related to Service User 1's child.*

f) *On 4 February 2021, you recorded a potential risk to Service User 1's pregnant partner in the safeguarding module but did not take any further steps to share this information with the appropriate professionals.*

g) *You concluded that there were no safeguarding concerns when this was not the case in light of the information disclosed by Service User 1.*

h) *In discussion with Colleague 1 on 15 April 2021 you indicated that as Service User 1 was still in prison you did not have to take any safeguarding action at that point.*

259. Allegation 8a. The Panel referred to the assessment of SU1. It was clear to the Panel that despite being told by SU1 that he had a diagnosis of depression and psychosis, Ms Okweri did not probe this any further with him. There was no evidence of Ms Okweri engaging with any other teams on this matter. Ms Okweri's oral testimony in relation to the events that had taken place was incoherent. Ms Okweri claimed that she had asked SU1about his situation and she suggested the lack of exploration in the assessment may have been because he was "not sure". She stated that she did go to the healthcare team for support and they told her to look on Systm1. None of this was evidenced in the assessment. The Panel found there were other avenues that Ms Okweri could have explored. The Panel found that Ms Okweri did not conduct checks with other professionals to determine if SU1 was diagnosed with psychosis and depression and found the allegation proved. PROVED.

260. Allegation 8b. The Panel heard evidence from Ms B who stated that in order to conduct a full risk assessment she would have expected Ms Okweri to have made further enquiries of SU1 in respect of the comment that he made, *"hear voices in*

their head telling them to do something bad" as without that information Ms Okweri would not have been able to assess SU1 fully. This would have impacted her ability to carry out a full risk assessment.

261. Ms Okweri in her evidence stated that she did discuss SU1's comment with the safeguarding lead and her manger M but conceded that there was no record of this.

262. The Panel found that the comment made by SU1 to MS Okweri suggested a risk of harm to others and therefore any reasonable person in a professional capacity would have been expected to investigate this further in order to carry out an effective risk assessment and put in place a plan to mitigate that risk. The Panel found no evidence of Ms Okweri exploring this further with SU1 and found the allegation proved. PROVED.

263. Allegation 8c. The Panel examined the SAP review that took place on 15 April 2021. This confirmed that the assessment took place on 26 January 2021, and a safeguarding report was created on 4 February 2021 in which Ms Okweri highlighted certain risks. In the SAP review dated 15 April 2021, the Panel found no record that Ms Okweri had taken any action relating to safeguarding.

264. Ms Okweri in her defence stated that she did raise her concerns with safeguarding and M, however there is no written record of this.

265. The Panel found that this demonstrated a lack of engagement with other professionals and a lack of professional curiosity to action tasks and progress matters. Ms B did acknowledge in her evidence that there was no immediate risk on this particular occasion. Ms B went on to say that consideration would also need to be made as to how long a SU had left on their sentence to determine what action would be appropriate. In this case SU1's remaining sentence was 4 months. The Panel carefully considered that this was a sufficiently short time within the context and therefore Ms Okweri was required to take action. The Panel found that Ms Okweri did not take adequate action in relation to SU1's safeguarding. The panel found this matter proved. PROVED.

266. Allegation 8d. The Panel examined the SAP review from 8 April 2021, where it was recorded by M that SU1's partner was expecting a baby and that this information needed to be shared with relevant agencies to safeguard effectively.

267. Ms Okweri in her defence stated that she was not aware of the whereabouts of the partner and felt there was no imminent risk however, Ms Okweri conceded that she should have contacted social services. The Panel determined that there was a clear directive upon Ms Okweri to share information for safeguarding purposes. The Panel found this matter proved. The Panel found that no safeguarding action had been taken by Ms Okweri and her admission of this fact was also taken into account.. PROVED.

268. Allegation 8e. Ms B in her evidence explained that if SU1 had raised the imposition of the restraining order she would have expected Ms Okweri to explore this further

with him in order that a full risk assessment could have taken place to assess the level of risk posed by SU1 to the unborn baby. Ms B explained that in her professional opinion there was an expectation on Ms Okweri to have explored this further.

269. Ms Okweri stated in her defence that because she did not see the restraining order there was no action for her to take.

270. The Panel found that Ms Okweri lacked a sufficient level of professional curiosity and situational awareness on this occasion There was no evidence before the panel to suggest she had attempted to ascertain the nature of the restrictions against SU1, despite an expectation upon her to do so. The Panel therefore found the allegation proved. PROVED.

271. Allegation 8f. Ms B in her witness statement outlined that she would have expected Ms Okweri to have shared this information with everyone involved and for it to have been recorded on CRiiS. There was no evidence to show that this happened or that it was recorded on CRiiS as an entry against SU 1's records.

272. The Panel found that Ms Okweri could have taken steps to ascertain where SU1's partner resided and there was no evidence to show that she took any steps to share this information. The Panel found the allegation proved. PROVED.

273. Allegation 8g. The Panel found that in light of the information disclosed by SU1 , that there was no record of Ms Okweri taking any action to mitigate safeguarding risks. Ms B in her evidence stated that '*if a SU says he is a risk to others then there is a safeguarding concern. Safeguarding concerns must be recorded in an active way to inform others that the SU could be a risk*'. The panel found that Ms Okweri should have highlighted safeguarding concerns in relation to SU1's pregnant partner but did not do so, therefore it found the allegation proved. PROVED.

274. Allegation 8h. In her response, Ms Okweri stated that the SU was still in prison and while he was due for release he was not an imminent risk. Ms B addressed the Panel on this issue and stated that whilst there may have been no immediate risk of harm because the SU was in prison, the information should still have been shared with social services to enable a support plan to be reviewed.

275. The Panel found that although SU1 may not have been an imminent risk, he was due for release, interventions take time to put in place, there were serious safeguarding concerns, and Ms Okweri should have been proactive to put in place an action plan at that point. The Panel therefore found that Ms Okweri's comments were inaccurate, and action was required. PROVED.

Allegation 9

9. *You did not raise a safeguarding concern for Service User 1 in a timely manner despite identifying risk factors in your assessment of 26 January 2021.*

276. Allegation 9. The Panel noted that the safeguarding concern in relation to SU1 was raised on 26 January 2021. According to the CRiiS records it was documented by Ms Okweri on 4 February 2021, approximately 5 days after the risk was identified. Ms B stated that she would have expected a safeguarding report to have been opened soon after a risk was identified, or at least within 24 hours. This would have been in line with CGL's Safeguarding Adults Policy. Ms B went onto state that if it was not possible to raise the necessary report within expected timescales then a line manager should have been informed.

277. Ms Okweri in her evidence stated that she did raise the concern on 4 February 2021 and 24 February 2021.

278. The Panel found that Ms Okweri did not raise a safeguarding concern for SU1 in a timely manner and this was in breach of the CGL policy and best practice. PROVED.

Allegation 10

10. In your Safeguarding Review of 20 January 2021:

a. The only risk management step you identified was advising Service User 2 not to breach a restraining order.

b. You suggested that the risks relating to Service User 2 were managed whilst Service User 2 was in custody.

c. You recorded that "systems were checked for info" but did not record what systems had been checked and/or what information had been checked.

d. You recorded that Service User 2's children were at potential risk of harm but did not identify which of Service User 2's [PRIVATE] children were at risk.

e. You noted that Service User 2 would be at risk if they breached the Restraining Order, but did not identify the nature of that risk

f. You did not inform the appropriate agencies regarding safeguarding to establish whether any other agencies were involved with, or needed to be involved with Service User 2, such as MARAC, MAPPA, or Social Care.

279. Allegation 10a. The Panel initially reviewed the safeguarding review notes for SU2 and in particular the comments recorded by Ms Okweri, where she noted the following, '*client advised not to go back to the house to see the children in order*

not to breach again'. The Panel noted that the safeguarding assessment recorded a number of risks but Ms Okweri had not recorded any other actions, apart from advising the SU not to return to the house.

280. The Panel noted that within Ms B's statement that she agreed with Ms Okweri and would also advise a client not to breach their restraining order, but that further steps were required prior to the SU's release in order to formulate a risk management plan, such as making contact with social services and/or probation. The Panel accepted Ms B's evidence and found the allegation proved. PROVED.

281. Allegation 10b. The Panel found this allegation proved by way of admission.

282. Allegation 10c. The Panel referred to the SAP review from 4 February 2021 where it was recorded that Ms Okweri was purported to have checked CRiiS to see the previous assessment. There was no other evidence of systems being checked by Ms Okweri. Ms B's opinion was that Ms Okweri would have been expected to have checked (and recorded that this had taken place) of enquiries undertaken via OASYS, CRiiS, Systm1 and NOMIS.

283. Ms Okweri in her evidence initially stated that a long time had passed and that she could not recall this information. During cross examination, Ms Okweri stated that she should have recorded what systems she had checked. The Panel found that there was a requirement for Ms Okweri to check all the systems, and she had not done so. The Panel found this allegation proved. PROVED.

284. Allegation 10d. The Panel found this allegation proved by way of admission.

285. Allegation 10e. The Panel examined the case recordings of SU2. In particular the Panel noted the entry by Ms Okweri in which she recorded the following risk, *'the risk of client returning to his ex-partners house again thereby breaching his order'*. In the SAP review on 4 March 2021, it was noted that Ms Okweri did identify the risk of SU2 breaching his restraining order, in that she noted that another violent incident could occur and there was a risk of SU2 going back to prison.

286. The Panel found therefore, that Ms Okweri did identify the nature of the risk, namely of SU2 going to his ex-partners house and another violent domestic event occurring, potentially resulting in a return to prison. The Panel therefore found this allegation not proved. NOT PROVED.

287. Allegation 10f. The Panel examined the case record of SU2 which identified that there were no records to demonstrate if Ms Okweri had made any contact with any appropriate agencies. This omission was further highlighted in the SAP review minutes from 4 March 2021 where it was recorded that Ms Okweri was aware of the need to contact relevant agencies. The Panel was unable to find any evidence of such contact taking place.

288. Ms Okweri in her evidence maintained that SU2 was appropriately managed whilst in custody, and that an action plan was still in place to make contact with

respective agencies prior to SU2's release. Ms Okweri stated that she had planned to contact all relevant organisations prior to his release knowing that all relevant information would be shared with appropriate authorities in the community and child protection.

289. The Panel were satisfied that it was Ms Okweri's duty as part of her role to mitigate risk and liaise with all appropriate agencies and it was clear from the record reviewed by the Panel that this had not taken place. The allegation was therefore found proved PROVED.

Allegation 11

11.In your assessment of 22 December 2020, you did not include any information about who the breaches of the Restraining Order or Service User 2's convictions for Grievous Bodily Harm related to.

290. The Panel found this allegation proved by way of admission.

Allegation 12

12. You did not complete the outstanding safeguarding actions identified by Colleague 2 on or around 4 March 2021 in a timely manner, or at all.

291. The Panel considered the minutes of the SAP Client Safeguarding Review and Reflective Practice Guidance dated 4 March 2021 where potential risks concerning SU 2 were identified to Ms Okweri and set out as outstanding safeguarding actions by K. The panel then went on to consider SU2's case records, focussing on contact that took place between Ms Okweri and SU2 after the aforementioned meeting on 4 March 2021. The Panel found no actions recorded that correlated specifically to those identified by K and therefore concluded that there was no evidence to suggest that Ms Okweri completed the same.

292. Ms Okweri in her evidence stated that at the time she was experiencing [PRIVATE].

Allegation 13

In relation to Service User 3:

13. Your safeguarding assessment dated 9 April 2021:

a. *Did not provide a sufficiently detailed analysis of the risks involved in Service User 3's case.*

b. *Did not provide the details of any other professionals involved with Service User 3.*

c. *Did not list the key risks identified for Service User 3 and/or what is being done to mitigate those risks.*

d. *Did not include information recording your professional assessment of the level of risk.*

293. Allegation 13a. The Panel considered the evidence of Ms B who examined the safeguarding assessment of SU 3 dated 9 April 2021 and concluded that in her opinion it read more like a narrative rather than an analysis of what Ms Okweri saw as risks. Ms B stated that she would have expected Ms Okweri to have listed all the risks identified and what would be expected to mitigate those risks, in particular risks to the SU and his family in light of a history of domestic violence. The Panel accepted the evidence of Ms B and agreed that the way the assessment was written and presented it would impact the way risks were potentially managed. The Panel found this allegation proved. PROVED.

294. Allegation 13b. The Panel reviewed the safeguarding assessment dated 9 April 2021 in respect of SU3. There was no evidence of Ms Okweri recording details of any other professional involved. The Panel accepted the evidence of Ms B that the assessment should have contained such information since it would have assisted in assessing the level of risk. The Panel found this matter proved. PROVED.

295. Allegation 13c. The Panel reviewed the safeguarding assessment dated 9 April 2021 in respect of SU 3. Ms B stated that she would have expected Ms Okweri to have listed all the risks identified and what would be expected to mitigate those risks. There was no evidence of Ms Okweri listing the key risks identified in respect of SU 3 or what was being done to mitigate those risks. The Panel found this allegation proved. PROVED.

296. Allegation 13d. The Panel reviewed the safeguarding assessment dated 9 April 2021 in respect of SU 3. The Panel considered the evidence of Ms B that the assessment should contain pertinent information relating to the SU which would in turn help in assessing the level of risk. The Panel found that the assessment lacked sufficient detail of Ms Okweri's professional observations in respect of the level of risk SU 3 posed. The Panel found this allegation proved. PROVED.

Allegation 14

14. You did not take any steps to contact Social Services to find out if they were involved with Service User 3's ex-partner and/or children despite this being an action identified in the assessment of 9 April 2021

297. Allegation 14. The Panel viewed the action plan from 9 April 2021 in which Ms Okweri had recorded 'contact [PRIVATE] social services to know if clients ex-partner is still working with them and if there is any current information.' The panel also considered the evidence of Ms B who addressed the risk of harm due to Ms Okweri not making contact with social services and as a consequence that this would have meant that there was no plan in place to address the family's safety.

298. The Panel also considered the SAP review dated 15 April 2021 in which M recorded that Ms Okweri confirmed that she did not contact social services by the date of that meeting. The Panel found this allegation proved based on the above evidence. PROVED.

Allegation 15

In relation to Service User 4:

15. You did not obtain sufficient detail of Service User 4's interest in young girls as expressed to you during a 1:1 session on 8 April 2021.

299. Allegation 15. The Panel considered the case recording in relation to SU4 where it was recorded that the SU '*mentioned that young girls made him to be in custody and he regretted following them to the shopping centre he was barred from coming*'.

300. Ms Okweri disputed throughout the proceedings that there was a concern regarding SU4's alleged interest in young girls. Ms Okweri considered that even if the SU had followed them, it did not indicate an interest in young girls but was because he was not allowed in the shopping mall. Ms Okweri stated that the SU himself was vulnerable therefore this lessened the risk.

301. Ms B in her evidence explained that this was a missed opportunity to understand the full picture in relation to SU4 and that Ms Okweri should have explored further with him so that she could fully assess the risk that he posed and mitigate that risk by planning for his eventual release.

302. The Panel found that Ms Okweri failed to appreciate and fully understand that SU4 may have presented as a risk to young girls. The Panel considered that Ms Okweri should have been sufficiently concerned to explore this further.

303. The Panel found that Ms Okweri did not obtain sufficient detail of SU 4's interest in young girls and therefore found the matter proved. PROVED.

Allegation 16

16. You did not share information with any relevant professional relating to Service User 4's interest in young girls as expressed to you during a 1:1 session on 8 April 2021.

304. The Panel have not been presented with any evidence within case records or meetings to demonstrate that Ms Okweri shared the information relating to SU4's expressed interest in young girls with any relevant professional . Ms Okweri in her evidence stated that she shared the information with other professionals but could not provide any record of this. The Panel were not persuaded by Ms Okweri's assertion and relied instead upon the documentary evidence before it. The Panel therefore found this allegation proved. PROVED.

Allegation 17

In relation to Service User 5:

17. Your case recordings were not accurate and/or timely in that:

a. your assessment for Service User 5 was completed on 25 January 2021but the case note was not written until 29 January 2021.

b. The contact date was recorded as 28 January 2021 when it should have been recorded as 25 January 2021.

305. Allegation 17a. This allegation stated that the assessment of SU5 took place on 25 January 2025 which was a Monday. The Panel was not presented with any evidence from Social Work England with regards to Ms Okweri's working pattern. Ms Okweri has stated that her usual pattern of work was Wednesday, Thursday and Friday but that she occasionally worked a Tuesday when training took place. Ms Okweri maintained that she never worked Mondays and the Panel was minded to accept this, there being no evidence to suggest otherwise. The Panel therefore concluded that on the balance of probability Ms Okweri did not work on Monday 25 January 2021 and thus it could not have been possible for her to have conducted a visit on that date. The Panel found this allegation not proved. NOT PROVED.

306. Allegation 17b. The Panel considered Social Work England's application as outlined in Mr Smith's closing submissions dated 30 May 2025 to amend allegation 17b. The Panel did not consider that finding allegation 17a not proved would amount to undercharging. The Panel determined that amending charge 17b at this late stage would have likely caused unfairness to Ms Okweri, considering the lateness of the application and the fact that Ms Okweri was unrepresented. The Panel therefore refused the application and found the allegation not proved on the basis that Ms Okweri could not have completed an assessment on 25 January 2021. NOT PROVED.

Allegation 18

18. Your case recordings were not sufficiently detailed in that:

a. On 22 January 2021, you recorded that "Client information updates was accessed for prior knowledge of client previous and current situation" but did not record any information about what systems were checked, why, or what was relevant within each system.

b. On 28 January 2021, you did not record adequate detail of any advice you gave Service User 5 during the assessment.

c. Your assessment on 28 January 2021 does not provide a full assessment of the Service User's strengths and vulnerabilities.

307. Allegation 18a. The Panel found this allegation proved by way of admission.

308. Allegation 18b. The Panel reviewed a family service assessment completed by Ms Okweri and dated 28 January 2021. The Panel found that Ms Okweri had not recorded adequate detail of any advice to SU5.

309. Ms Okweri confirmed that she did not work that day and therefore it could not have been her entry. It was put to Ms Okweri that the 28 January 2021 was one of her working days and that the entry has her name in the margin. The Panel found no evidence to suggest that the record was completed by anyone other than Ms Okweri. The Panel found this allegation proved. PROVED.

310. Allegation 18c. The Panel reviewed the assessment dated 28 January 2021 and could not find any evidence of a written record of SU5 strengths or vulnerabilities. The Panel found this matter proved. PROVED.

Allegation 19

In relation to Service User 6:

19. Your case recordings were not accurate in that your assessment took place on 3 March 2021, but you recorded the date of contact with Service User 6 for the assessment as 10 March despite Service User 6 having been transferred to a different prison on 8 March 2021.

311. Allegation 19. The Panel examined SU6's records. The entry was dated 10 March 2021. In the SAP review from 8 April 2021, M recorded that Ms Okweri visited SU6 on 3 March 2021 but the entry was dated 10 March 2021. It was noted by the Panel that SU6 was transferred out of the prison on 8 March 2021.

312. Ms Okweri in her evidence stated that she could not recall or comment on the allegation.

313. The Panel found that the record of the SAP review from 8 April 2021 was clear in that Ms Okweri's case recording was inaccurate. The Panel was satisfied that this allegation was proved. PROVED.

Allegation 20

20. On or around 8 March 2021, you did not update the Family Service Spreadsheet with Service User 6's release date and/or close Service User 6 from the spreadsheet following their transfer in a timely manner, or at all.

314. Allegation 20. The Panel referred to the SAP review from 15 April 2021. This contained input from M which demonstrated that the Family Service spreadsheet had not been updated for SU6 and did not show that he had been transferred to a different prison 5 weeks earlier. Ms Okweri's position was that she considered that other people had sabotaged her work.

315. Both Ms B and Ms B expressed the importance of keeping the Family Service spreadsheet up to date. The Panel accepted the witnesses' evidence and found that Ms Okweri had not updated the SU family service assessment with the necessary information. The Panel found this allegation proved. PROVED.

Allegation 21

In relation to Service User 7:

21. On or around 6 April 2021, you did not update the Family Service Spreadsheet with Service User 7's release date and/or close Service User 7 from the spreadsheet following their release in a timely manner, or at all.

316. Allegation 21. The Panel found this allegation proved by way of admission.

Allegation 22

In relation to Service User 8:

22. Your case management was inadequate, in that:

a. You did not action a referral for Service User 8 to the Learning and Disability Team in a timely manner, with the referral being actioned on or around 8 April 2021;

b. Your referral to the Learning and Disability Team was inappropriate as it was made after Service User 8 had been released from prison, which you knew, or ought to have known

317. Allegation 22a. The Panel was satisfied that the assessment of SU 8 took place on 3 March 2021. The referral was recorded on a case note dated 8 April 2021 which also included that SU8 was released on 23 March 2021. Ms B stated in her evidence that on the basis that SU8 was to be released from prison, then a referral to a community-based support team was appropriate rather than an in-prison referral.

318. Ms Okweri's responded that she could not recall the exact details of this allegation and questioned the accuracy of the recording.

319. The panel found that the referral was not made in a timely manner to the learning disability team as it took Ms Okweri almost a month to make the referral by which time SU8 had been released. The Panel therefore found the allegation proved. PROVED.

320. Allegation 22b. The Panel found that the referral to the learning and disability team was inappropriate as SU8 had already been released from prison, which Ms Okweri should have known about. PROVED.

Allegation 23

In relation to Service User 9:

23. Your assessment dated 7 April 2021 was inadequate in that it:

a. Was too descriptive

b. Did not note Service User 9's strengths and/or weaknesses

c. Did not detail what support Service User 9 was currently receiving

d. Did not identify areas where Service User 9 needed further support

e. Did not identify any other professionals Service User 9 was currently working with and/or how they were assisting Service User 9.

321. Allegation 23a. The Panel referred to the assessment of SU9 dated 7 April 2021. Ms B's review of the assessment in her witness statement raised concerns about the adequacy of the assessment including that it was too descriptive with very little analysis.

322. Ms Okweri in her evidence stated that she could not remember this SU and questioned the accuracy of the entry in the SU records.

323. The Panel, having read the assessment, agreed with Ms B's analysis that it was too descriptive. The Panel found that the assessment came across as having very little structure and although some information was captured, it lacked sufficient detail of Ms Okweri's professional observations. The Panel concluded that the

assessment was too descriptive in nature and therefore inadequate as it would not be possible to fully assess risk based on the information contained within it. The Panel found this allegation proved. PROVED.

324. Allegation 23b. The Panel referred to the assessment of SU9 dated 7 April 2021. The Panel accepted the evidence of Ms B that it was necessary to list the SU's strengths as this would indicate the SU's willingness to engage or explain their interests and motivations. The SU's weaknesses would be areas for support as well as strategies to build positive relationships. The Panel found no evidence within the assessment to demonstrate that Ms Okweri had identified SU9's strengths or weaknesses. The panel found this allegation proved. PROVED.

325. Allegation 23c. The Panel referred to the assessment of SU9 dated 7 April 2021. Having read the assessment the Panel concluded that there was no evidence to show that Ms Okweri identified what support SU9 was receiving. The Panel considered the assessment completed by Ms Okweri as inadequate. The Panel found this allegation proved. PROVED.

326. Allegation 23d. The Panel referred to the assessment of SU9 dated 7 April 2021. Having read the assessment the Panel concluded that there was no evidence to show that Ms Okweri identified what further support SU9 may need in the future. As above, the Panel accepted Ms B's evidence that there was an expectation to produce an assessment of a SU's needs. The Panel found this allegation proved. PROVED

327. Allegation 23e. The Panel referred to the assessment of SU9 dated 7 April 2021. The Panel accepted the evidence of Ms B that it would not be possible for inter service engagement to support SU9 if it was not known which other professionals were currently engaged with him. Furthermore, that it would be difficult to actively manage safeguarding without knowing which professionals to contact to discuss any measures needed. Having read the assessment the Panel concluded that there was no evidence to show that Ms Okweri identified any other professionals SU9 was currently working with or how they were assisting him. The Panel found this allegation proved. PROVED.

Allegation 24

24.The action plan you created for Service User 9 on 7 April 2021 was inadequate in that it:

a. Did not contain actions around other family members

b. Did not contain actions to assist Service User 9 with community support.

328. Allegation 24a. The Panel referred to the action plan within the assessment of SU9 dated 7 April 2021 which recorded the suggestion to make contact with his [PRIVATE]who was in another prison and his [PRIVATE]. Ms Okweri did not recall the details of this case. The Panel found there to be some action to contact family members within the assessment, and that whilst this was limited, there was sufficient evidence of discussion around family members to find the allegation not proved. NOT PROVED.

329. Allegation 24b. The Panel referred to an action recorded by Ms Okweri to make a referral to "psychiatrics in mental health team", although it is unclear whether that was in prison or a community based team. There was also a recorded action to make a referral to probation. The Panel found that the action of referral to probation is sufficient to demonstrate some assistance with community support and therefore did not find the allegation proved. NOT PROVED.

Allegation 25

25. You did not complete the actions listed in the action plan you created for Service User 9 on 7 April 2021 and/or did not record the outcome of any actions taken against the action plan.

330. Allegation 25. The Panel referred to the records of SU9. The Panel found that there was no evidence of any activity recorded beyond the actions listed by Ms Okweri on 7 April 2021 to demonstrate whether these action had been fulfilled and any outcomes arising. The Panel therefore found this allegation proved. PROVED.

Allegation 26

In relation to Service User 10:

26. Your assessment dated 03 March 2021 was inadequate in that it:

a. Was too descriptive.

b. Did not note Service User 10's strengths and/or weaknesses.

c. Did not detail what support Service User 10 was currently receiving.

d. Did not identify areas where Service User 10 needed further support.

e. Did not identify any other professionals Service User 10 was currently working with and/or how they were assisting Service User 10.

331. Allegation 26a. The Panel referred to the assessment of SU10 dated 3 March 2021. This allegation was supported by the evidence of Ms B, who stated that in her opinion this assessment should have been less descriptive. It contained insufficient detail of Ms Okweri's professional observations, assessments or plans. There was no, or insufficient risk information contained within the assessment such as the SU's children or details of any restrictions regarding contact.

332. Ms Okweri in her evidence stated that she could not recall anything about this case.

333. Having read the assessment the Panel accepted the evidence of Ms B and found that the assessment was too descriptive and read like a narrative with little analysis. The Panel found that the assessment contained a significant amount of background information on the SU but did not record Ms Okweri's professional assessment of risk. The Panel found the assessment to be inadequate on this basis.The panel found this allegation proved. PROVED.

334. The Panel found allegation 26b proved by way of admission.

335. Allegation 26c. The Panel referred to the assessment of SU10 dated 3 March 2021. Having read the assessment the Panel concluded that there was no evidence to show that Ms Okweri had identified what support SU10 was currently receiving and accepted Ms B's evidence that this should have been included. The Panel found this allegation proved. PROVED.

336. Allegation 26d. Having considered the assessment and looked specifically at the section headed "Action Plan", the Panel found that Ms Okweri did identify and list areas of support SU10 might need. Ms Okweri identified that SU10 required support with his addiction, money management, stress management, communication and relationship building. The Panel found that Ms Okweri did identify sufficient areas of further support that for SU10. The panel did not find this allegation proved. NOT PROVED.

337. Allegation 26e. The Panel referred to the assessment of SU10 dated 3 March 2021. Having read the assessment the Panel concluded that there was no evidence to show that Ms Okweri identified any other professionals SU10 was currently working with and how they were assisting him. The Panel accepted Ms B's evidence that she would expect this information to be included. The Panel found this allegation proved. PROVED.

Allegation 27

27. Following your assessment dated 03 March 2021, you did not complete and/or record the identified action of referring Service User 10 to the Learning Difficulties team.

338. Allegation 27. The Panel referred to the assessment of SU10 dated 3 March 2021, where the identified action states 'To make a referral to Learning Difficulties team'. Ms B addressed this in her statement where she stated that this action should have been followed up to ensure support was put in place for SU10. Ms Okweri in her evidence stated that she could not recall this case.

339. The Panel viewed SU10's records and found there was no evidence that Ms Okweri took any steps to complete the referral. The Panel accepted Ms B's evidence that this was something Ms Okweri should have done as part of her role. The Panel found this allegation proved. PROVED.

Allegation 28

28. *Following your assessment dated 03 March 2021, you did not take timely action in providing Service User 10 with the in-cell packs identified in the action plan.*

340. Allegation 28. The Panel referred to the assessment of SU10 dated 3 March 2021 in which it recorded that that the in-cell pack should have been provided to SU10. A further entry on 17 March 2021 recorded that SU10 received the in-cell pack. The Panel was not provided with any evidence of a CGL policy or guidance to indicate what a reasonable timescale was regarding the provision of in-cell packs to SU's. The Panel noted that it took Ms Okweri two weeks from completing the assessment to providing the in-cell pack to the SU. The Panel was not satisfied that this was completed in an untimely manner and therefore did not find the allegation proved. NOT PROVED.

Allegation 29

29. On or around between March and April 2021, you did not record a contact with Service User 10 in CRiiS after providing in-cell materials.

341. Allegation 29. The Panel referred to a note recording that the in-cell pack had been received by SU10 on 15 April 2021. The Panel found that this matter was recorded on 15 April 2021, which fell within the time period of the of allegation and therefore do not find this matter not proved. NOT PROVED.

Allegation 30

30. On or around 12 and/or 18 March 2021, you made contact with Service User 10's family without conducting and/or recording any checks on whether there were restrictions preventing Service User 10 from having contact with his family.

342. Allegation 30. The Panel referred to SU10's case records. An entry recorded on 12 March 2021 by Ms Okweri states'*external phone contact was made to client*

[PRIVATE].. as client requested but his [PRIVATE]. Further contact was recorded with SU10's [PRIVATE] on 18 March 2021. The details of the SAP review dated 8 April 2021 demonstrated that Ms Okweri should have checked with other professionals to ascertain whether it was safe and in the best interest of the family for her to contact SU10's relatives. The Panel noted that in Ms B's evidence she recorded the following, *it would have been prudent for Ms Okweri to have checked if there were any restrictions on contact prior to speaking with SU10's family'*.

343. Ms Okweri in her evidence stated that she could not recall the case.

344. The Panel found that there was no evidence to show that Ms Okweri undertook any checks to confirm if it was appropriate to contact SU 10's family. The Panel therefore found the matter proved. PROVED.

Allegation 31

In relation to Service User 11:

31. Your assessment dated 6 February 2020 was inadequate in that it:

a. Contained sentences which did not make sense, making the entry unclear.

b. Contained the following inappropriate language:

i. You described suicide as "selfish".

ii. You said Service User 11 "throws support back in peoples' faces".

c. Did not demonstrate empathy towards Service User 11.

d. Did not identify Service User 11's strengths.

e. Did not identify Service User 11's presenting issues.

f. Did not identify what support Service User 11 was currently receiving.

g. Did not identify appropriate next steps in order to support Service User 11.

h. Did not contain sufficient detail to enable other professionals to effectively manage risk.

345. Allegation 31a. The Panel considered the assessment of SU11 dated 6 February 2020. The Panel found that Ms Okweri had recorded sufficient information with enough clarity to allow another person to understand the entry. The Panel did not find this allegation proved. NOT PROVED.

346. Allegation 31b.i. The Panel carefully considered SU11's notes in which Ms Okweri described suicide as selfish. Ms Okweri did not deny in her evidence, that she used this term. Ms Okweri considered that the use of the word 'selfish' was appropriate

in the circumstances. The Panel disagreed with Ms Okweri's position and found that this was an inappropriate use of language to describe an individual's suicidal ideation. The panel found this allegation proved. PROVED

347. Allegation 31bii. The Panel found this allegation proved by way of admission.

348. Allegation 31c. The Panel having considered the assessment of SU 11 found that although there were examples of Ms Okweri using language which could not be considered as empathetic, most notably describing SU11's suicidal thoughts as selfish, when the assessment as a whole was considered, there were elements of empathy. The Panel considered the following remarks as an example of where Ms Okweri had demonstrated empathy regarding the SU's situation, *"…he has suffered mentally, emotionally and physically…"* . The Panel also noted Ms Okweri's submission that her aim was to offer compassion towards this SU. The Panel found that there was not sufficient evidence to find this allegation proved. NOT PROVED

349. Allegation 31d. The Panel considered the assessment and case records and found that there was no evidence of Ms Okweri recording SU11's strengths. It was the opinion of the Panel that Ms Okweri should have understood the need to capture the SU's strengths to assist the him The Panel found the allegation proved. PROVED.

350. Allegation 31e. The Panel found that Ms Okweri did identify that SU11 was exhibiting self-harm and that this had impacted him mentally, emotionally and physically. The Panel found that this was a presenting issue for SU11. The Panel found this allegation not proved. NOT PROVED.

351. Allegation 31f. The Panel considered the assessment and case notes of SU11 and could not find any record of Ms Okweri recording what support SU11 had received . The Panel found this allegation proved. PROVED.

352. Allegation 31g. The Panel considered the assessment in which Ms Okweri had identified programmes such as "NA, CA, FOG", that SU11 could access. Although the Panel did not have any information before it to suggest what these programmes were , the Panel determined it appeared that these may have formed part of the support package to assist the SU. The Panel found this allegation not proved. NOT PROVED.

353. Allegation 31h. The Panel carefully considered the assessment as a whole and again reviewed the written statement of Ms B. Ms B was of the opinion that the assessment lacked detail and would therefore have made it difficult for others to effectively manage risk. The Panel found that risk management was part of Ms Okweri's role. The Panel found this allegation proved. PROVED.

Allegation 32

In relation to Service User 12:

32. Your assessment dated 8 April 2021 was inadequate in that:

a. You did not explore and/or record why Service User 12 was working with the mental health team despite his account of having no mental health issues.

b. It does not contain sufficient detail regarding your conversation with Service User 12 during the assessment.

c. You did not obtain sufficient detail about Service User 12's previous convictions.

d. You did not assess Service User 12's level of risk.

354. Allegation 32a. The Panel reviewed SU12's assessment dated 8 April 2021. When giving evidence, Ms Okweri stated that she could not recall this case but also that this matter was outside the scope of her professional knowledge. The panel found that there was no written record of Ms Okweri demonstrating professional curiosity after being informed by SU12 that he had no mental health issues despite SU12 working with the mental health team. The Panel accepted Ms B's evidence that she would have expected this information to be included in the assessment. The Panel found this allegation proved. PROVED.

355. Allegation 32b. The Panel, having read, the assessment found that Ms Okweri had not demonstrated a sufficient level of professional curiosity despite being told by SU12 that he was working with the mental health team. Ms Okweri stated in her evidence that she could not recall this case. The Panel found that Ms Okweri had not explored or clarified with SU12 why he was working with the mental health team. As a consequence of Ms Okweri's inaction there were gaps in SU12's assessment and a lack of information regarding what actions were in place to manage any risks he may have posed. The Panel found this allegation proved. PROVED.

356. Allegation 32c. The Panel reviewed Ms B's evidence and specifically her written statement. Within her statement she recorded the following in relation to SU12, '*exploration of SU12's specific offences would have been pertinent and helpful to be detailed in the assessment as it would have determined which interventions would have been appropriate in prison and assess risk'*. The Panel considered Ms B's remarks and found that there was no records within the assessment to demonstrate that Ms Okweri had obtained information about SU12's previous convictions. The Panel found this allegation proved. PROVED.

357. Allegation 32d. As a result of the findings in the paragraph above the Panel found that as a consequence of the lack of gathering of relevant information it would be very difficult to assess the level of risk and harm in SU12's case. The assessment lacked any record of Ms Okweri assessing SU12's level of risk. The Panel found this allegation proved. PROVED.

Allegation 33

33. Your conduct at paragraph 2 and/or 4a, and/or 4b, was dishonest, in that:

a. In respect of paragraph 2, you knew that you had not completed Module 1- Getting SMART, yet told Colleague 1 that this was the case.

b. In respect of 4a, you knew you had not accessed client records on 16 July 2020.

c. In respect of 4b, you knew you had not accessed client records on 7 August 2020.

358. Allegation 33. The Panel carefully considered whether Ms Okweri's conduct, as set out in allegations 2, 4a and 4b, was dishonest. In reaching its decision, the Panel applied the two-stage test established in Ivey v Genting Casinos [2017] UKSC 67. The first stage required an assessment of Ms Okweri's actual state of knowledge or belief at the relevant time and the circumstances she was under. The second stage involved determining whether, considering that knowledge or belief, her conduct would be regarded as dishonest by the standards of ordinary, decent people.

Panel's findings on Dishonesty

359. In respect of allegation 33a, the Panel carefully considered again all the documents supplied in the hearing bundle as well as any statements supplied by Ms Okweri's and her oral evidence.

360. In an e mail from M to Ms Okweri on the 15 December 2020, Ms Okweri had been requested to complete SMART training. The Panel noted this action in the Support and Action Plan dated 16 December 2020 to 5 February 2021 which sought an improvement regarding SMART training by the week ending 29 January 2021.

361. Within Ms Okweri's e mail of the 31 March 2021 to M, she provided him with a list of activities she had completed whilst working from home on that occasion. Within that e mail Ms Okweri stated that she had completed SMART training.

362. On the 1 April 2021 Ms Okweri met M for a SAP meeting. At this meeting M informed A that she had not completed the outstanding modules on SMART.

363. Within the SAP minutes of 1 April 2021, the notes record that Ms Okweri had also received a further two working from home days on the 27 and 28 January 2021 to complete the training.

364. The SAP minutes on this date also record that Ms Okweri had informed MJ that she had been trying to contact SMART to access the training on the 31 March 2021 but had not received an e mail from SMART until 4pm on this day. Ms Okweri stated that she had been trying to contact M from SMART UK. The minutes further record that

when M asked Ms Okweri what she had been doing with her working day, she stated that she had completed the outstanding modules of Getting SMART.

365. The Panel also considered the e mail from M (Company Administrator for SMART) to M dated 19 April 2021. Within that e mail M confirmed that Ms Okweri had only completed 40% of the Getting SMART module and had yet to complete the whole of the facilitator module.

366. Within the SAP meeting record it notes that Ms Okweri confirmed to M that the work she had completed whilst working from home did not constitute a full working day and she informed M that she would complete SMART training in her own time.

367. The Panel found Ms Okweri's e mail of 31 March 2021 to MJ to be misleading and inaccurate. M had requested Ms Okweri to complete the training in December 2020 and she had still not completed it when she sent the e mail on the 31 March 2021.

368. Ms Okweri had been given time to complete the training and had not done so. There was no evidence from Ms Okweri that she had requested additional time or advised M of difficulties contacting M before the SAP meeting on 1 April 2021.

369. It was the Panels view that Ms Okweri knew, when emailing M on 31 March 2021 and also during her discussion with M on 1 April 2021 that she had not completed the Getting SMART training. Having determined a belief as to Ms Okweri's state of mind the Panel concluded that her conduct was dishonest and would be considered so by the standards of ordinary, decent people. The Panel rejected Ms Okweri's evidence that she had been confused and this was an honest mistake. The Panel found this allegation proved. PROVED

370. The Panel repeated its careful assessment of the documents relating to Ms Okweri's actions on the 16 July 2020 as well as the statements of R, L and C together with their oral accounts. The Panel then carefully considered Ms Okweri's evidence before determining whether her conduct had been dishonest on this occasion.

371. The Panel first reviewed the E mail sent by Ms Okweri to M on the 16 July 2020 timed at 7.58pm. In that E mail Ms Okweri set out that she had undertaken the following tasks whilst working from home on 16 July 2020:

- *Emails and other correspondence.*
- *Navigate through other relevant work apps.*
- *Reflective learning on prison domestic abuse Policy*
- *Checked some more updates on CRiiS, for ideas on what is going on with clients.*

372. The Panel then considered the statement of Ms B and her understanding as to how a CRiiS user would access case records for the purposes of undertaking reviews and establishing what 'is going on with clients.' In Ms B's view she concluded that it

was not possible to review anything on CRiiS, or see any significant information, without logging in.

373. Within Ms B's written statement she detailed the enquiries she made with CS to establish what a CRiiS user would see on a client file without logging in. Ms B established that this would only be high level information and not in her opinion sufficient to undertake the type of enquiries Ms Okweri claimed to have undertaken on 16 July 2020.

374. The Panel then went on to review the evidence of C and in particular the e mail he sent Ms B on the 24 June 2024 in which he confirmed the following:

"In order to 'study client records in preparation for review' (i.e. access the case notes within the client records) on CRiiS, the person would need to go into the client records on CRiiS and this would show up in the CRiiS user activity logs."

375. The Panel also analysed again the written statement of L and his e mail to M dated the 26 August 2020. The e mail from L contained a table which recorded eight separate occasions where Ms Okweri had viewed client files. These eight occasions occurred between 15 July 2020 and 25 August 2020 and consisted of three separate client files. The table identified that Ms Okweri accessed CRiiS on three occasions on 15 August 2020, between 14.55hrs and 18.56hrs and on 25 August 2020 on five occasions between 13.13hrs and 14.58hrs. The report produced by L confirmed that Ms Okweri did not access any client files on 16 July 2020.

376. The Panel also fully took into consideration the responses Ms Okweri made whilst under examination. Ms Okweri's position was that she could not remember what had happened at this time.

377. The Panel were persuaded by the evidence of the witnesses L, C and B that Ms Okweri did not access CRiiS on 16 July 2020. The Panel also found that her email to M on the same day was misleading and inaccurate as she would have been unable to undertake the work she described to M without accessing client records. The fact that Ms Okweri sent the e mail on 16 July 2020 whilst working from home and at the end of the working day further brought doubt that Ms Okweri was providing an accurate account of her work activity for that particular day.

378. In the Panel's view given the timing of the email at the end of the working day it would have been clear to Ms Okweri what work she had completed. The Panel found the email to M was not only vague in detail about any actual activity surrounding clients but also concluded that this was a deliberate act to cover up a lack of work undertaken by Ms Okweri. The Panel was not of the view that this could have been an honest mistake. Having determined a belief as to Ms Okweri's state of mind at the time of sending the email to M, the Panel concluded that her actions on 16 July 2020 were dishonest and would be considered so by the standards of ordinary decent people. The Panel therefore found Allegation 33b proved. PROVED

379. The Panel repeated its careful assessment of the documents relating to Ms Okweri's actions on the 7 August 2020 as well as the statements of B, L and C together with their oral accounts. The Panel then carefully considered Ms Okweri's evidence before determining whether her conduct had been dishonest on this occasion.

380. The Panel considered the email sent by Ms Okweri to M on 7 August 2020, listing the work she had completed that day. This included the assertion that Ms Okweri had checked CRiiS in order to obtain updates in preparation for client reviews. The Panel accepted the evidence of C and B who were of the firm belief that Ms Okweri would not have been able to gain any meaningful updates on clients unless she had clicked on the service user records, which would have created a digital footprint. The Panel went on to consider the table included by L in his email to M of 28 August 2020, which lists the dates on which activity by Ms Okweri on CRiiS was logged. No such activity is shown to have taken place on 7 August 2020, or indeed on any date between 15 July 2020 and 25 August 2020.

381. The Panel considered that Ms Okweri would have been aware of the work she had undertaken on 7 August 2020 when compiling her email of the same date and would have known that this did not include accessing client records on CRiiS. The Panel rejected Ms Okweri's defence that she had been confused due to her challenging circumstances at the time and that it had been an honest mistake. Having determined a belief as to Ms Okweri's state of mind at the time of sending the email to M, the Panel concluded that her actions on 7 August 2020 were dishonest and would be considered so by the standards of ordinary decent people.

382. The Panel found allegation 33c proved. PROVED.

Resumed Hearing 21 July 2025

Submissions, Finding and Reasons on Grounds

383. The Panel heard submissions from Mr Smith on the statutory grounds competence capability and misconduct and the issue of impairment. The Panel decided on each stage separately and each stage is dealt with under separate headings below.

384. Mr Smith submitted that whether the facts found proved in respect of the allegations amount to misconduct and/or lack of competence or capability is a matter of judgement for the Panel, rather than a matter of proof. Mr Smith further submitted that the particulars found proved within 2,4, and 33 amounted to the statutory ground of misconduct and the particulars found proved within allegations 1, 3, 5 to 32 amounted to a lack of competence or capability.

385. In relation to lack of competence, Mr Smith submitted that this is to be judged as an unacceptably low standard of professional performance judged on a fair sample of work. *(Calhaem v GMC [2007] EWHC 2606 Admin)*.

386. Mr Smith submitted that the Panel had access to a fair sample of Ms Okweri's work, with access to the records of 12 service users and the assessments for each of them. The Panel also had access to the capability report and SAP review meetings which demonstrated discussions on the various topics and themes arising through the allegations. Mr Smith submitted that all allegations could be considered to represent a fair sample of work because they all came under the umbrella of sufficiency of performance in Ms Okweri's role as a Family Support Worker within CGL. Furthermore, they provided evidence of Ms Okweri's attitude towards her work, the inadequate level of detail in assessments, and the lack of forward planning. This was in addition to the quality and timeliness of her work. All of these points fall under the umbrella of a failure to identify and respond appropriately to risk factors.

387. Mr Smith submitted that although allegations 1 (relating to an in-cell pack) and 3 (regarding timeliness of completing training) do not arise from the assessment of SU, they can none the less be considered in the same vein as the assessments as they demonstrate that Ms Okweri failed to adequately protect SU's from risk, in the same way that Ms Okweri failed to assess risk in the family service assessments.

388. In relation to the risk for the in-cell pack Mr Smith submitted that service users would seek to utilise the resources within it but would not be able to access them as they were aligned to the American penal system. Mr Smith referred to the evidence of Ms B where she stated that if the in-cell pack cited material which was not relevant, there was a risk that service users would not get the support they needed or may become disillusioned (paragraph 125 of findings of fact). This could lead to a lack of support for the service user, there by bearing similarities to Ms Okweri's short comings within assessments.

389. Mr Smith submitted that allegation 3 which related to completion of training in an appropriate timeframe despite direction from a senior colleague, that this illustrates the fact Ms Okweri failed to follow direction from management. Mr Smith submitted that this was a further example of Ms Okweri's work where she did not take appropriate action. Failing to complete this training carried the risk that Ms Okweri would not be equipped with the skills to adequately undertake her role. This was aggravated by the nature of the training and its potential to impact directly on a service user's life.

390. Mr Smith submitted that all allegations could be found to arise from a fair sample of the registrant's work. Furthermore, that allegations 1 and 3 were sufficiently serious, given the potential risks, that they could in fact stand on their own as demonstrating a lack of competence.

391. Mr Smith submitted that all these concerns arose through a lack of basic skills and poor performance on Ms Okweri's part, and not through outside influence, [PRIVATE] or a lack of support as suggested by Ms Okweri.

392. In relation to misconduct, Mr Smith referred to the case of *Roylance v GMC* in which misconduct was described as *"a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances"*. Furthermore, that it was not any professional misconduct which would qualify, the professional misconduct must be serious, and it must be linked to the social worker's profession.

393. Mr Smith submitted that the Panel's finding on the issue of dishonesty demonstrated that Ms Okweri deliberately lied on more than one occasion, her emails were misleading and inaccurate and therefore this was a deliberate act to cover up a lack of work undertaken by Ms Okweri.

394. Mr Smith submitted that in relation to allegations 2, 4, and 33, the evidence relied on by the Panel in finding the facts proved, pointed more towards misconduct. Mr Smith submitted that dishonesty with intent to cover something up can only be classed as serious. It occurred during the course of employment and was directly linked to Ms Okweri's role and therefore these allegations did amount to the statutory ground of misconduct.

395. Mr Smith submitted that for both statutory grounds, Ms Okweri was in breach of Social Work England's Professional Standards, in particular: 1.2; 2.1,2.2,2.4; 3.2; 3.3; 3.6; 3.8; 3.9; 3.10;3.11; 3.12; 3.13 and 4.2.

- 1.2- Respect and promote the human rights, views, wishes and feelings of the people I work with, balancing rights and risks and enabling access to advice, advocacy, support and services.

- 2.1- Be open, honest, reliable and fair.

- 2.2- Respect and maintain people's dignity and privacy.

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

- 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.

- 3.6- Draw on the knowledge and skills of workers from my own and other professions and work in collaboration, particularly in integrated teams, holding onto and promoting my social work identity.

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

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

- 3.10- Establish and maintain skills in information and communication technology and adapt my practice to new ways of working, as appropriate.

- 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.

- 4.2- Use supervision and feedback to critically reflect on, and identify my learning needs, including how I use research and evidence to inform my practice.

396. Ms Okweri provided written submissions on 21 July 2025 in relation to both the statutory grounds and impairment. Ms Okweri maintained that the issues occurred within her practice due to a lack of support, lack of access to IT equipment, and [PRIVATE], rather than as a result of her deficient professional performance as suggested by Mr Smith. Ms Okweri highlighted in particular:

    - A lack of IT equipment not being provided including a work laptop, which restricted her ability to access the various system Remotely. This included having to work from a mobile phone which severely restricted her ability to carry out tasks.

    - Working in a toxic culture where there was a significant lack of support from management and colleagues.

- [Private]

397. Ms Okweri submitted that throughout this period she worked solely from her work mobile phone, having to carry out essential tasks including completing mandatory training, accessing systems and preparing induction packs, which severely hampered her ability to carry out her role efficiently and in line with expectations. The physical and professional toll it took on her was substantial and still ongoing.

398. Ms Okweri addressed the level of support that she received as being minimal and inadequate in respect of the in-cell packs and generally throughout her time at CGL. Ms Okweri accepted that her caseload was reduced eventually but it came far later than it should have and did not address the wider challenges that she was facing.

399. Ms Okweri rejected the assertion that she lacked professional curiosity or failed to engage appropriately with external professionals and stated that she did not engage to the best of her ability, despite the operational limitations and lack of support at the time.

400. Ms Okweri asked the Panel to consider the full context of her working environment, including the lack of timely support, the physical consequences of poor resourcing and the emotional and professional strain she endured. These sustained systematic failings directly impacted on her ability to meet expectations, rather than a lack of competence. Ms Okweri addressed the finding on dishonesty and maintained that she did not set out to deceive her employer. With regards to the SMART training she spoke of a desire to "manage expectations" acknowledging that she should have been "upfront" with her manager and asked for support rather than "trying to down play the situation".

Legal advice

401. The Panel accepted the advice of the legal adviser on the issues of misconduct and competence and capability. The legal adviser also referred to the 'Impairment and Sanctions Guidance' dated 19 December 2022, which provided guidance in relation to misconduct and lack of competence and the differences between the statutory grounds.

402. The Panel understood from that advice that: -

- Lack of competence is an unacceptably low standard of professional performance judged on a fair sample of work. (*Calhaem v GMC [2007] EWHC 2606 Admin).*

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

- Misconduct is, in essence, a serious departure from the standards of conduct expected of social workers as professionals and what would be proper in the circumstances of the case. *[Roylance v General Medical Council (No.2) [2000] 1AC]*

- Whether a breach of professional rules should be treated as professional misconduct depended on whether it would be regarded as serious and reprehensible by competent and responsible [registrants] and on the degree of culpability. *[Solicitors Regulatory Authority v Day & Others [2018] EWHC 2726 (Admin)*.

- There is a high threshold of gravity for misconduct. Behaviour which is trivial, inconsequential, a mere temporary lapse or something otherwise excusable or forgivable does not constitute misconduct. *[Khan v Bar Standards Board [2018] EWHC 2184(Admin)]*

- The legal adviser reminded the panel that the question of misconduct was a matter for its judgment and that appropriate standards of conduct should be judged with reference to Social Work England's Professional Standards. Not every departure from those Standards would necessarily amount to misconduct. The departure had to be sufficiently serious; whether any particular departure was sufficiently serious to be categorised as misconduct was a matter for the judgement of the panel.

Decision on Grounds

403. The Panel at all times had in mind the overriding objective of Social Work England which included its duty to protect the public, promote and maintain public confidence in social workers in England and to promote and maintain proper professional standards for social workers in England. The Panel had regard to the 'Social Work England Impairment and Sanctions guidance'. It had regard to the Social Work England Professional Standards and bore in mind that a departure from the Standards does not necessarily constitute misconduct.

404. The Panel carefully considered both the statutory grounds of lack of competence and misconduct to decide which ground, if any, the behaviours of Ms Okweri fell

into. It decided that the behaviours of Ms Okweri in relation to allegations 2,4 and 33 did amount to serious professional misconduct. In relation to all the other allegations found proved, the Panel decided that the behaviours of Ms Okweri did amount to a lack of competence.

405. The Panel concluded that Ms Okweri's conduct, and behaviour fell far below the standards expected of a registered social worker. Her conduct amounted to failings of basic and fundamental tenets of the social work profession. The Panel determined that Ms Okweri's conduct was in breach of multiple Standards.

406. Based on the findings, the Panel considered that the misconduct and lack of competence of Ms Okweri's fell into two areas:

- failing to safeguard others;
- and dishonesty to her employer

407. In relation to the failure to safeguard others, the Panel considered whether those failings would meet the statutory ground of lack of competence. The Panel were satisfied that they did have a fair sample of Ms Okweri's work which included abundant information across 12 different service users with a range of different issues across a lengthy period. The Panel also noted that it had access to the Capability Report and the SAP review meetings which contained discussions of these concerns.

408. In relation to allegation 1 the Panel found that this amounted to lack of competence because Ms Okweri produced a document that was not fit for purpose. The evidence presented to the Panel suggested that one of the key roles was to support, advise and signpost service users in the context of the prison setting and that the in-cell packs were an important part of that. Ms Okweri produced a document which referenced the American penal system, and which was plagiarised using the internet. The Panel found this very concerning because it showed a lack of professionalism and a lack of critical thinking to be able to produce material for herself. The potential risk of harm to service users was high because the material cited was not relevant nor available and therefore the service users could be prevented from accessing the support they needed.

409. In relation to allegation 3 the Panel found that this amounted to a lack of competence. The Panel determined that this was a fundamental aspect to Ms Okweri's role because if the training was not completed; it had an impact on her ability to access systems, to carry out research and therefore she would be impaired in her ability to help service users. The Panel considered the timeframe Ms Okweri took to complete the training despite repeated instructions from management which showed a lack of action to follow management direction.

410. The Panel considered allegation 5 in its own right since this related to Ms Owkeri not taking adequate steps to resolve issues with her access to key IT systems as

directed by her manager. The Panel considered the length of time it took Ms Okweri resolve her IT issues, despite being instructed to on numerous occasions by her manager, demonstrated Ms Okweri's failure to take initiative in resolving issues and taking accountability for her own actions. The Panel determined that these failings amounted to a lack of competence.

411. In relation to allegations 6 – 32 the Panel found that taken as a whole, Ms Okweri's behaviour amounted to a lack of competence because of the number of deficiencies within service users records which included:

- failure to provide adequate support,
- failure to assess risk properly,
- failure to recognise safeguarding issues,
- a lack of professional curiosity,
- a lack of engagement with other professionals,
- a failure to act upon management direction and take on responsibility for own actions.

412. The Panel found that the standard of Ms Okweri's performance was consistently low across all elements of her practice.

413. The Panel agreed that Ms Okweri's lack of competence was highlighted especially (but not exclusively) by practice regarding the following service users:

- SU3 – Ms Okweri failed to recognise and carry out appropriate safeguarding by failing to contact social services to find out if they were involved with SU3's [PRIVATE] despite this being an action identified in the assessment of 9 April 2021. This was especially concerning as it put children and a potentially vulnerable adult at risk of harm.

- SU4 - Ms Okweri failed to recognise and act upon SU4's interest in young girls as expressed to her during a 1:1 session on 8 April 2021. Ms Okweri dismissed the comment and failed to recognise the seriousness of the concern and did not take appropriate action to explore this issue further with the service user. The Panel found it concerning that Ms Okweri had maintained this view throughout the hearing and appears unable to recognise the seriousness of SU4's disclosure, which could be indicative of a significant risk to members of the public.

- SU11 – Ms Okweri described suicide as 'selfish' and stated that SU11 "throws support back in people's faces". The panel heard in witness

evidence from Ms B that SU11 found these comments distressing, which could have led to significant harm to himself or a lack of trust/engagement with those attempting to support him.

414. The Panel determined Ms Okweri's failure to safeguard others, to adequately assess and respond to risks in a timely manner and to complete workflows appropriately demonstrating a lack of competency. The Panel took into account that these failures had persisted across a lengthy period, despite Ms Okweri having adequate and sufficient support to enable her to meet the expectations of her role. The failures related to multiple service users and their families and placed service users at risk of harm. Despite Ms Okweri showing some level of insight, during her supervision, into tasks and actions which remained outstanding, she continued to repeat her failings and place service users at risk. The Panel considered that safeguarding is a key part of the social worker role, and the priority is to make sure that service users are protected and to take the necessary steps to ensure their wellbeing. The Panel found that the aforementioned fallings amounted to a lack of competence and capability.

415. Ms Okweri's failure to safeguard others, included not accurately recording information within case notes and not recording information within case notes in a timely manner was a serious failure. The Panel took into account the evidence it had received, about the importance of accurate and timely recording. This included that a failure to adequately record meant that other professionals involved, or who may have been required to pick cases up, would not be fully informed on the service users' current situation. The Panel had evidence of the recording expectations, which would have been made clear to Ms Okweri in her induction and supervision. However, her failings persisted across a lengthy period and related to multiple service users. The requirement to record is a basic and core social work duty which Ms Okweri did not fully adhere to.

416. Ms Okweri provided some written mitigation as to why she believed the failings had arisen. However, as set out earlier in this decision, the Panel found that Ms Okweri was adequately and sufficiently supported. This included a reduction in her caseload, being subject to a Support Action Plan to manage her work, a change of manager when requested and additional training from colleagues. The Panel concluded that Ms Okweri had not provided any reasonable justification for consistently breaching the Standards. Her conduct was serious as it related to safeguarding and occurred on multiple occasions, across many months and impacted on multiple service users. The Panel considered that the facts found proved would be seen as far below what is expected by fellow practitioners and therefore amounts to the statutory ground of lack of competence.

417. In relation to dishonesty, the Panel decided that this amounted to serious misconduct. The Panel found that Ms Okweri should have been aware of the importance of honesty and transparency when dealing with her employer. Her

dishonesty related to a number of occasions and was exacerbated as she created a false narrative and provided fabricated emails to try and secure a favourable outcome for her own gain. The Panel took into account that there was an opportunity for Ms Okweri through her SAP reviews to be honest, but she was not, and instead she made the conscious decision to send emails with inaccurate information, purporting them to be truthful. Within her various submissions provided throughout the hearing, including after the fact finding stage Ms Okweri had maintained she had not behaved dishonestly.

418. The Panel considered this to be a serious departure from the Standards expected of social workers. Ms Okweri's dishonesty showed a breach of a most basic and fundamental tenet of the social work profession.

419. The Panel considered that allegations 2, 4 and 33 would be seen as far below what is expected by fellow practitioners and concluded that individually and cumulatively, they amount to misconduct.

Finding and reasons on current impairment

420. Mr Smith submitted that a finding of impairment was a matter of judgement for the Panel.

421. He referred to the Statement of Case and to the following cases:

- *CHRE v (1) NMC & (2) Grant [2011] EWHC 927 (Admin)*
- *Cohen v GMC [2008] EWHC 581 [Admin]*
- *Meadow v GMC [2007] 1 WB 462*

422. Mr Smith submitted that Ms Okweri's fitness to practice is currently impaired on the personal and public components. Mr Smith submitted that in relation to the allegations, these related to breaches of fundamental tenets of the profession and that these breaches resulted in consequential harm to service users.

423. Mr Smith submitted that the evidence before the Panel about Ms Okweri's insight and reflection is extremely limited. Although Ms Okweri stated that she has reflected on these points, she does not explain how or what she would do differently if faced with similar circumstances. As regards the training certificates Ms Okweri had provided, Mr Smith stated that the majority pre-date the concerns and are of limited use to the Panel. In relation to training there is limited evidence of areas of safeguarding, record keeping and assessments.

424. In relation to Ms Okweri's current role, Mr Smith submitted that no references from her current employer have been provided which demonstrate in any detail her

current performance or inform the Panel of what her day to day role entails and therefore the Panel was unable to place any weight on this.

425. Mr Smith submitted that Ms Okweri has, in her written submissions, expressed some remorse and shown limited insight. He submitted that the insight was limited as whilst she acknowledged some understanding of the deficiencies, she also sought to blame management due to her perceived lack of support. Mr Smith submitted that Ms Okweri had provided limited evidence of remediation in relation to lack of competence.

426. Mr Smith submitted that in relation to allegations 2,4 and 33 dishonesty is hard to remediate. He submitted that Ms Okweri had provided limited evidence of insight and that the risk of repetition remains.

427. Mr Smith submitted that given the serious findings, the public would be shocked if a finding of impairment were not made in this case.

428. Although she did not specifically address the question of whether she believes her fitness to practise is impaired, it could be inferred from Ms Okweri's written submissions of 21 July 2025 that she denies this.

Legal advice

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

- The existence of impairment is a matter for the panel's own independent judgment or assessment.

- A social worker is fit to practise when they have the skills, knowledge, character and health to practise their profession safely and effectively without restriction. If a panel decides that a social worker's fitness to practise is impaired, this means that it has serious concerns about the social worker's ability to practise safely, effectively, or professionally.

- As stated in *Meadow v General Medical Council [2006] EWCA Civ 1390*, the purpose of fitness to practise proceedings is not to punish the practitioner for past misdoings but to protect the public against the acts and omissions of those who are not fit to practise.

- Protection of the public, as defined in s.37 of the Children and Social Work Act 2017, comprises protecting, promoting and maintaining the health, safety and well-being of the public, promoting and maintaining public confidence in social workers and promoting and maintaining proper

professional standards for social workers. The panel should consider whether a finding of impairment is required for any or all of those three purposes.

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

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

- When assessing whether a finding of impairment is required in order to protect the health, safety and well-being of the public, the panel should consider the extent to which the social worker's conduct gave rise to harm or a risk of harm and the likelihood of that conduct being repeated. Assessment of the risk of repetition involves consideration of (i) the social worker's previous history and their conduct since the concerns about their conduct arose and (ii) the extent to which they have developed insight into their misconduct and (iii) the extent to which they have taken steps to remedy any failings on their part which led to that misconduct.

- A finding of personal impairment is usually not needed if (a) the social worker has understood the causes of, and learnt from, any mistakes or misjudgements; and (b) there is no risk of repetition. However, the panel should also consider whether a finding of impairment is required in order to maintain public confidence and proper professional standards (the public component of impairment). Depending on the circumstances, a finding of impairment on these grounds can be necessary even where the social worker poses no current risk to the public.

- The legal adviser reminded the panel that impairment was to be judged at the present date and that the personal component of impairment involved a careful assessment of the risks of repetition of the behaviour in question. Regardless of this, however, the Panel was also obliged to consider whether

the public interest required a finding of impairment to be made on the basis that the absence of such a finding would undermine the reputation of the profession in the eyes of a reasonable and fully informed member of the public.

Decision

430. In determining whether Ms Okweri's fitness to practise was impaired, the Panel had regard to the guidance provided by Social Work England, which outlined the factors to be considered in such cases, including actual or potential harm, likelihood of repetition, previous history, insight, remediation, admissions, and testimonials. The Panel also considered Ms Okweri's explanations including her working conditions and her previous good record.

431. After careful consideration of all the evidence and the relevant legal and regulatory frameworks, the Panel concluded that Ms Okweri's fitness to practise as a social worker was currently impaired. This decision was based on the above findings of misconduct and lack of competency. This included Ms Okweri's failure to fulfil her professional obligations, the potential risk of harm her actions posed to service users, the scale of the failures, and her dishonesty.

432. The Panel considered that its findings on misconduct and lack of competence showed that Ms Okweri had acted in a way that placed service users at risk of harm. Ms Okweri's role was to carry out professional assessments/support plans in a timely, accurate and effective way and to prevent, delay, or defer the need for on-going support for SUs by maximising opportunities for them. The above findings on fact demonstrate that Ms Okweri failed to do so on multiple occasions and this ultimately meant that service users were not always safeguarded, and consequently, were placed at risk of harm.

433. Whilst the Panel recognised that Ms Okweri had been heavily supervised, and she had engaged in this process, this did not mitigate the risks identified. The Panel was not persuaded that these failings had been solely due to work related pressures, as the evidence suggested that Ms Okweri's workload was not unreasonable and had in fact been reduced as part of her SAP reviews. The Panel noted that while Ms Okweri had made some admissions regarding her failings, including her failure to progress tasks and referrals, they did not extend to the dishonesty, which was a critical element of the case.

434. The Panel kept in mind that the facts found against Ms Okweri related to both her professional practice, and to her lack of honesty. The Panel considered that character concerns, such as dishonesty, are often harder to remediate because it is more difficult to produce objective evidence of reformed character. The Panel considered whether Ms Okweri's lack of competence and misconduct was capable

of being remedied providing that sufficient insight, remediation and reflection could be evidenced and whether the behavior was likely to be repeated.

435. The Panel considered the submissions provided by Ms Okweri about the circumstances at the time of the misconduct, and how events had materialised.

436. In relation to the safeguarding failures, the Panel noted that whilst Ms Okweri had acknowledged some of her deficiencies, she had also sought to deflect the majority of the blame onto her management and the work environment. Ms Okweri's explanation of not being sufficiently supported, lack of IT equipment and [PRIVATE] as barriers to performance had not been accepted by the Panel and did not adequately account for the seriousness of her failings, nor did it demonstrate the level of reflection required to remediate her practice.

437. The Panel determined that Ms Okweri's written submissions did not offer meaningful reflections on her practice. They did not demonstrate insight into how her failings resulted in risk to multiple service users over multiple months, or how her actions impacted on her colleagues and the profession.

438. In relation to dishonesty, whilst Ms Okweri was entitled to deny the particulars of the allegations, the Panel had rejected her defence.

439. Ms Okweri's denial of dishonesty undermined the Panel's confidence in her ability to fully reflect on her actions and the impact it had on service users, their families and on her colleagues and other professionals. The Panel found that this lack of insight and reflection into her dishonesty was a significant concern, as it suggested that she did not fully appreciate the seriousness of her misconduct, leading to a risk of repetition in the future.

440. Furthermore, no independent evidence had been presented including from her current employer to reassure the Panel that she would not act in the same way if she was presented with a challenging caseload or situation in the future. The Panel had concerns that Ms Okweri may revert back to bad practices and act dishonestly when faced with difficult situations particularly when she is overwhelmed.

441. The Panel found that the dishonesty was serious, it was repeated during the dates in question, and it was for personal gain. Honesty is key to good social work practice as social workers are routinely trusted with access to highly sensitive and confidential information. Further, other agencies, including the regulator rely on social workers providing them with honest information to enable them to undertake their own roles and responsibilities.

442. The Panel determined that it had very little information before it from Ms Okweri relating to remediation. Whilst it accepted that she was not in a social worker role, nonetheless it would have been possible to undertake appropriate training courses, and/or provide testimonials from her current employer or colleagues, which would have assisted the Panel and reassured them of greater insight and

efforts of remediation. Some of the previous certificates that had been provided predated the allegations.

443. The Panel also considered the more recent training certificates submitted by Ms Okweri albeit late and during the Panels deliberations. The Panel determined having viewed them that they did not appear to address the specific challenges faced by Ms Okweri, further highlighting a lack of sufficient reflection or remedial action on her part. Without evidence that Ms Okweri had actively worked to address the issues relating to safeguarding, risk assessment or the dishonesty identified in the case, the Panel found that these training certificates did not sufficiently mitigate the risks identified.

444. The Panel also considered the one testimonial provided by Ms Okweri's ex-colleague from her current workplace and although it was positive and addressed Ms Okweri's punctuality and reliability, it did not directly address the core issues of the case and failed to acknowledge the concerns regarding Ms Okweri's ability to identify risk, safeguard others and fulfil her professional duties more broadly.

445. The Panel had no confidence that Ms Okweri recognised the significance of the findings against her, nor that she fully accepted her role and responsibility in relation to the failings. The Panel had concerns that if Ms Okweri were to find herself in a similar situation again, in a challenging role, she would not have the tools, skills and competence to carry out the role effectively.

446. Whilst the Panel acknowledged that Ms Okweri was not working in a qualified social work position at the time of the findings against her, similar skills should have been engaged. The expectation of someone in her position was to have the analytical tools to be able to identify key information from assessments of service users and then to analyse this to inform the next steps for support. This was lacking in Ms Okweri's practice.

447. The Panel concluded that Ms Okweri's misconduct, including dishonesty and failure to progress a large volume of time critical safeguarding work, posed a significant risk to the public, particularly vulnerable service users. The Panel was particularly concerned about the risk of repetition, as Ms Okweri had not demonstrated the level of insight or remediation needed to ensure that she can work independently and safely, and that similar failings would not occur in the future.

448. The Panel therefore decided on the personal element of impairment that Ms Okweri's fitness to practise was currently impaired.

449. The Panel next considered whether a finding of current impairment was necessary in the public interest. The Panel was mindful that the public interest encompassed not only public protection but also the declaring and upholding of proper standards of conduct and behaviour as well as the maintenance of public confidence in the profession.

450. The Panel determined that Ms Okweri's dishonesty and failure to meet professional standards were damaging to public confidence in social work. The potential risk to vulnerable service users, combined with the failure to acknowledge or demonstrate a full understanding of the misconduct, meant that a finding of impairment was necessary not only to protect the public but also to uphold the standards of conduct expected of social workers. Dishonesty is deeply damaging to public trust in the profession, and the Panel considered that this had not been sufficiently remediated in Ms Okweri's case.

451. In finding that Ms Okweri did not conduct herself in such a way as to adhere to a number of the Social Work England Professional Standards, the Panel determined that she had breached fundamental tenets of the social work profession. The Panel considered that safeguarding vulnerable people, accurate and timely communication, and honesty, lie at the heart of social work practice.

452. The Panel considered that members of the public would be concerned if the regulator were not to mark the seriousness of Ms Okweri's misconduct with a finding of current impairment on public interest grounds. The Panel considered that to not make a finding of current impairment of fitness to practise in relation to those matters, given the number of breaches of the Standards, would undermine public trust and confidence in the profession. The Panel was satisfied that this finding was necessary to protect the public, maintain public confidence in the profession, and uphold the standards expected of social workers.

453. The Panel therefore decided on the public interest element of impairment that Ms Okweri's fitness to practise is currently impaired.

Resumed Hearing 26 August 2025

Submissions and Decision on Sanctions

454. The Panel heard submissions from Mr Smith on sanctions.

455. Mr Smith invited the Panel to impose a suspension order. He submitted on behalf of Social Work England that, in accordance with Social Work England's Impairment and Sanctions Guidance, that suspension is the most appropriate sanction for Ms Okweri. Mr Smith submitted that the primary purpose of a sanction in this context is to protect the public and uphold the integrity of the social work profession, rather than to punish the registrant. As set out in the guidance, the Panel must consider the severity of the misconduct and lack of competence found, weighing mitigating against aggravating factors, and determine whether a sanction can sufficiently protect the public and maintain public confidence in the profession.

456. Mr Smith contended that, in considering the mitigating factors, it was acknowledged;

- Ms Okweri had no prior regulatory findings against her.
- She had provided a positive character reference.
- Ms Okweri had made early admissions to some allegations.
- Ms Okweri had engaged with the fitness to practise process which had taken place over an extended period of time.

457. While these factors were noted, Mr Smith asserted that they had to be considered alongside the aggravating factors which include the following;

- The seriousness of the misconduct and lack of competence.
- Ms Okweri's dishonesty.

458. The persistent and repeated failings of her practice which affected;

- Multiple service users, and which included the failure to progress safeguarding work, breaching multiple standards, deflection of blame for her shortcomings onto others and the risk of harm to service users throughout the period covered by the allegations.

459. Mr Smith submitted that the Panel could impose a suspension order for up to three years and the duration of the suspension in this case should be at the higher end of the scale given the seriousness of the conduct found proved. It would mark the seriousness of Ms Okweri's conduct and would also give sufficient time for Ms Okweri to conduct any remediation, show insight and reflection. Mr Smith also invited the Panel to attach recommendations to any suspension order, to enable a future Panel when reviewing the suspension order to assess Ms Okweri's level of insight and remediation.

460. Mr Smith, however, did note that there are factors that the Panel outlined in their decision, which could properly lead to the consideration of a removal order. Mr Smith noted that the Panel had found Ms Okweri's fitness to practise was impaired on the grounds of misconduct and lack of competence. Mr Smith informed the Panel that a suspension order can be imposed for both lack of competence and misconduct findings. However, in respect of lack of competence a removal order is not an option. So, if the Panel were to consider a removal order, then it can only be for the misconduct allegations.

461. Mr Smith submitted that it was for the Panel to determine where to place Ms Okweri's misconduct on the scale of seriousness and whether a suspension order was sufficient to protect the public and maintain public confidence or whether only a removal order could achieve this. Mr Smith referred the Panel to the Sanctions

Guidance at paragraph 172 which describes the different types of dishonesty the Panel should consider on a scale of seriousness. Mr Smith submitted that Ms Okweri's dishonesty fell towards the lower end of the scale.

462. Mr Smith submitted that nothing short of a suspension order would be sufficient in this case to mark the seriousness of the findings against Ms Okweri, protect the public or maintain public confidence. The severity of Ms Okweri's failings put service users at significant risk of harm whilst her dishonesty lead to a risk of missed opportunities for support and safeguarding. This failure to act appropriately, undermined the core duties of a social worker, particularly the duty to safeguard vulnerable individuals and to act with honesty and integrity. Mr Smith reminded the Panel that they had found that Ms Okweri's fitness to practise remained impaired due to her lack of insight into the seriousness of her actions. This failure to reflect meaningfully on her lack of competence and misconduct raised concerns about the risk of repetition, as she had not demonstrated adequate understanding of the impact of her behaviour.

463. Mr Smith submitted that a conditions of practice order would not be appropriate as the conditions would need to be so onerous that they would amount to suspension. Conditions of practice would not adequately mark the seriousness of the dishonesty and safeguarding failings, that the Panel found proved. Furthermore, there are no conditions that could be formulated to mitigate against future dishonesty.

464. Mr Smith referred to the Sanctions Guidance when considering why a suspension order may be appropriate. Mr Smith submitted that there is some evidence that Ms Okweri has shown some insight albeit not in relation to all the allegations. Mr Smith noted that there is also some evidence through various pieces of correspondence from Ms Okweri throughout the hearing process expressing apology and a willingness to improve her practice. Mr Smith highlighted that the Guidance does state that it is in the public interest for qualified social workers to return to practice when safe to do so.

465. Mr Smith submitted that the main issue for the Panel to consider is whether Ms Okweri can resolve and remediate her failings.

466. In conclusion Mr Smith submitted that provided that sufficient time is given to remediate the concerns, that the most appropriate order is a suspension order, alongside recommendations which would direct Ms Okweri to undertake written reflections, demonstrations of insight and also to provide evidence of training undertaken to improve competence, especially in the area of safeguarding. In respect of dishonesty and in order for Ms Okweri to return safely to practice there should be a recommendation that Ms Okweri provide some insight and reflection to how dishonesty can impact public protection and public confidence in the profession.

467. Ms Okweri made submissions and answered questions under [PRIVATE]. Ms Okweri apologised for her shortcomings and for not taking appropriate action when necessary. Ms Okweri directed the Panel to the previous submissions she had made throughout the hearing process and reflections that she had submitted. Ms Okweri maintained that she did all that she could in the circumstances that she faced at the time which affected her ability and performance.

468. Ms Okweri stated that she fully understood the gravity of the situation and that she had demonstrated this in her reflective statements that she had submitted, which provided an insight of her understanding of the allegations against her and how seriously she took the situation. Ms Okweri stated that she was ashamed to be in this situation.

469. Ms Okweri maintained that she acted honestly, and that it was never the case that she sought to deceive her manager. Ms Okweri stated that she had reflected upon how her actions may have come across to others and that it would never happen again. When asked by Mr Smith if she now accepts that she was dishonest Ms Okweri responded by stating she could not recall. She failed to answer the question.

470. Ms Okweri stated that in her current role as a Live Well Care Co-ordinator she is doing extremely well and has improved. When asked what training she had undertaken between 2022 and 2025 Ms Okweri stated that she had completed safeguarding training in her current role although she was unable to provide any documentation for this. Furthermore, that she had enrolled onto an online psychotherapy course. Ms Okweri submitted several certificates for various courses during the course of her evidence and after the Panel had retired to deliberate. Mr Smith did not object to these being submitted but did express his astonishment that the Panel was still receiving CPD certificates at this late stage in the proceedings despite Ms Okweri being advised as far back as the 15 July 2025 in a parties meeting to do so.

471. When asked to explain her current role Ms Okweri struggled to outline her main duties or explain to the Panel what a typical day looked like. Ms Okweri did provide written submissions later in the proceedings explaining her role and responsibilities. Ms Okweri also provided her contract of employment, payslip and application pack at the request of the Panel to assist them in understanding her current role.

472. Ms Okweri was asked by Mr Smith whether her current employer or manager was aware of these proceedings. Ms Okweri stated that her manager had sent an email to Social Work England and was therefore aware. Ms Okweri was challenged on this point since the email in question was not written by her current manager but an ex colleague and was limited to a character reference. Ms Okweri initially maintained that her manager was aware, but on later questioning by the Panel, she conceded

that her current manager was not aware, thought she maintained that she had informed her employer at the time she was appointed.

Legal Advice

473. The Panel heard and accepted the legal advice from the legal adviser on all the available options on sanction as set out in the Regulations. The Panel was advised to consider the Sanctions Guidance dated 19 December 2022.

474. The legal adviser advised that the Panel must pursue the overarching objective of the regulator when exercising its functions. The Panel must apply the principle of proportionality, balancing Ms Okweri's interests with the public interest. The purpose of a sanction is not to be punitive but is to protect the public and the wider public interest. The public interest includes maintaining public confidence in the profession and its regulator and upholding proper standards of conduct and behaviour. The sanction imposed should be the minimum necessary to protect the public.

475. The Panel was advised to consider any aggravating and mitigating factors and it must consider each available sanction in ascending order of severity having had regard to the Social Work England Impairment and Sanctions Guidance, together with its determination on grounds and impairment.

Decision

476. The Panel reminded itself that it had concluded that Ms Okweri's fitness to practise was found to be currently impaired, due to her misconduct, her dishonesty and her lack of competence.

477. The Panel applied the principle of proportionality by weighing Ms Okweri's interests with the public interest and by considering each available sanction in ascending order of severity. The Panel also considered the mitigating and aggravating factors in determining what sanction, if any, to impose.

478. The Panel identified the following mitigating factors:

- Ms Okweri had no previous fitness to practise history.
- Ms Okweri's engagement with Social Work England despite the lengthy process.
- Ms Okweri's full and partial admissions to some allegations.
- A character reference that was provided, although the Panel noted its limited value as it did not address any of the findings against Ms Okweri nor did it indicate that the author was aware of the concerns raised.

- Evidence of some remediation through continuous professional development (CPD).
- Ms Okweri had expressed remorse and some level of insight in relation a number of the lack of competence findings.

479. The Panel identified the following aggravating factors:

- Ms Okweri's conduct in relation to the lack of competence findings was a consistent theme across multiple cases and repeated over a number of months, causing consequential risk of harm to multiple service users. Those failings which related to a lack of action regarding matters of safeguarding were of particular concern.
- Ms Okweri showed limited insight into her failings.
- Ms Okweri provided limited evidence of remediation. In her reflection piece Ms Okweri stated what steps she had taken but not what she had learnt.
- There was a finding of dishonesty which occurred on more than one occasion. Ms Okweri consistently denied these allegations.
- Ms Okweri's deflection of blame onto others rather than accepting responsibility for her shortcomings.
- Ms Okweri showed no improvement in her work despite receiving extensive support over a prolonged period.
- There was a breach of multiple professional standards.

480. Considering the serious nature of the findings of fact it had made, the Panel decided that taking no action, or issuing advice or a warning, would not be adequate to protect the public, as they would not restrict Ms Okweri's practice.

481. The Panel assessed there to be a risk of repetition of the dishonesty as well and the behaviours that had led to a lack of competence finding and so considered that the public could not currently be adequately protected unless Ms Okweri's practice was restricted. Further, taking no action, or issuing advice or a warning, would not maintain public confidence in the profession or promote proper professional standards, considering the panel's findings.

482. The Panel next considered whether a conditions of practice order would be sufficient to protect the public and wider public interest. The Panel, however, noted paragraph 114 of the Impairment and Sanctions Guidance, which stated:

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

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

483. The Panel reminded itself that it had found that Ms Okweri had shown limited insight and that remediation was also limited and there was a risk of repetition. Her reflective statements did not demonstrate insight into how her failings resulted in risk to multiple service users over multiple months, or how her actions impacted on her colleagues and the profession.

484. The Panel also had concerns regarding the way Ms Okweri presented herself throughout these proceedings. Ms Okweri in her evidence had been unwilling to answer basic 'Yes/No' questions or had been evasive in her answers. Ms Okweri had also been unable to follow simple instructions such as filing documentation when requested. The Panel had concerns regarding Ms Okweri's evidence about her current role, for example her statement that she interacted with up to 50 clients a day. The Panel found it difficult to understand how Ms Okweri could potentially engage with up to 50 clients a day and record these appointments in a meaningful way. The Panel also had concerns that Ms Okweri was unable to describe her job role in simple terms. The Panel determined that Ms Okweri has had several opportunities throughout these proceedings to show what she had learnt but had not done so. This further supported the conclusion that Ms Okweri had not grasped the seriousness of the allegations.

485. With this in mind the Panel considered that conditions of practice would not be sufficient to prevent the risk of repetition, nor would it be sufficient to satisfy the public interest element, as the public and other agencies including the regulator must be able to trust the accuracy of information provided by social workers. Furthermore, the Sanctions Guidance at paragraph 119 states that it would not be appropriate to impose a conditions of practice order in cases where dishonesty had been found. The Panel was satisfied that workable conditions could not be formulated to maintain public confidence, promote proper professional standards or adequately protect the public given its findings on dishonesty, safeguarding concerns, and particularly because of Ms Okweri's attitudinal shortcomings. Furthermore, any conditions that might allow Ms Okweri to practice safely would need to be so stringent as to be tantamount to suspension.

486. The Panel went on to consider making a suspension order. The Panel considered paragraphs 137-138 of the Impairment and Sanctions Guidance, which state as follows:

"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*

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

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

487. The Panel considered that the facts proved involved serious breaches of the professional standards, as set out in its earlier findings. The Panel was mindful of the severity and persistence of Ms Okweri's failings and misconduct, including dishonesty which she has continued to deny. However, the Panel was of the opinion that Ms Okweri had demonstrated some insight and attempts at remediation, albeit limited, and therefore, concluded that suspension could address the public interest concerns and the risks posed by Ms Okweri's failure to safeguard vulnerable service users. Ms Okweri had been somewhat apologetic, had completed some CPD and had engaged throughout the lengthy fitness to practice process.

488. For all the above reasons the Panel determined that a suspension order was sufficient to protect the public, maintain public confidence in the profession and uphold professional standards rather than imposing a removal order. The Panel agreed with Mr Smith's submissions regarding dishonesty being at the lower end of the scale of seriousness and therefore in this case it did not merit a removal order.

489. The Panel concluded that the appropriate and proportionate order is a suspension order of two years to reflect the seriousness of the allegations and allow Ms Okweri time to comply with the recommendations set out below.

490. The Panel considered the following recommendations should be attached to the suspension order to enable a future Panel to be able to assess Ms Okweri's level of insight and remediation at the time of review:

491. To supply the reviewing panel the following:

Testimonials

- A testimonial from your employer setting out your current competence and professionalism regarding record keeping. This will need to cover in particular – timeliness of record keeping, its accuracy and actioning.
- A testimonial from your current employer which details how you are communicating with service users and colleagues whilst in the workplace. This needs to cover the appropriateness of your communication with service users for both written and verbal contact. In relation to your colleagues the reviewing panel would benefit from gaining an understanding on how you are bringing matters requiring urgent action to their attention.
- A testimonial from your current employer which sets out how you are performing regarding the identification and prioritisation of vulnerable service users and in particular how you manage urgent safeguarding actions.
- A testimonial from your employer which sets out your approach to matters of honesty and integrity. The reviewing panel would benefit from gaining an understanding how you have managed ethical matters in the workplace which have required you to demonstrate honesty and integrity.

492. Any references and/or testimonials supplied to the reviewing panel must be signed and dated by the author providing their position and employer. The author of these documents should explain their relationship to you and whether they are aware of the fitness to practise concerns that have been found against you.

493. To participate in and reflect on any learning gained, from a Code of Ethics Course that specifically addresses the issue of dishonest conduct and the importance of openness and honesty in the workplace. This should take the form of a group based learning setting to enable you to benefit from challenge and discussion with your peers rather than an on-line multiple choice based intervention.

Reflection

494. To complete a Reflective piece outlining learning from the Fitness to Practice process as a whole. To cover the following points and any other information you feel relevant:

- where did your conduct fall short of what was expected of you as a social worker?
- why did it fall short?
- what were the risks to service users?

- what should you have done?
- what will you do differently in the future?
- how do you feel about your conduct on reflection?
- what was the impact or potential impact on the service user, any colleagues or the reputation of social work as a whole?

Training

495. To undertake training in the following areas:

- Safeguarding vulnerable adults
- Accurate record keeping
- Writing analytical reports
- Interagency/multidisciplinary working and information sharing
- Communication skills for working with vulnerable adults
- Assessment skills in Social Work practice

496. Course titles need not match exactly with those listed above, but you should be able to demonstrate that those areas have been meaningfully addressed and formed a substantive part of the training attended.

497. Training should take place "live" and in a group environment (either online or face-to-face) and not in the form of self-guided learning. Certificates or other evidence of attendance should be provided, detailing the training provider, format and length of course.

498. You should provide an up-to-date record of the above and any other training/CPD undertaken during the suspension period, with a reflective piece for each item, outlining what you have learnt and how you intend apply this learning to improve future practice.

Interim Order

499. Subsequent to his submissions on sanction, Mr Smith, on behalf of Social Work England, made an application for an 18-month interim suspension order to cover the period during which Ms Okweri may make an appeal against the suspension order and the period required for any such appeal to be concluded. This was on the basis that such an order was necessary to protect the health, safety and well-being of the public and to maintain public confidence and proper professional standards and would be consistent with the Panel's reasons for making the suspension order.

500. The Panel heard and accepted the advice of the legal adviser on its power to make an interim order under paragraph 11(1)(b) of Schedule 2 of the Social Workers Regulations 2018.

501. In light of its decision on sanction the Panel 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 if an interim suspension order was not made.

502. Accordingly, the Panel concluded that an interim suspension order was necessary for the protection of the public, including the wider public interest. The Panel decided that the appropriate length would be eighteen months to allow time for any potential appeal to be considered by the High Court.

503. When the appeal period expires, this interim order will come to an end unless an appeal has been filed with the High Court. If there is no appeal, the final order of suspension shall take effect when the appeal period expires.

504. Mr Smith made an application to revoke the existing interim order which is made under schedule 2, paragraph 8(2) and replace it with a new interim order under schedule 2, paragraph 11(1)(b). Ms Okweri did not object to this application being made today despite not having had the benefit of the 7 day notice period. The Panel acceded to this application.

Right of appeal:

505. 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.

506. 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.

507. 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.

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

Review of final orders:

509. 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

510. 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:

511. 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.