# Social worker: Gina Whiteley
# Registration number: SW23552
# Fitness to Practise
# Final Hearing

Dates of hearing: 01 December 2025 to 15 December 2025 (not sitting on 10 December 2025)

Resumed hearing: 12 February 2026

Hearing venue: Remote hearing

Hearing outcome: Fitness to practise impaired - Removal Order

Interim order: Interim suspension order (18 months)

## Introduction and attendees:

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

2. Ms Whiteley did not attend and was not represented.

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

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

| **Adjudicators** | **Role** |
|---|---|
| Barry Greene | Chair |
| Sarah Redmond | Social worker adjudicator |
| Sarah McAnulty | Lay adjudicator |

| **Hearings team/Legal adviser** | **Role** |
|---|---|
| Andrew Brown | Hearings officer |
| Lauryn Green | Hearings support officer/hearings officer 12 February 2026 |
| Zill-e Huma | Legal adviser |
| Scott McDonnell | Legal adviser – 12 February 2026 |

## Service of notice:

5. The panel was informed by Ms Sharpe, that notice of this hearing was sent to Ms Whiteley, by email and next day delivery service on 30 October 2025, to the addresses provided by the social worker (namely her registered email address and postal address as it appears on the Social Work England register). Ms Sharpe submitted that the notice of this hearing had been duly served.

6. The panel had careful regard to the documents contained in the final hearing service bundle as follows:

    - A copy of the notice of the final hearing dated 30 October 2025 and addressed to Ms Whiteley at her email and postal address which she provided to Social Work England;
    - An extract from the Social Work England Register detailing Ms Whiteleys registered address;
    - A copy of a signed statement of service, on behalf of Social Work England, confirming that on 30 October the writer sent by email and next day delivery service to Ms Whiteley at the address referred to above: notice of hearing and related documents;

7. The panel heard and accepted the advice of the legal adviser in relation to service of notice.

8. Having had regard to Rules 16, 44 and 45 of Social Work England's Fitness to Practise Rules 2019 (as amended) ("The Rules") and all of the information before it in relation to the service of notice, the panel was satisfied that notice of this hearing had been served on Ms Whiteley in accordance with The Rules.

## Proceeding in the absence of the social worker:

9. The panel heard submissions in support of proceeding in the absence of Ms Whiteley. Ms Sharpe, on behalf of Social Work England, submitted that it would be fair and appropriate for the panel to proceed in the absence of Ms Whiteley. She submitted that the panel could properly be satisfied that Ms Whiteley had been served with the Notice of Hearing in accordance with the Rules and that all reasonable steps had been taken to bring the proceedings to her attention. Ms Whiteley had acknowledged receipt of correspondence by email on 30 October, albeit stating that she could not initially access the documents, and the full hearing bundle had subsequently been sent to her in hard copy by post. The Notice of Hearing contained clear directions requiring Ms Whiteley to indicate whether she intended to attend and to file any observations by 21 November. No response had been received.

10. Ms Sharpe further submitted that Ms Whiteley had failed to comply with earlier procedural directions, including the requirement to provide a response to the Statement of Case by 10 October, and she had not engaged with the Case Management Meeting held on 27 October, having neither attended nor responded to the applications made in advance of that hearing. Ms Whiteley had also failed to attend the earlier Case Management Meeting in December 2023. Ms Sharpe reminded the panel that, within Ms Whiteley's earlier written correspondence contained in the Social Worker's Response bundle dated 2023, Ms Whiteley had expressly stated that she did not intend to engage with the fitness to practise process, did not intend to practise in the future, and had requested removal from the Register. Ms Sharpe submitted that, taken cumulatively, this amounted to a voluntary waiver of Ms Whiteley's right to attend and be represented at the hearing.

11. Ms Sharpe submitted that there was no realistic prospect that an adjournment of any length would secure Ms Whiteley's future attendance, given her stated position and ongoing non-engagement. No application for an adjournment or postponement had been made, and no explanation had been provided for her absence. She further submitted that there was a strong public interest in the expeditious disposal of the proceedings, particularly given that a number of professional witnesses had arranged their attendance in accordance with the hearing timetable. She submitted that the culture of adjournment and delay was discouraged and that an adjournment at this late stage would inevitably cause significant inconvenience to witnesses and to the regulator. Ms Sharpe therefore invited the panel to conclude that it was fair, proportionate, and in the public interest to proceed in Ms Whiteley's absence.

12. Ms Sharpe also addressed a discrepancy in the stated start time of the hearing, which had been listed as 10:00 in the Notice, whereas the customary sitting time would ordinarily be 9:30. She submitted that this inconsistency did not affect the fairness of proceeding in absence, particularly as Ms Whiteley had not attended by 10:30. She confirmed that further correspondence could be sent to Ms Whiteley to clarify that future sitting days would commence at 9:30. However, she submitted that this issue did not undermine the fairness of proceeding with the hearing that day.

13. The panel heard and accepted the advice of the legal adviser in relation to proceeding in the absence of Ms Whiteley. The legal adviser advised that once the panel was satisfied that effective service had been properly effected, the decision whether to proceed in Ms Whiteley's absence was a matter of judicial discretion to be exercised with caution and fairness. The legal adviser referred the panel to the authorities of R v Jones [2003] 1 AC 1, Tait v Royal College of Veterinary Surgeons [2003] UKPC 34, and GMC v Adeogba [2016] EWCA Civ 617, which establish that a tribunal may proceed where Ms Whiteley has been properly notified of the hearing and has voluntarily chosen not to attend, provided fairness is maintained. In particular, the legal adviser reminded the panel that in the absence of good reason for non-attendance, and where proper notice has been given, it will usually be fair to proceed.

14. The legal adviser further advised the panel that it must balance Ms Whiteley's right to a fair hearing against the public interest, including the interests of public protection, the maintenance of confidence in the profession, and the proper and timely disposal of regulatory proceedings. The panel was directed to consider whether Ms Whiteley's absence was voluntary, whether any explanation or adjournment request had been received, whether there was a realistic prospect that an adjournment would secure attendance, and whether proceeding would cause unfairness to Ms Whiteley.

15. The legal adviser concluded that if the panel was satisfied that Ms Whiteley had been properly served, had not recently engaged, had provided no good reason for non-attendance, and that an adjournment would be unlikely to secure future attendance, then it would be fair, proportionate, and in the public interest to proceed in Ms Whiteley's absence.

16. The panel carefully considered the legal advice it had received in relation to service and proceeding in absence, together with the submissions made on behalf of Social Work England. The panel was satisfied that Ms Whiteley had been properly served with notice of the hearing and that all reasonable steps had been taken to bring these proceedings to her attention. The panel noted that Ms Whiteley had not attended the hearing, had made no application for an adjournment, and had provided no explanation for her absence.

17. The panel took into account that Ms Whiteley had, through earlier written correspondence, indicated that she did not intend to engage with the fitness to practise process, did not intend to practise as a social worker in the future, and had expressed a wish to be removed from the Register. While recognising that this position did not, in

itself, prevent Ms Whiteley from attending the final hearing should she have wished to do so, the panel observed that there had been no indication that she was unable to attend and no request for a postponement. In those circumstances, the panel was satisfied that Ms Whiteley had voluntarily absented herself from the proceedings.

18. The panel further considered that this matter related to serious allegations and that there was a strong public interest in the timely disposal of the case. The events underlying the allegations extended back over a significant period of time, in some respects to as far back as 2016, and the panel was satisfied that an adjournment would be unlikely to secure Ms Whiteley's future attendance, given her sustained lack of engagement with the proceedings, including her failure to engage with case management directions and earlier hearings. The panel concluded that it would be unreasonable and contrary to the interests of justice to delay the determination of the case further.

19. The panel acknowledged that there is always a potential disadvantage to a social worker in not attending their own proceedings. However, it was satisfied that any such disadvantage was mitigated in this case by the fact that Ms Whiteley had previously provided written representations during the investigation, which the panel would take fully into account.

20. Balancing all relevant factors, including fairness to Ms Whiteley, the public interest, the need for the expeditious disposal of proceedings, and the absence of any realistic prospect that an adjournment would secure her attendance, the panel determined that it was fair, proportionate, and in the interests of justice to proceed in Ms Whiteley's absence.

21. The panel further directed that Ms Whiteley be contacted by email to inform her that, for the remainder of the hearing days, the panel may sit from as early as 9:00 am.

## Preliminary matters:

22. Ms Sharpe made submissions on behalf of Social Work England that, at the Case Management Meeting on 27 October 2025, the panel granted the application for procedural directions and admitted hearsay evidence in the form of two emails sent by Dr Kothari, a Clinical Psychologist. At that time, Social Work England informed the panel that searches of the General Medical Council (GMC) register had produced no results in respect of Dr Kothari.

23. Ms Sharpe submitted that, following further reflection, Social Work England had since identified that Dr Kothari was in fact registered with the Health and Care Professions Council (HCPC). However, she submitted that this additional information did not amount to a material change of circumstances for the purposes of Rule 29, as the HCPC register did not provide any direct or meaningful contact details beyond a general geographical location. While it was accepted that further enquiries could, in theory, be made of the HCPC, Ms Sharpe submitted that such steps would not be proportionate

given the proximity of the final hearing and the limited nature of the further evidence that would be sought, namely a production statement only.

24. Ms Sharpe therefore submitted that the original decision of the Case Management Meeting panel to admit the hearsay evidence remained fair and firmly in the interests of justice. She submitted that the new information did not undermine the basis of the earlier ruling and that the panel should permit the original direction to remain binding and undisturbed under Rule 29.

25. The panel heard and accepted the advice of the legal adviser that, pursuant to Rule 29 of the Fitness to Practise Rules, case management directions made at a Case Management Meeting remain binding unless the panel is satisfied that there has been a material change of circumstances or that it would not be in the interests of justice for the direction to remain binding. The legal adviser explained that a "material change" must be more than minor and must meaningfully affect the factual basis on which the original decision was made.

26. The panel was advised to consider whether the new information that Dr Kothari is registered with the HCPC fundamentally altered the earlier position on the admissibility of hearsay evidence, including whether that registration realistically and proportionately enabled direct contact at this late stage of proceedings. The panel was further advised that, separately, it must assess whether it would be contrary to the interests of justice for the original direction to remain binding, taking into account fairness, relevance and reliability of the evidence, proportionality, the stage of the proceedings, and any potential prejudice.

27. The legal adviser reminded the panel that while the reasoning of the Case Management Meeting panel provided important context, the panel retained full discretion to reach its own independent judgment on whether either limb of Rule 29 was engaged, having regard to the submissions made and the circumstances as they now stood.

28. The panel considered the submissions made on behalf of Social Work England in relation to the admissibility of the hearsay evidence of Dr Gemma Kothari and the application of Fitness to Practise Rule 29. The panel noted that, since the Case Management Meeting, it had been established that Dr Kothari is registered with the HCPC, although no direct or current contact details were available beyond a general geographical location. The panel carefully considered whether this constituted a material change of circumstances.

29. The panel determined that the further information regarding HCPC registration did not amount to a material change in circumstances within the meaning of Rule 29(a). The panel was satisfied that the original basis upon which the Case Management Meeting panel admitted the hearsay evidence had not been fundamentally undermined. The panel also considered whether it would be contrary to the interests of justice for the original direction to remain binding under Rule 29(b), taking into account proportionality, the limited nature of the further evidence that might be obtained, and the advanced stage of the proceedings.

30. Accordingly, the panel concluded that the admission of the hearsay evidence, as determined by the Case Management Meeting panel, remained fair and in the interests of justice. The panel therefore directed that the original case management direction admitting the hearsay evidence should remain binding and undisturbed.

31. Following the completion of Mrs Clemson's evidence in chief, an issue arose in relation to witness availability, as it became apparent that Dr Ashforth would not be available on the following day if the hearing were to continue in the existing sequence. In light of this, the panel heard submissions from Ms Sharpe on behalf of Social Work England and also received legal advice from the legal adviser on the panel's powers under Rule 32 to regulate its own procedure, including the order in which witnesses are heard.

32. Having considered those submissions and the legal advice, the panel determined that it was appropriate to pause Mrs Clemson's evidence at that stage and proceed instead with the evidence of Dr Ashforth while she was available. This course was adopted in order to avoid unnecessary delay, to ensure the efficient progression of the hearing, and to manage witness availability effectively. The panel was satisfied that this adjustment to the sequence of evidence was fair and did not give rise to any unfairness to either party.

33. With regard to Allegation 4 the panel noted a minor typographical error within its wording, namely that it referred to "1" rather than "Service User 1". The panel was satisfied that this was a clerical error only and that its intended meaning was clear from the context of the allegation.

34. In the exercise of its discretion, the panel made a minor amendment to Allegation 4 so that it correctly referred to "Service User 1". The panel concluded that this amendment was purely technical in nature, did not alter the substance of the allegation, and caused no prejudice or unfairness to either party.

35. The panel considered the wording of Allegation 5 and noted that, in light of the evidence, the phrase "*you*" more accurately reflected the panel's intended evaluation if it were amended to read "it encouraged her to .....", so as to focus on the effect of the work undertaken rather than on a specific act of direct instruction.

36. In the exercise of its discretion, the panel therefore made a minor amendment to Allegation 5 by substituting the word "*you*" with "it". The panel was satisfied that this amendment was minor and technical in nature, did not alter the substance of the allegation, and did not cause any unfairness or prejudice to either party.

## Allegations:

*"The allegations arising out of the regulatory concerns referred by the Case Examiners on 6 July 2022 are:*

*While registered as a social worker*

*1. You failed to maintain professional boundaries with SU 1 in that you:*

*a. Had contact with Service User 1 outside of your working hours between around November 2019 to April 2021 and/or*

*b. Had contact with Service User 1 using your personal email address prior to April 2021 and/or*

*c. Maintained a relationship with Service User 1after 22 April 2021 and/ or*

*d. Contacted Service User 1 using your personal mobile telephone after April 2021.*

*2. In January 2020, you did not take appropriate action in response to a safeguarding concern in respect of Service User 1.*

*3. You failed to maintain complete and accurate records in relation to Service User 1 in that you:*

*a. Did not record all of your contact and / or work with Service User 1 and/ or;*

*b. Did not record relevant emails sent to you by Service User 1.*

*4. You did not complete required work in respect of service user 1 in that you:*

*a. Did not produce and / or record a care plan and/ or;*

*b. Did not produce and / or record a comprehensive assessment.*

*5. Between December 2019 and April 2021, you undertook work with Service User 1 which was inappropriate in that:*

*a. It encouraged her to dissociate and/ or;*

*b. It was done without appropriate and/or documented supervision.*

*6. In relation to Service User 2, you:*

*a. Represented that Service User 2 had a health condition which had not been diagnosed by a psychiatrist in or around February 2021 and/ or;*

*b. Undertook work with Service User 2 without appropriate clinical supervision and/ or multi-disciplinary input between around August 2019 and February 2021.*

*7. In relation to Service User 3, you:*

*a. Did not maintain adequate records of your interactions and / or*

*b. Did not produce and / or record a care plan and / or;*

*c. Did not produce and / or record a comprehensive assessment and / or*

*d. Did not handle Service User 3's medical records appropriately.*

*8. In or around February 2011 and / or June 2012, you inaccurately represented and / or recorded that Service User 4 had a diagnosis of Dissociative Identity Disorder."*

## Admissions:

37. The panel considered whether any admissions had been made by Ms Whiteley. It noted in earlier correspondence on 21 March 2022 she addressed some of the allegations however given that Ms Whiteley has not attended these proceedings and has not recently engaged in any meaningful way, the panel decided the correspondence from 2022 could not be considered as admissions. In line with Rule 32c(i)(a) of the Rules, the panel then went on to determine the disputed facts.

## Summary of Background:

38. On 16 November 2019, the Health and Care Professions Council received a referral from Service User 4 concerning Ms Whiteley. At that time, Ms Whiteley had previously been employed by Leeds City Council from January 2000 until September 2015 within a Mental Health Social Work Team that operated as an integrated service with the local NHS mental health provider. During that period, Ms Whiteley acted as the allocated social worker for Service User 4 over a number of years between approximately 2003 and 2012.

39. On 23 February 2021, Social Work England received a further referral from a member of the public who wished to remain anonymous. That referral raised concerns regarding Ms Whiteley's conduct in relation to Service User 1, who had been allocated to her during her later employment at Kirklees Council.

40. Ms Whiteley was employed by Kirklees Council from April 2017 until September 2021 within the North Kirklees Enhanced Team 1, a multi-disciplinary integrated team comprising staff from Kirklees Council and the South West Yorkshire Partnership Foundation Trust. During this period, she held three concurrent roles: Approved Mental Health Practitioner (AMHP), social supervisor undertaking Ministry of Justice reports, and care co-ordinator. Ms Whitley was acting in the capacity of care co-ordinator for Service User 1.

41. Kirklees Council became aware of Social Work England's investigation in or around April 2021. From 22 April 2021, Ms Whiteley remained off work on continuous leave until she left her employment on 30 September 2021. Following this, Kirklees Council undertook an internal audit and review of a number of her cases. As a result of that review, further concerns were formally referred to Social Work England on 23 September 2021 by Mrs Clemson, who was at that time the Clinical Team Manager for North Kirklees Enhanced Team 1. These further concerns related to Service User 1 and extended to matters involving Service User 2 and Service User 3.

## Submissions and legal advice on facts:

### Social Work England:

42. Ms Sharpe submitted to the panel that Social Work England bore the burden of proving the disputed factual allegations on the balance of probabilities. She reminded the panel that there had been no formal admissions and that, in accordance with the Fitness to Practise Rules, the panel was required to determine each factual particular on the evidence. Ms Sharpe invited the panel to consider the totality of the contemporaneous documentary records alongside the oral evidence of the professional witnesses, which she submitted had been consistent, measured, and mutually corroborative.

43. In relation to Allegation 1, Ms Sharpe submitted that the evidence established repeated breaches of professional boundaries with Service User 1. The records demonstrated frequent contact outside of Ms Whiteley 's contracted working hours, use of personal email and personal mobile telephone, and continued contact after she had gone off sick in April 2021 and had been instructed not to maintain any further contact. The evidence of Ms Epstein, Mrs Clemson and Dr Ashforth was consistent that such contact constituted a clear boundary breach. The hearsay evidence of Service User 1 regarding ongoing contact was consistent, promptly disclosed, and strongly corroborated by professional observations and records.

44. In respect of Allegation 2, Ms Sharpe submitted that the January 2020 disclosure by Service User 1 raised a clear safeguarding concern. The contemporaneous record identified follow-up action for Ms Whiteley, yet there was no evidence that she escalated the matter to safeguarding or discussed it with her line manager. Mrs Clemson confirmed that no such escalation occurred. The failure to act was therefore proved.

45. Turning to Allegation 3, Ms Sharpe submitted that Ms Whiteley failed to maintain complete and accurate records for Service User 1. There were unrecorded contacts, inadequate summary entries, and no proper recording of emails that were repeatedly referred to in the records. Despite concerns being raised by Dr Kothari and instructions given by Mrs Clemson, the records remained deficient.

46. In respect of Allegation 4, Ms Sharpe submitted that there was no recorded care plan or comprehensive assessment for Service User 1. These were core requirements of the care co-ordinator role. Mrs Clemson's contemporaneous audit in May 2021 confirmed their absence, and this was supported by the wider record and supervision history.

47. In relation to Allegation 5, Ms Sharpe submitted that the evidence showed Ms Whiteley undertook inappropriate work with Service User 1 by engaging in dissociation-focused and memory recovery work that encouraged dissociation. This was supported by Service User 1's account, Ms Whiteley's own records, and the professional evidence of

Dr Ashforth, Mrs Clemson and Dr Kothari. The work was undertaken without appropriate or documented supervision. No multi-disciplinary team (MDT) oversight or authorised psychological supervision was in place.

48. In respect of Allegation 6, Ms Sharpe submitted that the letter drafted by Ms Whiteley to Service User 2's GP in February 2021 clearly represented that Service User 2 had a dissociative condition with multiple personality states. There was no evidence of any such diagnosis by a psychiatrist or other suitably qualified clinician. The same letter demonstrated that she undertook complex trauma and memory work without appropriate clinical supervision or multidisciplinary input.

49. Turning to Allegation 7, Ms Sharpe submitted that Ms Whiteley failed to maintain adequate records for Service User 3, failed to produce a care plan and comprehensive assessment, and handled Service User 3's medical records inappropriately. The records showed brief, outcome-deficient notes, no care plan, no comprehensive assessment, and the unauthorised retention of confidential medical records outside Trust systems and beyond the end of employment.

50. Finally, in relation to Allegation 8, Ms Sharpe submitted that Ms Whiteley inaccurately recorded and represented that Service User 4 had a diagnosis of Dissociative Identity Disorder in both a February 2011 Department of Working Pensions (DWP) document and in a June 2012 discharge summary. Service User 4's GP completed an independent review of the GP records and confirmed that no such diagnosis had ever been made. Ms Naismith confirmed that Ms Whiteley had no authority to diagnose. The documentary evidence was clear and compelling, and supported by Service User 4's consistent account.

51. Ms Sharpe therefore submitted that each of the factual particulars in Allegations 1–8 had been proved on the balance of probabilities.

## Social worker:

52. Ms Whiteley did not submit any formal written submissions to assist this Hearing panel. However, during the course of the proceedings she provided written correspondence in response to the regulatory concerns, contained within the Social Worker's Response bundle. In that correspondence she initially denied having contact with Service User 1 outside her working hours but later accepted that this may have occurred due to flexible working arrangements; she admitted contacting Service User 1 using her personal mobile telephone and described this as an error of judgement which she now regretted; she stated that any deficiencies in record keeping in respect of Service Users 1 and 3 were not intentional but arose from limited working hours and workload pressures; and she admitted taking possession of Service User 3's medical records, maintaining that they were stored securely and were not accessed.

## Legal advice:

53. The panel heard and accepted the advice of the legal adviser, who advised that the panel's function at this stage of the proceedings was to determine whether the factual allegations were proved or not proved. The legal adviser reminded the panel that the burden of proof rested throughout on Social Work England and that the applicable standard of proof was the civil standard, namely the balance of probabilities. The panel was further advised that hearsay evidence was admissible in professional regulatory proceedings but must be approached with care, in accordance with the principles set out in cases such as Thorneycroft v Nursing and Midwifery Council.

54. The legal adviser further advised that the panel must assess the totality of the evidence in the round, including oral testimony, written witness statements, contemporaneous documentary records and any hearsay evidence admitted. The panel was reminded that witness demeanour was not a reliable indicator of truthfulness and that its focus should instead be on the consistency of the evidence, its internal coherence, and its alignment with contemporaneous records and other reliable material. Particular weight could properly be attached to contemporaneous records created at or around the time of the events in question.

55. Finally, the legal adviser advised that the panel must consider each allegation and each particular separately and avoid generalised reasoning. The panel was reminded that, at this stage, it was not concerned with impairment or sanction, but only with findings of fact. The legal adviser emphasised the importance of providing clear, logical, and transparent reasons for each finding, so that the parties, the regulator, and the public could properly understand how and why the panel had reached its conclusions.

## Finding and reasons on facts:

56. In reaching its decision, the panel took full and careful account of all of the evidence before it, including the oral evidence, all of the written evidence presented to it, and the contemporaneous documentary material, including the correspondence from Ms Whiteley during the course of the process. The panel evaluated the evidence in the round and approached each allegation separately, assessing each particular on its own merits. The panel exercised appropriate caution when considering hearsay evidence, carefully weighing its reliability, the circumstances in which it was given, and the extent to which it was corroborated by other material. The panel assessed the consistency, credibility, and overall weight of the evidence allegation by allegation and made its findings on the balance of probabilities following a detailed, structured, and reasoned evaluation.

57. The panel found that all of the witnesses called by Social Work England, namely Mr Wyatt, Ms Epstein, Dr Ashforth, Mrs Clemson and Ms Naismith, gave their evidence in a professional, measured, clear and helpful manner. Each witness answered questions carefully and within the bounds of their recollection and professional responsibilities. Where the passage of time limited their ability to recall specific detail, this was stated openly and without hesitation. The panel noted not only a high degree of consistency between the oral evidence and the written statements, particularly in the case of Mrs Clemson, but also clear corroboration between the oral evidence and the contemporaneous documentary records. The panel was satisfied that none of the witnesses sought to exaggerate, deflect or mislead, and that each provided honest, balanced and objective testimony intended to assist the panel in its decision-making.

**Allegation 1**

58. Allegation 1 alleges that Ms Whiteley failed to maintain professional boundaries with Service User 1.

59. The panel first considered whether Ms Whiteley was subject to a professional duty to maintain appropriate professional boundaries with Service User 1 at the relevant time. The panel accepted the submissions made by Social Work England that maintaining professional boundaries is a fundamental duty required of all registered social workers in all of their interactions with service users and that this duty is not role-specific or employment-specific. This position was consistently supported by the evidence of Ms Epstein, Mrs Clemson and Dr Ashforth, each of whom confirmed in their respective witness statements and oral evidence that boundary maintenance is a core tenet of social work practice.

60. The panel was taken to the relevant professional standards which applied to Ms Whiteley throughout the material period, namely the HCPC Standards of Performance, Conduct and Ethics, the HCPC Standards of Proficiency, and the Social Work England Professional Standards. The panel was satisfied that these standards clearly impose an overarching obligation on all social workers to establish and maintain appropriate professional boundaries at all times. The panel further accepted that, as a registered social worker, Ms Whiteley would have been fully aware of this duty.

61. The panel next considered the specific vulnerabilities and personal circumstances of Service User 1 in order to assess the professional context in which this duty was required to be exercised. The panel accepted the unchallenged evidence of Dr Ashforth that Service User 1 had a significant history of trauma and abuse, including sexual and emotional abuse, and carried a diagnosis of Emotionally Unstable Personality Disorder.

62. The panel also accepted the evidence of Mrs Clemson in her witness statement and oral evidence that Service User 1 struggled with attachment, had difficulty understanding and maintaining boundaries, experienced low mood and anxiety,

engaged in self-harming behaviours, and was prone to dissociation, meaning that at times she could disengage from her focused state of mind and was not always in full control of her actions. The panel was satisfied that these features rendered Service User 1 a particularly vulnerable service user for whom clear, consistent and professionally robust boundaries were essential.

63. The panel then considered the professional relationship between Ms Whiteley and Service User 1. The panel accepted the evidence of Mrs Clemson that Service User 1 was formally allocated to Ms Whiteley in her role as care co-ordinator from December 2018 until June 2021. The panel further accepted that Ms Whiteley went off sick in April 2021, at which point Mrs Clemson assumed the role as Service User 1's care co-ordinator. The panel was satisfied that for the majority of the relevant period Ms Whiteley occupied a position of professional authority and responsibility in relation to Service User 1. The panel was also satisfied that this relationship carried an inherent power imbalance, placing a heightened obligation on Ms Whiteley to maintain clear, appropriate and professional boundaries at all times.

64. In considering the wording of the allegation, the panel carefully considered the use of the word "failed". The panel accepted the submission that an allegation framed in this way requires the panel to be satisfied first that a duty existed and secondly that the duty was not met to the required professional standard. The panel was satisfied that the duty to maintain professional boundaries arose directly from the professional standards governing Ms Whiteley's conduct as a registered social worker and did not depend upon the existence of any specific local Trust policy. The panel accepted the evidence of Ms Epstein, Mrs Clemson and Dr Ashforth that the requirement to maintain professional boundaries is embedded within national professional standards and is a fundamental feature of safe and lawful social work practice.

65. Accordingly, the panel was satisfied, on the balance of probabilities, that throughout the relevant period Ms Whiteley owed a clear, well-established and fundamental professional duty to maintain appropriate professional boundaries with Service User 1.

66. The panel therefore determined that the stem of Allegation 1 is established as the proper professional framework against which the remaining factual particulars are to be assessed.

**Allegation 1(a)**

67. Allegation 1(a) alleges that Ms Whiteley had contact with Service User 1 outside of her working hours between around November 2019 and April 2021.

68. The panel first considered Ms Whiteley's contractual working arrangement. The panel accepted the evidence of Mrs Clemson that Ms Whiteley worked on a part-time basis for Kirklees Council within the integrated multidisciplinary team, working Tuesdays, Wednesdays and either a half day or a full day on alternative Thursdays. The panel was

satisfied that Mondays and Fridays were not Ms Whiteley's contracted working days and that this arrangement was consistently in place throughout the relevant period.

69. The panel then considered the documentary case records which were produced from contemporaneous entries made by Ms Whiteley herself and from other professionals. The case records demonstrated multiple instances of contact between Ms Whiteley and Service User 1 on Fridays, which the panel was satisfied were non-working days for Ms Whiteley. These included recorded contacts in January, February and March 2020, as well as further recorded contacts in October 2020. The panel was particularly assisted by the entry made by Ms Whiteley herself in April 2020 in which she expressly recorded that she was visiting Service User 1 on her working days and contacting her by telephone on her non-working days. The panel regarded this entry as clear and compelling evidence that Ms Whiteley knowingly maintained contact with Service User 1 on days when she was not contracted to work.

70. The panel also considered the evidence arising from the audit of Ms Whiteley's caseload undertaken by Mrs Clemson in May 2021. That audit identified further examples of recorded contact between Ms Whiteley and Service User 1 on non-working days in May 2020. The panel accepted Mrs Clemson's evidence that these were identified through a cross-check of Ms Whiteley's case recordings against her known working pattern and leave records. The panel was satisfied that this provided further objective support for the allegation.

71. The panel attached significant weight to the contemporaneous concerns expressed by other professionals at the time. The panel accepted the evidence that during a clinical meeting in April 2020 concerns were formally recorded about Ms Whiteley maintaining contact with Service User 1 on her non-working days and about the risk of Service User 1 becoming overly dependent upon her. The panel further accepted the evidence that, in supervision in May 2020, Mrs Clemson explicitly raised with Ms Whiteley the importance of not working on days off and not having contact with service users outside of contracted working hours, both to protect professional boundaries and to avoid over-reliance on a single practitioner. The panel accepted Mrs Clemson's evidence that Ms Whiteley was encouraged to introduce alternative workers to Service User 1 to ensure appropriate boundary management.

72. The panel carefully considered whether there was any professional necessity which justified Ms Whiteley continuing to make contact with Service User 1 on her non-working days. The panel accepted the evidence that Service User 1 was known to, and had access to, crisis and out-of-hours services, and that other professionals within the multidisciplinary team were available to provide support when Ms Whiteley was not working. The panel was satisfied that there was no evidence of understaffing, emergency compulsion, or operational necessity which required Ms Whiteley to continue such routine contact outside of her contracted hours. The panel was further satisfied that this was not a case of isolated emergency intervention but reflected a repeated pattern of contact over a prolonged period.

73. The panel accepted the consistent professional opinion of the witnesses that routine contact with service users outside of contracted working hours constitutes a breach of professional boundaries. The panel accepted Mrs Clemson's evidence that maintaining boundaries within a multidisciplinary framework is essential to prevent dependency and to ensure safe, proportionate and professionally accountable care delivery. The panel also accepted that concerns about Ms Whiteley's boundary management were raised at the time by other professionals and were not simply retrospective observations.

74. Having carefully considered all of the evidence, the panel was satisfied on the balance of probabilities that Ms Whiteley did have contact with Service User 1 outside of her working hours on multiple occasions during the period alleged. The panel was further satisfied that this contact was not isolated, was not compelled by emergency necessity, and occurred despite professional guidance and supervisory instruction to the contrary.

75. **Accordingly, the panel finds Allegation 1(a) proved**.

**Allegation 1(b)**

76. Allegation 1(b) alleges that Ms Whiteley had contact with Service User 1 using her personal email address prior to April 2021. The panel carefully considered whether Service User 1 did in fact communicate with Ms Whiteley by email and, if so, whether that communication took place via Ms Whiteley's personal rather than professional email account.

77. The panel first considered the contemporaneous case records, many of which were authored by Ms Whiteley herself. Those records repeatedly refer to Service User 1 emailing Ms Whiteley about highly sensitive matters, including her memories of past abuse, intrusive flashbacks, emotional distress and what Ms Whiteley described as "episodes". The panel noted that the case records repeatedly described ongoing email correspondence as a regular feature of the professional relationship. The panel further noted that one record described an email from Service User 1 in which she expressed suicidal intent, confirming that email was being used as a means of communicating acute risk.

78. The panel considered the email from Dr Kothari, who, in February 2020, raised a concern with Mrs Clemson about the absence of these emails from the official clinical record. Dr Kothari queried why emails from Service User 1 about past abuse were not visible on the system used by the team, and noted that such correspondence should ordinarily be stored so that senior clinicians had full sight of relevant communications. The panel regarded this as significant because it demonstrated that, at the time, senior clinicians expected such emails to exist within the organisational record but were unable to locate them.

79. The panel then considered the evidence of Mrs Clemson in relation to her review of Ms Whiteley's work email account during the internal investigation which followed Ms Whiteley's period of sickness absence after April 2021. Mrs Clemson confirmed that she obtained access to Ms Whiteley's professional email account through information governance and reviewed all emails between Ms Whiteley and Service User 1 that were retrievable. Mrs Clemson's evidence was that there were very few such emails on Ms Whiteley's work account and that this did not reflect the frequency of email contact clearly documented within the clinical case notes. The panel accepted this evidence.

80. The panel attached weight to Mrs Clemson's evidence that, when she raised this discrepancy directly with Service User 1, Service User 1 confirmed that she had been emailing Ms Whiteley using Ms Whiteley's personal email address. The panel acknowledged that Service User 1's account constituted hearsay evidence. However, the panel was satisfied that this account was strongly supported by the surrounding documentary and professional evidence, including the repeated references to email correspondence in the clinical records, the concerns raised by Dr Kothari about the absence of those emails from the clinical system, and the absence of those same emails from Ms Whiteley's professional email account following formal review.

81. The panel also considered whether it was plausible that the emails had been sent to an alternative professional account rather than to Ms Whiteley's personal email address. The panel accepted the evidence that Ms Whiteley had been issued with a work laptop and a work email account by her employer, and that Ms Epstein had confirmed that this council email account had been checked as part of the investigation. The panel was satisfied that this effectively ruled out the possibility that the emails had been routinely directed to Ms Whiteley's professional email address.

82. The panel further accepted the consistent professional evidence that the use of personal contact details, whether by email or telephone, to communicate with service users constitutes a breach of professional boundaries. The panel accepted the evidence that all members of the multidisciplinary team were issued with work devices precisely to avoid the risks associated with personal contact routes, to ensure proper record keeping, transparency, professional oversight and safeguarding. The panel was satisfied that the use of a personal email address in this context undermined those safeguards and removed critical professional oversight of sensitive and high-risk communications.

83. The panel also considered whether there was any professional justification for Ms Whiteley permitting Service User 1 to email her via a personal account. The panel was satisfied that no such justification had been identified. The evidence demonstrated that structured support systems, including duty and crisis services, were available to Service User 1 and that there was no operational necessity requiring Ms Whiteley to bypass professional communication systems.

84. Taking all of the evidence together, the panel was satisfied on the balance of probabilities that Service User 1 did communicate with Ms Whiteley by email on

multiple occasions prior to April 2021, that those emails contained highly sensitive and risk-related content, and that those emails were sent to Ms Whiteley's personal email address rather than her professional email account.

85. **Accordingly, the panel finds Allegation 1(b) proved.**

**Allegation 1(c)**

86. Allegation 1(c) alleges that Ms Whiteley maintained a relationship with Service User 1 after 22 April 2021. The panel first considered the circumstances in which Ms Whiteley ceased working and the instructions that were given to her at that time. The panel accepted the evidence of Ms Epstein that, following notification from Social Work England of concerns in relation to Service User 1, she and Mrs Clemson met with Ms Whiteley to advise her that she was the subject of a regulatory investigation and to instruct her that she was not to have any further contact with Service User 1 while that investigation was ongoing. The panel noted that there was some minor uncertainty as to the precise date of this meeting, but accepted that it took place after the employer received notification from Social Work England and by no later than 22 April 2021. The panel was satisfied that the exact date of the meeting did not affect the reliability of the evidence as to its content. The panel further accepted that shortly after this meeting, and no later than 22 April 2021, Ms Whiteley went off sick from her role and did not subsequently return to work.

87. The panel considered that, regardless of the precise timing of the meeting, it would have been plainly inappropriate for a social worker who was off sick and not fit to work to maintain professional contact with a service user. The panel also accepted the consistent evidence of the professional witnesses that, once a social worker has been expressly instructed not to contact a particular service user because of an ongoing regulatory investigation, any continued contact would be wholly unacceptable and contrary to basic professional expectations.

88. The panel then considered the evidence relating to the serious incident of self-harm suffered by Service User 1 in September 2021 and the disclosures made in that context. The panel accepted the evidence of Dr Ashforth that she saw Service User 1 for a therapy session on 20 September 2021 with the purpose of conducting a structured analysis of the events leading to the self-harm. The panel noted that Dr Ashforth described Service User 1 at that time as visibly anxious and distressed, reluctant to engage, and struggling to think clearly. Following that session, Service User 1 sent a lengthy text message to Dr Ashforth in which she described profound feelings of abandonment, a longing for a parental-type relationship, and difficulty tolerating the boundaries inherent in therapy. The panel considered that this message was consistent with a pattern of blurred attachment and boundary difficulties in her relationships with professionals.

89. The panel accepted the evidence of Mrs Clemson about her visit to Service User 1 on 21 September 2021 to assess her safety and explore possible triggers for the self-harm incident. The panel was taken to the contemporaneous record of that visit. The panel accepted the evidence that, within the clinical records, the term "unwanted source" was used in place of Ms Whiteley's name in order to protect her identity in the context of an ongoing investigation, but that relevant staff, including Dr Ashforth, were informed confidentially that "unwanted source" referred to Ms Whiteley. The panel heard evidence that this term "unwanted source" was a term devised after advice from human resources. The panel was satisfied that, when read in that context, the contemporaneous note of the 21 September 2021 visit provided strong support for the proposition that the person described by Service User 1 was in fact Ms Whiteley.

90. In that record, Service User 1 initially appeared reluctant to identify the person whose failure to contact her had triggered the self-harm, but then disclosed, in response to probing questions, that an "unwanted source" had been in contact with her since first going off sick from work. Service User 1 reported that this "unwanted source" had been texting and calling her, that they had been meeting in the car and going for walks, and that therapeutic work had been continuing. She further reported that "unwanted source" had told her it would be dangerous to stop their work and that contact had continued nearly every day. She described the immediate trigger for the self-harm as the failure of "unwanted source" to contact her on her birthday, which she experienced as abandonment by the only person she believed cared about her.

91. The panel also accepted the evidence that, during this same period, Service User 1 disclosed that she had been seeing a "friend" called "Diane" regularly, including on Tuesdays in July and September 2021, and that she later confirmed to Dr Ashforth that "Diane" was in fact Ms Whiteley. The panel regarded the use of a pseudonym in this way as further evidence of the closeness and secrecy of the ongoing relationship between Service User 1 and Ms Whiteley.

92. The panel considered the additional disclosure made by Service User 1 to Dr Ashforth on 21 and 22 September 2021. The panel accepted the evidence that Service User 1 telephoned Dr Ashforth in an anxious and distressed state, admitted that she had been deceitful in not previously disclosing the continuing contact with Ms Whiteley, and confirmed that the self-harm incident had been triggered by Ms Whiteley not contacting her as promised. The panel noted that Service User 1 expressed guilt for having "told on" Ms Whiteley and described a powerful emotional wish for Ms Whiteley to "be her mum". She also disclosed that when she was in a dissociated state she was allowed by Ms Whiteley to call her "mummy". The panel considered that these disclosures, made in the context of ongoing therapy and recorded contemporaneously by Dr Ashforth, were detailed, specific and consistent with the earlier account given to Mrs Clemson.

93. The panel attached weight to the further disclosure that when Ms Whiteley went off sick, she told Service User 1 she would not be working but would contact her from a different mobile phone because she believed it would be harmful to end their contact

suddenly. The panel was satisfied that this indicated a deliberate decision by Ms Whiteley to continue a relationship with Service User 1 outside of, and in spite of, her employment status and the explicit instruction not to have contact.

94. The panel also considered the fact that Service User 1 demonstrated knowledge of matters that would most likely have come from Ms Whiteley. In particular, Service User 1 knew that information had been given about Ms Whiteley to "the registering body" and that Ms Whiteley had resigned from her post. The panel accepted that, while in theory this information could have been obtained indirectly, there was no evidence that it had been communicated by anyone else, and the panel considered it far more likely that it was provided by Ms Whiteley herself during their continuing contact.

95. The panel recognised that the evidence of the continuing relationship after April 2021 derived in significant part from what Service User 1 told others and was therefore hearsay. However, the panel was satisfied that this hearsay evidence was reliable and should be given substantial weight. It was internally consistent, detailed, and repeated to more than one professional; it was recorded in contemporaneous clinical notes by both Mrs Clemson and Dr Ashforth; it was against Service User 1's own interests in that she expressed guilt and fear about the consequences of disclosure; and it was strongly corroborated by the employer's subsequent actions, including revoking Ms Whiteley's access to systems, making a safeguarding referral, and sending a formal letter reminding her that she had been instructed not to contact Service User 1.

96. The panel also took into account its earlier finding that Ms Whiteley had, over a prolonged period, engaged in contact with Service User 1 outside of her contracted working hours and had used personal means of communication. In the panel's view, those established patterns of behaviour, and Ms Whiteley's failure to adhere to supervisory guidance in relation to boundaries, made it inherently more likely that she would have continued to maintain an inappropriate relationship with Service User 1 despite being off sick and despite the instruction not to contact her.

97. Having considered all of the evidence in the round, the panel was satisfied on the balance of probabilities that, following her departure from work in April 2021 and in direct contravention of managerial instruction, Ms Whiteley continued to maintain a relationship with Service User 1 by way of regular telephone and text contact using her personal phone, by meeting her in person, and by continuing to provide therapy-like input until at least September 2021.

98. **Accordingly, the panel finds Allegation 1(c) proved.**

**Allegation 1(d)**

99. Allegation 1(d) alleges that Ms Whiteley contacted Service User 1 using her personal mobile telephone after April 2021. The panel considered whether, following Ms

Whiteley going off sick in April 2021, she continued to have contact with Service User 1 using a personal telephone rather than her work-issued device.

100. The panel accepted the evidence that Ms Whiteley had been issued with a single work mobile telephone by her employer at the outset of her role. The panel further accepted the evidence of Mrs Clemson that all members of the multidisciplinary team were required to use only work-issued devices for communication with service users in order to preserve professional boundaries, ensure transparency, and avoid blurring the distinction between professional relationships and personal friendships. The panel was satisfied that the use of a personal mobile telephone for contact with a service user was clearly prohibited within accepted professional practice.

101. The panel carefully considered the disclosures made by Service User 1 to both Mrs Clemson and Dr Ashforth in September 2021. The panel accepted the evidence that, during a home visit on 21 September 2021, Service User 1 told Mrs Clemson that after Ms Whiteley went off sick in April 2021, Ms Whiteley had continued to contact her by way of telephone calls and text messages from Ms Whiteley's personal phone. The panel also accepted the contemporaneous note in which Service User 1 described that contact as occurring nearly every day and that it took place via a different number from Ms Whiteley's usual work number.

102. The panel further accepted the evidence of Dr Ashforth that, on 22 September 2021, Service User 1 independently disclosed that when Ms Whiteley went off sick she contacted her and stated that she would no longer be working but would now contact her from a different mobile phone, because Ms Whiteley believed that if the contact ended suddenly it could be harmful to Service User 1. The panel noted that, during this disclosure, Service User 1 expressed that the change of phone number had initially felt "sinister" to her, but she clarified that she did not believe it was intended in that way. The panel regarded this level of detail as significant.

103. The panel recognised that Service User 1's accounts to Mrs Clemson and Dr Ashforth constituted hearsay evidence. However, the panel was satisfied that this hearsay evidence was reliable and should be given substantial weight. The disclosures were made independently to two different professionals, on separate occasions, in close temporal proximity, and were consistent in all material respects. The disclosures were recorded promptly and contemporaneously by both Mrs Clemson and Dr Ashforth in the course of their professional duties. Both professionals were, at the time, aware of the ongoing regulatory investigation into Ms Whiteley, and the panel was satisfied that they would therefore have exercised particular care in accurately recording what was said.

104. The panel also took into account the presentation of Service User 1 at the time of disclosure. The evidence described her as anxious, distressed and vulnerable, but also as knowledgeable and highly intelligent. The panel was satisfied that there was no suggestion that Service User 1 lacked the capacity to give an accurate account of events. The panel further attached weight to the fact that Service User 1 clearly did not

wish to cause difficulties for Ms Whiteley and, on the contrary, expressed guilt, worry about the consequences for Ms Whiteley, and a sense of "letting her down" by making the disclosures. The panel was satisfied that this significantly undermined any suggestion that Service User 1 was motivated by malice or fabrication.

105. The panel further noted that Service User 1 was careful and measured in her account. She expressly stated that Ms Whiteley had not visited her home since going off sick and that contact was instead by telephone, text and meetings for walks. The panel considered that this level of restraint and specificity was inconsistent with exaggeration or invention.

106. The panel also considered the wider evidential context. If Ms Epstein's evidence is accepted, Ms Whiteley had been expressly instructed not to have any contact with Service User 1 while the investigation was ongoing. The panel considered that the use of a different, personal mobile number, rather than Ms Whiteley's work-issued phone, was entirely consistent with an attempt to avoid detection by the Trust or the Council. The panel was also satisfied that Ms Whiteley had only ever been issued with one work mobile telephone, meaning that any continued telephone contact after April 2021 could only have taken place via a personal device.

107. The panel further took into account that, in her written response, Ms Whiteley admitted that she had, on occasion, used her personal mobile telephone to contact Service User 1 and stated that she regretted doing so. The panel regarded this admission as further support for the allegation.

108. Taking all of the evidence together, the panel was satisfied on the balance of probabilities that, after April 2021 and after she had gone off sick and been instructed not to contact Service User 1, Ms Whiteley did continue to contact Service User 1 using her personal mobile telephone.

109. **Accordingly, the panel finds Allegation 1(d) proved.**

**Allegation 2**

110. Allegation 2 alleges that in January 2020, Ms Whiteley did not take appropriate action in response to a safeguarding concern in respect of Service User 1. The panel began by considering the contemporaneous record of 12 January 2020, made by a member of staff following crisis contact with Service User 1. In that record, it was noted that Service User 1 had said there was a chance she could be pregnant, that she had "*been back to the men who abused her*", that she recognised signs and symptoms from previous pregnancies, and that she had missed a period. The member of staff recorded that, because of Service User 1's good relationship with Gina (Ms Whiteley), it had been agreed that the matter would be documented so that it could be discussed further with her at a later point. There was no suggestion in that record of immediate or imminent risk requiring emergency intervention.

111. The panel accepted the evidence of Dr Ashforth and Mrs Clemson that, in light of Service User 1's complex trauma history, her vulnerabilities and the suggestion of possible ongoing abuse, this information was capable of amounting to a safeguarding concern. The panel also accepted that the Trust's Safeguarding Adults Policy and CPA and Care-Co-ordination Policy place duties on staff to act where they become aware of actual or potential abuse. Those policies state in clear terms that "*all staff who observe abuse or who have a concern in relation to a service user will report those issues as soon as possible to their line manager*", and that where there are concerns of "*potential adult abuse the Trust safeguarding policy must be instigated*". The policies, the associated guidance and the safeguarding flowchart all emphasise that responsibility lies, in the first instance, with the staff member who becomes aware of, or directly receives, the disclosure of abuse.

112. The panel then considered how those duties applied to the events of January 2020. It was common ground that the first recipient of Service User 1's disclosure on 12 January 2020 was a nurse who took the call, and not Ms Whiteley. The nurse recorded the disclosure and indicated that it would be discussed with Ms Whiteley, but there was no evidence before the panel that this nurse had herself sought advice from her line manager or the safeguarding team, or that she had made, or attempted to make, a safeguarding referral in accordance with the policy. That nurse was not called to give evidence, so the panel was not able to explore what, if any, further steps were taken, whether Ms Whiteley was in fact informed directly, or what guidance was received.

113. The panel noted that the next entry by Ms Whiteley was a contact with Service User 1 on 15 January 2020. That record did not refer to the disclosure made on 12 January 2020. The panel accepted that, as the allocated care co-ordinator, Ms Whiteley had ongoing safeguarding responsibilities for Service User 1. However, the panel did not accept that Social Work England had demonstrated, on the evidence available, that she was in fact the practitioner who first became aware of the specific disclosure recorded on 12 January 2020. The mere fact that the earlier entry appeared within the clinical record did not, in the panel's judgment, establish that by 15 January 2020 Ms Whiteley had necessarily seen that entry or appreciated its safeguarding implications, particularly in the context of a busy multidisciplinary service, multiple contemporaneous crisis contacts, and Ms Whiteley's part-time working pattern. The panel accepted the evidence that practitioners do not necessarily re-read all recent entries before each contact and that several other staff had contact with Service User 1 in the same period.

114. The panel also considered the later evidence that, in September 2021, Service User 1 told Mrs Clemson that she had been going back to her abusers and that the "*unwanted source*" knew about this and was the only person who tried to keep her safe. The panel treated this as hearsay evidence. The panel did not regard it as sufficient, on its own, to establish that in January 2020 Ms Whiteley was the first or direct recipient of the specific information disclosed to the nurse, nor that she was therefore the person upon whom the safeguarding policy placed the primary duty to initiate safeguarding procedures at that time.

115. The panel accepted that, with hindsight, it would have been preferable for Ms Whiteley to have identified and explored the disclosure recorded on 12 January 2020 when she next returned to work. However, the allegation requires the panel to be satisfied, on the balance of probabilities, that Ms Whiteley failed to take appropriate action in response to a safeguarding concern. In circumstances where the safeguarding policies place the primary duty to escalate on the person receiving the disclosure; where there is no evidence that Ms Whiteley was directly informed of the disclosure by the nurse; where other members of the multidisciplinary team were involved with Service User 1 in the same period; and where no direct evidence was available from the nurse who first received the disclosure, the panel was not satisfied that Social Work England had established that any failure to act in January 2020 lay with Ms Whiteley.

116. For these reasons, the panel finds that Social Work England has not established, on the balance of probabilities, that in January 2020 Ms Whiteley failed to take appropriate action in response to a safeguarding concern in respect of Service User 1.

117. **Accordingly, the panel finds this allegation not proved.**

**Allegation 3(a)**

118. Allegation 3(a) alleges that Ms Whiteley failed to maintain complete and accurate records in relation to Service User 1 in that she did not record all of her contact and/or work with Service User 1. The panel first considered the applicable professional and organisational requirements governing record keeping. The Care Programme Approach (CPA) and Care Co-ordination Policy requires that *"a record of contact with the client will be kept on the electronic record; the records are required to give details of the delivery of service/intervention as per the care plan and will provide evidence of monitoring and support the evaluation of care"* and that records must be completed *"as soon as possible and within a maximum of 24 hours"*. The same policy further specifies that *"the CPA care co-ordinator will ensure that detailed integrated professional records are maintained to document the assessment, care planning and review processes within the CPA policy framework"*.

119. The panel also considered the Trust's Clinical Record Keeping Guidance which states *"if it's not written down there is no evidence it ever happened, ensure that you record everything that is relevant to the person's care"* and requires that records *"identify any risks or problems that have arisen and steps taken to deal with them so that colleagues who use the records have all the information they need"*. The Trust's Health Management Records Policy further requires that records must be *"accurate and relevant"* and that *"entries must be made during or as soon as possible after the event to be recorded"*. The panel was satisfied that these requirements applied directly to Ms Whiteley in her role as Service User 1's allocated care co-ordinator.

120. The panel then considered the evidence relating to the standard and completeness of Ms Whiteley's records in respect of Service User 1. The panel accepted the evidence of Mrs Clemson that, as part of her management oversight, she cross-referenced Ms Whiteley's Outlook calendar with the clinical case records and identified that a greater number of visits to Service User 1 were scheduled than were actually recorded within the case notes. The panel accepted Mrs Clemson's evidence that this demonstrated that some contacts had not been recorded at all. The panel also accepted her evidence that the records which did exist were often extremely brief and lacking in meaningful clinical detail. The panel found this evidence to be clear, consistent and reliable.

121. The panel placed particular weight on the "summary of recent contact" entries made by Ms Whiteley herself. On one occasion, Ms Whiteley recorded that she had been visiting on her working days and contacting by telephone on her non-working days, yet this summary represented the only entry for a prolonged period and did not record individual telephone calls or visits as separate contacts. On another occasion, Ms Whiteley recorded that she had spoken with Service User 1 on two days and visited her on two further days, yet again recorded only a single brief summary entry. The panel accepted Mrs Clemson's oral evidence that it was not appropriate for multiple contacts to be collapsed into a single, limited summary entry and that separate records should have been made for each contact with proper clinical content.

122. The panel also considered the content of the individual entries that were made by Ms Whiteley. A number of entries referred in vague terms to *"continued work around trauma and current safety"*, *"memory work"* and *"past issues"* but contained no meaningful narrative of what that work entailed, what therapeutic approach was being applied, what risks were identified, what progress had been made, or what plan had been agreed. The panel accepted the evidence of Dr Ashforth that these notes read as brief care coordination visits rather than as records of any structured psychological or therapeutic work. Dr Ashforth stated that she would have expected psychological work to be clearly marked, for example as a DBT session, with a narrative setting out what work was undertaken, what had changed, what the plan was, and what risks were discussed. The panel accepted this evidence and found that Ms Whiteley's records fell materially below that standard.

123. The panel also placed weight on the fact that concerns about the inadequacy of Ms Whiteley's recording were raised with her during supervision in June and July 2020. The panel accepted the evidence that Ms Whiteley was given dedicated admin time to address her backlog of recording and that she agreed that she would document everything on the Trust's recording system. Notwithstanding this, the panel was satisfied that the quality and completeness of her records in relation to Service User 1 did not materially improve thereafter.

124. The panel considered the account given by Service User 1 as to the nature and extent of the work she said was undertaken with Ms Whiteley. The panel treated this evidence as hearsay but found it to be reliable and consistent with other aspects of the evidence.

The account described emotionally intensive work around trauma and attachment which was not reflected with any adequacy in the written records. The panel also noted that Ms Whiteley did not provide any detailed explanation of what that work consisted of, beyond the brief and repetitive phrases contained in her notes. The panel was therefore satisfied that the limited documentation did not accurately or fully represent the nature of the work being undertaken.

125. The panel further accepted Mrs Clemson's evidence that the lack of transparency in Service User 1's records created a high risk to Service User 1's safety, as other professionals could not properly understand what work had taken place, what risks had been identified, or what safeguards had been put in place. The panel regarded that risk as particularly serious in light of Service User 1's profound vulnerabilities.

126. Taking all of the evidence together, the panel was satisfied on the balance of probabilities that Ms Whiteley failed to record all of her contact and/or work with Service User 1 and that the records she did make were frequently overly brief, lacked necessary clinical detail, and did not accurately reflect the extent or nature of the work being undertaken. The panel was further satisfied that this conduct fell well below the requirements of the relevant policies and expected professional standards.

127. **Accordingly, the panel finds Allegation 3(a) proved**.

**Allegation 3(b)**

128. Allegation 3(b) alleges that Ms Whiteley did not record relevant emails sent to her by Service User 1. The panel first considered the documentary evidence demonstrating that Service User 1 regularly communicated with Ms Whiteley by email over a prolonged period. From at least April 2019 onwards, there were frequent and repeated references within the SystmOne case records to Service User 1 emailing Ms Whiteley, particularly in relation to intrusive memories, flashbacks, emotional distress and risk. The panel also noted that Ms Whiteley herself referred to these emails during the daily Flexible Assertive Care Treatment meetings attended by approximately eighteen professionals involved in Service User 1's care. The panel was therefore satisfied that relevant emails were being sent to Ms Whiteley on a recurring basis and were being relied upon in the management of Service User 1's care.

129. Despite these frequent references, the panel noted the clear absence of any saved email correspondence within Service User 1's electronic record. There were no records made by Ms Whiteley identifying when emails were received, what issues they raised, what risks they conveyed, or what actions were taken in response. The panel was satisfied that this absence was not an isolated oversight but represented a sustained failure to document a significant mode of communication.

130. The panel attached significant weight to the contemporaneous concern raised by Dr Kothari in February 2020. In an email to Mrs Clemson, Dr Kothari stated: *"I know 1 has*

*sent emails to Gina about past abuse but these are not on SystmOne (as far as I can tell). Annika has put the emails from [Service User 1] on to the 'communications and letters' so this should be standard practice."* The panel regarded this as clear evidence that, at that time, senior clinicians expected Service User 1's emails to be saved to the clinical record and were unable to locate them.

131. The panel accepted the evidence of Mrs Clemson that, following this concern, she explicitly instructed Ms Whiteley to record all emails from Service User 1 on the electronic file so that they would be accessible to senior clinicians and managers. The panel further accepted that during supervision in May 2020, it was acknowledged that Ms Whiteley had experienced some technical difficulty in setting up the email file, but that the expectation was made clear that emails should be saved in a shared location so that other professionals could view them. The panel accepted Mrs Clemson's evidence that she understood Ms Whiteley would be acting on those instructions.

132. The panel was satisfied that, notwithstanding these clear instructions and the passage of significant time thereafter, Ms Whiteley failed to save the emails or otherwise ensure that their content was made available to the wider clinical team. Mrs Clemson only became aware, after Ms Whiteley had left her role, that the emails had never been properly recorded or uploaded for other staff to access. The panel was satisfied that this demonstrated a continuing failure, rather than a temporary or technical one.

133. The panel considered whether any explanation had been provided for this failure. While reference was made to technical difficulties, the panel was not satisfied that such difficulties could reasonably account for the complete absence of recorded emails over such a prolonged period, particularly in circumstances where Ms Whiteley continued to refer to those same emails in multidisciplinary meetings. The panel noted that one possible explanation was that the emails were being sent to Ms Whiteley's personal email address rather than her professional account. However, the panel made clear that the underlying reason was not determinative. The essential point was that relevant clinical communications were received by Ms Whiteley and were not recorded in the clinical record as required.

134. The panel was satisfied that these emails were plainly "relevant" within the meaning of the record keeping policies. They concerned Service User 1's past abuse, her current distress, her flashbacks, and, at times, acute risk. The absence of any record of these communications meant that other professionals were deprived of vital information necessary to provide safe, coordinated and informed care.

135. The panel therefore concluded that Ms Whiteley failed to maintain complete and accurate records in that she did not record relevant emails sent to her by Service User 1, notwithstanding clear policy requirements, supervisory instructions, and contemporaneous professional concern.

136. **Accordingly, the panel finds Allegation 3(b) proved.**

**Allegation 4(a)**

137. Allegation 4(a) alleges that Ms Whiteley did not complete required work in respect of Service User 1 in that she did not produce and/or record a care plan**.**

138. The panel first considered whether a care plan was a required document for Service User 1. The Care Programme Approach and Care Co-ordination Policy requires that *"all individuals receiving secondary mental health services… will have a care/support plan"* and that where the person is subject to CPA, this must be a formal care plan. The Key Standards further require that *"all service users… should have a plan or statement of care or treatment which is current and relevant"*, that *"a care plan must be produced with a paper copy offered to the service user"*, that *"a copy of the care plan will be given to the service user's GP"*, and that *"the care plan [is] to include crisis and contingency plans"*. The panel was satisfied that these mandatory requirements applied directly to Service User 1.

139. The CPA Policy further provides that *"the care plan must be co-produced with the care co-ordinator leading on consultation with the service user"*. The panel therefore found that the production and recording of the care plan was a core and non-delegable responsibility of Ms Whiteley as Service User 1's allocated care co-ordinator.

140. The panel placed significant weight on the evidence of Dr Kothari and Mrs Clemson as presented to the panel. Dr Kothari gave evidence that she raised explicit concerns regarding the absence of a clear care plan and communicated those concerns directly to Mrs Clemson. In her email of February 2020, Dr Kothari stated: *"I am not clear how we ought to be managing her (i.e. her care plan)… we do need a clear plan about how to manage her. This is particularly because Gina works part time so other staff need to know about her care plan and her history."* Mrs Clemson confirmed in her evidence that she received this communication, understood it as raising a significant concern, and treated it accordingly. The panel was satisfied that this demonstrated collaboration between Dr Kothari and Mrs Clemson within their evidence to the panel regarding the absence of a care plan.

141. The panel then considered the audit undertaken by Mrs Clemson in or around May 2021. The panel accepted her evidence that this audit was undertaken for the practical purpose of enabling all of Ms Whiteley's cases to be safely transferred. Mrs Clemson confirmed that, during this audit, she specifically checked for required core documentation and identified that no care plan was in place for Service User 1. This finding was recorded contemporaneously within the audit documentation.

142. The panel found no reason to doubt the accuracy or reliability of that audit. The panel was satisfied that, had a care plan existed, it would necessarily have been identified during that process. The panel further accepted Mrs Clemson's evidence that, in the absence of a care plan, other professionals would not have had a clear understanding

of what care was being delivered, what interventions were planned, or what crisis and contingency measures were in place to safeguard Service User 1.

143. The panel also took into account that Ms Whiteley's administrative work had been repeatedly raised as a concern in supervision. In that wider context, the panel was satisfied that the continued absence of a care plan was not a minor or technical omission.

144. Taking all of the evidence together, the panel was satisfied on the balance of probabilities that Ms Whiteley did not produce and/or record a care plan for Service User 1 as required.

145. **The panel therefore finds Allegation 4(a) proved.**

**Allegation 4(b)**

146. Allegation 4(b) alleges that Ms Whiteley did not complete required work in respect of Service User 1 in that she did not produce and/or record a comprehensive assessment**.**

147. The panel first considered whether a comprehensive assessment was required in respect of Service User 1. The CPA Policy identifies the care co-ordinator's core functions as including the duty to carry out a *"comprehensive needs assessment"*. The Record Keeping Clinical Guidance provides that the comprehensive assessment *"provides a single point where the outcomes of a specialist mental health assessment is recorded"* and that it *"should provide a detailed and holistic overview of a person's health and social care needs"*. It further requires that the assessment must be completed on referral and reviewed where there are significant changes, and updated at least annually.

148. The panel accepted the clarification given by Mrs Clemson in her oral evidence that a "new comprehensive assessment" and a "comprehensive assessment" referred to the same required document within the Trust's systems.

149. The panel again placed significant weight on the May 2021 audit undertaken by Mrs Clemson. Mrs Clemson gave clear, consistent evidence that the audit identified that there was no comprehensive assessment in place for Service User 1 at that time. This absence was recorded contemporaneously within the audit documentation.

150. The panel also accepted the combined evidence of Dr Kothari and Mrs Clemson, as presented to the panel, that collaborative concerns had previously been raised about the lack of proper assessment documentation on Service User 1's file. The panel was satisfied that this formed part of the backdrop to the formal audit.

151. The panel noted that the audit documentation confirmed that, although some risk assessments were present, no comprehensive assessment existed which provided the

holistic overview required by policy. The panel was satisfied that a risk assessment could not substitute for a comprehensive assessment.

152. The panel again took into account the established pattern of deficiencies in Ms Whiteley's record-keeping and administration, which had been repeatedly addressed in supervision. In that broader context, the panel was satisfied that the prolonged absence of a comprehensive assessment represented a sustained failure to complete required core clinical documentation.

153. The panel further found that, in the absence of a comprehensive assessment, other professionals were deprived of a coherent overview of Service User 1's needs, risks and personal circumstances. The panel considered this to undermine safe multidisciplinary working and to expose Service User 1 to preventable risk.

154. Taking all of the evidence together, the panel was satisfied on the balance of probabilities that Ms Whiteley did not produce and/or record a comprehensive assessment for Service User 1 as required.

155. **The panel therefore finds Allegation 4(b) proved.**

**Allegation 5(a)**

156. Allegation 5(a) alleges that Ms Whiteley, between December 2019 and April 2021, undertook work with Service User 1 which was inappropriate in that it encouraged her to dissociate.

157. The panel first considered the clinical background of Service User 1. She had a diagnosis of Emotionally Unstable Personality Disorder, a significant history of trauma, and symptoms consistent with Post-Traumatic Stress Disorder, including flashbacks, hypervigilance and dissociation. The panel accepted the evidence of Dr Ashforth that dissociation is a trauma response in which a person becomes disconnected from themselves and their surroundings.

158. The panel attached significant weight to the account given by Service User 1 to Dr Ashforth in April 2021, when Dr Ashforth sought to understand the nature of the work that had previously been undertaken with Ms Whiteley. Service User 1 explained that the work had centred on giving her dissociated childlike states, referred to as "littles", a "voice". Service User 1 described interacting with Ms Whiteley while in a dissociated, childlike state, including speaking to her as a young girl and later being told by Ms Whiteley what had occurred during periods she could not remember. The panel was satisfied that this account was not provided in the context of a complaint but as an explanation of previous work.

159. The panel considered whether Service User 1's account was supported by the contemporaneous records. Although Ms Whiteley's recording was persistently sparse

and inadequate, the panel noted frequent references within the case records to "memory work", engaging with flashbacks, working with past trauma, and references to Service User 1's childlike persona, "Bonnie". The panel further noted that in email correspondence with Mrs Clemson dated May 2020, Ms Whiteley referred to encouraging different dissociated states to become "co-conscious", describing this as a therapeutic aim.

160. The panel placed significant weight on the email from Dr Kothari to Mrs Clemson in which Dr Kothari expressed concern that the plan recorded within the CPA documentation was for Service User 1 to recover all of her childhood memories, and described that plan as inappropriate and risky. The panel accepted the combined evidence of Dr Kothari and Mrs Clemson that they regarded this approach as clinically unsafe.

161. The panel accepted the compelling evidence of Dr Ashforth and Mrs Clemson that the MDT approach was focused on grounding, stabilisation, and keeping service users in the "here and now", with the aim of encouraging integration and discouraging dissociation. Both witnesses described techniques used to interrupt dissociation, including checking awareness, physical prompts, and verbal reorientation. Dr Ashforth explained that she later observed a reduction in dissociation after contracting with Service User 1 that she (Dr Ashforth) would not respond to dissociated childlike communications from Service User 1.

162. By contrast, the panel accepted the professional opinion of Dr Ashforth that the nature of the work described by Service User 1, and reflected in Ms Whiteley's limited records and correspondence, would be likely to increase dissociation rather than reduce it. The panel attached particular weight to Dr Ashforth's evidence that encouraging engagement with dissociated child states would lead to further fragmentation rather than integration.

163. The panel applied the ordinary meaning of "encourage", namely to "make something more likely to happen". On that basis, the panel was satisfied that the effect of the work undertaken by Ms Whiteley was to make dissociation more likely to occur. The panel therefore found that, even if Ms Whiteley did not explicitly instruct Service User 1 to dissociate, the nature and structure of the work itself encouraged dissociation in its effect.

164. The panel noted that Ms Whiteley was allocated to Service User 1 as a care co-ordinator, not as a therapist or psychologist, and that Service User 1 did not have a medical diagnosis of Dissociative Identity Disorder from a psychiatrist. The panel was satisfied that the work undertaken exceeded the scope of Ms Whiteley's role.

165. Taking all of the evidence together, the panel was satisfied on the balance of probabilities that the work undertaken by Ms Whiteley with Service User 1 was inappropriate and that it encouraged Service User 1 to dissociate.

166. **The panel therefore finds Allegation 5(a) proved.**

**Allegation 5(b)**

167. Allegation 5(b) alleges that Ms Whiteley, between December 2019 and April 2021, undertook work with Service User 1 which was inappropriate in that it was done without appropriate and/or documented supervision.

168. The panel accepted that Ms Whiteley received line management supervision from Mrs Clemson approximately every six to eight weeks. This supervision was managerial rather than clinical in nature and did not constitute therapeutic oversight.

169. The panel accepted Mrs Clemson's evidence that in May 2020 she became aware that Ms Whiteley had been receiving external "clinical supervision" from a person known to her personally. There was no contract in place, the supervision was said to be provided on a "good will" basis, and there were no records whatsoever of the content of that supervision.

170. The panel accepted Mrs Clemson's evidence that external supervision required formal Trust agreement, contractual safeguards, and confidentiality protections. This position was consistent with the Trust Supervision Policy, which provides that "clinical supervision may be received from outside the Trust with the agreement of the line manager".

171. Following escalation, it was agreed that Ms Whiteley should engage in reflective clinical supervision with Dr Ashforth. The panel accepted the evidence that Ms Whiteley attended only two sessions, cancelled others, and failed to attend further scheduled sessions.

172. The panel reviewed the reflective practice notes from September 2020 and January 2021. These records did not contain detailed scrutiny of dissociation-focused work, memory recovery, or engagement with dissociated child states. Instead, the records reflected general reporting of progress. The panel was satisfied that this demonstrated the absence of meaningful clinical oversight of the work in question.

173. The panel attached weight to Dr Ashforth's March 2021 communication indicating that Ms Whiteley had failed to attend scheduled reflective sessions and that internal supervision might be required for "accountability and responsibility".

174. The panel found that there were no supervision records evidencing structured risk evaluation, MDT agreement, or appropriate therapeutic oversight of the dissociation-focused work. The only evidence of any external supervision came from Ms Whiteley's own account and a letter provided to Social Work England in June 2022 by Dr Michael Beattie, Consultant Clinical Psychologist. He gives a background of having been involved in group supervision work with Ms Whiteley and others, "*The Clinical*

*Supervision group began to meet with 6 members for 4 hours each month from September 2003 but over the years members have drifted away because of time constraints or professional developments. However Miss Whiteley and I have continued with Clinical Supervision the same monthly schedule from September 2003 to the present.*" The panel was satisfied that this fell far short of appropriate and/or documented supervision. There were no notes or records produced of the type and extent of this supervision and it was outside of any recognised or agreed arrangement with the Trust or any of Ms Whiteley's management.

175. Taking all of the evidence together, the panel was satisfied on the balance of probabilities that the work undertaken by Ms Whiteley with Service User 1 was carried out without appropriate and/or documented supervision.

176. **The panel therefore finds Allegation 5(b) proved.**

**Allegation6(a)**

177. Allegation 6(a) alleges that Ms Whiteley, in or around February 2021, represented that Service User 2 had a health condition which had not been diagnosed by a psychiatrist.

178. The panel first considered the clinical background of Service User 2. She had a diagnosis of Emotionally Unstable Personality Disorder and had previously been diagnosed with Bipolar Disorder in 2019. The panel accepted the evidence that she had a history of childhood abuse and neglect. Ms Whiteley acted as Service User 2's care co-ordinator from October 2019 until she went off sick in April 2021.

179. The panel considered the contemporaneous case records in which Ms Whiteley made repeated references to dissociative symptoms and dissociative features in Service User 2's presentation. These included references to childlike parts, "switching", nightmares, flashbacks, and dissociative distress. However, the panel noted that these entries reflected Ms Whiteley's observations and interpretations rather than any formal medical diagnosis made by a psychiatrist.

180. The panel then carefully considered the letter sent by Ms Whiteley to Service User 2's GP in February 2021. In that letter, Ms Whiteley described herself as an Approved Mental Health Professional and social worker and referred to her qualifications in working with adults abused in childhood, together with her stated qualification to administer the Structured Clinical Interview for Dissociative Disorders. The letter contained an extensive narrative of Service User 2's history, presentation, and memory recovery work.

181. Crucially, the panel noted that Ms Whiteley expressed the clear opinion that Service User 2 "has a dissociative condition" and that this condition presented as "at least three personality states". The panel was satisfied that this was presented as a definitive clinical conclusion rather than a provisional observation. In correspondence with

Social Work England Ms Whiteley had the following to say in response to this allegation *"[Service User 2] requested that I write to her GP, to explain her symptomology, as she found it difficult to do that, and so I did that."*

182. The panel accepted the evidence of Mrs Clemson that there was no record within Service User 2's clinical file of any diagnosis of a dissociative disorder, whether Dissociative Identity Disorder or otherwise, having been made by a psychiatrist. The panel further accepted that only a doctor is qualified to make such a medical diagnosis.

183. The panel also considered whether Ms Whiteley was qualified to make such a diagnosis in her own right. While the panel noted Ms Whiteley's assertion within the letter that she was qualified to administer the Structured Clinical Interview for Dissociative Disorders, the panel found that there was no evidence within the records that such an assessment had been formally completed with Service User 2, nor any documented outcome of such an assessment.

184. The panel was satisfied that the content and structure of the letter would lead the GP, or any reasonable reader, to understand that Service User 2 had a diagnosed dissociative condition with multiple personality states. The panel further found that this representation was made despite the absence of any diagnosis by a psychiatrist.

185. The panel considered that whether Service User 2 did or did not, in fact, meet diagnostic criteria for a dissociative disorder was not determinative. The issue for the panel was whether Ms Whiteley represented that such a diagnosis existed when it had not been made by an appropriately qualified medical professional. The panel was satisfied that she did so.

186. Taking all of the evidence together, the panel was satisfied on the balance of probabilities that Ms Whiteley represented that Service User 2 had a dissociative health condition when no such diagnosis had been made by a psychiatrist.

187. **The panel therefore finds Allegation 6(a) proved.**

**Allegation 6(b)**

188. Allegation 6(b) alleges that Ms Whiteley, between around August 2019 and February 2021, undertook work with Service User 2 without appropriate clinical supervision and/or Multi-Disciplinary Team (MDT) input**.**

189. The panel first considered the role in which Ms Whiteley was employed. She was allocated to Service User 2 in the capacity of care co-ordinator and was not employed as a therapist, psychologist, or medical practitioner. The panel accepted the evidence that any psychological or trauma-focused work undertaken by a care co-ordinator required appropriate clinical supervision and input from the MDT, in particular the team psychologist.

190. The panel considered the available supervision records relating to Service User 2. The only reference to Service User 2 within the supervision records was an entry dated 11 February 2021, which recorded that she was struggling due to physical health issues that were under investigation and were impacting on her wellbeing. The panel noted that this entry contained no reference whatsoever to dissociation, childhood trauma work, memory recovery, or the complex psychological interventions described in the letter sent by Ms Whiteley to the GP on or around the same date.

191. The panel attached particular weight to the uncontested evidence of Dr Ashforth that she did not recognise Service User 2's initials and that Service User 2 had never been brought to reflective practice or clinical supervision with her. The panel accepted Dr Ashforth's evidence that had Service User 2 been discussed, this would have been recorded.

192. The panel further attached weight to the evidence of Mrs Clemson that, despite a supervision session taking place on the same day as the GP letter was sent, Ms Whiteley did not raise the issues described in that letter, did not request clinical guidance, and did not seek supervision in relation to the highly complex and sensitive work she was undertaking with Service User 2.

193. The panel examined the content of the GP letter as direct evidence of the nature of the work undertaken by Ms Whiteley. That letter described in detail work involving childhood trauma, memory recovery, exploration of abuse, identification of dissociated "parts", speculation as to the content of repressed memories, and the management of what Ms Whiteley described as multiple personality states. The panel found that this constituted psychological therapy rather than care co-ordination.

194. The panel attached significant weight to the email from Dr Kothari in August 2021 in which she confirmed that concerns had arisen as a direct result of the work Ms Whiteley had undertaken with Service User 2 and that this work had had a negative impact both on the patient and on the team who were attempting to "counteract it". Dr Kothari made clear that there had been no consultation with other professionals in respect of dissociation or Dissociative Identity Disorder, despite such a diagnosis normally requiring repeated observations and multiple professional inputs, including medical input.

195. Dr Kothari further identified that no objective diagnostic measures had been used, that Service User 2 had become invested in reporting Dissociative Identity Disorder -type symptoms, and that she had been encouraged to recall and document traumatic experiences in detail without prior stabilisation work. The panel accepted her evidence that stabilisation work should always precede trauma-focused work and that this had not occurred.

196. The panel was satisfied that there was a complete absence of documented MDT discussion, psychological oversight, or medically led supervision in relation to the work

undertaken by Ms Whiteley with Service User 2. The panel further found that this absence persisted across the whole period alleged.

197. The panel concluded that the nature of the work undertaken was such that it plainly required close clinical supervision and MDT oversight. That oversight was neither sought nor obtained.

198. Taking all of the evidence together, the panel was satisfied on the balance of probabilities that Ms Whiteley undertook work with Service User 2 without appropriate clinical supervision and without appropriate MDT input.

199. **The panel therefore finds Allegation 6(b) proved.**

**Allegation 7(a)**

200. Allegation 7(a) alleges that Ms Whiteley did not maintain adequate records of her interactions with Service User 3.

201. The panel considered the evidence relating to the standard of record keeping required by Trust policies, including the Care Programme Approach and Care Co-ordination Policy and the Trust's Clinical Record Keeping Guidance. The panel accepted that these policies require clear, timely, accurate and sufficiently detailed records to reflect the purpose of contact, the intervention delivered, risk assessment, and outcomes.

202. The panel considered the audit undertaken by Mrs Clemson in May 2021, during which she described the case notes of Service User 3 as "very brief". The panel accepted Mrs Clemson's evidence that, in general terms, she considered the quality of recording to be inadequate when compared with expected standards. However, the panel noted that Mrs Clemson also accepted that where only a brief welfare contact had taken place, a shorter entry might be appropriate.

203. The panel carefully reviewed the full body of Service User 3's case records spanning several years. The panel noted that there was consistent and regular recording of contact throughout the relevant period, including face-to-face visits, welfare checks, and ongoing contact through to February 2021. There were no extended gaps in recording which would indicate a complete failure to document contact.

204. The panel noted that some of the entries were short and summary in nature, particularly in relation to wellbeing, work, parenting, and family relationships. While these entries were not detailed, they were not inconsistent with routine care co-ordination contacts.

205. The panel attached particular attention to the entries relating to dissociation, memory work, mind-mapping, childhood trauma, and the administration of the SCID-D. The panel accepted that although there were references to these areas of work, the outcome of the SCID-D process was not formally documented. However, the panel

noted that these entries largely fell outside the specific allegation period and did not, of themselves, establish a sustained failure to maintain adequate records.

206. The panel further considered whether the brief nature of some entries was sufficient to establish inadequate record keeping. The panel noted the absence of clear evidence detailing what specifically should have been recorded but was not, particularly given that the records did reflect repeated contact and ongoing engagement. The panel found that this materially distinguished Allegation 7(a) from the record keeping failures identified elsewhere.

207. Taking the evidence as a whole, the panel was not satisfied that the threshold for inadequate record keeping had been met. The panel concluded that while some entries were brief, the records did not demonstrate a failure to maintain adequate records to the standard required for a finding of misconduct.

208. **The panel therefore finds Allegation 7(a) not proved.**

**Allegation 7(b)**

209. Allegation 7(b) alleges that Ms Whiteley did not produce and/or record a care plan for Service User 3.

210. The panel reminded itself of the requirements of the Care Programme Approach and Care Co-ordination Policy (the CPA Policy), which states that all individuals receiving secondary mental health services and subject to CPA must have a formal care/support plan. The CPA Policy and associated Clinical Record Keeping Guidance also require that such a plan is current, relevant, co-produced with the service user where possible, recorded on the clinical system, and shared appropriately, including with the service user and their GP.

211. The panel accepted the evidence of Mrs Clemson that, as part of her audit of Ms Whiteley's cases in May 2021, she reviewed the records for Service User 3 and identified that, although a risk assessment was in place, there was no care plan recorded on the system. The panel considered that this audit was carried out contemporaneously, for the practical purpose of reallocating caseloads, and that there was no apparent reason for Mrs Clemson to misstate or misunderstand what documents were or were not present in the file.

212. The panel also took into account the letter from Service User 3 dated 5 October 2021, in which she stated that she had "never had sight of this or indeed any care plan". While the panel did not regard this as determinative on its own (since a care plan might theoretically exist without having been shared properly), it considered this to be consistent with the absence of any care plan within the clinical records at the time of the audit.

213. The panel noted that the existence of a care plan is a binary matter: either such a document was produced and recorded or it was not. There was no evidence before the panel of any historic care plan having been created by Ms Whiteley for Service User 3, nor any suggestion in Ms Whiteley's own material that such a document existed but had been misfiled or lost. The panel considered that, had a care plan been prepared, it would reasonably be expected to appear in the records reviewed by Mrs Clemson in May 2021.

214. The panel was satisfied that Service User 3 was subject to CPA, that a care plan was required, and that it was Ms Whiteley's responsibility as care co-ordinator to ensure that such a plan was produced and recorded. In circumstances where the audit identified no care plan, and there was no evidence to the contrary, the panel concluded that Ms Whiteley did not produce and/or record a care plan for Service User 3.

215. **The panel therefore finds Allegation 7(b) proved.**

**Allegation 7(c)**

216. Allegation 7(c) alleges that Ms Whiteley did not produce and/or record a comprehensive assessment for Service User 3.

217. The panel again had regard to the CPA Policy and the Trust's Clinical Record Keeping Guidance. These documents make clear that one of the core functions of the care co-ordinator is to complete a comprehensive assessment, to provide a detailed and holistic overview of the service user's mental health and social care needs. The comprehensive assessment should be completed on referral, reviewed when there are significant changes, and updated at least annually. It forms the central, single point at which the outcomes of specialist mental health assessment are recorded.

218. The panel accepted the evidence of Mrs Clemson that, during her audit in May 2021, she identified that for Service User 3 there was a risk assessment on file but no comprehensive assessment (referred to in some Trust documentation as a "new comprehensive assessment"). The panel noted that this distinction was clarified in Mrs Clemson's evidence: the terminology "new comprehensive assessment" was understood by her, and within the Trust, to refer to the required comprehensive assessment document for CPA cases.

219. The panel regarded the presence of a risk assessment but the absence of a comprehensive assessment as supporting the reliability of the audit. It demonstrated that the audit was not a superficial review, but one which distinguished between different types of documentation and recognised what was present and what was missing.

220. There was no evidence before the panel that any comprehensive assessment for Service User 3 had been completed by Ms Whiteley and subsequently mislaid or

archived elsewhere. Nor was there any suggestion in Ms Whiteley's written material that such an assessment existed. The panel considered that, had a comprehensive assessment been produced in accordance with policy, it would have been visible within the electronic record reviewed as part of the audit.

221. The panel was satisfied that Service User 3 met the criteria for CPA, that a comprehensive assessment was required, and that it was Ms Whiteley's responsibility as care co-ordinator to ensure it was completed and recorded. In the absence of any such document and in light of the clear audit evidence, the panel concluded that Ms Whiteley did not produce and/or record a comprehensive assessment for Service User 3.

222. **The panel therefore finds Allegation 7(c) proved.**

**Allegation 7(d)**

223. Allegation 7(d) alleges that Ms Whiteley did not handle Service User 3's medical records appropriately.

224. The panel considered the evidence concerning Service User 3's paper medical records and the circumstances in which they came into Ms Whiteley's possession. The panel accepted the evidence of Mrs Clemson that, during a conversation with Service User 3 on 27 October 2021, Service User 3 explained that when she was in her former employment, she had been required to obtain paper copies of her medical records and that Ms Whiteley, her then care co-ordinator, had taken those records for safekeeping. The panel also accepted that Mrs Clemson searched the office for these records and was unable to locate them.

225. The panel accepted the evidence of Ms Epstein that, following this disclosure, she contacted Ms Whiteley on 1 November 2021. Ms Whiteley confirmed that she had the records in a *"safe place"*. The panel accepted that Ms Epstein advised that it would be inappropriate for Ms Whiteley to contact Service User 3 directly and offered instead to arrange collection of the records. The panel noted that Ms Whiteley responded that she did not need to take instruction from Ms Epstein any longer as she was no longer employed by the Council.

226. The panel further accepted that later on 1 November 2021, Ms Whiteley sent a text message confirming that she would return the records to the Community Mental Health Team base that afternoon, which she then did. The panel also took into account Ms Whiteley's written acknowledgement within her response that she had kept the records at Service User 3's request, accepted that this had been an error, and stated that the records were securely kept and never accessed.

227. The panel reminded itself of the Trust's Health Records Management Policy, which states that staff are personally responsible for the security of any health records in their

possession and that records must only be taken home when it is *"absolutely unavoidable"*. Where records are not returned to base at the end of the working day, prior authorisation from the service manager is required.

228. The panel found that there was no evidence that it had been *"absolutely unavoidable"* for Ms Whiteley to take possession of Service User 3's medical records or to retain them away from the workplace for any extended period. There was also no evidence that any authorisation had been sought or granted for this course of action. The panel further noted that there was no record made within the Trust systems that Ms Whiteley had taken possession of these records at any stage.

229. The panel attached particular concern to the fact that, by the time this matter came to light in October and November 2021, Ms Whiteley was no longer employed by the Council and had not sought to return the records of her own volition. The panel considered that continued possession of a service user's confidential medical records after the end of the professional relationship, in an unknown private location, was fundamentally incompatible with professional obligations relating to confidentiality, security, and proper records management.

230. While the panel acknowledged Ms Whiteley's assertion that the records were stored securely and never accessed, the panel concluded that this did not address the core failing. The issue was not whether the records were read, but the fact of their unauthorised removal from secure Trust control, their retention without approval or recording, and the failure to return them promptly when the professional relationship had ended.

231. The panel concluded that any regulated health or social care professional would reasonably be expected to understand that personal possession of a service user's confidential medical records, outside of formal Trust systems and without authorisation, was inappropriate.

232. **The panel therefore finds Allegation 7(d) proved.**

**Allegation 8**

233. Allegation 8 alleges that, in or around February 2011 and/or June 2012, Ms Whiteley inaccurately represented and/or recorded that Service User 4 had a diagnosis of Dissociative Identity Disorder.

234. The panel first considered the professional context in which Ms Whiteley was working with Service User 4. The panel accepted that, during the relevant period, Ms Whiteley was employed by Leeds City Council as a social worker working within the Care Programme Approach framework. The job description produced showed responsibilities consistent with an adult social worker role, including assessment, care planning and care co-ordination, but did not include the diagnosis of mental health

conditions. The panel accepted the clear evidence of Ms Naismith that the diagnosis of mental disorders, including Dissociative Identity Disorder, fell outside the scope of a social worker's role and was reserved to suitably qualified medical or psychological professionals, such as psychiatrists, doctors, or clinical psychologists, following appropriate assessment.

235. The panel noted that Service User 4 had, in some of her correspondence, described Ms Whiteley as a *"psychiatric social worker"* and as seeing her *"in her capacity as a psychotherapist"*. However, the panel accepted the documentary and oral evidence from the local authority that Ms Whiteley's role was that of a social worker and that she was not employed or authorised by the Trust or Council to act as a psychotherapist or to make formal psychiatric diagnoses. The panel considered that this context was important when assessing the accuracy and propriety of any recorded diagnoses within official records or reports authored by Ms Whiteley.

236. The panel then turned to the two key documents relied upon in support of the allegation.

237. First, the panel considered the Factual Report for Disability Living Allowance completed and signed by Ms Whiteley for the Department for Work and Pensions in February 2011. In the section headed *"Diagnosis of psychiatric condition(s) with brief history and dates of onset"*, the report stated that Service User 4 had *"Dissociative Identity Disorder – as indicated by SCID-D"* and went on to note that she had been receiving therapy for seven years. The panel was satisfied that this was a clear and unequivocal representation to an external statutory agency that Service User 4 had a diagnosis of Dissociative Identity Disorder. The wording was that of a concluded diagnosis, rather than a tentative formulation or working hypothesis.

238. Secondly, the panel examined the discharge summary dated 19 June 2012, authored by Ms Whiteley and contained within the limited mental health notes available for Service User 4. In that document, under the heading *"Discharge Plan"*, Ms Whiteley wrote that Service User 4 *"has a diagnosis of Dissociative Identity Disorder"* and further described her presentation in terms of an *"altered personality state"* and an *"adolescent boy"* ego state. The panel considered that, in the context of a formal discharge document, this statement amounted to the recording of Dissociative Identity Disorder as an established diagnosis within the clinical record.

239. The panel then considered whether these representations were accurate.

240. In doing so, the panel attached substantial weight to the evidence of Service User 4's GP, Service User 4's GP, who was asked by the Council to review her medical records in light of her complaint. Service User 4's GP confirmed that, having reviewed the records held at the GP practice for the relevant period, he could find no diagnosis of Dissociative Identity Disorder in any of the letters or documentation received. He noted that there was evidence of involvement from the Community Mental Health Team at Malham House, but that no diagnosis of Dissociative Identity Disorder had been

recorded by a psychiatrist or other medical practitioner. The panel accepted that, in ordinary practice, a diagnosis as significant as Dissociative Identity Disorder would be expected to appear in GP records and in psychiatric correspondence. Its absence from those records was a strong indicator that no such formal diagnosis had ever been made.

241. Service User 4's GP identified two earlier entries of particular relevance. An entry from 3 August 2005 recorded that Service User 4 *"says suffering from dissociative disorder and anxiety"*. A further entry from November 2005 recorded that she *"says has seen psychotherapist today and been told for the first time that she has dissociative identity disorder"*. The panel considered that these entries demonstrated that any reference to Dissociative Identity Disorder originated from what Service User 4 reported she had been told, rather than from a formal clinical diagnosis recorded by a psychiatrist or clinical psychologist. The panel further considered that these entries corroborated Service User 4's later account that she had first been told she had Dissociative Identity Disorder by Ms Whiteley.

242. The panel also considered the evidence that only limited case notes were available from 2010 onwards, and that there were gaps in earlier records. The panel reminded itself that the absence of records is not, of itself, determinative. However, when taken together with Service User 4's GP's review, the absence of any diagnosis of Dissociative Identity Disorder from a psychiatrist or clinical psychologist, and the clear evidence as to who is authorised to make such a diagnosis, the panel was satisfied that there was no reliable evidence that Dissociative Identity Disorder had ever been formally diagnosed by a suitably qualified professional.

243. The panel then considered the hearsay evidence of Service User 4. In her 2019 complaint, made after she had obtained her records, she asserted that the claim she had a diagnosis of Dissociative Identity Disorder was false and that no such diagnosis appeared in her medical or social care records. She further asserted that she had first been told she had Dissociative Identity Disorder by Ms Whiteley. The panel was aware that Service User 4 had made earlier complaints which had not been upheld and treated her evidence with appropriate caution. However, the panel noted that her account on this specific point was strongly corroborated by Service User 4's GP's independent review of the medical records and by the documentary evidence authored by Ms Whiteley herself. In those circumstances, the panel attached significant weight to Service User 4's hearsay evidence on this issue.

244. The panel then considered the reference to SCID-D within the DWP report. The panel understood that SCID-D is a structured assessment tool and not a diagnosis in itself. The panel noted that there was no recorded outcome of any formal SCID-D assessment undertaken by a psychiatrist or clinical psychologist in respect of Service User 4. Even if elements of SCID-D had been used, the panel was satisfied that this would not amount to a formal diagnosis of Dissociative Identity Disorder. The phrase *"Dissociative Identity*

*Disorder – as indicated by SCID-D"* therefore represented Ms Whiteley's own conclusion rather than a diagnosis made by a suitably qualified professional.

245. The panel also considered Ms Whiteley's written response in which she suggested that Service User 4 felt that Dissociative Identity Disorder was a *"best fit"* for her and that the work was collaborative. The panel accepted that practitioners may hold working formulations. However, the panel was clear that there is a fundamental distinction between discussing possible formulations and formally recording or representing that a service user *"has a diagnosis"* of a specific psychiatric condition. The language used by Ms Whiteley in both the 2011 DWP report and the 2012 discharge plan was definitive and assertive, not provisional.

246. The panel reminded itself that this allegation concerns inaccurate representation and/or recording. The panel was satisfied that Ms Whiteley did represent and record that Service User 4 had a diagnosis of Dissociative Identity Disorder and that, on the basis of all the medical and documentary evidence before it, that representation was inaccurate.

247. Taking all of the evidence together, the panel was satisfied on the balance of probabilities that, in or around February 2011 and June 2012, Ms Whiteley inaccurately represented and/or recorded that Service User 4 had a diagnosis of Dissociative Identity Disorder.

248. **The panel therefore finds Allegation 8 proved.**

## Submissions and legal advice on misconduct:

### Summary of submissions on misconduct on behalf of Social Work England:

249. Ms Sharpe made submissions to the panel on behalf of Social Work England. Ms Sharpe submitted that the panel was required to determine whether the facts found proved amounted to misconduct. This was a matter of judgment for the panel rather than a matter of further proof. She reminded the panel that, as confirmed in *Council for the Regulation of Health Care Professionals v General Medical Council and Biswas* [2006] EWHC 464 (Admin), the characterisation of misconduct was a matter for the panel applying its own independent professional judgment to the established facts.

250. Ms Sharpe referred the panel to the definition of misconduct set out in *Roylance v General Medical Council (No. 2)* [2001] 1 AC 311, in which misconduct was described as conduct falling short of what would be proper in the circumstances, assessed by reference to the professional standards ordinarily expected of a practitioner. She submitted that any finding of misconduct must be firmly grounded in, and consistent with, the facts found proved and must not extend beyond them.

251. Ms Sharpe submitted that the panel had already made robust and detailed findings of fact demonstrating fundamental failures in core aspects of social work practice. She emphasised that the failures identified were not minor lapses or isolated errors, but went to the heart of safe, transparent and accountable care delivery, and represented serious departures from the professional standards applicable at the relevant times.

252. Ms Sharpe submitted that the panel had found proved that essential care plans and comprehensive assessments were not produced or recorded for Service Users 1 and 3. She reminded the panel that it had already identified, by reference to the Trust's policies, that the production and recording of care plans and comprehensive assessments were core functions of a care coordinator. She submitted that this conduct breached professional obligations requiring social workers to work in a safe and effective manner, to maintain accurate and comprehensive records, and to provide service users and carers with the information necessary to understand decisions made about their care. She submitted that the absence of this work meant there was no clear plan, structure or purpose underpinning the care of these service users, despite their acknowledged complexity, and that this significantly undermined coordinated, informed and safe care delivery.

253. Ms Sharpe submitted that accurate, comprehensive and contemporaneous record keeping was a fundamental requirement of social work practice across all regulatory frameworks applicable in this case. She submitted that the panel had found that the absence of adequate records impeded effective multidisciplinary working and prevented appropriate oversight. This conduct breached obligations to keep full, clear and accurate records, to manage information in accordance with applicable legislation and guidance, and to contribute effectively to multidisciplinary working. She submitted that these were basic and core professional requirements, and that the failures found proved represented a serious departure from expected standards.

254. In relation to Service User 3, Ms Sharpe submitted that the panel had found that Ms Whiteley retained confidential medical records after the end of the professional relationship. Although the records were eventually returned, the panel had found no evidence as to how those records were stored, secured or whether they were accessible to others during that period. Ms Sharpe submitted that this conduct breached fundamental obligations relating to confidentiality, information governance and record security, including duties to protect service users' privacy, to handle confidential information lawfully and sensitively, and to keep records secure from loss, damage or inappropriate access. She relied on the panel's finding that the continued possession of confidential medical records after the end of the professional relationship was fundamentally incompatible with professional obligations relating to confidentiality, security and proper records management.

255. Ms Sharpe submitted that, in relation to inaccurate representations of diagnosis concerning Service Users 2 and 4, the panel had found that Ms Whiteley represented to other professionals, including the service users' GP and the Department for Work and

Pensions, that the service users had dissociative identity disorder or dissociative conditions without appropriate assessment or formal diagnosis. She submitted that this conduct breached obligations to work within the limits of professional competence, to act within scope of practice, to use professional judgment appropriately, and to ensure that information shared with others was accurate and reliable. Ms Sharpe submitted that accurate diagnostic information was essential both for appropriate care and treatment and for effective inter-agency decision-making. She submitted that the panel had accepted evidence demonstrating the real and practical difficulties encountered by other professionals as a result of these inaccuracies, and that Service User 4 had expressed disappointment and concern about the inaccurate diagnoses recorded in her records. She further submitted that the steps taken by Leeds City Council to amend those records demonstrated that other professionals regarded accuracy as essential.

256. Ms Sharpe submitted that, in respect of Service Users 1 and 2, the panel had found that Ms Whiteley undertook work without any, or adequate, supervision or oversight, contrary to Trust policy. She submitted that this conduct breached professional obligations requiring social workers to recognise the limits of their practice, to seek advice and supervision when necessary, and to use supervision to support and enhance the quality and safety of their practice. She reminded the panel that it had accepted evidence explaining why supervision was essential, particularly when working with complex and vulnerable service users.

257. Ms Sharpe further submitted that the panel had found that Ms Whiteley worked outside her scope of practice by delivering psychologically-based interventions without the involvement of the team psychologist or the wider multidisciplinary team. She submitted that this conduct breached obligations to practise only within areas of appropriate knowledge, skill and experience, to maintain appropriate professional boundaries, and to work collaboratively within a multidisciplinary framework. She submitted that the absence of oversight meant there was no professional scrutiny of whether the interventions were appropriate or safe, and that this exposed service users to unacceptable and avoidable risk. She submitted that the panel had found that this conduct resulted in actual harm to Service User 1, including increased dissociation and distress.

258. Ms Sharpe reminded the panel that, as confirmed in *Solicitors Regulation Authority v Day and Others* [2018] EWHC 2726 (Admin) and *Khan v Bar Standards Board* [2018] EWHC 2184 (Admin), not every breach of professional standards amounted to misconduct. However, she submitted that this case involved sustained and serious failures, a high degree of culpability, and conduct which competent and responsible social workers would regard as serious and reprehensible.

259. Ms Sharpe submitted that the conduct found proved breached multiple core professional standards across the relevant regulatory frameworks and undermined service user safety, effective multidisciplinary working, confidentiality, professional

boundaries and public trust. She submitted that the conduct therefore directly engaged Social Work England's overarching objectives of protecting the public, maintaining public confidence in the social work profession, and upholding proper professional standards.

260. Ms Sharpe submitted that, taken individually and cumulatively, each element of the conduct found proved fell seriously short of what would have been proper in the circumstances. Accordingly, Social Work England invited the panel to find that the facts found proved amounted to misconduct in respect of all allegations found proved.

## Legal advice:

261. The panel heard and accepted the advice of the legal adviser in relation to the approach to determining misconduct. The panel was advised that it was required to exercise its own independent professional judgment when deciding whether the facts found proved amounted to misconduct. The panel was reminded that this stage did not involve any further determination of factual matters, but required an assessment of the legal characterisation of the conduct already found proved.

262. The legal adviser drew the panel's attention to the authority of *Council for the Regulation of Health Care Professionals v General Medical Council and Biswas* [2006] EWHC 464 (Admin), confirming that the question of whether conduct amounts to misconduct is a matter for the judgment of the panel itself and does not require expert evidence. The panel was further advised that there is no statutory definition of misconduct under the Social Workers Regulations 2018 or the Fitness to Practise Rules 2019. However, guidance is provided by the decision in *Roylance v General Medical Council (No. 2)* [2001] 1 AC 311, in which misconduct was described as conduct falling short of what would be proper in the circumstances, assessed by reference to the standards ordinarily expected of a professional practitioner.

263. The panel was advised to consider whether the conduct found proved represented a serious departure from the standards set out in the Social Work England Professional Standards, the Code of Ethics, and other relevant professional guidance governing the profession. The legal adviser emphasised that the threshold for a finding of misconduct is a high one, and that minor errors, isolated lapses, or inadvertent shortcomings would not ordinarily meet that threshold.

264. The legal adviser further reminded the panel of the principles arising from *Solicitors Regulation Authority v Day and Others* [2018] EWHC 2726 (Admin) and *Khan v Bar Standards Board* [2018] EWHC 2184 (Admin), which make clear that not every breach of professional standards will amount to misconduct. Whether a breach does so depends on its seriousness, the degree of culpability involved, and whether the conduct would be regarded as serious and reprehensible by competent and responsible members of

the profession. Conduct that is trivial, inconsequential, or a temporary lapse is unlikely to amount to misconduct.

265. The panel was also advised to assess the seriousness of the conduct by reference to its nature, any risk posed to service users, the impact on public confidence in the profession, and the extent of any deviation from professional expectations. The legal adviser reminded the panel that any finding of misconduct must be firmly grounded in, and consistent with, the facts found proved and must not extend beyond them.

## Panel's finding and reasons on misconduct:

266. The panel next considered whether the facts found proved amount to misconduct. The panel did so by applying its own independent professional judgment to the conduct established, recognising that this stage involves a legal characterisation of the proven conduct and does not require further factual findings or expert evidence. The panel ensured that its conclusions on misconduct were firmly grounded in, and consistent with, the facts found proved and did not extend beyond them.

267. The panel reminded itself that there is no statutory definition of misconduct under the Social Workers Regulations 2018 or the Fitness to Practise Rules 2019. The panel applied the approach in *Roylance v General Medical Council (No.2)*, namely that misconduct is conduct falling short of what would be proper in the circumstances, with the standard of propriety often found by reference to the professional rules and standards ordinarily required of a practitioner in the relevant circumstances.

268. The panel further reminded itself that not every breach of professional rules will amount to misconduct; the threshold is a high one. Whether a breach constitutes misconduct depends on its nature and extent, the degree of culpability, and whether it would be regarded as serious and reprehensible by competent and responsible members of the profession. Conduct which is trivial, inconsequential, or a temporary lapse is unlikely to amount to misconduct. The panel assessed seriousness by reference to the nature of the conduct, the vulnerability of the service users, the risks created, the impact on public confidence, and the degree of deviation from professional expectations.

269. The panel approached misconduct allegation-by-allegation, and then assessed the overall seriousness of the proven conduct.

**Allegation 1(a) to (d): Professional boundaries with Service User 1**

270. The panel found proved that Ms Whiteley had contact with Service User 1 outside of her contracted working hours, used her personal email address and personal mobile telephone for contact, and continued the relationship after 22 April 2021 in circumstances where she had been instructed not to have further contact. The panel found this to be a serious breach of fundamental professional expectations,

particularly given the vulnerability of Service User 1, the inherent power imbalance, and the prolonged and persistent nature of the conduct.

271. The panel was satisfied that the conduct engaged and breached the Social Work England Professional Standards (2019) applicable during the material period, including in particular *"1.7- Recognise and use responsibly, the power and authority I have when working with people, ensuring that my interventions are always necessary, the least intrusive, proportionate and in people's best interests."* The panel considered that Ms Whiteley's sustained out-of-hours contact and use of personal contact methods blurred boundaries and increased dependency, rather than ensuring that interventions remained necessary, proportionate and in Service User 1's best interests.

272. The panel was further satisfied that the conduct breached *"2.3- Maintain professional relationships with people and ensure that they understand the role of a social worker in their lives"* and *"3.1- Work within legal and ethical frameworks, using my professional authority and judgement appropriately."* The panel found that the continuation of contact after clear instruction not to do so, coupled with communication through personal channels, was inconsistent with ethical practice and the maintenance of professional relationships within proper boundaries.

273. In addition, the panel was satisfied that the use of personal email and personal mobile telephone for sensitive communications engaged and breached *"2.6- Treat information about people with sensitivity and handle confidential information in line with the law."* The panel accepted that private email and personal phone contact removed communications from secure organisational systems, undermined transparency, limited clinical oversight, and created confidentiality and safeguarding risks.

274. The panel was also satisfied that the conduct breached *"5.2- Behave in a way that would bring into question my suitability to work as a social worker while at work or outside of work."* The panel considered that competent and responsible social workers would regard the prolonged and continuing boundary breaches, particularly after managerial intervention, as serious and reprehensible.

275. The panel considered the proved consequences and context. Service User 1 was a particularly vulnerable service user with attachment difficulties and a history of self-harm and dissociation. The panel found that the continuation of contact and therapeutic intervention, outside organisational oversight and after instruction to stop, materially increased the risk of harm and was professionally indefensible. The panel was satisfied that the conduct contributed to Service User 1's heightened distress and dependency and formed part of the circumstances associated with the serious self-harm incident. The panel was careful not to characterise the conduct as the sole cause of self-harm, but found that the conduct made a material contribution to the risk environment and emotional destabilisation described in the findings of fact.

276. The panel concluded that Allegation 1(a) to (d), individually and together, amounted to misconduct. In reaching this conclusion, the panel considered that the conduct

represented a sustained and serious failure to maintain appropriate professional boundaries in circumstances involving a highly vulnerable service user. The panel was satisfied that the continuation of contact outside authorised channels and after clear managerial instruction undermined professional safeguards, displaced organisational oversight, and eroded the necessary distinction between professional support and personal involvement. Competent and responsible social workers would regard such conduct, particularly when persistent and resistant to direction, as a serious departure from accepted professional standards. The panel was satisfied that the seriousness, duration and impact of the conduct met the high threshold required for a finding of misconduct.

**Allegation 3(a) and 3(b): Failure to maintain accurate records and failure to record relevant emails (Service User 1)**

277. The panel found proved that Ms Whiteley failed to maintain complete and accurate records of her contact and/or work with Service User 1 and failed to record relevant emails sent by Service User 1, including emails containing sensitive and risk-related information. The panel regarded accurate, comprehensive and timely record keeping as a fundamental professional requirement, particularly in circumstances where a service user presents with significant complexity and risk.

278. The panel noted that Ms Whiteley worked on a part-time basis within a multidisciplinary team. The panel was satisfied that, in those circumstances, the wider multidisciplinary team necessarily relied on Ms Whiteley's records to understand the nature, frequency and content of her work with Service User 1, to identify emerging risks, and to make informed decisions about care planning and risk management in her absence. The panel considered that accurate record keeping was therefore essential to continuity of care, transparency, and effective safeguarding.

279. The panel found that the absence of full and accurate records, including the failure to save and record relevant emails, deprived other professionals of vital information necessary to provide coordinated, informed and safe care. The panel was satisfied that incomplete or missing information had the potential to misrepresent Service User 1's presentation, obscure levels of distress or risk, and prevent timely or appropriate intervention by other members of the team. In the panel's judgment, this significantly increased the risk of harm to the service user.

280. For the period governed by the Social Work England Professional Standards, the panel was satisfied that the conduct breached *"3.11- Maintain clear, accurate, legible, and up to date records, documenting how I arrive at my decisions."* The panel found that Ms Whiteley's limited, collapsed or absent records did not provide a clear or reliable account of what work had taken place, what risks had arisen, or how professional judgments had been reached.

281. Where applicable, the panel was also satisfied that the conduct engaged the HCPC Standards of Performance, Conduct and Ethics, including *"10.1 - You must keep full,*

*clear and accurate records for everyone you care for, treat, or provide services to"* and *"10.2 - You must complete all records promptly and as soon as possible after providing care, treatment or other services."* The panel further considered that the conduct engaged the HCPC Standards of Proficiency for Social Workers, including *"7.3 - understand the principles of information governance and be aware of the safe and effective use of health and social care information"* and *"9.7 - be able to contribute effectively to work undertaken as part of a multidisciplinary team."*

282. The panel also considered that Ms Whiteley did not appropriately respond to supervisory input intended to address these recording failures and did not use supervision to improve the quality and safety of her practice, engaging *"12.1 - be able to use supervision to support and enhance the quality of their social work practice."*

283. The panel concluded that the failures were not minor administrative oversights. They were repeated, persisted over a prolonged period, and occurred in circumstances where accurate information was critical to the safe management of a highly vulnerable service user. The panel was satisfied that Allegations 3(a) and 3(b) amounted to misconduct.

**Allegation 4(a) and 4(b): Failure to produce/record a care plan and comprehensive assessment (Service User 1)**

284. The panel found proved that Ms Whiteley did not produce and/or record a care plan and did not produce and/or record a comprehensive assessment for Service User 1. The panel regarded the absence of these core documents as a fundamental failure in care coordination, given that care plans and comprehensive assessments provide the structure, rationale and purpose for care, support safe MDT working, and provide transparency and continuity.

285. For the Social Work England period, the panel was satisfied that the conduct breached *"3.11- Maintain clear, accurate, legible, and up to date records, documenting how I arrive at my decisions."* The panel found that without a care plan and comprehensive assessment, there was no recorded framework setting out needs, risks, interventions, goals, crisis arrangements or review processes, notwithstanding the complexity of Service User 1.

286. To the extent that any part of the conduct fell within the HCPC regulatory period, the panel was satisfied that it also breached *"10.1 - You must keep full, clear and accurate records for everyone you care for, treat, or provide services to."* and *"10.2 - You must complete all records promptly and as soon as possible after providing care, treatment or other services."* The panel found that the absence of these documents over time, and the confirmation by audit that they were not present, could not reasonably be characterised as a trivial lapse.

287. The panel concluded that Allegations 4(a) and 4(b) amounted to misconduct because they represented sustained failures in essential care coordination functions,

undermined safe care delivery, and materially reduced the ability of colleagues to understand and deliver consistent support. The panel considered that the absence of a care plan and comprehensive assessment deprived the multidisciplinary team of a shared understanding of Service User 1's needs, risks, and agreed interventions, and removed the transparency and accountability that such documents are intended to provide. In the panel's judgment, these omissions significantly impaired effective oversight, continuity of care, and informed decision-making, particularly in circumstances involving a highly vulnerable service user with complex needs. Competent and responsible social workers would regard the failure to produce and record these fundamental documents over a sustained period as a serious departure from professional standards. The panel was satisfied that the seriousness of these failures met the high threshold required for a finding of misconduct.

**Allegation 5(a) and 5(b): Inappropriate dissociation-focused work and lack of appropriate/documented supervision (Service User 1)**

288. The panel found proved that Ms Whiteley undertook work with Service User 1 which was inappropriate in that it encouraged her to dissociate and that this work was carried out without appropriate and/or documented supervision. The panel found these matters to be particularly serious because they concerned high-risk trauma-related work with a highly vulnerable service user and took place outside proper clinical governance, MDT oversight, and documented supervision arrangements.

289. The panel was satisfied that this conduct breached the Social Work England Professional Standards (2019) in the following terms. The panel found that the work engaged and breached *"1.7- Recognise and use responsibly, the power and authority I have when working with people, ensuring that my interventions are always necessary, the least intrusive, proportionate and in people's best interests."* The panel found that encouraging dissociation was not consistent with necessary, proportionate interventions in Service User 1's best interests in the context of the MDT's stabilisation approach.

290. The panel was satisfied that the conduct also breached *"2.3- Maintain professional relationships with people and ensure that they understand the role of a social worker in their lives."* The panel found that Ms Whiteley's role was that of a care coordinator and that the therapeutic-style work, undertaken without appropriate governance and supervision, blurred role boundaries and undermined the clarity of the professional relationship.

291. The panel further found that the conduct breached *"3.1- Work within legal and ethical frameworks, using my professional authority and judgement appropriately."* The panel concluded that undertaking psychologically-based work which exceeded Ms Whiteley's scope, without appropriate supervision and without effective MDT input, did not reflect appropriate use of professional judgment or authority.

292. The panel was satisfied that *"5.2- Behave in a way that would bring into question my suitability to work as a social worker while at work or outside of work."* was also engaged. The panel found that competent and responsible practitioners would regard unsupervised, inappropriate trauma-focused work with vulnerable service users, continuing despite professional concerns and without meaningful oversight, as serious and professionally unacceptable.

293. The panel placed weight on its factual findings that Service User 1 experienced increased dissociation and distress and that the work continued unchecked for a sustained period. The panel concluded that the nature, duration, risk and impact of this conduct plainly met the high threshold for misconduct.

294. The panel concluded that Allegations 5(a) and 5(b) amounted to misconduct. In reaching this conclusion, the panel considered that the sustained nature of the conduct, the absence of appropriate supervision, and the deviation from the agreed multidisciplinary approach represented a serious failure to adhere to fundamental principles of safe and accountable practice. The panel was satisfied that undertaking psychologically-based, trauma-focused work outside appropriate governance arrangements exposed Service User 1 to avoidable risk and removed essential safeguards designed to protect highly vulnerable individuals. The panel considered that competent and responsible social workers would regard such conduct as a serious misuse of professional authority, particularly where it persisted over time and in the face of identifiable concerns. The panel was satisfied that the seriousness of this conduct, viewed in the round, met the high threshold required for a finding of misconduct.

**Allegation 6(a) and 6(b): Service User 2 – inaccurate representation of diagnosis and absence of supervision/MDT input**

295. The panel was satisfied that the conduct fell seriously short of professional expectations and was inconsistent with the Social Work England Professional Standards (2019), including *"3.1- Work within legal and ethical frameworks, using my professional authority and judgement appropriately."* The panel found that presenting a diagnosis-like formulation in the absence of psychiatric diagnosis, and without appropriate consultation or oversight, did not reflect appropriate use of professional authority or ethical judgment.

296. The panel was also satisfied that the conduct breached *"1.7- Recognise and use responsibly, the power and authority I have when working with people, ensuring that my interventions are always necessary, the least intrusive, proportionate and in people's best interests."* The panel found that undertaking complex trauma-focused work without supervision or MDT agreement exposed Service User 2 to unnecessary risk and could not properly be characterised as proportionate or in the service user's best interests.

297. In addition, the panel found that the conduct was inconsistent with *"2.3- Maintain professional relationships with people and ensure that they understand the role of a social worker in their lives."* The panel considered that the representation of diagnostic conclusions, and the nature of the work undertaken, blurred the boundaries between the role of a care coordinator and that of a clinician qualified to diagnose psychiatric conditions, thereby undermining clarity of role and professional relationship.

298. The panel further found that the conduct engaged *"3.11- Maintain clear, accurate, legible, and up to date records, documenting how I arrive at my decisions."* The panel concluded that the representation of a dissociative condition was not supported by appropriate diagnostic evidence or a clearly documented professional rationale, and therefore did not meet the required standard of accuracy or transparency in professional recording.

299. The panel was also satisfied that the conduct engaged *"5.2- Behave in a way that would bring into question my suitability to work as a social worker while at work or outside of work."* The panel considered that competent and responsible social workers would regard the communication of unsupported diagnostic assertions, together with the undertaking of high-risk trauma-related work without appropriate supervision or MDT oversight, as professionally unacceptable.

300. The panel was satisfied that this conduct went beyond a mere error of judgment. It represented a fundamental failure to recognise the limits of professional competence and the safeguards required when working with vulnerable service users. The panel considered that the absence of appropriate supervision and multidisciplinary oversight, taken together with the manner in which information was conveyed to other professionals, demonstrated a serious misuse of professional authority.

301. In the panel's judgment, competent and responsible social workers would regard this conduct as a serious departure from accepted professional standards, capable of undermining safe practice and public confidence in professional judgment. The panel was therefore satisfied that the high threshold for misconduct was met and concluded that Allegations 6(a) and 6(b) amounted to misconduct.

**Allegations 7(b), 7(c) and 7(d): Service User 3 – absence of core CPA documents and inappropriate handling of medical records**

302. The panel found proved that Ms Whiteley did not produce and/or record a care plan for Service User 3 and did not produce and/or record a comprehensive assessment, and further found proved that she did not handle Service User 3's medical records appropriately, including retaining confidential medical records after the professional relationship had ended.

303. In relation to the care plan and comprehensive assessment, the panel concluded that the same fundamental record-keeping obligations applied as addressed above

(allegation 4a & 4b), and that the absence of these core documents undermined safe, coordinated care and the ability of colleagues to understand needs, risks and plans.

304. In relation to the medical records, the panel was satisfied that the conduct engaged and breached the Social Work England Professional Standards (2019), including *"2.3- Maintain professional relationships with people and ensure that they understand the role of a social worker in their lives"*, *"2.6- Treat information about people with sensitivity and handle confidential information in line with the law."* and *"3.1- Work within legal and ethical frameworks, using my professional authority and judgement appropriately."* The panel found that continued possession of confidential medical records, outside organisational control and after the end of employment, was fundamentally incompatible with confidentiality, security and proper records management obligations.

305. The panel concluded that Allegations 7(b), 7(c) and 7(d) amounted to misconduct. In reaching this conclusion, the panel considered that the combined failures in relation to care planning, assessment and the handling of confidential medical records represented a serious departure from fundamental professional responsibilities. The panel was satisfied that these failures undermined the principles of transparency, accountability and continuity that are central to safe and effective social work practice. In particular, the continued retention of confidential medical records after the professional relationship had ended was incompatible with the trust placed in social workers to safeguard highly sensitive personal information. Competent and responsible practitioners would regard such conduct as professionally unacceptable, particularly where it exposes service users to risks relating to confidentiality and information security. The panel was satisfied that the seriousness of this conduct met the high threshold required for a finding of misconduct.

**Allegation 8: Service User 4 – inaccurate representation/recording of Dissociative Identity Disorder**

306. The panel found proved that in or around February 2011 and/or June 2012 Ms Whiteley inaccurately represented and/or recorded that Service User 4 had a diagnosis of Dissociative Identity Disorder in formal documents. The panel found this was serious because it involved definitive representations of a significant psychiatric diagnosis to external bodies and within discharge documentation, without reliable evidence of a formal diagnosis by an appropriately qualified professional.

307. The panel was satisfied that the conduct breached the General Social Care Council Codes of Practice 2002 applicable at the relevant time, namely *"5.8 – behave in a way, in work or outside work, which would call into question your suitability to work in social care services;" "6.1 – Meeting relevant standards of practice and working in a lawful, safe and effective way;"* and *"6.2 – Maintaining clear and accurate records as required by procedures established by your work."* The panel found that competent and responsible practitioners would regard the making and recording of such a diagnosis-

like assertion, without proper medical basis, as serious and professionally unacceptable.

308. The panel concluded that Allegation 8 amounted to misconduct. In reaching this conclusion, the panel placed weight on the significance of recording and communicating diagnostic information within formal documents, which are relied upon by other professionals and organisations when making decisions about care, support and risk. The panel considered that the inaccurate representation of a serious psychiatric diagnosis, absent a proper medical basis, had the potential to misinform subsequent assessments and interventions and to affect the way in which Service User 4 was understood and supported by others. Competent and responsible social workers would regard the recording of such diagnosis-like information without appropriate qualification or verification as a serious failure to meet professional standards of accuracy, responsibility and professional judgment. The panel was satisfied that the seriousness of this conduct met the high threshold required for a finding of misconduct.

309. Having assessed each allegation found proved individually and cumulatively, the panel was satisfied that the conduct involved serious departures from fundamental professional standards. The conduct was not trivial, isolated or temporary. It involved vulnerable service users, persistent boundary violations, inappropriate and unsupervised high-risk psychological work, inaccurate diagnostic representations, and sustained failures in record keeping and care-planning. The panel was satisfied that competent and responsible social workers would regard the conduct as serious and reprehensible. The conduct fell well below the standards expected of a registered social worker and was capable of undermining public confidence in the profession.

310. **Accordingly, the panel finds that Ms Whiteley's conduct, as proved, amounts to misconduct.**

## Allegation 9

> *"9- You were subject to findings by the Disclosure and Barring Service, on 15 September 2022 which resulted in you being included on the Disclosure and Barring Service's Children's Barred list and the Adult's Barred list.*
>
> *The matter at 9 above amounts to the statutory ground of inclusion on a DBS barred list.*
>
> *Your fitness to practise is impaired by reason of misconduct and / or your inclusion by the Disclosure and Barring Service on the Children and Adult's Barred Lists"*

## Submissions and legal advice on Allegation 9:

## Submissions on behalf of Social Work England:

311. Ms Sharpe made submissions on behalf of Social Work England. She invited the panel to consider Allegation 9, which concerns Ms Whiteley's inclusion on the Disclosure and Barring Service ("DBS") barred list.

312. Ms Sharpe reminded the panel that it had now been provided with the relevant versions of the Statement of Case, the witness statements and the documentary material, together with an additional document identifying the newly unredacted information relied upon in respect of Allegation 9. She explained that this material clearly identified where the relevant information could be found within the bundles.

313. Ms Sharpe submitted that Kirklees Council had made a referral to the DBS arising from various matters of concern relating to Ms Whiteley. She acknowledged that there was some overlap between the matters considered by the DBS and those which had previously been before the panel in respect of Allegations 1 to 8. However, she emphasised that the DBS decision was not an exact duplication of those allegations, as the DBS had relied upon additional matters beyond those considered by the panel.

314. Ms Sharpe reminded the panel that, given that overlap, the Case Management panel had determined, on Social Work England's application, that it would be fair for the panel to consider the DBS material only after it had reached its own independent factual determinations in respect of Allegations 1 to 8. She submitted that this approach ensured that the panel was not unfairly or unduly influenced by the DBS decision when making its factual findings. She further submitted that the DBS decision was a separate and discrete matter from the panel's fact-finding function.

315. Ms Sharpe explained that, for those reasons, the panel had not been provided with any evidence relating to the outcome of the DBS referral at the fact-finding stage of the proceedings. She submitted that it was now appropriate, at this stage, for the panel to consider the DBS evidence.

316. Ms Sharpe referred the panel to the final decision issued by the Disclosure and Barring Service on 15 September 2022. She submitted that, by that decision, the DBS determined that it was appropriate to include Ms Whiteley on the barred list in respect of working with both children and vulnerable adults. She did not take the panel through the detailed reasoning contained within that decision, submitting that it was a matter the panel could consider for itself.

317. Ms Sharpe reminded the panel that, pursuant to regulation 25(2)(g) of the Social Workers Regulations 2018, inclusion on the DBS barred list constitutes a separate and distinct statutory ground. She submitted that the panel's task in respect of Allegation 9 was therefore to determine, on the balance of probabilities, whether Ms Whiteley had been included on the DBS barred list.

318. Ms Sharpe submitted that this fact was established to the requisite standard by the DBS final decision of 15 September 2022. She further submitted that this evidence was supported by more recent confirmation from the Disclosure and Barring Service, dated August 2025, which confirmed that the decision to include Ms Whiteley on the barred list remained in force and had not been appealed or reviewed.

319. Ms Sharpe submitted that, in those circumstances, the panel could be satisfied, as a matter of fact and on the balance of probabilities, that Ms Whiteley had been included on the DBS barred list since 15 September 2022. She therefore invited the panel to find Allegation 9 proved.

320. Ms Sharpe submitted that, if the panel were to find Allegation 9 proved, it followed that the statutory ground of impairment by reason of inclusion on the DBS barred list was made out pursuant to regulation 25(2)(g) of the Social Workers Regulations 2018. She submitted that this statutory ground was distinct from misconduct and was not a matter she sought to address as a separate evaluative stage.

321. Ms Sharpe concluded by submitting that, if Allegation 9 and the statutory ground were found proved, the question of current impairment should be considered by the panel globally, together with all other findings made in the case.

### Legal Advice:

322. The panel heard and accepted the advice of the legal adviser who advised the panel that, in determining whether the allegation concerning inclusion on the Disclosure and Barring Service Children's and Adults' Barred Lists was proved, the panel was required to apply the civil standard of proof, namely the balance of probabilities. The legal adviser reminded the panel that the burden of proof rested with Social Work England throughout and that it was for Social Work England to satisfy the panel, on the balance of probabilities, that Ms Whiteley had been included on the DBS Children's Barred List and the DBS Adults' Barred List as alleged.

323. The legal adviser advised the panel that this was a factual determination. The panel was not being asked to consider whether the DBS decision was correct, reasonable, or justified, nor to revisit or reassess the underlying conduct relied upon by the DBS. The panel's task was confined to determining whether the fact of inclusion on the barred lists had been established.

324. The legal adviser advised the panel that, in assessing whether the allegation was proved, it was entitled to place weight on the documentary evidence before it, including the DBS decision and the subsequent confirmation that the barring decision remained in force. If, having considered that evidence, the panel was satisfied that it was more likely than not that Ms Whiteley had been included on the DBS Children's and Adults' Barred Lists with effect from the stated date, it could properly find the allegation proved.

325. The legal adviser further advised the panel that inclusion on a barred list was a separate and discrete statutory ground, distinct from misconduct, lack of competence, or other conduct-based grounds. The legal adviser advised that the Social Workers Regulations 2018 provide that inclusion on a children's barred list or adults' barred list constitutes an independent statutory ground upon which a registrant's fitness to practise may be impaired, and that this ground is established by the fact of inclusion itself rather than by any re-examination of the conduct that led to the barring decision.

326. The legal adviser advised that, if the panel was satisfied on the balance of probabilities that Ms Whiteley had been included on the DBS Children's and Adults' Barred Lists as alleged, paragraph 9 of the allegation could properly be found proved as a matter of fact, and that in those circumstances the corresponding statutory ground would be established without the need for any further evaluative exercise at that stage.

327. The legal adviser advised the panel that the consequences of such a finding would fall to be considered at the impairment stage, where the panel would assess Ms Whiteley's fitness to practise in the round, having regard to public protection, public confidence in the profession, and the maintenance of proper professional standards.

## Panel's Findings on Allegation 9:

328. The panel considered Allegation 9, which alleges that Ms Whiteley was included on the Disclosure and Barring Service Children's and Adults' Barred Lists.

329. In reaching its decision, the panel applied the civil standard of proof, namely the balance of probabilities, and reminded itself that the burden of proof rested with Social Work England throughout.

330. The panel considered the documentary evidence relating to the DBS decision. That evidence confirmed that a final decision was made by the Disclosure and Barring Service on 15 September 2022 to include Ms Whiteley on the barred lists in respect of working with both children and adults. The panel noted that the decision clearly related to Ms Whiteley and that there was no suggestion that the authenticity or accuracy of the document had been challenged.

331. The panel further considered the subsequent confirmation provided by the Disclosure and Barring Service, which confirmed that the barring decision remained in force and had not been appealed, revoked or reviewed. The panel noted that this confirmation stated that any future review of the barring decision would not take place until 15 September 2032.

332. The panel accepted the advice of the legal adviser that its task was confined to determining whether the fact of inclusion on the barred lists had been established and that it was not required, nor permitted, to consider the merits or reasoning of the DBS decision itself. The panel also accepted that inclusion on the barred lists constitutes a

separate and discrete statutory ground, distinct from misconduct or other conduct-based grounds.

333. Having considered the documentary evidence as a whole, and noting that it was clear, consistent and unchallenged, the panel was satisfied that it was more likely than not that Ms Whiteley was included on the DBS Children's and Adults' Barred Lists with effect from 15 September 2022 and that this inclusion remains in force.

334. **Accordingly, the panel finds Allegation 9 proved.**

335. The panel further finds that, as a consequence of that factual finding, the statutory ground of inclusion on the DBS Children's and Adults' Barred Lists is established. The panel reminded itself that the implications of this finding fall to be considered at the impairment stage, where Ms Whiteley's fitness to practise will be assessed in the round, having regard to public protection, public confidence in the profession, and the maintenance of proper professional standards.

## Submissions and legal advice on impairment:

### Submissions on behalf of Social Work England:

336. Ms Sharpe made submissions to the panel to consider the issue of Ms Whiteley's current impairment. She reminded the panel that there is published Social Work England guidance on impairment contained within the Impairment and Sanctions Guidance and invited the panel to have regard to that guidance when undertaking its assessment.

337. Ms Sharpe submitted that impairment is a matter for the panel's professional judgment. She reminded the panel that there is no burden or standard of proof at this stage. A social worker is fit to practise if they are suitable to be registered without restriction. Impairment is concerned with whether the registrant is fit to practise today and in the future.

338. Ms Sharpe referred the panel to the established authorities, including *Cohen v General Medical Council*, and reminded the panel that not every finding of misconduct will automatically result in a finding of impairment. There will be cases where conduct represents an isolated error, the risk of repetition is remote, and the practitioner's fitness to practise is not impaired. However, the court made clear that it is highly relevant to consider whether the conduct is easily remediable, whether it has in fact been remedied, and whether it is highly unlikely to be repeated.

339. Ms Sharpe submitted that, while some of the concerns in this case might in theory be capable of remediation, the panel was entitled to conclude that, in reality, the conduct proved was not easily remediable. She submitted that the conduct went to fundamental tenets of the social work profession and persisted despite concerns,

warnings and supervisory input being raised with Ms Whiteley throughout the relevant period. She invited the panel to consider whether Ms Whiteley's failure to respond appropriately to supervision and instruction was indicative of an attitudinal concern.

340. Ms Sharpe submitted that the panel had already made detailed findings, at both the facts and statutory grounds stages, regarding the risks posed to service users. She reminded the panel of its findings that Ms Whiteley's conduct materially increased the risk of harm to a service user, was professionally indefensible, contributed to heightened distress and dependency, and formed part of the circumstances associated with serious self-harm incidents. While acknowledging that the panel had not found the conduct to be the sole cause of those incidents, Ms Sharpe submitted that the panel had properly concluded that it made a material contribution to a harmful risk environment.

341. Ms Sharpe submitted that the Impairment and Sanctions Guidance makes clear that decisions at each stage of the process must be consistent with findings made at earlier stages. She submitted that the conduct proved in this case, taken individually and collectively, presented an unacceptable and avoidable risk of harm to particularly vulnerable service users over a sustained period of time. Those risks were serious and would have been obvious to any social worker, particularly one with Ms Whiteley's level of professional experience.

342. Turning to remediation and risk of repetition, Ms Sharpe submitted that there was no evidence of remediation before the panel. There was no evidence of training, reflection, learning, or steps taken to address the concerns. Ms Sharpe further submitted that Ms Whiteley had not indicated an intention to undertake remediation in the future and had instead sought removal from the register. Given the significant passage of time since the concerns were raised and the complete absence of targeted remediation, Ms Sharpe submitted that there was no evidence to demonstrate that the risk of repetition had been addressed.

343. Ms Sharpe submitted that evidence of remediation is only one aspect of the panel's assessment, but that the panel must also consider insight. She submitted that Ms Whiteley had provided no meaningful evidence of insight or reflection. While Ms Whiteley had made a brief reference to regretting the use of her personal phone to contact a service user, Ms Sharpe invited the panel to consider the limited nature of that comment, the context in which it was made, and whether it amounted to genuine insight or remorse. She reminded the panel of the observations in *Grant*, drawing on the principles articulated by Dame Janet Smith, that insight must be real, informed and demonstrable.

344. Ms Sharpe invited the panel to consider the questions identified in *Grant*, namely whether the practitioner has in the past, and/or is liable in the future, to put service users at unwarranted risk of harm; to bring the profession into disrepute; or to breach fundamental tenets of the profession. Ms Sharpe submitted that the panel would have little difficulty in answering those questions affirmatively on the facts of this case. She

reminded the panel that it had found breaches of fundamental professional obligations, including maintaining appropriate professional boundaries, practising within the scope of the role, maintaining accurate and adequate records, handling confidential information appropriately, and seeking and following supervision.

345. Ms Sharpe submitted that, given the absence of evidence of insight, remediation or meaningful reflection, the panel was entitled to conclude that the forward-looking limb of those questions was also satisfied and that Ms Whiteley remained liable in the future to place service users at risk, bring the profession into disrepute, and breach fundamental tenets of the profession.

346. Ms Sharpe reminded the panel that the purpose of fitness to practise proceedings is not to punish past wrongdoing, but to protect the public, as articulated in *Meadow v General Medical Council*. While the assessment is forward-looking, it necessarily requires consideration of past conduct to inform the assessment of current risk.

347. Ms Sharpe submitted that the panel should scrutinise carefully the quality of any insight relied upon. She reminded the panel that the Impairment and Sanctions Guidance makes clear that a mere assertion of wrongdoing is unlikely to be sufficient and that insight is also demonstrated by early disclosure, cooperation with investigations and openness with employers. She submitted that there was no evidence before the panel that Ms Whiteley had made full or early disclosures or demonstrated insight into the risks posed to service users or the wider public interest.

348. Ms Sharpe addressed the limited testimonial evidence before the panel and submitted that it did not address the concerns in this case or demonstrate insight or remediation. She further submitted that the absence of recent professional testimonials, while explicable given Ms Whiteley's circumstances, nevertheless meant that there was no evidence before the panel of any improvement in practice or steps taken to address the concerns.

349. Ms Sharpe submitted that, in light of the absence of insight, remediation or evidence addressing the risk of repetition, the personal component of impairment was clearly made out.

350. Turning to the public component, Ms Sharpe submitted that public confidence in the profession and in the regulator would be undermined if a finding of impairment were not made in this case. She reminded the panel of its own findings that the conduct involved serious departures from fundamental professional standards, was not trivial, isolated or temporary, involved vulnerable service users, persistent boundary violations, unsupervised high-risk work, inaccurate representations, and sustained failures in record keeping. She submitted that a fully informed and reasonable member of the public would expect a finding of impairment in those circumstances.

351. Ms Sharpe further submitted that the public interest was reinforced by the fact that Ms Whiteley is included on the DBS Children's and Adults' Barred Lists. The public would

expect that a social worker barred by another statutory body from working with children and adults would not be regarded as fit to practise without restriction.

352. Ms Sharpe submitted that, taken individually and collectively, the findings made by the panel demonstrate that Ms Whiteley's fitness to practise is currently impaired on both the personal and public components by reason of her misconduct and by reason of her inclusion on the DBS barred lists. She therefore invited the panel to find that Ms Whiteley's fitness to practise is currently impaired.

## Legal Advice:

353. The panel heard and accepted the advice of the legal adviser, who advised that impairment is a matter for the panel's own professional judgment, applying the relevant legal principles to the facts found proved.

354. The legal adviser advised the panel that it should have regard to Social Work England's published Impairment and Sanctions Guidance. While the guidance is not determinative and does not fetter the panel's discretion, it provides a structured framework to support a consistent and proportionate approach. The panel was advised to consider the guidance alongside the established legal principles and the facts found proved, with due regard to public protection, the maintenance of public confidence in the profession, and the promotion and enforcement of proper professional standards.

355. The legal adviser advised the panel that the test for impairment comprises two components: the personal component and the public component. The personal component focuses on the registrant's insight, remediation and risk of repetition. The public component concerns the need to maintain confidence in the profession and to declare and uphold proper professional standards.

356. The legal adviser referred the panel to the guidance in *Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council and Grant* [2011] EWHC 927 (Admin). The panel was advised that it should consider whether the registrant's past conduct or failings, and their current position, indicate that they have in the past, and/or are liable in the future, to put service users at unwarranted risk of harm, to bring the profession into disrepute, or to breach fundamental tenets of the profession. The legal adviser further advised that *Grant* emphasises that impairment is not solely concerned with past conduct, but requires a forward-looking assessment of current and future risk and the wider public interest.

357. The legal adviser also reminded the panel of the forward-looking approach endorsed in *Cohen v General Medical Council* [2008] EWHC 581 (Admin), including consideration of whether the concerns identified are remediable, whether they have in fact been remedied, and whether they are highly unlikely to be repeated.

358. Finally, the legal adviser advised the panel that it must determine whether the registrant is currently fit to practise without restriction. If the panel concludes that the registrant

is not fit to practise without restriction, then the registrant's fitness to practise is impaired.

### Panel's decision on impairment:

359. The panel proceeded to consider whether Ms Whiteley's fitness to practise is currently impaired. In doing so, the panel had regard to Social Work England's published Impairment and Sanctions Guidance and reminded itself that impairment is a matter for its own professional judgment. The panel adopted a holistic assessment based on all the findings it had made to date, including its findings of fact and its determination of the statutory grounds.

360. The panel reminded itself that impairment is forward-looking and concerns whether Ms Whiteley is fit to practise today and in the future. The panel had regard to the principles in *Cohen v General Medical Council* and *CHRE v NMC and Grant*. The panel reminded itself that not every finding of misconduct will inevitably lead to a finding of impairment and that there may be cases where the misconduct is an isolated lapse, easily remediable, has been remedied, and is highly unlikely to be repeated. The panel therefore considered whether the concerns in this case were capable of remediation in practice, whether they had in fact been remedied, and whether the risk of repetition was highly unlikely.

361. The panel first considered the nature and gravity of the misconduct and statutory ground found proved. The panel was satisfied that the conduct was sustained and serious. It extended over a significant period, involved multiple service users, and occurred within different practice contexts. The panel found that the misconduct was not trivial, isolated or temporary. It involved persistent boundary violations, work undertaken outside the scope of the care coordinator role, failures to engage appropriately with supervision and management direction, and sustained deficiencies in record keeping and care planning. The panel also found that Ms Whiteley's actions led to a wider failure to safeguard vulnerable service users entrusted to her care.

362. In assessing the personal component of impairment, the panel considered the risk of harm and the risk of repetition. The panel reminded itself of its findings that Ms Whiteley's conduct in relation to Service User 1 materially increased the risk of harm, was professionally indefensible, and contributed to heightened distress and dependency, forming part of the circumstances associated with a serious self-harm incident. While the panel did not find Ms Whiteley's conduct to be the sole cause of the incident, it found that the conduct made a material contribution to the risk environment and emotional destabilisation. The panel also took into account that other service users raised concerns about their care and experience, including by way of formal complaint, and that contemporaneous records reflected difficulties with engagement and distress which were not appropriately addressed. The panel was satisfied that the proven conduct presented an unacceptable and avoidable risk of harm to particularly vulnerable service users.

363. The panel then considered whether the concerns were easily remediable. While it accepted that some aspects of professional practice may be capable of remediation in theory, the panel concluded that, in the circumstances of this case, the concerns were not readily remediable. The panel placed significant weight on the fact that concerns were repeatedly raised with Ms Whiteley over time, including through supervision, management direction and professional challenge, yet there was no evidence that this resulted in meaningful change to her practice. The panel concluded that Ms Whiteley's failure to respond appropriately to supervisory advice and instruction was indicative of an attitudinal difficulty which materially increased the risk of repetition. The panel further considered that undertaking therapeutic or high-risk psychological work outside the scope of the care coordinator role was not merely a skills deficit but represented a fundamental departure from safe and appropriate professional boundaries.

364. The panel found that there was no evidence before it of remediation. There was no evidence of training, reflective work, learning, supervision or targeted steps taken to address the concerns. The panel also noted the absence of any expressed intention to undertake remediation in the future and the fact that Ms Whiteley sought removal from the register rather than engagement with the substance of the regulatory concerns. While the panel noted that Ms Whiteley stated she had not sought to practise since leaving her former employment and did not intend to practise again, the panel reminded itself that impairment cannot be determined by intention alone and must be assessed by reference to insight, remediation and risk.

365. The panel also considered whether Ms Whiteley had demonstrated insight or remorse. It found that she had provided no meaningful evidence of insight into the concerns, the risks posed to vulnerable service users, or the impact of her conduct on service users and the wider public interest. The panel noted limited expressions of regret in relation to the use of a personal mobile phone and the storage of records, but concluded that these remarks were narrow in scope and did not demonstrate an understanding of the seriousness of the misconduct, the safeguarding implications, or the fundamental professional standards breached. The panel also took into account the tenor of Ms Whiteley's written response material, including the extent to which she sought to minimise or challenge aspects of the concerns. The panel was satisfied that the absence of insight, reflection and remediation meant that the risk of repetition had not been addressed.

366. The panel further attached weight to the evidence that Ms Whiteley's conduct led her employer to undertake a retrospective review of historic records. The panel considered this to be a significant and relevant factor when assessing both the seriousness of the misconduct and the public component of impairment. Accurate, contemporaneous record-keeping is a fundamental safeguard in social work practice, underpinning accountability, continuity of care and public trust. The need for an organisation to revisit and scrutinise historic records as a consequence of a practitioner's conduct undermines confidence in the reliability of those records and, by extension, in the

profession and the public bodies that rely upon them. The panel considered that this consequence further demonstrated the gravity of the misconduct.

367. The panel also considered the public component of impairment. Applying the approach in *Grant*, the panel was satisfied that Ms Whiteley's misconduct brought the profession into disrepute and involved breaches of fundamental tenets of social work, including maintaining professional boundaries, practising within scope, safeguarding vulnerable service users, maintaining accurate and adequate records, handling confidential information appropriately, and seeking and applying appropriate supervision. The panel concluded that a fully informed and reasonable member of the public would be seriously concerned if a finding of no impairment were made in these circumstances, and that public confidence in the profession and the regulator would be undermined.

368. In addition, the panel took account of its finding that Ms Whiteley is included on the DBS Children's and Adults' Barred Lists. The panel considered that this is a separate statutory ground and that, in the context of impairment, it reinforced the public interest in ensuring that confidence in the profession and the regulator is maintained.

369. Having considered all of the above matters individually and collectively, the panel concluded that Ms Whiteley's fitness to practise is currently impaired. The panel found impairment on the personal component, on the basis that there is an ongoing risk arising from the absence of insight and remediation and the consequent risk of repetition and harm. The panel also found impairment on the public component, concluding that public confidence in the profession and the maintenance of proper professional standards require a finding of current impairment in this case.

370. Accordingly, the panel finds that Ms Whiteley's fitness to practise is currently impaired.

371. The hearing adjourned at the conclusion of proceedings on 15 December 2025 and was listed on 12 February 2026 to consider what sanction, if any should be made.

## Preliminary matters

372. Upon the hearing being reconvened on 12 February 2026 the panel confirmed that it had been provided with additional material for the purpose of the hearing, namely a service and supplementary bundle (11 pages) and a transcript of the hearing so far (381 pages).

## Service of Notice

373. The panel was informed by Ms Sharpe that notice of this hearing was sent on 16 December 2025 to Ms Whiteley by email to an address provided by the social worker (namely their registered address as it appears on the Social Work England register). Ms Sharpe submitted that the notice of this hearing had been duly served.

374. The panel of adjudicators had careful regard to the documents contained in the final hearing service bundle as follows:

- A copy of the notice of the resumed hearing dated 16 December 2025 and addressed to Ms Whiteley at her email address which she provided to Social Work England;
- An extract from the Social Work England Register as of 16 December 2025 detailing Ms Whiteley's registered email address;
- A copy of a signed statement of service, on behalf of Social Work England, confirming that on 16 December 2025 the writer sent by email to Ms Whiteley's email address referred to above: notice of hearing and related documents.

375. The panel accepted the advice of the legal adviser in relation to service of notice.

376. Having had regard to the Social Work England (Fitness to Practise) Rules 2019 (as amended) ("the Rules") and all the information before it in relation to the service of notice, the panel was satisfied that notice of this hearing had been served on Ms Whiteley in accordance with Rules 14, 15, 44 and 45.

## Proceeding in the absence of the social worker

377. The panel heard the submissions of Ms Sharpe on behalf of Social Work England. Ms Sharpe submitted that notice of this hearing had been duly served.

378. Ms Sharpe reminded the panel that Ms Whiteley had not attended the previous hearing and she had indicated that she would not be participating in proceedings.

379. Ms Sharpe informed the panel that Ms Whiteley had not replied to the notice of hearing, but she had signed a consent order on 26 January 2026 for the interim order that was in place to be extended by the High Court.

380. Further, Ms Whiteley's last substantive engagement with these proceedings was in 2023. Ms Sharpe submitted that Ms Whiteley had voluntarily absented herself from the proceedings and informed the panel that no application for an adjournment had been made.

381. The panel was invited to proceed in the interests of justice and the expeditious disposal of this hearing.

382. 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 Rule 43 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 guidance 'Service of notices and proceeding in the absence of the social worker'.

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

384. The panel noted that Ms Whiteley had been sent notice of today's hearing and the panel was satisfied that she was aware of today's hearing.

385. The panel concluded that Ms Whiteley had chosen voluntarily to absent herself. The panel had no reason to believe that an adjournment would result in Ms Whiteley's attendance. Having weighed the interests of Ms Whitely in regard to her attendance at the hearing with those of Social Work England and the public interest in an expeditious disposal of this hearing, the panel determined to proceed in Ms Whiteley's absence.

## Decision and reasons on sanction

### Submissions by Social Work England

386. Ms Sharpe reminded the panel of its findings with regard to the allegations that it had found proved and the findings of impairment.

387. Ms Sharpe referred the panel to Social Work England's "Impairment and sanctions guidance" (the guidance) and that any sanction should be the minimum necessary to protect the public.

388. Ms Sharpe submitted that no action, warning or advice was not appropriate as this would not restrict Ms Whiteley's practice and therefore would not protect the public.

389. With regard to conditions of practice Ms Sharpe submitted that such a sanction would not be appropriate in this matter and referred the panel to paragraph 118 of the guidance, "Conditions of practice are less likely to be appropriate in cases of character, attitude or behavioural failings. They may also not be appropriate in cases raising wider public interest issues."

390. Ms Sharpe submitted that Ms Whiteley's misconduct was attitudinal in nature and she had failed to demonstrate insight or remediation. In addition no conditions of practice could be put in place as the panel could have no confidence that they would be complied with.

391. Ms Sharpe reminded the panel that it had found Ms Whiteley had no insight into her behaviour. Ms Sharpe submitted that no conditions of practice could be devised that would be proportionate, appropriate and workable in light of the allegations found proved.

392. Ms Sharpe also reminded the panel that Ms Whiteley had said that she did not intend to practise as a social worker. This would cast doubt on her complying with a conditions of practice order, in particular when there had been deliberate breaches of protocols and professional standards by Ms Whiteley and she had actively sought to avoid oversight and guidance.

393. Ms Sharpe submitted that conditions of practice would not sufficiently protect the public, nor would it be in the public interest for such a sanction to be put in place.

394. Ms Sharpe then addressed the panel on the sanction of a suspension order. She referred the panel to the guidance and factors which should be considered in order to

properly make a suspension order. This included that there was evidence of insight and remediation by a registrant. Ms Sharpe submitted that Ms Whiteley had demonstrated neither.

395. Ms Sharpe submitted that a suspension order would be inappropriate as it would not adequately protect the public and it would be inconsistent with the panel's earlier findings.

396. Ms Sharpe submitted that a removal order was the necessary sanction and there could be no other outcome.

397. Ms Sharpe submitted that there had been an abuse of position and trust by Ms Whiteley. She had crossed professional boundaries and her behaviour had had a serious adverse effect on the health and wellbeing of service users.

398. Ms Sharpe submitted that Ms Whiteley was unwilling or unable to remediate and there was clear evidence that she did not wish to practise as a social worker in the future.

399. Ms Sharpe reminded the panel that Ms Whiteley was unable to work with adults and children due to her vetting being suspended until 2032 by the Disclosure and Barring Service. As such Ms Whiteley could not return to working as a social worker until after that time.

400. Ms Sharpe identified mitigating and aggravating factors in this case.

401. With regard to mitigation Ms Sharpe referred the panel to Ms Whiteley's long career with no adverse findings against her.

402. Ms Sharpe suggested that there were several aggravating factors, namely, Ms Whiteley's lack of insight, repeated and persistent misconduct despite warnings and guidance, and the harm and risk of harm caused to vulnerable service users, particularly Service User 1.

403. Ms Sharpe concluded her submissions by inviting the panel to make a removal order in this case.

## Legal Advice

404. The panel heard and accepted the advice of the legal adviser with regard to sanction. The panel should consider that the imposition of a sanction is primarily to protect the public, not to punish Ms Whiteley, although a sanction may have a punitive effect.

405. The panel should consider what sanctions are available and refer to Social Work England's "Impairment and sanctions guidance". The panel must start from the least restrictive sanction. The legal adviser reminded the panel that insight and remediation are important factors. The panel should also identify any aggravating and mitigating factors in the case when deliberating on sanction.

## Panel's Decision

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

407. The panel noted the mitigating and aggravating factors in this case.

Mitigating factors:

- Ms Whiteley had no previous disciplinary or fitness to practise concerns during her lengthy career.

Aggravating factors:

- There had been actual and enduring harm and a risk of harm to vulnerable service users and in particular Service User 1.
- Ms Whiteley's misconduct was repeated and persistent in nature despite oversight and guidance
- The enduring harm was serious and would possibly impact the service users for years to come.
- Ms Whiteley misused her position of trust to pursue her own professional interests
- She continued to contact and engage with service users outside of the work setting.
- Ms Whiteley demonstrated a lack of remediation, remorse.

408. The panel considered each available sanction in ascending order.

## No action, warning or advice

409. The panel decided that no action, a warning or advice was not appropriate as none of these measures would restrict Ms Whiteley's practice and therefore protect the public.

## Conditions of practice

410. The panel could not identify any conditions that would address Ms Whiteley's conduct, which was serious, took place on multiple occasions and was attitudinal in nature.

411. This sanction would require Ms Whiteley to participate and there was no evidence before the panel to show that she would.

412. Ms Whiteley had deliberately avoided supervision and had not responded to management challenge in the past.

413. Some of Ms Whiteley's misconduct took place outside of work and no conditions of practice could be put in place to address this.

### Suspension

414. The panel considered the criteria for making a suspension order, which included evidence of insight and remediation. The panel found no evidence that Ms Whiteley is willing or able to resolve or remediate her failings.

415. The panel did not consider that a suspension order would adequately protect the public.

416. Ms Whiteley had committed serious breaches of professional standards and crossed professional boundaries. Her misconduct was attitudinal in nature.

417. The panel also noted that Ms Whiteley has not practised as a social worker for several years and she had said she did not wish to return to the profession.

418. The panel decided that it would not make a suspension order. The panel considered a member of the public would be deeply concerned if Ms Whiteley had the opportunity to return to the profession after a period of suspension in light of the facts and allegations that were found proved.

### Removal Order

419. The panel decided to make a removal order. The panel decided that no other sanction would adequately protect others and public confidence would be undermined if a removal order wasn't made. Any other sanction would be incompatible with the panel's earlier findings.

420. There had been a considerable abuse of her position of trust by Ms Whiteley. She had taken advantage of the autonomy that she had been given and when challenged failed to respond appropriately.

421. Ms Whiteley had abused her position when away from the workplace. Her misconduct was prolonged and persistent.

422. The panel took Ms Whiteley's failure to engage with these proceedings since 2023, as indicative of her position regarding not wishing to return to social work practice.

423. The panel noted paragraph 149 of the guidance and that a removal order may be appropriate in cases involving abuse of trust, which was the case here.

424. The panel also took into account Ms Whiteley's lack of insight into the potential consequences of her actions and her inability and unwillingness to remediate and there was clear evidence that she does not want to practise as a social worker in the future.

425. The panel also noted that Ms Whiteley would be unable to fully remediate before 2032 due to her vetting being suspended until then, but this was not a factor in the decision making of the panel.

426. The panel decided that a removal order needed to be made to:

- protect the public from harm
- maintain public confidence
- declare and uphold professional standards

427. The panel considered that a removal order is a sanction of last resort and should be reserved for those categories of cases where there is no other means of protecting the public and the wider public interest. The panel decided that Ms Whiteley's case falls into this category because of the nature and gravity of her misconduct and the ongoing risk of repetition.

428. The panel concluded that Ms Whiteley's current impairment and continuing risk to service users required that she should be removed from the register to protect the public from harm. The panel was satisfied that any lesser sanction would also undermine public trust and confidence in the profession and would be wholly insufficient to maintain professional standards.

429. In reaching this conclusion the panel balanced the public interest against Ms Whiteley's interests. The panel took into account the consequential personal and professional impact a removal order may have upon Ms Whiteley, but concluded that these considerations were significantly outweighed by the panel's duty to give priority to public protection and the wider public interest.

## Interim Suspension Order

430. In light of its findings on sanction, the panel next considered an application by Ms Sharpe for an interim suspension order of 18 months to cover the appeal period before the final order becomes effective.

431. An interim suspension order would be necessary in accordance with Schedule 2, paragraph 11(1)(b) of the Social Workers Regulations 2018 to cover the appeal period. Ms Sharpe submitted that an interim suspension order was necessary in light of the findings made by the panel, the current and ongoing risk of repetition of serious harm and was necessary to protect the public.

432. The panel heard and accepted the advice of the legal adviser with regard to the imposition of an interim suspension order. The legal adviser informed the panel that the test is that such an order is necessary for the protection of the public and/or in the best interests of the social worker.

433. The panel considered whether to impose an interim suspension order. It was mindful of its earlier findings and the risk of repetition and decided that it would be wholly incompatible with those earlier findings to permit Ms Whiteley to practise during the appeal period. The panel determined that an interim suspension order is necessary to protect the public.

434. Accordingly, the panel concluded that an interim suspension order of 18 months is necessary for the protection of the public. When the appeal period expires, this interim order will come to an end unless an appeal has been filed with the High Court. If there is no appeal, the final order of removal shall take effect when the appeal period expires.

## Right of appeal:

435. 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:

- 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.

- the decision of the regulator on review of an interim order, or a final order, other than a decision to revoke the order.

436. 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.

437. 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.

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

## Review of final orders:

439. Under Paragraph 15(1), 15(2) and 15(3) of Schedule 2 of the regulations:

440. 15(1) The regulator must review a suspension order or a conditions of practice order, before its expiry

441. 15(2) The regulator may review a final order where new evidence relevant to the order has become available after the making of the order, or when requested to do so by the social worker

442. 15(3) A request by the social worker under sub-paragraph (2) must be made within such period as the regulator determines in rules made under Regulation 25(5), and a final order does not have effect until after the expiry of that period

443. Under Rule 16(aa) of the rules a social worker requesting a review of a final order under Paragraph 15 of Schedule 2 must make the request within 28 days of the day on which they are notified of the order.

### The Professional Standards Authority:

444. 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.