Social worker: Cheryl Vertigan
Registration number: SW17896
Fitness to Practise
Final Hearing

Dates of hearing: 01 September 2025 to 12 September 2025 and 06 January 2026 to 07 January 2026

Hearing venue: Remote hearing

Hearing outcome:
Fitness to practise impaired, advice

Introduction and attendees:

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

2. Ms Vertigan attended and was represented by Ms Christina Ramage from the British Association of Social Workers ("BASW").

3. Social Work England was represented by Ms Sophie Sharpe, Case Presenter from Capsticks LLP.

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

Adjudicators	**Role**
Alexander Coleman	Chair
Jasmine Nembhard-Francis	Social worker adjudicator
Richard Weydert-Jacquard	Lay adjudicator

Hearings team/Legal adviser	**Role**
Jo Cooper & Hannah McKendrick	Hearings officers
Chiugo Eze	Hearings support officer
Neville Sorab	Legal adviser

Allegations:

5. Ms Vertigan faces the following allegation:

While registered as a social worker and employed by Stoke on Trent City Council:

1. You failed to safeguard Child A between 24 -27 November 2021 in that you:

a. Did not schedule a strategy meeting

b. Did not hand over the case to the morning shift

c. Did not arrange or conduct a visit to Child A to check on their welfare

d. Did not arrange or conduct a section 47 enquiry

e. Did not arrange or consider arranging a medical assessment of Child A

2. You failed to safeguard Child B between 17-20 June 2021 in that you:

a. Did not schedule a strategy meeting

b. Did not hand over the case to the morning shift

c. *Did not conduct or arrange for Child B to be visited in hospital*

d. *Did not speak to Child B's parents, and/ or care givers and/ or the police to determine what steps could be taken to protect child B*

The matters set out at paragraphs 1 and 2 above amount to the statutory ground of misconduct.

Your fitness to practise is impaired by reason of your misconduct.

Admissions:

6. 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.*"

7. Following the reading of the allegations the panel Chair asked Ms Vertigan whether she admits any of the allegations.

8. Ms Vertigan informed the panel that she admitted allegations 1(a), 1(b), 1(c), 1(d), 1(e), 2(a) and 2(d).

9. The panel therefore found allegations 1(a), 1(b), 1(c), 1(d), 1(e), 2(a) and 2(d) proved by way of Ms Vertigan's admissions.

10. The panel noted that Ms Vertigan denied allegations 2(b) and 2(c).

11. In line with Rule 32c(i)(a) of the Rules, the panel then went on to determine the disputed facts.

Background:

12. During the period of the allegations, Ms Vertigan was employed in the role of Specialist Practitioner within the Emergency Duty Team ("EDT"). The emergency duty team ("EDT") is operated overnight from 17:00 until 08:30 Monday to Thursday and from 16:30 on a Friday until 08:00 on Monday. The EDT is made up of senior practitioners, and the operational guide for EDT covers everything from the role of EDT to the referral process. The role of the EDT can be summarised as follows:

    "*Stoke on Trent Emergency Duty Team (EDT) provides an emergency contact point for all aspects of social work in Stoke outside regular operational hours. This includes cover during the night, weekends, and bank holidays. The service provides help or advice for urgent individual or family problems that require immediate social work attention. This includes:*

    - *Children in need of protection*

- *Immediate concerns about children, their safety and well-being*
- *Acute mental health problems*
- *Adults with care and support needs to be deemed to be at risk of harm*
- *Crisis homelessness assessments*

EDT is principally responsible for providing an emergency service in situations where there is a real and immediate threat to life, safety, health or liberty.

EDT responds to out of hours referrals where intervention from the Local Authority is required to safeguard a vulnerable adult or child, and where it would not be safe, appropriate or lawful to delay that intervention to the next working day."

13. The concerns relate to Ms Vertigan's conduct when handling two referrals to the EDT. The first concerns Child A, which was received on 25 November 2021. The second concerns Child B, which was received on 18 June 2021. The referral relating to Child A involved a report that Child A had allegedly been thrown across a room the previous night. The referral concerning Child B was that Child B had been involved in an accident and it was reported that the child had been with two friends when a car ran him over and two men got out with crow bars and threatened to put Child B in the boot of the car. Child B was taken to hospital.

Allegation 1 (Child A):

14. On Thursday 25 November 2021, Ms Vertigan was the shift coordinator on shift which started at 16:30 in the EDT. The shift coordinator coordinates the calls and responses. They are responsible for delegating the work, handing over and overseeing the smooth running of the shift. The shift coordinator is also expected to contribute to the work arising from demands and undertake visits to ensure welfare if necessary.

15. On 25 November 2021 at 18:20, Ms Vertigan took a call from Child A's father in relation to Child A, a three-month-old baby. The referral information was that Child A had allegedly been thrown across a room the previous night.

16. The Working Together 2018 document provides a guide to inter-agency working to safeguard and promote the welfare of children. The Working Together 2018 document indicates that "*wherever there is reasonable cause to suspect a child is suffering or is likely to suffer harm, there should be a strategy discussion including social care, police and health*". The Working Together 2018 document further states that "*Where there are child protection concerns (reasonable cause to suspect a child is suffering or likely to suffer significant harm) local authority social care services must make enquiries and decide if any action must be taken under section 47 of the Children Act 1989"*. Ms Vertigan admits that she did not arrange a strategy meeting, due to becoming absorbed

by her own duties. Ms Vertigan set out in her response to the regulatory concerns, in a document dated 15 August 2025, that "*this was absolutely inappropriate*".

17. Ms Vertigan's case note of the call from 25 November 2021 records that she asked Child A's father questions to clarify details about the incident, and that EDT would follow up with the police. Following the uploading of my case note on Liquid Logic, the established process for a case open to social care was to alert both the social worker and the team manager. In her response to the regulatory concerns, in a document dated 15 August 2025, Ms Vertigan was of the belief that she had alerted both, but this turned out not to be the case. She is unclear as to how this happened and it was not her intention.

18. A visit to Child A's house, with the police, should have been conducted to check on Child A's welfare, as well as the welfare of any other children in the house. If Child A had sustained any injuries these could have been potentially identified if a visit had taken place if these were visible. Ms Vertigan sets out in her response to the regulatory concerns, in a document dated 15 August 2025, that:

> "*As the co-ordinator, I should have ensured that the visit took place, if the childcare worker was busy or unable to do so, then I or OH should have gone out and attended the family home. […] I was of the understanding that I had advised DB that she would need to undertake a visit to the family home which she agreed.*
>
> *[…]*
>
> *Without further follow-up, we were unaware if [the police] had visited or not. On reflection, when dealing with external partners like the police, it's imperative that I seek regular updates on the ongoing situation.*"

19. Section 47 of the Children Act 1989 places a duty upon a local authority to investigate where they have "*reasonable cause to suspect that a child is suffering or likely to suffer significant harm*". This includes making "*such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare*". Ms Vertigan does not dispute that a section 47 enquiry should have taken place in the instance of Child A. This would have initially been the responsibility of the child care social worker on shift. In their absence or inability, it would have been down to another colleague on shift. However, given that Ms Vertigan had direct involvement, it would have been expected that Ms Vertigan would have arranged or conducted a section 47 enquiry.

20. In her response to the regulatory concerns, in a document dated 15 August 2025, Ms Vertigan accepts that given the concerns raised, a medical assessment should also have been completed to determine whether Child A had suffered any injuries. Ms Vertigan should have also looked at contacting the on-call paediatrician from the hospital to attend the strategy meeting. This was not done.

Allegation 2 (Child B):

21. On 18 June 2021, Ms Vertigan was the shift coordinator. Ms Vertigan received a call at 23:16 from an external agency that works with young people called Catch 22. The information received was that Child B had been involved in an accident and it was reported that the child had been with two friends when a car ran him over and two men got out with crow bars and threatened to put Child B in the boot of the car. The case note completed by Ms Vertigan indicates that police and paramedics attended the incident, and that Child B was hospitalised and required an operation to put pins into his legs from knee to ankle following the incident. It further indicated that Child B was involved with gangs. Whilst in hospital Child B's phone was said to be constantly ringing, and calls were further made to Child B's mother asking her for money.

22. If a child is at risk of significant harm, then a strategy meeting is needed, and one should have been arranged in this case. Ms Vertigan, in her response to the regulatory concerns, in a document dated 15 August 2025, set out that:

> "*At the time of the call, I recognised that several professionals were informed and aware of the current incident. I concluded that it would be more appropriate for the strategy discussion to take place later in the morning when all agencies were present in a more planned way.*
>
> *[…]*
>
> *From my 6 years of experience on EDT, in all the strategy discussions I have held within the early hours of the morning, it has been agreed that, when the young person is in a place of safety to discuss in the morning.*
>
> *I can categorically state that had Child B not been in the hospital and a place of safety, I would have been contacting 999 for urgent support and strategy discussion.*
>
> *[…]*
>
> *In the future I would categorically contact the police regardless of the time or whether the person is in a place of safety to ensure that appropriate information sharing, ensure that agencies are aware and develop a safety plan.*"

23. Handovers take place at every shift swap to cover the cases that are outstanding and any actions that need to be taken. It is alleged that Ms Vertigan did not follow up or handover the case to the morning shift. This is denied by Ms Vertigan in her response to the regulatory concerns, in a document dated 15 August 2025, which sets out that she handed the case over to the morning shift, as evidenced by the daily logs. Ms Vertigan accepts that her case notes do not have a clear plan or rationale for her own actions.

24. It is alleged that Ms Vertigan did not conduct or arrange for Child B to be visited in hospital. Ms Vertigan, in her response to the regulatory concerns, in a document dated 15 August 2025, denies this allegation, setting out:

"*I confirm that I did not visit Child B in hospital, as detailed previously it was approximately 00:30 when I received the referral and at that time I did not believe it was appropriate to visit the hospital due to the time. The referrer had informed me that she had been with Child B the previous night and he was settled, in hospital, a place of safety, and the support worker, SS, was visiting first thing in the morning. My initial thoughts were that Child B would be settled and potentially asleep following his operation and potential medication. As detailed above, I handed the case over to my colleague at 08:00, and we discussed whether a sessional worker should visit to gain further details and support them in making a statement to the police or informing them of our duties to do so.*"

25. Ms Vertigan took no action after receiving the referral, and no action is recorded in the case note entry, that Ms Vertigan spoke with Child B's parents and care givers, and held discussions with the police in respect of what could be done to protect Child B. Ms Vertigan, in her response to the regulatory concerns, in a document dated 15 August 2025, set out that:

"*At the time of the dealing with the referral it was the early hours of the morning, I was of the belief at that time that it was late to be calling the caregivers, they were aware of the incident. On reflection, I should have attempted to contact the caregivers to advise that we have been made aware and offer emotional support. The caregivers may have able to offer additional information other than what was reported. In addition to the referrers opinion, the caregivers may be disappointed that we hadn't made contact in a timely manner. Given that we were not aware contact had not initially been made.*"

26. At a Case Management Meeting held on 23 October 2024, a Panel of Adjudicators determined that the cases against Ms Vertigan and Ms Bolton were to be joined with the following relevant directions:

    1. "*The fitness to practise cases FTPS-20008 and FTPS-20149 be joined to be heard together at the same time by the same fitness to practise panel.*
    2. *Both Ms Vertigan and Ms Bolton shall be entitled to remain present throughout the facts stage and any grounds stage of the hearing, subject to any application for matters to be heard in private. There is no obligation on either to remain present in relation to matters of evidence and submissions unrelated to their own case.*
    3. *If the impairment and/or sanction stages are reached in the hearing, the panel will hear evidence and representations separately, without Ms Vertigan and Ms Bolton being present to hear the other person's case.*
    4. *Otherwise it will be for the panel chair to manage the process bearing in mind any matters such as admissions and time constraints of witnesses.*"

Summary of evidence:

27. The panel received evidence from Ms Sheena Adams who set out:

    a. Her role at the time of the allegations, which is the same role that she has currently, is that of Strategic Manager, Head of Services, at Stoke on Trent City Council.

    b. Ms Vertigan and Ms Bolton were both in role when Ms Adams joined the team.

    c. She managed Ms Gulshin Rayaz, the interim service manager, who line managed both Ms Vertigan and Ms Bolton.

    d. Ms Adams acted as a direct line manager to Ms Vertigan between May and July 2021, as the post of line manager was vacant then.

    e. The coordinator on shift coordinates the calls and responses. They are responsible for delegating the work, handing over and overseeing the smooth running of the shift. They also have to contribute to the work arising from demands and undertake visits to ensure welfare if necessary.

    f. There is also a child care social worker, whose responsibility is to respond to all calls relating to children where there is a welfare or safeguarding concern. All calls should be recorded on the child's file and appropriate actions taken, such as undertaking a welfare visit, chairing strategy discussions, arranging and facilitating child protection medicals and securing a safe place for the child, this list is not exhaustive. The child care social worker is the lead practitioner for children on shift, although dependent on need would also act as coordinator, adult social worker or approved mental health professional ("AMHP") if qualified.

    g. The adult social worker and AMHP's responsibility on shift is to respond to all calls relating to welfare or safeguarding concerns for adults and where a mental health assessment may be required. They would then follow up on any actions required, such as undertaking safety and welfare visits, completing a mental health assessment with General Practitioners ("GP's"), and chairing a strategy discussion; this list however, is not exhaustive. It is important to note that the roles are divided for the purpose of the rota to ensure sufficient cover across all areas of the service. All senior practitioners were aware, that despite their identified role on the rota, they were all accountable for covering the work required on any given shift, and should a child care matter arise where the allocated child care social worker was not available, then it was an expectation that another social worker on shift would manage this. The needs of our customers were always paramount and

the role of the coordinator was to ensure all aspects of the shift were responded to appropriately.

h. Ms Vertigan was the shift coordinator on the evening of the 25 November 2021. Ms Vertigan was responsible for overseeing work that needed to be completed. Ms Vertigan had been an employee of the Council for over nine years. She was a fulltime member of staff, employed on a permanent basis and had been on the EDT since 2017.

i. On the evening of 25 November 2021, Ms Bolton was on shift and on the rota she was the child care social worker and so had the responsibility to respond and undertake any action to any calls received regarding children.

j. Ms Vertigan took the call concerning Child A and handed the information over to Ms Bolton. Ms Vertigan recorded her discussion with the family on the child's electronic file. All senior practitioners were office based that evening and as such the information would have been verbally handed over to Ms Bolton, this was confirmed in both Ms Vertigan's and Ms Bolton's interviews for Ms Adams' internal investigation.

k. It was the joint responsibility of Ms Vertigan and Ms Bolton to give an updated report and hand over to the day team. There is no evidence that LiquidLogic was updated at the end of the EDT shift. Ms Vertigan cannot recall if she came to an agreement with Ms Bolton concerning the handover.

l. In her internal investigation, Ms Adams established that the shift was sufficiently staffed and there were no other priorities that evening. Child A should have been the priority as there was nothing else that took precedence. There were ample workers to cover all matters which came into the EDT on 25 November 2021.

m. Ms Adams had performance data to see what work each social worker was being undertaken. The work each social worker was undertaking was also evidence by entries into LiquidLogic (an electronic case management system) and a handwritten log book.

n. The role of the shift coordinator included how the rota was managed. There has since been a review of how EDT functions, including the rota, but the case concerning Child A was not the reason for the change.

o. When Ms Adams was notified by Ms Ramage that Ms Vertigan had worked 11 shifts in a row leading up to 25 November 2021, Ms Adams set out that Ms Vertigan took on this additional time and made this decision herself. Ms Vertigan is responsible for her own wellbeing. The specialist practitioners, of which Ms Vertigan was one, managed their own time, including the rota at the time of the allegations as there was no line manager. If there were any problems, Ms Adams expected members of the EDT team to notify her.

p. Ms Adams did not think EDT staff were under pressure at the time. Although Ms Adams appreciated that there was a duty of care from managers to staff, there was also a duty on staff to bring any problems to the attention of managers. In a previous matter, Ms Adams supported Ms Bolton over the phone in which Ms Bolton was professional and supportive.

q. If there is a gap in the rota due to sickness/leave/illness, then the shift is covered by another social worker or an agency worker.

r. Morale was quite low in the EDT at the time as the practitioners were covering a wider remit in adults, children and housing.

s. When she commenced her role in 2020, Ms Adams was aware that Stoke upon Trent City Council had received a rating of "inadequate" for social work. Ms Adams helped improve services by implementing good procedure guides and made policies and procedures more available.

t. Between autumn 2020 and autumn 2021, there had been some improvements in relation to training and opportunities, but there were some things which still were not as they should be. For example, there was a lack of a manager in EDT, for which Ms Adams stepped in to cover. Ms Adams spent some time individually with Ms Bolton.

u. Although Ms Bolton was "emotional" during Ms Adams' internal investigation, Ms Bolton fully engaged with meeting and with investigation process, but Ms Bolton did not attend the final meeting.

28. The panel received evidence from Ms Olwyn Hammersley who set out:

a. At the time of the concerns, she was a part time senior practitioner with the EDT. Her role as part of the EDT team was to provide a reactive out of hours service on behalf of the Council to anyone in the Stoke-on-Trent community who was at risk or risk of harm and the individual required an (assessed) immediate response to negate risk and ensure safety. The service was described as a generic service and so all team members were required to proficient in work with children and adults.

b. The EDT team worked on a rolling rota.

c. She is not sure when Ms Bolton came to the EDT but they worked on shifts together very often, on average one or two times per week depending on the rota. Ms Hammersley and Ms Bolton did a lot of overtime due to the needs of the service. If they were working on shift together, Ms Hammersley would tend to deal with all of the mental health concerns and Ms Bolton would mostly deal with childcare due to the skill mix and needs of the service.

d. As part of Ms Bolton's employment, she was training for her AMHP qualification and Ms Hammersley was her practice teacher for AMHP stage one.

e. Ms Bolton would come out with Ms Hammersley to observations targeted at Ms Bolton's mental health learning. Ms Bolton would shadow Ms Hammersley on Mental Health Act assessments and then they would go back to the office and reflect. These observations were for Ms Bolton to learn about the legislation, how to apply the legal framework and also to learn the roles and responsibilities of other agencies that were involved in Mental Health Act assessments such as doctors. They were working to meet competencies to a standard where Ms Bolton would qualify to go on to her second year of training. Ms Bolton responded well to Ms Hammersley's feedback.

f. Ms Vertigan was in the EDT and Ms Vertigan and Ms Hammersley worked together for around 6 years. Ms Vertigan qualified as an AMHP whilst Ms Vertigan and Ms Hammersley were working together and Ms Hammersley supported Ms Vertigan through that. Ms Vertigan and Ms Hammersley worked together when they were on the rota together which was around 5 or 6 times a month dependent on the needs of the service.

g. When a referral comes into EDT, the person receiving the call would get a brief explanation of what the issue is. The issue then goes to the EDT coordinator, who would then screen the call, record the call, risk assess the information received, and then give the case a priority in relation to the risk to the individual. There is a pro forma form which helps to remind of the information required.

h. EDT all sit in the same office, where there are two banks of four desks.

i. There are three methods of transferring information: Liquid Logic, the EDT Log Book and the handover to the incoming shift. The Log book was an internal method that the EDT would use to assist their practice. The log book would not be handed over to the day team. Liquid Logic was the recognised method of communication. The handover to the day team was the opportunity to review the entries in the log book. The log book eventually became a draft which was transferred into Liquid Logic. At some point after the incident with Child A, the log book changed from being handwritten to electronic.

j. There are situations where the police can react first and they also have powers to safeguard children. The EDT would then have a strategy meeting with the police to discuss the next steps.

k. If specific concerns need a strategy discussion with the police, this should be held with an Inspector level or above, but in practice, this is often delegated to a Sergeant.

l. The EDT shift coordinator on 25 November 2021 was Ms Vertigan and Ms Vertigan took the call on Child A. Ms Hammersley cannot recall any

conversation where tasks were allocated between Ms Vertigan and Ms Bolton.

m. Although she initially planned to pick up her partner mid-shift, Ms Bolton then did not need to go and pick him up. Ms Hammersley cannot recall if Ms Bolton was there at the end of her shift on 25 November 2021.

n. On 25 November 2021, there were other pieces of work as well as Child A and mental health work. That evening was hectic and busy, but this was just the nature of EDT which is unpredictable. Ms Hammersley also said that the EDT is always busy and hectic, but that the EDT team had worked together for a long time and would work through allocated work as it came in. The EDT team always worked to support each other. There was a stoic atmosphere to get the EDT team through work.

o. The incident concerning Child A was different as it had already been responded to by the police. The EDT team would expect the police to have some social service knowledge, have previous social service contacts and for the police to discuss the issues with EDT.

p. In her internal interview, Ms Hammersley said "*why have they left this for so long*". When questioned, Ms Hammersley said that this was her initial concern. However, every case is different and there may be legitimate reasons for delaying reporting.

q. In regard to handovers, there are handovers at all different times over the evening. There are handovers via Liquid Logic that come through from the day teams, the EDT team would also check for emails or there may be phone calls from the day team to add more context to the Liquid Logic handovers. During the shift there can several handovers in regard to current referrals being dealt with. At around 23:30 in anticipation of the change of shift at midnight where only 1 social worker stays on until morning, the EDT team would go through the logbook and talk through each contact to cover what is live and where actions still need to be taken, what has been recorded to picked up the next day and what has been closed. In the morning, everything should then on Liquid Logic to go to the receiving teams and the desktop should notify the receiving team manager and social worker that there is information to considered. If there is nothing to handover, this is confirmed to the receiving day team.

r. On 25 November 2021, there was not EDT team manager. Even when there was no team manager, EDT kept going as it was a very experienced team.

s. The EDT team shared with management concerns about long working hours. Some people were getting tired as they were going above and beyond the maximum hours that they could manage. This was brought to management's attention before the incident with Child A.

t. Two team members managed the EDT rota, which was an existing rolling rota. Team managers would have oversight over who filled rota slots. Often, there were significant gaps in the rota. The gaps in the rota were due to staff availability and the mix of skills required. 6-8 core members of the staff covered most of the EDT hours. Management was aware that it was the same individuals covering EDT shift. Management had access to the rota and time sheets.

u. Ms Hammersley and Ms Bolton did a lot of overtime due to the needs of the service. 60 hours a week would not be unusual.

v. Although it was not the EDT team's responsibility to avoid everything collapsing, the EDT team felt an expectation from management that the EDT team should cover what was required. If the EDT did not "step up", team managers would find someone to stand in, or stand in themselves. EDT team members did not need to know the background to cases. Whoever was coordinating the shift would lead the process to guide any casual social workers within the team. There was an expectation from management for EDT members to cover shifts.

w. It is a custom and practice that all work that is completed is covered in the log book. The log book is to ensure that work has been completed.

x. Every referral has to be treated as genuine unless further information came in to challenge that assumption. The motivation for a call is low down in the list of importance of a call.

y. EDT did not have access to health information of someone who had been referred. This included any background to medical information such as doctor visits, health care visits, etc. There would, however, be some information on Liquid Logic concerning child in need, child protection and the records of supervising social workers. The level of health information available would depend on the level of input by previous social workers.

29. The panel received evidence from Ms Rayaz who set out:

a. Between July 2021 and June 2023, she was the service manager for EDT. Ms Rayaz worked from 9am-5pm. Ms Rayaz considered her working hours left a gap as EDT was an out of hours team, so this was a managerial gap which Ms Rayaz wanted to fill.

b. Ms Rayaz said that she was very well aware of the capabilities and limitations of EDT staff, and consequently knew how to restructure the team in order to make the service better.

c. Ms Rayaz also worked as an audit and improvement consultant at Stoke upon Trent City Council and owned her own children's home in Nottinghamshire. Ms Rayaz used to work 3-days a week in the office. Ms

Rayaz disagreed that she was too busy to deal with complaints and issues raised by Ms Bolton, as she is a high performer and has been commended in many roles.

d. Ms Rayaz was Ms Bolton's supervisor and carried out supervision meetings with her on a monthly basis, usually remotely. They also met in team meetings. There may have been some supervision meetings which were missed due to absences. If a supervision meeting was missed, a scheduled supervision meeting would take place at the next convenience of both parties. Ms Rayaz said that Ms Bolton never brought it to her attention that there were excess cases in EDT and that further helps was needed in EDT.

e. Ms Rayaz said that she would know if the EDT workload was unmanageable as staff would stay after hours to finish any work. This was not the case.

f. The purpose of creating templates was to provide guidance to social workers when taking calls. This included taking the details of the person contacting EDT; gathering referral information; unpicking referral information; asking probing questions to best understand the situation. These templates were shared and accessible to all practitioners.

g. The structure of EDT was not to have a team manager, just a service manager. This was because the social workers in the team were expected to have a certain level of experience and qualifications. Where the EDT team needed supervision, Ms Rayaz was always available for discussion. There was no difference for the EDT team to have a service manager compared to a line manager.

h. In November 2021, there was a set pattern of shifts which rotated every so often. A social worker's shift hours would be different each time depending on which shifts they picked up and if they had chosen to pick up additional hours. Ms Rayaz had access to the rota to see how many shifts each social worker was working. As part of improvement work within the EDT team, Ms Rayaz took responsibility for the EDT rota, although this took place after November 2021. Members of staff had a good oversight of the EDT rota. Where there was difficulty in getting the EDT rota filled, Ms Rayaz obtained bank workers or agency workers to fill the gaps. Ms Rayaz took a staged approach to bringing in bank/agency workers into EDT. A formal restructure did not happen before November 2021.

i. Ms Rayaz always told the EDT staff that if they were unable to work for the EDT, there was no pressure on them to work. Any staffing shortages were Ms Rayaz's concern and not that of the EDT team.

j. Ms Rayaz was unaware that Ms Vertigan had worked 11 shifts in a row. Ms Rayaz said it was the responsibility of each individual to bring to management's attention any issue of being overworked or working at

maximum capacity. Ms Rayaz cannot recall if any EDT staff member raised with her as an issue the number of hours that they were working. Ms Rayaz considers the EDT team was supported well during her tenure as EDT service manager.

k. Some EDT staff may have opted out of the EU working time directives, but Ms Rayaz was unsure. Ms Rayaz did not conduct a risk assessment of the hours of work that each EDT member of staff was undertaking.

l. Ms Verigan took a call from Child A's father at 18:20 in relation to Child A, a three-month-old baby. The referral information was that Child A had allegedly been thrown across a room the previous night. Ms Bolton accessed Child A's file.

m. The operational guide for EDT covers the process of a strategy meeting. Where a child is suffering or likely to suffer significant harm, a call should be made to the police sharing the information received and requesting a strategy meeting. A strategy meeting usually takes place over the phone or through some form of virtual communication. With the case of Child A who had allegedly been thrown across a room there may have been potential injuries and so Ms Vertigan and Ms Bolton should also have looked at getting the on-call Paediatrician (who is available 24 hours a day) from the hospital to attend the meeting as well. A strategy meeting was held on 26 November 2021. Ms Bolton did not attend in the first instance, as set out in the police record.

n. Once a referral is received by the shift coordinator it is their responsibility to demonstrate professional curiosity in gathering all of the relevant information and then it is about using their social worker skills to decide the next steps. However, if the coordinator is on another line, the other staff in the office can take the calls, hence the crossover. Relevant information is gathered by looking over the case file of the individual. If there is no information the child on the system, the social worker would create a file if the referral information warrants this and proceed with the relevant actions based on the referral information received. How far back a social worker would be expected to look at a service user's case file would depend on the information held on file and the level and or nature of the concerns.

o. Ms Rayaz was Ms Vertigan's line manager from July 2021. A plan of support and training is available to assist EDT team members.

p. Child B's case came to Ms Rayaz's attention when she was "*dip-sampling*" case notes. The case notes for Child B were insufficient and there was no consideration to holding a strategy meeting. The Head of Services emailed Ms Vertigan in relation to her handling of Child B's case.

q. As well as a strategy meeting being arranged within a 1-hour timeframe, given what happened to Child B, it should have been arranged for someone to go visit Child B who was in the hospital, for reassurance, checks and supervision. Ms Vertigan should have spoken to Child B's parents and caregivers as they were the relevant people who could help to safeguard and protect Child B (especially as Child B was staying with his girlfriend's mother and not his own parents). There should have also been discussions with the police in respect of what they can do to protect the child. The EDT workers would have been responsible for ensuring the welfare of Child B until the day time staff came on shift. Ms Vertigan's responsibility was the overnight/weekend plan to ensure the child was protected from any further harm and their needs were met. Even though a hospital is a safe place, there may have been further safeguarding concerns to tell the hospital, whether Child B could leave the hospital grounds, and it was not known the state of Child B in the hospital. A lot of unknown factors that would have warranted an in-depth safeguarding issues, especially as there would have likely been a section 47 investigation due to the seriousness of the attack.

r. If no visit took place to Child A or Child B, Ms Rayaz would have expected this to be documented in Liquid Logic with a rationale as to why this did not take place.

s. Any handovers at shift changes need to be recorded in Liquid Logic. The EDT log book is not an adequate handover.

t. Concerning Child A, Ms Rayaz considered that 40 minutes between the first and second case note to be a very long time given the concerns raised about Child A. However, Ms Rayaz was unaware of the team make up and priorities on 25 November 2021. Given the concerns for Child A, it would have been helpful for an on-call manager to be updated and for the coordinator and another EDT member to execute actions in a joined-up working approach. There is an overlap of responsibilities on shift and so between Ms Vertigan and Ms Bolton, one of them should have identified that a strategy meeting was needed. They both had the responsibility to be looking through Child A's file and understanding the child's history before then arranging a strategy meeting and looking at someone going out to visit the child in the meantime if the strategy meeting could not take place immediately.

u. A handover is expected at the end of every shift, including if a social worker leaves and works from home; a phone call to handover would be expected.

v. If a social worker was not on annual leave, they would be encouraged to attend training.

30. Ms Vertigan provided the following evidence:

a. She started in EDT on a permanent basis in 2015, after being an EDT sessional worker for a few months.

b. In 2019-2020, EDT was called into a meeting where they were told that front line services were being disbanded and that the EDT was going to be restructured. This raised concerns within the EDT team that their roles were going to be made non-existent. The review of EDT passed to three strategic managers (Ms Adams being the third) and lasted three years. Ms Vertigan cannot recall if notice of the EDT restructure took place after the OFSTED grading of "inadequate". Nothing was put in place to assist the EDT team with the review process.

c. The morale of the EDT team became quite low and continued to fall, especially when the EDT did not have a manager. Ms Rayaz constantly criticised EDT and was constantly negative about EDT. This reduced the morale of the EDT team even more.

d. Ms Vertigan took on more shifts in the EDT team as she felt financial pressures at home and also felt pressure to fill gaps within the EDT team so as not to let other EDT members down. As a team, the EDT team were supportive of each other.

e. In 2021, Ms Vertigan did not have a good work/life balance.

f. Ms Rayaz was not available for support when the EDT team was on shift. Ms Rayaz's supervision was completed virtually. The team did not feel connect to management at all. Ms Vertigan started to have difficulties with Ms Rayaz in 2021 and should have raised this with higher management, but did not. Ms Rayaz was extremely difficult to work with; Ms Vertigan would often come out in floods of tears after interacting with her. Ms Rayaz was extremely negative (including in her supervision meetings), would smack the desk and would not accept anything that she did not agree with, which meant that everyone was forced to agree with her. Ms Vertigan cannot recall Ms Rayaz ever saying anything positive. Ms Vertigan thought Ms Rayaz's feedback was not unfair, but the way in which Ms Rayaz brought it up was inappropriate. Ms Vertigan did not read her supervision notes with Ms Rayaz until the internal disciplinary hearing as she found them "*pointless*" (but acted on anything raised verbally in Supervision meetings). Ms Vertigan was afraid of Ms Rayaz's reactions during supervision. The relationship with Ms Rayaz was not two-way.

g. The EDT team always had regular team meetings, but following the appointment of Ms Rayaz, these were more used to discuss learning/development/training. Templates and good practice guides were also produced. Ms Rayaz used to dip-sample EDT social workers' cases.

h. There was not a widening of social workers available for EDT, as claimed by Ms Rayaz. EDT had the same sessional workers (people who work for the Council, but not EDT workers, picking up EDT shifts).

i. The effect of the low morale made the EDT team increasingly tired and grumpy, which does have an impact. EDT felt like the "forgotten team"; under constant review, but no change nothing happening.

j. For the EDT team, a service manager delivered line management. There was no team manager for EDT. Managers would come into the office for a few hours to see what was being handed over. The EDT team did not feel supported (as claimed by Ms Adams).

k. She was "*mortified*" about her case recording, which had been raised with her over a couple of months in her supervisions. Ms Vertigan was aware of her weaknesses.

l. Leading up to 25 November 2021, Ms Vertigan had completed 11 consecutive shifts. Ms Vertigan set out that working 11 shifts in a row is "*totally unsafe*" as her sleep pattern was not right and she was quite irritable, which was an indication that she was not in a good place to be at work as she could put people at risk.

m. Ms Vertigan completed additional shifts for both additional funds and to fill gaps in the rota. At times, Ms Vertigan felt as though she had to volunteer for shifts as other EDT team members were tired and fatigued and she had to fill the gaps. Ms Vertigan felt that she had to cover shifts in meetings with management, who said that they were "*not going to grant annual leave unless someone covers it*". Ms Vertigan does not agree with Ms Rayaz who said that EDT workers did not have to work additional shifts if they cannot and that this was solely a problem for Ms Rayaz. The EDT was not short staffed when the referrals for Child A and Child B came through.

n. When the call came in from Child A's father, Ms Vertigan asked Child A's father a number of questions including whether the baby was ok and ascertained what had happened. Child A's father referred to Child A's mum as being manipulative. When Ms Vertigan asked Child A's father further questions, Child A's father responded with "*I don't know duck, this is all I know.*" Ms Vertigan was alarmed at what she was hearing and was disappointed that she could not get more information from Child A's father. Child A's father was panicked on the phone. Ms Vertigan was concerned that this case had been reported 24 hours after the incident took place.

o. She cannot recall if Ms Bolton was in the room when she took the call from Child A's father. Once she found Ms Bolton, Ms Vertigan discussed Child A's case with her verbally. They discussed the welfare of Child A and why Child A's father took so long to make a report (the day after the incident). The delay

in the call from Child A's father did not make Ms Vertigan suspicious about the motive of Child A's phone call. Ms Vertigan relayed to Ms Bolton what Child A's father told her, that she may have to go out to this call and to give the police a ring. Ms Vertigan did not tell Ms Bolton directly to set up a strategy meeting for Child A. Ms Vertigan believed that she handed over the call to Ms Bolton. Ms Vertigan set out that she should have been clearer in her rationale to Ms Bolton to contact the police and arrange a strategy discussion. Ms Vertigan's instructions to Ms Bolton were not particularly urgent.

p. Ms Vertigan's concern was on Child A's safety and not concerning the mental health of Child A's mother. Neither Ms Vertigan not Ms Hammersley (who was the mental health practitioner on the EDT team) raised concerns about Child A mother's mental health. Ms Vertigan cannot recall Ms Bolton saying that Child A's case was a mental health case.

q. Child A's case warranted an urgent response, even if it was suspected that the referral was malicious. The comments from Child A's dad did not influence how Ms Vertigan handed over the case to Ms Bolton. Ms Vertigan considers that it was appropriate to delegate Child A to Ms Bolton as Ms Bolton is an experienced practitioner who should know what to do. Ms Vertigan had no concerns that Ms Bolton would not be able to carry out Child A's case. Ms Bolton did not tell Ms Vertigan that she could not manage Child A's case.

r. Ms Bolton left the shift on 25 November 2021 at 1030pm. At the point of leaving, Ms Bolton did not update Ms Vertigan on Child A's case. At the end of the shift, at midnight, Ms Bolton did not update Ms Vertigan on the progress of Child A's case. Ms Vertigan did not follow up with Ms Bolton at 1030pm or at the end of the shift was that once she delegated the work to Ms Bolton, Ms Vertigan got caught up with her own work and made a mistake on her part in not checking up on Child A's case with Ms Bolton.

s. She knew that she picked up the referral concerning Child B after 1230am as both of her colleagues had already left. Following receipt of the referral, Ms Vertigan contacted Kylie from Catch 22. Kylie had been out to see Child B. Ms Vertigan should have contacted management concerning the case of Child B.

t. Child B was staying with his girlfriend's mum. Ms Vertigan did not check, at the time of Child B's referral who had parental responsibility for Child B. She was aware that Child B's mother was deceased and that Child B's father visited him in hospital. Ms Vertigan considers that it would have been appropriate to contact Child B's father.

u. Ms Vertigan did not handover Child B on Liquid Logic, and her recordings on Liquid Logic were poor as they did not have any rationale for actions taken

and thinking of next steps, for which she is ashamed. It was not a requirement, when Ms Vertigan was there, to record next steps on Liquid Logic.

v. During the handover for Child B, which was have been at 8am on Saturday morning, Ms Vertigan would have used the daily log rather than Liquid Logic. The daily log would have been an excel spreadsheet. She handed over to her colleague Lynne, who was part of the Multi-Agency Child Exploitation (MACE) panel. Handover to a MACE panel member does not negate the need for a strategy meeting. Ms Vertigan handed over 4 cases to Lynne on that morning (Saturday 19 June 2021), of which Child B was one. The handover with Lynne included a wider discussion of next steps going forward. During the handover, Ms Vertigan mentioned to Lynne that no one had gone to visit Child B.

w. Ms Vertigan noted, concerning Child B, that there had been no entries or recorded actions until 9:21am on the Monday. There was no evidence that anyone visited Child B over the weekend; no strategy discussion had been arranged; or safety provisions been enacted over the weekend. Ms Vertigan considered that the verbal handover of Child B's case had not been taken forward over the weekend. Ms Vertigan had no explanation why none of the discussed steps which took place had been acted upon. Ms Vertigan considered that the handover is not clear in her recordings, but that she had a clear, long discussion with Lynne on the Saturday morning.

x. She did not visit Child B in the hospital. Ms Vertigan believed that by handing over, that a visit would have been undertaken, or at the very least there would have been contact with the hospital to check if he is awake, settle, would like a social worker to visit, inform him that a social worker is aware and devise a safety plan.

31. Ms Bolton provided the following evidence:

a. Sessional workers would provide a back up to the EDT core staff. The sessional workers would wait at home until they were called to provide support for EDT. Sessional workers would not do the EDT coordinator role, which would always be undertaken by a core EDT staff member, as they would need to know what EDT needed to cover.

b. All EDT staff members played a role to ensure that the rota was filled. There was an expectation that core EDT staff members would complete shifts to cover the rota. Ms Bolton disagrees with Ms Rayaz that shifts were only picked up by EDT staff if they could accommodate them.

c. There was a financial gain to doing extra shifts on the rota. At times, Ms Bolton worked 17-hour shifts. There was no training for EDT staff to complete the rota and EDT staff were expected to maintain the rota.

d. EDT had its own customs and practices. Unfortunately, this is likely to have led to bad practices such as improper recording of information.

e. EDT staff members were worried about the future due to the restructure, being two months without a manager and having an agency manager from mid-2021. Ms Bolton did not consider that morale was low, but that there was upset between team members due to personalities within the team, mostly Ms Rayaz's manner. Some team members were reluctant to change and there were a lot of negative conversations. Ms Bolton cannot remember when EDT was informed about the restructure. Ms Bolton did not consider morale to be low enough to share anything with management.

f. Ms Rayaz never attended an EDT shift. In supervision meetings, Ms Rayaz showed no empathy, provided no reflection and the supervision meetings felt scripted and like a "*box ticking*" exercise. Supervision meetings with Ms Rayaz were always remote and did not really reflect on cases. Ms Bolton did not feel supported by Ms Rayaz. Ms Bolton could not challenge Ms Rayaz and did not even try to challenge her. The negativity from Ms Rayaz had a tangible effect on the team; everyone on the EFT was really upset. It was impossible to build any relationship with Ms Rayaz as she was not available/present during EDT hours, and she was only available virtually. Ms Bolton did not try and get hold of Ms Rayaz out of hours. When help was needed during EDT hours, the EDT team would call on-call managers.

g. Supervision meetings did not address major concerns such as staffing. No agency workers were in place before November 2021. A lot of sessional workers refused to help EDT due to Ms Rayaz as she was unapproachable. The use of sessional workers was authorised prior to the arrival of Ms Rayaz.

h. Ms Rayaz dip-sampled cases. Ms Bolton considered Ms Rayaz's concerns to be valid, but manner in which concerns were raised were poor.

i. Team meetings focused upon training and improvements in the service. The improvements focused upon getting better recording and the creation of templates for documenting actions.

j. EDT felt like a forgotten service.

k. Ms Bolton was not present when the call for Child A came into EDT. Ms Bolton knew she was not in the EDT room when the call for Child A came in as when she returned, an AMHP was sitting in her seat speaking to Ms Vertigan and Ms Hammersley about Child A.

l. When Ms Vertigan delegated the call to Ms Bolton, Ms Bolton understood the delegation that she may need to go out on a visit as a baby had been thrown across a room. Nothing from Ms Vertigan suggested to Ms Bolton that this referral was urgent. When Ms Bolton left the office, she told Ms Vertigan in

relation to Child A that she would give her a call if the police called her back. Ms Bolton did not contact Ms Vertigan at the end of her shift.

m. Ms Bolton left the office at 1030pm on 25 November 2021 as she had been unwell and the shift was quite quiet. Ms Bolton went home to work and worked until midnight. Although she was unwell on 25 November 2021, Ms Bolton did not want to let the team down, so came to work. In hindsight, Ms Bolton realised that she was not 100% on her game coming to work when she was unwell. Both Ms Vertigan and Ms Hammersley knew that Ms Bolton was unwell on 25 November 2021.

n. Ms Bolton and Ms Vertigan worked many shifts together and trusted each other's abilities. As Ms Bolton trusted Ms Vertigan's judgement calls, Ms Bolton responded to Ms Vertigan, including her lack of urgency for Child A, and she followed Ms Vertigan's actions to call the police and go out. Ms Bolton was also of the view that the police did not treat Child A's case as an emergency. Ms Bolton told the police that although she is the only child social worker on shift, she would be available for a visit if required.

o. Ms Bolton assumed that an adult caring for Child A would have sought help from somewhere the day of the incident. Therefore, there would have been more urgency if the incident with Child A happened that night.

p. The call regarding Child A would also require a generalised assessment whether the call was malicious.

q. Child A's case did not raise any safeguarding issues as the family had been in child protection, then child in need, so the family was making progress.

r. EDT could have done a joint visit to Child A along with the police, but this could not just be requested. Ms Bolton had concerns over her own safety visiting Child A alone. A joint visit is likely to take place after a strategy discussion.

s. On 25 November 2021, EDT was fully staffed and EDT could take appropriate safeguarding action.

Finding and reasons on contested facts:

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

<u>Allegation 2(b) – You failed to safeguard Child B between 17-20 June 2021 in that you did not hand over the case to the morning shift:</u>

33. The panel has not seen the daily log (and excel spreadsheet) and has not received any information from "Lynne" or anyone else that she case was handed over to her.

34. Ms Vertigan provided the following evidence that she handed over the case of Child B to the morning shift:

    a. She did not handover Child B on Liquid Logic, and her recordings on Liquid Logic were poor as they did not have any rationale for actions taken and next steps.

    b. During the handover for Child B, which was have been at 8am on Saturday morning, she would have used the daily log (and excel spreadsheet) rather than Liquid Logic.

    c. She handed over to her colleague Lynne. She handed over 4 cases to Lynne on that morning (Saturday 19 June 2021), of which Child B was one. The handover with Lynne included a wider discussion of next steps going forward.

    d. Ms Vertigan considered that the handover is not clear in her recordings, but that she had a clear, long discussion with Lynne on the Saturday morning.

35. The panel has the following circumstantial evidence:

    a. There is no record of a handover being completed from Ms Vertigan to Lynne.

    b. Ms Vertigan is a senior social worker who should have known to hand over appropriately, in a team that she has worked in for years.

    c. As the case concerning Child B was so serious, it would have been expected that some action was taken over the weekend, but none was recorded to have been taken by the day staff on Monday morning.

36. As the burden falls upon Social Work England to prove the allegation, the panel does not consider this allegation to have been proved on the basis that:

    a. Due to the lack of contemporaneous recording before the panel, there is no evidence either way that Ms Vertigan handed the case of Child B over to the morning shift.

    b. As Ms Vertigan should have known to hand over the case of Child B to the morning shift, and her testimony is that she did, this is the only direct evidence before the panel as to whether Ms Vertigan handed over the case of Child B to the morning shift.

    c. The lack of action concerning Child B could have been for several reasons (e.g. a lack of action from Lynne) rather than solely to do with a lack of action from Ms Vertigan.

37. Consequently, the panel find allegation 2(b) to not be proved.

    This allegation is found not proved.

Allegation 2(c) – You failed to safeguard Child B between 17-20 June 2021 in that you did not conduct or arrange for Child B to be visited in hospital:

38. The panel is not in receipt of any documentation that Ms Vertigan visited Child B or arranged a visit by another social worker to Child B. The panel is not in receipt of any contemporaneous document which sets out the rationale of Ms Vertigan's actions.

39. Ms Vertigan provided the following evidence whether she conducted or arranged for Child B to be visited in hospital:

    a. She did not visit Child B in the hospital.

    b. During the handover, she mentioned to Lynne that no one had gone to visit Child B. Ms Vertigan believed that by handing over, that a visit would have been undertaken, or at the very least there would have been contact with the hospital to check if he is awake, settle, would like a social worker to visit, inform him that a social worker is aware and devise a safety plan.

40. The panel considers that Ms Vertigan did not visit Child B in the hospital, and has provided testimony to that effect. The panel also considers that Ms Vertigan did not arrange for another social worker to visit Child B in hospital on the basis that, according to her own testimony, during her handover to Lynne, Ms Vertigan does not provide evidence that she expressly told Lynne to visit Child B in the hospital. It appears that Ms Vertigan, at best, may have implied to Lynne to visit Child B in the hospital, but Ms Vertigan:

    a. simply mentions to Lynne that no one had gone to visit Child B; and

    b. believes that, by handing over, a visit would have been undertaken.

    The panel does not consider this to be Ms Vertigan arranging for Child B to be visited in hospital.

41. Consequently, the panel find allegation 2(c) to be proved.

    This allegation is found proved.

42. Furthermore, the panel gave consideration the following issues. Although these issues do not go directly to the allegations, they go towards Ms Vertigan's possible impairment and sanction, should these stages of the case be reached (*Levy v SRA [2011] EWHC 740 (Admin), para 34*). Each issue will be dealt with in turn.

    Morale of EDT in 2021

43. The panel considers morale to be a nebulous concept which is difficult to gauge without speaking to a majority of the EDT staff. Therefore, the panel found it difficult to gauge the morale of EDT in 2021, but on the narrow evidence provided considered that morale fluctuated over time depending on several factors.

44. Morale was lowered due to:

    a. Anxiety in the team caused by the announcement that there would be changes in the team. This anxiety was exacerbated due to the length of time it took for the changes to be implemented. It made EDT feel like the "*forgotten child*" within social services at Stoke upon Trent City Council.

    b. Ms Adams provided evidence that morale was quite low in EDT as the practitioners were covering a wider remit in adults, children and housing.

    c. Not having a permanent direct manager.

    d. The perceived criticisms and negativity of Ms Rayaz.

    e. The EDT team felt an expectation from management that the EDT team should cover what was required.

45. The panel considered the following to demonstrate that morale was not as low as could be within EDT:

    a. EDT shifts were well staffed around the times of both allegations.

    b. On 21 November 2025, Ms Bolton went home at 1030pm and worked from home, on what was considered to be a quiet day.

    c. Ms Bolton had sufficient capacity within her EDT shifts to complete her AMHP training.

    d. Ms Bolton provided evidence that she did not consider morale to be low enough to share anything with management, but that there was upset between team members due to personalities within the team, mostly Ms Rayaz's manner.

<u>Adequacy of management oversight provided to EDT in 2021</u>

46. The panel considered EDT to have had a stable manager in place until around May 2021, when EDT then did not have a manager for two months until Ms Rayaz's appointment.

47. The panel considered EDT management oversight to be adequate in 2021 in the following areas:

    a. EDT had an on-call manager during its shifts.

    b. Management were intent on improving EDT's training and practice, such as recording. For example, management put in place templates for EDT staff to use.

48. The panel considered EDT management oversight to be inadequate in 2021 in the following areas:

a. Being clear of what impact any restructure would have on EDT staff members.

b. Ensuring that staff were not overworked.

c. Ensuring that the rota was fairly distributed and that pressure was not put on EDT members to fill in rota shifts.

Workload pressures within the EDT in 2021, namely staffing and hours

49. The panel considered that EDT staff were working a lot. At the time of the incident with Child A, Ms Vertigan worked 11 shifts in a row. Ms Bolton claimed to have worked 17-hour shifts. It appears that EDT staff worked over and above the hours they were contracted to work.

50. Nevertheless, the panel considers the following provide reasons why the high working hours were not solely to do with work pressures:

a. At the time of both incidents set out in the allegations, EDT was fully staffed.

b. At the time of the incident with Child A, Ms Bolton went home and worked from home between 1030pm and midnight.

c. Both Ms Vertigan and Ms Bolton mentioned the financial benefits which they sought from working extra EDT shifts.

d. Ms Bolton had sufficient capacity within her EDT shifts to complete her AMHP training.

Whether the initial referral in relation to Child A was considered or treated as a malicious referral by Ms Vertigan and Ms Bolton

51. The panel considers that Ms Vertigan and Ms Bolton demonstrated professional curiosity when they queried why Child A's case came to EDT 24 hours after Child A had been thrown across a room. Ms Hammersley shared the same professional curiosity. The panel was of the view that initial referral in relation to Child A was not considered or treated to be a malicious referral by Ms Vertigan and Ms Bolton, but rather was not treated as credible by Ms Vertigan and Ms Bolton for the following reasons:

a. Ms Vertigan and Ms Bolton's behaviour does not align with the seriousness of the incident. The proven allegations do not demonstrate behaviour consistent with obtaining a report that a 3-month-old child had been thrown across a room. This referral included a credible threat or risk to Child A.

b. Ms Bolton provided evidence that nothing from Ms Vertigan suggested to her that the referral of Child A was urgent.

c. Ms Bolton left the office at 1030pm, when she told Ms Vertigan that she would give her a call, in relation to Child A, if the police called her back.

d. Ms Bolton did not contact Ms Vertigan at the end of her shift, in relation to Child A.

e. There appeared to be an element of groupthink in that Ms Bolton did not appear to question Ms Vertigan's actions/urgency, as they had worked many shifts together and trusted her abilities. Ms Bolton responded to Ms Vertigan's actions/demeanour, including her lack of urgency for Child A.

f. Ms Bolton told the police that although she is the only child social worker on shift, she would be available for a visit if required, rather than visiting Child A.

Submissions on grounds:

52. Concerning misconduct, on behalf of Social Work England, Ms Sharpe set out that the failures can be properly characterised as misconduct on the basis that:

a. The allegations involve failures to take action regarding the safeguarding of children.

b. Both Child A (who was subject to a Children in Need plan) and Child B were vulnerable children reported to have been the victims of physical violence. Ms Vertigan's failures to take appropriate actions to ensure that Child A and Child B were safeguarded had the potential to place them at a risk of further harm. Both Child A and B were reported to have been the victims of significant physical attacks, and Ms Vertigan's failure to take appropriate safeguarding actions is a serious shortcoming in the circumstances. Safeguarding failures go to the heart of social work.

c. Ms Vertigan was employed as a specialist practitioner, and was therefore experienced and in a senior position which raises the seriousness of her failure to take appropriate actions.

d. The following Social Work England Professional Standards (July 2019) are engaged:

> *Be accountable for the quality of my practice and the decisions I make*
>
> *3.2. Use information from a range of appropriate sources, including supervision, to inform assessments, to analyse risk, and to make a professional decision.*
>
> *3.4. Recognise the risk indicators of different forms of abuse and neglect and their impact on people, their families and their support networks.*

3.5. Hold different explanations in mind and use evidence to inform my decisions.

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.

3.11. 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.

53. Concerning misconduct, on behalf of Ms Vertigan, Ms Ramage submitted that it is accepted that the failings are likely to constitute misconduct.

Finding and reasons on grounds:

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

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

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

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

a. In the circumstances, Ms Vertigan failed to appropriately safeguard Child A and Child B, both vulnerable service users. Safeguarding failures go to the heart of social work.

    i. In the case of Child A, there was serious risk to a 3-month-old.

    ii. In the case of Child B, Ms Vertigan knew that he was actually harmed.

    iii. The failure to safeguard both Child A and Child B placed them at risk of potential further harm.

b. Ms Vertigan was a senior social worker who should have known about childcare law and the processes in relation to incidents such as the ones concerning Child A and Child B.

c. Ms Vertigan failed to adhere to the Social Work England Professional Standards (July 2019) as set out in paragraph 52(d) above.

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

Submissions on impairment:

58. During the impairment stage, Ms Ramage read out a pre-prepared statement and Ms Vertigan provided the following evidence:

a. Between November 2021 and May 2022, she completed approximately 60 courses. These were training sessions that Ms Vertigan found herself and were not mandatory training. Ms Vertigan undertook this training in order to "*go back to basics*", refresh her social worker knowledge, learn more and not lose her social worker skills. She wanted to take all training opportunities and paid for the training herself.

b. After the internal investigation into her actions concerning Child A, Ms Vertigan was redeployed by Stoke on Trent City Council to a records role. In this role she does subject access requests for families, which involves redacting private and safeguarding matters. Further, she prepares chronologies for CAFCAS and provides relevant information to the police. She was made the manager of the records team and is still in this role, Access to Records Manager, which she does full time (37 hours per week).

c. She completed her AMHP revalidation in 2024 which involved shadowing fellow AMHPs and completing a portfolio which was assessed.

d. Since September 2024, she has also been a sessional worker for EDT, focusing on adult care. She works, on average, one session per week (8 hours per week).

e. She was originally given an interim suspension order by Social Work England in relation to the risk posed by her during the investigation into these matters, but in December 2022, the interim suspension order was changed to an interim conditions of practice order. In October 2024, the interim order was revoked in its entirety.

f. She has learned a lot since the time of the allegations. She now has two fantastic managers and knows her limitations. She is mortified that the incidents which resulted in the allegations took place and would not want anything like this to happen again. She has put safeguards in place to ensure that she does not exceed her limitations. For example, if she does an EDT shift, she will take a break from her substantive post in records. She has clear boundaries and has discussed this with management.

g. She now had a good relationship with management due to the poor relationship that she had with Ms Rayaz, which she does not want to be repeated. If her needs are not being met, she will escalate immediately to management.

h. When she hands over cases now, she checks and re-checks, for example the time the referral came in and what the referral is about. She had added additional columns to her checks, including whether she has alerted the correct people. If her shift finishes at 5pm she "*very commonly*" stays an extra hour to check and re-check that she has not missed anything.

i. [PRIVATE] She is now very open and honest and not afraid to ask for support.

j. She had reflected upon the effect the allegations had on the service users and their families, the social work profession, herself, and Stoke on Trent City Council. Her failings let everyone down as they could have led to serious case reviews. EDT were struggling filling in hours and the loss of two social workers would have exacerbated pressures on EDT. She did not conform to the Standards, which let down social workers throughout England and the EDT team.

k. Members of the public would be horrified about what happened. She was there to safeguard children and she failed to do so.

l. She is not financially motivated to do the EDT sessional work, but does it as she loves being a social worker, loved the AMHP role and is good at it. If she cannot cope with her working hours, she would not take on EDT shifts. She has more anxiety when working within the EDT team due to the shame she feels after letting down two children and their families. She is more conscious about checking and re-checking work when she is on an EDT shift to make sure that something similar never happens again.

m. She is happy where she is, and in the future would consider therapeutic based work. If a role became available in the AMHP team, she would consider it.

n. She loves helping and supporting children and the mental health side of social work. She feels social work is rewarding.

59. On behalf of Social Work England, Ms Sharpe submitted that Ms Vertigan is currently impaired:

a. Although it is acknowledged that Ms Vertigan has undertaken significant CPD and has completed a significant number of courses, the question before the panel is whether this training has been imbedded into Ms Vertigan's practice.

b. Although Ms Vertigan admitted most of the allegations and has further completed written reflections demonstrating insight into the alleged failings, the issues concern Ms Vertigan's judgement which may not be as easily remediable.

c. Although Ms Vertigan has cooperated with the internal investigation and remained engaged during regulatory process, her actions, as proved in the factual findings, breached a fundamental tenet of the social work profession, namely safeguarding children.

d. A finding of impairment is also required on the public component of current impairment, to maintain public confidence in the profession and to promote and maintain proper professional standards for social workers in England.

60. On behalf of Ms Vertigan, Ms Ramage submitted that Ms Vertigan is no longer impaired given:

a. She has been open, genuine and honest in her insight.

b. She has taken many steps to improve her practice.

c. She has been open with her colleagues about the regulatory concerns that she is facing, in order to improve her practice and her reputation.

d. She worked with an interim conditions order and been engaged with Social Work England, where the interim order was eventually removed.

e. Her personal life is now settled and would not result in an impact upon her professional life.

f. Due to her anxiety about making any mistakes in the future, any risk of repetition is low.

g. She now has identified actions that she can take should any concerns arise, including raising concerns to senior management.

h. She has progressed her career and is now an AMHP and a manager and takes on EDT shifts.

i. She is responsible in balancing her social work with her personal life.

Finding and reasons on current impairment:

61. The panel accepted the advice of the legal adviser that when considering impairment, the panel should consider whether Ms Vertigan is currently impaired in relation to the misconduct. The panel was asked by the legal adviser to consider:

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

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

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

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

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

63. At the outset, the panel considered the Registrant's insight and remediation.

64. The panel considers that Ms Vertigan has shown substantial insight, given:

    a. She had shown a lot of genuine remorse concerning her actions over Child A and Child B.

    b. She has identified and taken responsibility for the mistakes that led up to the proven allegations.

    c. She has reflected upon the impact her actions had over Child A, Child, B, their family and friends, the EDT, the reputation of Stoke on Trent City Council, and the reputation of social workers in general.

    d. She has been open with her colleagues about the regulatory concerns that she is facing, in order to improve her practice and her reputation.

    e. She worked with an interim conditions order and been engaged with Social Work England, where the interim order was eventually removed.

    The panel commends Ms Vertigan for this substantial insight.

65. The panel considered that Ms Vertigan has partially remediated her practice, given:

a. All the courses that she has undertaken, many of her own volition, to ensure that her practice remains robust to prevent against similar misconduct in the future.

b. The excellent testimonials and references that she has received concerning her practice.

Again, the panel commends Ms Vertigan for all the positive action she has taken to rebuild her practice.

66. However, the panel considers that the following concerns remain in Ms Vertigan's practice:

a. There is a concern that Ms Vertigan is working an excessive number of hours. She currently works a 37-hour week, plus on average a further eight hours doing an EDT shift. Ms Vertigan provided evidence that she "*very commonly*" remains at the end of her shift for a further hour to check and re-check her work to ensure that no mistakes are made. The panel considers this extra hour add further time to Ms Vertigan's work week. Although Ms Vertigan provided evidence that she takes time off after she works an EDT shift (either annual leave or in lieu), this is instead of time which Ms Vertigan could be away from work. The panel is concerned that Ms Vertigan overworking (for example, 11 shifts in a row) was a contributory factor to the misconduct. Working excessive hours, therefore, raises the risk of future misconduct and does not demonstrate that Ms Vertigan has embedded the need to avoid overwork and the risks this brings into her current practice.

b. The panel considers that Ms Vertigan's confidence in her practice is not fully restored given her need to check and re-check her work to ensure that no mistakes are made. The panel is confident that, over time, Ms Vertigan's confidence in her practice will be fully restored, but the lack of confidence raises the risk of future misconduct.

<u>Whether Ms Vertigan has acted in the past and/or is liable in the future to act so as to put a service user at unwarranted risk of harm</u>

67. Ms Vertigan's actions in the proven allegations demonstrate that she has acted in the past so as to put service users at unwarranted risk of harm. She failed to safeguard both Child A and Child B.

68. Given the incomplete remediation from Ms Vertigan as set out in paragraph 66 above, the panel considers that Ms Vertigan is liable in the future to act so as to put a service user at unwarranted risk of harm. These risks are exacerbated given Ms Vertigan's evidence of her preference towards EDT work and AMHP work, the latter of which she may consider undertaking on a more full-time basis. The nature of both EDT work and AMHP work are likely to put pressure on Ms Vertigan to work additional hours.

Whether Ms Vertigan has in the past and/or is liable in the future to bring the social work profession into disrepute

69. By failing to safeguard Child A and Child B, the panel considers that Ms Vertigan has in the past brought the social work profession into disrepute.

70. For the reasons set out in paragraphs 66 and 68 above, the panel considers that Ms Vertigan is liable in the future to bring the social work profession into disrepute.

Whether Ms Vertigan has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the social work profession

71. By failing to safeguard Child A and Child B, the panel considers that Ms Vertigan has breached a fundamental tenet of the social work profession, namely the requirement to safeguard service users, especially vulnerable service users.

72. For the reasons set out in paragraphs 66 and 68 above, the panel considers that Ms Vertigan is liable in the future to breach a fundamental tenet of the social work profession.

Whether Ms Vertigan has in the past acted dishonestly and/or is liable to act dishonestly in the future

73. The panel does not consider Ms Vertigan's honesty has been brought into question during these proceedings. Ms Vertigan has not in the past acted dishonestly and/or is not liable to act dishonestly in the future.

Panel's conclusion on impairment

74. In light of the above, the panel considered Ms Vertigan's fitness to practise to be currently impaired on the personal element.

75. Further, members of the public would be concerned to learn that a social worker had undertaken the misconduct set out in the proven allegations. Although Ms Vertigan has shown substantial insight and partial remediation, the lack of remaining remediation, as set out in paragraph 66 above (and exacerbated by the factors set out in paragraph 68 above), run the risk that Ms Vertigan may repeat the actions which resulted in the finding of misconduct. Consequently, the panel considered Ms Vertigan's fitness to practise to be impaired on the wider public interest element, namely maintaining public confidence in social workers in England and maintaining proper professional standards for social workers in England.

Interim order:

76. At 4pm on Friday 12 September 2025, the panel determined that there was insufficient time to consider sanction in relation to Ms Vertigan. Consequently, on behalf of Social Work England, Ms Sharpe made an application under section 11(1)(a), Schedule 2 of the Social Workers Regulations 2018 for an interim order. Ms Sharpe submitted:

a. an interim conditions of practice order is necessary given:

    i. The panel found there to be a risk of repetition of the misconduct, albeit on a discrete basis.

    ii. The risk of misconduct relates to the management of Ms Vertigan's working hours and professional confidence.

    iii. Ms Vertigan has previously demonstrated that she is willing and capable to comply with an interim conditions of practice order, as she was under one for a lengthy period.

b. the first ten conditions from the conditions bank would be appropriate as restrictive sanctions need not be imposed.

c. a period of 12 months should suffice given that this should be sufficient time for all professional diaries to align to recommence the Final Hearing.

d. An interim suspension order would be disproportionate in the circumstances.

77. In response, Ms Ramage submitted:

a. An interim order is entirely unnecessary to safeguard the public.

b. Ms Vertigan has worked hard to improve her practice.

c. Ms Vertigan has already been subject to both an interim suspension order and an interim conditions of practice order, for which she did everything to comply.

d. Ms Vertigan has engaged fully and there has been no cause for concern in her practice since the allegations, which were in 2021.

e. Ms Vertigan remains under the supervision of the reporter that she had when subject to an interim conditions order.

f. An interim order would be a punitive measure which would have an immediate effect on Ms Vertigan's current work. She will need time to get a reporter and time to get things in place.

g. An interim conditions order would be a backwards step for Ms Vertigan to demonstrate to Social Work England that she has been making progress in her practice.

78. The panel next considered whether to impose an interim order. It was mindful of its earlier findings and decided that although impairment was found on a discrete basis, an interim conditions of practice order was needed to protect the public given there is a risk of repetition of the misconduct should Ms Vertigan work excessive hours or be affected at work by a lack of confidence. Consequently, the panel considered the following interim conditions to be necessary in order to protect the public:

1. *You must notify Social Work England within 7 days of any professional appointment you accept or are currently undertaking and provide the contact details of your employer, agency or any organisation with which you have a contract or arrangement to provide social work services, whether paid or voluntary.*

2. *You must allow Social Work England to exchange information with your employer, agency or any organisation with which you have a contract or arrangement to provide social work or educational services, and any reporter or workplace supervisor referred to in these conditions.*

3.

    a. *At any time you are providing social work services, which require you to be registered with Social Work England, you must agree to the appointment of a reporter nominated by your employer and approved by Social Work England. The reporter must be on Social Work England's register.*

    b. *You must not start or continue to work until these arrangements have been approved by Social Work England.*

4. *You must provide reports from your reporter to Social Work England every 6 months and at least 14 days prior to any review and Social Work England will make these reports available to any workplace supervisor referred to in these conditions on request.*

5. *You must inform Social Work England within 7 days of receiving notice of any formal disciplinary proceedings taken against you from the date these conditions take effect.*

6. *You must inform Social Work England within 7 days of receiving notice of any investigations or complaints made against you from the date these conditions take effect.*

7. *You must inform Social Work England if you apply for social work employment / self-employment (paid or voluntary) outside England within 7 days of the date of application.*

8. *You must inform Social Work England if you are registered or subsequently apply for registration with any other UK regulator, overseas regulator or relevant authority within 7 days of the date of application [for future registration] or 7 days from the date these conditions take effect [for existing registration].*

9. *You must keep your professional commitments – and hours – under review and limit your social work practice in accordance with your workplace supervisor's advice.*

10. *You must provide a written copy of your conditions, within 7 days from the date these conditions take effect, to the following parties confirming that your registration is subject to the conditions listed at 1 to 9, above:*

    a. *Any organisation or person employing or contracting with you to undertake social work services whether paid or voluntary.*

    b. *Any locum, agency or out-of-hours service you are registered with or apply to be registered with in order to secure employment or contracts to undertake social work services whether paid or voluntary (at the time of application).*

    c. *Any prospective employer who would be employing or contracting with you to undertake social work services whether paid or voluntary (at the time of application).*

    d. *Any organisation, agency or employer where you are using your social work qualification/knowledge/skills in a non-qualified social work role, whether paid or voluntary.*

11. *You must permit Social Work England to disclose the above conditions, 1 to 9, to any person requesting information about your registration status.*

79. The panel considered a period of 12 months to be appropriate given that this should be sufficient time for all professional diaries to align to recommence the Final Hearing.

Resumption of final hearing:

80. The final hearing resumed on 06 January 2026. Ms Vertigan was not in attendance and neither was her representative, Ms Ramage. Ms Sharpe made the following submissions to proceed in the absence of Ms Vertigan and Ms Ramage:

    a. There has been good service. The Notice of Hearing was sent to Ms Vertigan and Ms Ramage, her representative, at their respective registered email addresses on 16 October 2025, which is more than 28 days in advance of this final hearing. Good service has been served in accordance with the Rules.

    b. It would be fair to proceed in the absence of Ms Vertigan and Ms Ramage in light of the email from Ms Ramage to the Social Work England Hearings Team dated 16 December 2025 which set out that both herself and Ms Vertigan would not be attending, but that the final hearing should proceed. The email also provided extensive written submissions. On 05 January 2026, Ms Vertigan also provided further evidence and submissions for the panel's consideration.

c. Ms Ramage has said that further delay in postponing this hearing would not be in Ms Vertigan's interests and the hearing should proceed in their absences.

d. There is a public interest in bringing this matter to a final disposal. This also aligns with Ms Vertigan's interests.

81. The panel was in receipt of an email from Ms Ramage to the Social Work England Hearings Team dated 16 December 2025 which set out:

> "*The decision we have taken is that the hearing should proceed without either of us being present, we have prepared our submission to the panel which is attached to this email.*
>
> *The submission covers our presentation on Sanction: it should be read in place of my presenting it in person. I do hope that you understand the registrant has been through a very long and stressful process, not only the hearing itself but the years leading to the hearing- It is with regret that I cannot see this hearing through to its conclusion but we have together, endeavoured to cover all the points we would have made in person.*"

82. The panel accepted the advice of the legal adviser in relation to the factors it should take into account when considering this application. This included reference to Rules 43 and 44 of the Rules and the cases of *R v Jones [2002] UKHL 5*; *General Medical Council v Adeogba [2016] EWCA Civ 162*. The panel also took into account Social Work England's guidance "*Service of notices and proceeding in the absence of the social worker*".

83. The panel considered all of the information before it, together with the submissions made by Ms Sharpe on behalf of Social Work England. The panel considered that:

a. Notice of this hearing had been served on Ms Vertigan in accordance with Rules 44 and 45;

b. Ms Vertigan and Ms Ramage have voluntarily absented themselves from the remainder of the principal hearing as a result of the email from Ms Ramage to the Social Work England Hearings Team dated 16 December 2025;

c. The email from Ms Ramage to the Social Work England Hearings Team dated 16 December 2025, as well as the further communication of 06 January 2026 provided substantive submissions on behalf of Ms Vertigan;

d. Ms Ramage has said that further delay in postponing this hearing would not be in Ms Vertigan's interests and the hearing should proceed in their absences; and

e. There is a public interest – which algins with Ms Vertigan's interest – in bringing this matter to a final disposal.

Consequently, the panel determined to proceed in Ms Vertigan's absence.

Submissions on sanction:

84. On behalf of Social Work England, Ms Sharpe submitted:

a. The panel found Ms Vertigan:

i. Impaired on the personal component on a discrete basis – that of working excessive hours and having a lack of professional confidence.

ii. Had substantial insight;

iii. Demonstrated genuine remorse;

iv. Provided sustained reflection;

v. Adhered to the interim conditions of practice order;

vi. Undertook remediation which was targeted to address weaknesses in her practice; and

vii. Received excellent testimonial references.

b. Ms Vertigan has provided a report from her workplace reporter and supervisor, Ms Bradley. Ms Bradley has not raised any concerns over the hours that Ms Vertigan works and set out that Ms Vertigan has made appropriate use of reflective supervision. Ms Bradley has oversight of Ms Vertigan's hours, which are appropriate and measured. Ms Bradley has no concerns in relation to Ms Vertigan's professional confidence.

c. Ms Vertigan has complied with the interim conditions of practice which have been in place since September 2025; a period of 4 months.

d. Prior to these fitness to practice proceedings, Ms Vertigan has had a long history of unblemished practice.

e. Taking no action would not be appropriate where there is an ongoing risk of repetition, and in this matter, given the seriousness of the concerns. Taking no further action would not maintain public confidence in the profession or be in the wider public interest.

f. Giving advice would not be appropriate given the efforts made by Ms Vertigan to remediate her practice.

g. A warning would be appropriate as it is a clear disapproval of Ms Vertigan's conduct. Ms Vertigan's fitness to practice is limited and there is a low risk of repetition. Ms Vertigan has demonstrated insight. A warning would be appropriate where no appropriate or proportionate conditions could be imposed and a suspension order would be disproportionate. A warning for a period of three years would be appropriate. Despite the seriousness of the

concerns, Ms Vertigan has demonstrated safe practice and has worked well under supervision since the fitness to practice proceedings have commenced.

h. If the panel considers it necessary to protect the public, Social Work England then recommend imposing a conditions of practice order. If the panel considers that a restrictive sanction is not proportionate, then a warning order is recommended. Ms Vertigan's practice is capable of being remedied; the current interim conditions would be proportionate, workable and verifiable; Ms Vertigan poses no harm to the public when under conditions; and Ms Vertigan is capable of following conditions.

i. A suspension or removal would be disproportionate in the circumstances as they would not address the concerns raised over working excessive hours and Ms Vertigan's professional confidence.

85. On behalf of Ms Vertigan, Ms Ramage provided written submissions on sanctions. These submissions included:

"public protection — we have been clear that we believe Ms Vertigan does not present a risk to the public, she has fully remediated and is a valued employee having returned to social work successfully.

public interest (to maintain confidence in the social work profession) — Ms Vertigan has taken every effort possible to show insight and remediation. I believe any member of the public would support the view that she has shown integrity with how she has engaged with this process despite the challenges it has brought.

It is stated in the sanction guidance that:

• Decision makers should test the appropriateness and proportionality of a proposed sanction. It is good practice to do this by considering all available sanctions. NO FURTHER ACTION IS ONE OF THOSE AVAILABLE TO THE PANEL.

• The decision makers should consider mitigating and aggravating factors when considering which sanction may be appropriate or proportionate.

The mitigating factors include,

evidence of the social worker's insight, remorse and understanding of the problem, and their attempts to address it. early admission of the facts — ALL OF WHICH ARE PRESENT.

• full engagement with investigations

• apologies to anyone affected.

• any efforts to prevent behaviour recurring. DO NOT CONFUSE PREVENTATIVE MEASURES WITH OF LACK OF CONFIDENCE OR RISK. MS VERTIGAN HAS MADE IT CLEAR THAT SHE WORKS TO PREVENT REPETITION - WITHOUT UNDUE ADDITIONAL HOURS - SHE HAS ACHIEVED THIS AND HER MANAGER REPORTS NO CONCERNS IN THIS REGARD

• Evidence that the social worker has done remediation which addresses the deficiencies that led to the concerns. This may include (any of the following):

o the successful completion of education or training courses — OVER 175!

o satisfactory performance appraisals — ACHIEVED.

o other positive feedback in relation to their professional practice ACHIEVED.

• personal mitigation such as (either of the following): periods of stress or illness

o personal and financial hardship – [PRIVATE]

o absence of previous fitness to practise history — 11 YEARS UNBLEMISHED HISTORY PRIOR TO THESE CONCERNS.

• evidence of good character in the form of character references and testimonials ACHIEVED.

• contextual factors which are relevant are:

o the level of experience of the social worker at the time AS TESTIMONIALS PROVE

o the level of support the social worker received (such as training and/or supervision at work) HER EMPLOYERS HAS REMAINED SUPPORTIVE AND FACILITATED HER RETURN TO SOCIAL WORK SUCCESSFULLY

o evidence of wider or systematic issues in the workplace — WE HEARD IN HEARING THE ISSUES AROUND THE MANAGEMENT OF THIS TEAM AND THE LACK OF OVERSIGHT TO PREVENT SUCH PRACTICE ISSUES OCCURING

Where decision makers find impairment, an outcome of 'no further action' could be possible in cases where the finding of impairment itself is enough to protect the public or address the public interest. This is our position and respectfully ask the panel to find no further action is proportionate.

Bearing in mind that the purpose of the regulatory proceedings is not to punish - a finding of impairment we believe IS sufficient to protect the public or address the public interest without the need for any further action. I BELIEVE THE PANEL CAN BE SATISFIED THAT A FINDING OF NO FURTHER SANCTION REQUIRED IS JUSTIFIED GIVEN THE EFFORTS, REMEDIATION AND IRREFUTABLE EVIDENCE THIS REGISTRANT HAS PROVIDED TO THE HEARING"

Decision on sanction:

86. The panel accepted the advice of the legal adviser that it must pursue the overarching objective when exercising its functions. The purpose of a sanction is not to be punitive although a sanction imposed may have a punitive effect. The panel considered the least restrictive sanction first and then moved up the sanctions ladder as appropriate. The panel had regard to the Sanctions Guidance.

87. The panel considered the following factors to be mitigating:

    a. Ms Vertigan has no previous fitness to practice concerns.

    b. Ms Vertigan has shown substantive insight.

    c. During the time of the concerns, Ms Vertigan was suffering from difficult personal circumstances. [PRIVATE]

    d. Ms Vertigan has undertaken significant and targeted training and learning in relation to safeguarding matters.

    e. Ms Vertigan has received a very positive report from her current workplace reporter and supervisor, Ms Bradley. In particular, the panel notes the following part of the report:

        "*I am able to confirm that Cheryl actively reflects upon assessments and promotes confidence in all of her professional decision making. Working out of hours often demands autonomous decisions to be achieved in a timely manner and Cheryl certainly addresses this well.*

        Cheryl utilises the forum of supervision to reflect and discuss on her work _ I have no concerns around her confidence to practice in all area's of the work she completes.

        We continue to balance Cheryl's current working commitments with the hours that she is supporting to ensure that these are appropriate and measured — there are no concerns in this regard."

88. The panel considered there to be no aggravating factors.

89. The panel found that Ms Bradley's workplace report to be a significant document demonstrating Ms Vertigan's progress to remediate the outstanding concerns in her practice. The panel considered that, at present, Ms Bradley's workplace report has demonstrated that both she and Ms Vertigan are focusing on ensuring that Ms Vertigan does not work excessive hours and that she is regaining her professional confidence in a social work setting. Consequently, the concerns which led to her being personally impaired are being addressed. Given this evidence which was not before the panel in September 2025, and alongside her insight and remediation, the panel does not consider that Ms Vertigan poses a risk so that her practice needs to be restricted.

90. Nevertheless, the panel considered that taking no action would not address the seriousness of the proven allegations and would not be sufficient to protect the public, maintain public confidence in the profession and uphold proper standards of conduct and behaviour.

91. The panel next considered whether it was appropriate to impose advice or a warning. The panel had regard to paragraphs 100 and 102 of the Sanctions Guidance:

> "100. *We will publish the written decision setting out the advice or warning on our website. We will also record it on the social worker's public extract of the register. The recording remains on the public extract of the register for the period identified by the decision maker (1, 3 or 5 years). This ensures anyone who accesses the public extract of the register or the website is aware of the advice or warning. This includes those directly involved with a social worker.*
>
> *102. The advice should set out the steps the social worker should take to avoid repeating the conduct that contributed to the concern."*

92. The panel considered that advice would be proportionate to protect the public. It would advise what Ms Vertigan needed to do to ensure that her practice is not impaired and also be on her social work record so that any employers would know what was needed for Ms Vertigan's practice to no longer be impaired. The panel also considered that advice would be in the wider public interest as the panel considered that since the finding of impairment in September 2025, Ms Vertigan has worked to remediate her practice to remedy any impairment. She has worked with Ms Bradley to do this. It is in the public interest to have a conscientious social worker in practice, and an informed member of the public would consider advice to be proportionate given Ms Vertigan's journey since the time of the allegations. The panel considered that the following advice would assist Ms Vertigan from overworking and guide her to ensure that her hours are balanced and that her practice remains safe and meets the appropriate standards, and consequently, her professional confidence is also maintained.

93. The panel therefore advised:

> "*It is advised that Ms Vertigan ensures that she is aware of the hours she works in any week to avoid potential stress, over-work, and loss in professional confidence. She is to maintain balance in her working hours and*

continue to use her line management supervision to support her. It is advised that Ms Vertigan discusses with her line manager any personal/professional pressures she may be under at any time. This will enable her to receive the support necessary in order to practice safely as a social worker and meets the appropriate standards."

94. The panel considered whether it was appropriate to impose a warning. The panel had regard to paragraph 107 of the Sanctions Guidance:

> "*A warning order shows clear disapproval of the social worker's conduct or performance. A warning order is a signal that the social worker is highly likely to receive a more severe sanction if they repeat the behaviour.*"

95. The panel considered that Ms Vertigan is fully aware that her proven misconduct would be disapproved of. The panel does not consider there to be any benefit in further warning Ms Vertigan, where advice would be more appropriate to indicate and guide Ms Vertigan as to how to maintain an unimpaired practice. The panel is conscious that the sanction needs to be proportionate to protect the public and to be in the wider public interest, and its primary purpose is not to be punitive.

96. The panel considered that advice for a period of 1 year to be sufficient to protect the public and be in the wider public interest on the basis that:

    a. Ms Vertigan is fully aware that her conduct fell below the requisite standards. Since the time of the proven misconduct, she has completed ample relevant and targeted training;

    b. These fitness to practice proceedings have been ongoing for a significant period, during which time Ms Vertigan has demonstrated a high degree of insight and increasingly remediated her practice; and

    c. Ms Vertigan has been under interim conditions of practice for an extended period of time. Again, during this period, she has reflected, expressed remorse, demonstrated insight and increasingly remediated her practice.

Interim order:

97. In light of its findings on sanction, the panel next considered an application by Ms Sharpe to revoke the interim conditions of practice order imposed by the panel on 16 September 2025 under section 11(1)(a), Schedule 2 of the Social Workers Regulations 2018 on the basis that to would not be in the public interest or in Ms Vertigan's own interests to continue with the section 11(1)(a) interim order. BASW, of whom Ms Ramage was instructed from, has provided an email dated 07 January 2026 setting out: "*I have taken instruction from Ms Vertigan, who confirms her agreement to waiving notice in respect of the reviewing of the ICOPO*". Revoking the current section 11(1)(a) interim order would avoid any further hearings and unnecessary stress for Ms Vertigan.

98. The panel accepted the advice of the legal adviser that:

    a. section 14(1)(c), Schedule 2 of the Social Workers Regulations 2018 sets out that an interim order made under section 11(1)(a), Schedule 2 of the Social Workers Regulations 2018 must be reviewed when new evidence relevant to the order has become available after the making of the order.

    b. section 14(5)(a), Schedule 2 of the Social Workers Regulations 2018 permits the panel to revoke the order.

    c. section 14(6), Schedule 2 of the Social Workers Regulations 2018 sets out that the panel may not take any actions under section 14(5)(a), Schedule 2 of the Social Workers Regulations 2018, including revoking the order, unless it has first informed the social worker of the proposed step and given them the opportunity to make submissions.

99. The panel considered there to be new evidence relevant to the section 11(1)(a) interim order, namely the imposition of a non-restrictive sanction, that of advice. The panel further notes that through the email from BASW dated 07 January 2026, that Ms Vertigan has been informed of the proposed steps and waived any right to give submissions. The panel considered that the continuation of the section 11(1)(a) interim order would be:

    a. wholly incompatible with the earlier disposition;

    b. wholly incompatible with Ms Ramage's detailed submissions for the panel to dispose of this matter with no further action;

    c. disproportionate; and

    d. unfair on Ms Vertigan

    to continue with the section 11(1)(a) interim order.

100. Accordingly, the panel revoked the section 11(1)(a) interim order.

Right of appeal:

101. 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.

102. 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.

103. 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.

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

The Professional Standards Authority:

105. 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.