Social worker: Oghenerukevwe Ebiegbe
Registration number: SW124784
Fitness to Practise
Final Hearing

Dates of hearing: Monday 16 to Tuesday 24 February 2026

Hearing venue: Remote hearing

Hearing outcome:
Fitness to practise impaired, suspension order (24 months)

Interim order:
Interim suspension order (18months)

Introduction and attendees:

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

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

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

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

Adjudicators	**Role**
Catherine Boyd	Chair
Julie Brown	Social worker adjudicator
Richard Weydert-Jacquard	Lay adjudicator

Hearings team/Legal adviser	**Role**
Paul Harris	Hearings officer
Cat Conway	Hearings support officer
Zill-e Huma	Legal adviser

Service of notice:

5. The panel was informed by Ms Atkin that notice of this hearing was sent to Ms Ebiegbe by email to an address provided by Ms Ebiegbe (namely her registered address as it appears on the Social Work England register). Ms Atkin 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 18 December 2025 and addressed to Ms Ebiegbe at her email address which she provided to Social Work England;
    - An extract from the Social Work England Register as of 18 December 2025 detailing Ms Ebiegbe's registered email address;
    - A copy of a signed statement of service, on behalf of Social Work England, confirming that on 18 December 2025 the writer sent by email to Ms Ebiegbe at the address referred to above the notice of hearing and related documents.

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

8. Having had regard to Rules 44 and 45 of Social Work England's Fitness to Practise Rules 2019 (as amended) (the "FTP Rules 2019"), and having considered all of the information

before it concerning service, the panel was satisfied that notice of this hearing had been properly served on Ms Ebiegbe in accordance with those provisions.

Proceeding in the absence of the social worker:

9. On behalf of Social Work England, Ms Atkin applied for the panel to proceed in the absence of Ms Ebiegbe.

10. Ms Atkin submitted that proper service had been effected in accordance with the relevant procedural rules. The Notice of Hearing and accompanying documentation had been sent to the email address held by Social Work England for Ms Ebiegbe. That email address had been used by Ms Ebiegbe in recent correspondence with Capsticks and the Hearings Team, including communications in November 2025 and again shortly before the hearing. In those circumstances, it was appropriate to conclude that the email address remained active and that she had received the Notice of Hearing. Ms Atkin reminded the panel that it was not necessary to establish actual receipt; rather, the requirement was that reasonable steps had been taken to effect service.

11. Ms Atkin further submitted that Ms Ebiegbe was plainly aware of the hearing. In an email dated 12 February 2026, she stated that the hearing could proceed in her absence. This, Ms Atkin submitted, amounted to a clear and voluntary decision not to attend. She emphasised that Ms Ebiegbe had not sought an adjournment, despite having been informed on more than one occasion that she could apply for a postponement if she wished to do so.

12. Ms Atkin directed the panel to Social Work England's Guidance on Service of Notices and Proceeding in the Absence of a Social Worker (December 2022), which confirms that where proper notice has been given, a panel may proceed provided it is satisfied that doing so is fair and proportionate. The panel must consider whether the absence is voluntary, whether there is a realistic prospect that an adjournment would secure attendance, and whether proceeding would cause unfairness.

13. Ms Atkin referred the panel to the relevant authorities. In *R v Jones [2002] UKHL 5*, the House of Lords confirmed that an individual may waive the right to be present by voluntarily absenting themselves, provided they are aware of the hearing, and that the discretion to proceed must be exercised with care and fairness. In *Tait v Royal College of Veterinary Surgeons [2003] UKPC 34*, it was emphasised that the discretion to proceed in absence must be exercised cautiously and with fairness at its centre.

14. Ms Atkin further relied on *General Medical Council v Adeogba*; in which the Court of Appeal confirmed that there is no premium on non-attendance and that where proper notice has been given and no good reason is advanced for absence, it will usually be fair to proceed. The Court emphasised the public interest in the expeditious disposal of regulatory proceedings.

15. In relation to Ms Ebiegbe's health matters raised in correspondence, Ms Atkin referred to *General Medical Council v Hayat [2018] EWCA Civ 2796*, in which the Court of Appeal addressed adjournments sought on health grounds and confirmed that cogent and independent medical evidence is ordinarily required to justify postponement. Such evidence should address the nature of the condition, its impact on the individual's ability to participate, and the likely duration of any incapacity. Ms Atkin submitted that no such independent medical evidence had been provided in this case. In the absence of that evidence, there was no basis upon which the panel could conclude that an adjournment would secure attendance on a future date.

16. Ms Atkin submitted that Ms Ebiegbe's absence was voluntary, that she had clearly indicated that the hearing could proceed, and that there was no realistic prospect that an adjournment would result in her attendance. She further submitted that the public interest in the fair, economical and expeditious resolution of allegations, the interests of witnesses who were present and ready to give evidence, and the proper use of hearing time weighed in favour of proceeding.

17. In conclusion, Ms Atkin submitted that, balancing the registrant's right to a fair hearing with the wider public interest, it was fair, proportionate and appropriate for the panel to proceed in the absence of Ms Ebiegbe.

18. The panel heard and accepted the advice of the legal adviser in relation to proceeding in the absence of the registrant. The legal adviser referred the panel to the point that, once service is established, the discretion to proceed is a judicial one which must be exercised with great care and caution. The panel must balance the registrant's right to a fair hearing against the wider public interest.

19. The panel was advised that, in accordance with Social Work England's Guidance on Service of Notices and Proceeding in the Absence of the Social Worker (December 2022), where proper notice has been given a panel may proceed provided it is satisfied that doing so is fair and proportionate. Relevant considerations include whether the absence is voluntary, whether there is a realistic prospect that an adjournment would secure attendance, and whether proceeding would result in unfairness.

20. The legal adviser referred the panel to the relevant authorities. In *R v Jones [2003] 1 AC 1*, the House of Lords confirmed that a registrant may waive the right to be present by voluntarily absenting themselves with knowledge of the hearing. In *Tait v Royal College of Veterinary Surgeons [2003] UKPC 34*, it was emphasised that the discretion must be exercised cautiously and with fairness at its centre. In *General Medical Council v Adeogba* and *General Medical Council v Visvardis [2016] EWCA Civ 162*, the Court of Appeal confirmed that there is no premium on non-attendance and that, where proper notice has been given and no good reason advanced for absence, it will usually be fair to proceed.

21. In relation to health grounds for postponement, the panel was advised that a mere assertion of ill health is insufficient. Objective and sufficiently detailed medical evidence is ordinarily required to explain the nature of the condition, its impact on

attendance or participation, and the likely duration of incapacity. The legal adviser referred to *General Medical Council v Hayat [2018] EWCA Civ 2796*, in which the Court of Appeal confirmed that unsupported medical assertions do not automatically render proceedings unfair and that the burden lies on the registrant to demonstrate that their health genuinely prevents participation.

22. The panel was further advised that it must weigh the registrant's right to attend against the public interest in public protection, maintaining confidence in the profession, and the expeditious disposal of proceedings. The panel must consider whether the registrant had been properly notified, whether there had been engagement, whether any substantiated application for adjournment had been made, and whether an adjournment would realistically secure attendance.

23. In reaching its determination to proceed in absence, the panel first considered whether service of the Notice of Hearing had been properly effected. Having reviewed the service bundle and the correspondence exhibited, the panel was satisfied that the Notice of Hearing and accompanying documentation had been sent to the email address held by Social Work England for Ms Ebiegbe. The panel noted that this was the same email address used by Ms Ebiegbe in recent communications with the regulator and its representatives, including correspondence shortly before the hearing. The panel was satisfied that reasonable steps had been taken to effect service in accordance with the Rules and that service had been properly established.

24. The panel considered whether it was fair and appropriate to proceed in Ms Ebiegbe's absence. The panel accepted the advice of the legal adviser and took into account Social Work England's Guidance on Service of Notices and Proceeding in the Absence of the Social Worker (December 2022), together with the authorities of *R v Jones [2003] 1 AC 1, Tait v Royal College of Veterinary Surgeons [2003] UKPC 34, General Medical Council v Adeogba; General Medical Council v Visvardis [2016] EWCA Civ 162*, and *General Medical Council v Hayat [2018] EWCA Civ 2796*.

25. The panel noted that Ms Ebiegbe had expressly indicated in correspondence that the hearing could proceed in her absence. She had not applied for an adjournment. Although reference had been made to health matters in correspondence, no independent or objective medical evidence had been provided to explain the nature of any condition, its impact on her ability to attend or participate, or the likely duration of any incapacity. In line with the guidance in *Hayat*, the panel was satisfied that a bare assertion of ill health, without supporting medical evidence, was insufficient to justify postponement.

26. The panel considered whether an adjournment would realistically secure Ms Ebiegbe's attendance on a future date. In the absence of any medical evidence or formal application for postponement, and given her clear indication that the matter could proceed without her, the panel concluded that there was no realistic prospect that an adjournment would result in her attendance. The panel was satisfied that her absence was voluntary in the legal sense described in Jones.

27. The panel balanced Ms Ebiegbe's right to attend and participate against the wider public interest. It took into account the public interest in the fair, economical and expeditious disposal of regulatory proceedings, the need to maintain public confidence in the profession and the regulatory process, and the interests of the witness who was present and ready to give evidence. The panel also considered the efficient use of hearing time and resources.

28. The panel was satisfied that proceeding in absence would not result in unfairness. It noted that Ms Ebiegbe had engaged with the regulatory process previously and that her written responses and reflections were before the panel and would be taken into account. The panel confirmed that no adverse inference would be drawn solely from her absence.

29. Having weighed all relevant factors carefully and exercising its discretion with the required caution, the panel concluded that it was fair, proportionate and in the public interest to proceed in the absence of Ms Ebiegbe.

Preliminary matters:

30. On behalf of Social Work England, Ms Atkin reminded the panel at the outset of the hearing of the provisions within the Social Work England the "FTS Rules 2019" concerning public and private hearings. She submitted that, pursuant to Rule 37, the general position is that hearings are to be held in public. However, she drew the panel's attention to Rule 38, which provides that a hearing, or part of a hearing, shall be held in private where the proceedings are considering the physical or mental health of the registered social worker. Ms Atkin indicated that certain documents within the hearing bundles refer to Ms Ebiegbe's health and that, to comply with the mandatory requirement of the Rules, any questioning or submissions that touch upon those matters should properly be heard in private session. She therefore proposed that, where health issues arose during the evidence, the panel move into private session for that limited purpose, before returning to public session thereafter.

31. On behalf of Social Work England, Ms Atkin made an application for Jayne Hodson, the witness called by Social Work England, to be supported during the hearing by her colleague, Mr George Mark-Bell.

32. Ms Atkin submitted that Ms Hodson would feel more comfortable giving her evidence if Mr Mark-Bell were permitted to remain present as a supporter. It was made clear that Mr Mark-Bell's role would be limited to that of a supportive presence only. He would not be giving evidence, would not intervene in proceedings, and would not communicate with Ms Hodson during the course of her evidence. His function would be solely to provide reassurance.

33. Ms Atkin further submitted that panels have a broad discretion to make reasonable case management decisions designed to facilitate a witness giving their best evidence, provided such measures are consistent with fairness. Allowing a witness to have a

supporter present is an accepted and proportionate step in regulatory proceedings where it assists participation without prejudicing the registrant.

34. It was additionally submitted that Mr Mark-Bell is a mutual colleague and is already aware of, and has been involved in, the health-related discussions about Ms Ebiegbe that are likely to be referred to during the hearing. In those circumstances, his presence during both public and private sessions would not introduce any new confidentiality concerns beyond those already inherent in the proceedings. Ms Atkin confirmed that Mr Mark-Bell understood the confidential nature of private sessions and the limits of his role.

35. It was proposed that Mr Mark-Bell be formally recognised as a witness supporter and be permitted to remain present during both the public and private parts of the hearing while Ms Hodson was giving evidence. Ms Atkin confirmed that he would keep his camera on so that Ms Hodson could see him for reassurance, but that he would not otherwise participate. Mr Mark-Bell would also be visible to the panel.

36. In those circumstances, Ms Atkin invited the panel to exercise its discretion to permit Mr George Mark-Bell to attend as a supporter for Ms Hodson during both the public and private sessions of the hearing.

37. The panel heard and accepted the advice of the legal adviser in relation to the request for a witness supporter.

38. The panel was advised that it has a discretionary power under Rule 32 of the Fitness to Practise Rules 2019 to regulate its own procedure, which includes permitting a witness to be accompanied by a colleague or other support person. The exercise of that discretion must be guided by principles of fairness and natural justice, ensuring that proceedings remain fair to all parties.

39. The legal adviser reminded the panel that it must balance the purpose of the requested support against considerations of procedural fairness. Relevant factors include whether the support is genuinely to assist the witness to give clear and accurate evidence, whether the presence of a supporter would create any unfair advantage or prejudice, and whether appropriate boundaries can be set to preserve the integrity of the process. The supporter must not act as an advocate, answer questions on behalf of the witness, or otherwise interfere with the panel's questioning.

40. The panel was further advised that allowing reasonable support can enhance fairness by enabling a witness to participate effectively, particularly where issues of anxiety, stress or health arise. However, there is no automatic entitlement for a supporter to remain during private sessions. The panel must consider confidentiality, the nature of the matters being discussed, and whether the supporter's presence remains appropriate.

41. The legal adviser concluded that any decision should be reasoned, proportionate and recorded, with clear limits placed on the role of the supporter if permission is granted.

42. The panel carefully considered Ms Atkin's application for Mr Mark-Bell to act as a supporter for Ms Hodson during her evidence, including during any private sessions of the hearing.

43. The panel accepted the advice of the legal adviser that it has a broad discretion under Rule 32 of the Fitness to Practise Rules 2019 to regulate its own procedure, including permitting a witness to be accompanied by a supporter, provided that doing so is fair and does not prejudice any party. The panel reminded itself that the discretion must be exercised carefully, balancing the need to facilitate the witness giving their best evidence against considerations of confidentiality, procedural integrity and fairness.

44. The panel noted that Ms Hodson requested the presence of Mr Mark-Bell for reassurance and moral support. It was made clear that his role would be limited to that of a supportive presence only. He would not give evidence, would not address the panel, and would not prompt or communicate with Ms Hodson during her evidence. The panel was satisfied that the purpose of the request was to assist the witness to give her evidence confidently and clearly, and not to confer any improper advantage.

45. The panel carefully considered whether Mr Mark-Bell's prior involvement in the matters under consideration created any unfairness. The panel noted that Mr Mark-Bell had been a colleague and line manager and had been present at meetings during the period of Ms Ebiegbe's employment where her health matters were discussed. It was clear from the documentation that he had knowledge of her health issues as they were known at the time. The panel accepted the submission that he would not have access to, nor be privy to, any subsequent medical information developed after Ms Ebiegbe left Rochdale Borough Council ("the Council"). The panel was satisfied that his knowledge was limited to matters already contained within the documentary record and discussed contemporaneously.

46. The panel considered whether the presence of Mr Mark-Bell during private sessions might prejudice the registrant's interests. It noted that the registrant was not in attendance and had not had the opportunity to object to the application. The panel was mindful of the need to protect confidential information and considered whether health matters could be neatly separated from other issues. Having reviewed the documentation and the explanation provided, the panel was satisfied that Mr Mark-Bell's knowledge of the relevant health matters at the time meant that his continued presence would not introduce any new confidentiality concerns beyond those already inherent in his prior involvement.

47. The panel also considered whether it was appropriate in principle for a senior practitioner to require a supporter. While the panel recognised that experienced professionals are ordinarily expected to give evidence independently, it acknowledged that regulatory proceedings can be stressful. The panel was satisfied that permitting a supporter in a clearly defined and limited role would assist the witness without undermining the integrity of the proceedings.

48. Having weighed all relevant factors, including fairness to the registrant, the witness's need for support, and the public interest in receiving clear and reliable evidence, the panel concluded that it was fair, proportionate and appropriate to permit Mr Mark-Bell to attend as a supporter for Ms Hodson.

49. The panel therefore granted the application. Mr Mark-Bell was permitted to remain present during both public and private sessions while Ms Hodson gave evidence, on the clear basis that he would act solely as a supporter and would not participate in the proceedings.

Allegations:

50. "*The allegation arising out of the regulatory concerns referred by the Case Examiners on 9 August 2022 is:*

1.Whilst registered as a social worker, and whilst employed by Rochdale Borough Council in the period between August 2019 and August 2020: With respect to:

a. Service User 4, you

i. did not progress a review / assessment adequately and/or in a timely way;

ii. did not maintain sufficiently detailed, and/or up to date, case records.

b. Service User 5, you

i. did not progress a review / assessment adequately and/or in a timely way:

ii. did not maintain sufficiently detailed, and/or up to date, case records;

iii. did not involve them in the review / assessment of their care and support needs, either adequately or at all.

c. Service User 6, you

i. did not progress an assessment adequately and/or in a timely way:

ii. did not maintain sufficiently detailed, and/or up to date, case records;

iii. did not involve them in decisions about their care and/or support, either adequately or at all;

iv. did not consider mental capacity and/or best interest decision making, either adequately or at all.

d. Service User 7, you

i. did not progress an assessment adequately and/or in a timely way;

ii. did not maintain sufficiently detailed, and/or up to date, case records;

iii. did not involve them in decisions about their care and/or support, either adequately or at all

iv. did not consider mental capacity and/or best interest decision making, either adequately or at all.

e. Service User 3, you

i. did not progress an assessment adequately and/or in a timely way;

ii. did not maintain sufficiently detailed, and/or up to date, case records;

iii. did not involve them in decisions about their care and/or support, either adequately or at all;

iv. did not consider mental capacity and/or best interest decision making, either adequately or at all.

Service User 1, you

i. did not progress an assessment adequately and/or in a timely way;

ii. ii. did not maintain sufficiently detailed, and/or up to date, case records;

iii. did not adequately involve them in the assessment of their care and support needs;

iv. did not consider mental capacity and/or best interest decision making, either adequately or at all.

g. Service User 2, you

i. did not progress an assessment adequately and/or in a timely way;

ii. did not maintain sufficiently detailed case records;

iii. did not adequately involve them in the assessment of their care and support needs.

h. Service User 8, you

i. did not demonstrate independent decision-making and/or initiative when progressing a safeguarding enquiry;

ii. did not take sufficient steps to involve Service User 8 in the safeguarding enquiry in the period between 12 December 2019 and 29 January 2020.

2. You failed to analyse and/or respond to risk(s) to one or more service users by your conduct at 1(a)(i), and/or 1(c)(i), and/or 1(d)(i), and/or 1(e)(i), and/or 1(f)(i) and/or 1(g)(i).

3. You did not establish, and/or maintain, sufficient knowledge and skills with respect to the Council's 'ALLIS' system.

The matters as may be found proven at paragraphs 1 – 3 above amount to the statutory ground lack of competence and/or capability.

Your fitness to practise is impaired by reason of lack of competence and/or capability."

Admissions:

51. The panel noted that, although earlier during her engagement in the process Ms Ebiegbe had made certain expressions of acceptance within her correspondence and reflective statement, she had not made any formal admissions to the allegations. The panel therefore proceeded on the basis that all matters remained in dispute and required full consideration and determination on the evidence

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

Summary of evidence:

Social Work England Submissions:

53. Ms Atkin, on behalf of Social Work England, submitted that the concerns before the panel arose from Ms Ebiegbe's employment as a newly qualified social worker within the Adult Care Services Department of the Council. She noted that Social Work England received a referral from the Council on 14 August 2020 regarding Ms Ebiegbe, who at the time was known as Oghenerukevwe Udosen, also known as "Ruke" Udosen.

54. Ms Atkin reminded the panel that Ms Ebiegbe commenced employment with the Council on 19 August 2019 on a part-time basis, working three days per week, Monday to Wednesday. She was placed on the Council's Assessed and Supported Year in Employment (ASYE) programme, designed to provide additional support to newly qualified social workers. She completed an induction programme which included opportunities to meet with her line manager, Ms Jayne Hodson, complete e-learning, and shadow other professionals. She also received IT training, including training on "Assessments & Action Plans" on 12 September 2019.

55. Ms Atkin further reminded the panel that, prior to commencing employment, Ms Ebiegbe had set out in her application form details of placements undertaken as part of her social work degree. She described experience of completing mental capacity assessments, working with older adults, hospital discharge planning and safeguarding, and working in pressurised environments where prioritisation of urgent cases was required. She also indicated that she was adaptable and competent in using IT systems. Social Work England submitted that these matters were relevant to the panel's consideration of expectations of competence and awareness, including the Mental Capacity Act.

56. Ms Atkin explained that in September 2019 Ms Ebiegbe was allocated six cases, including those of Service Users 4, 5, 6, 7 and 3. In October 2019 she was allocated a further four cases, including Service Users 1 and 2. She was not allocated new cases in November 2019, but in December 2019 she was allocated a Safeguarding Enquiry concerning Service User 8.

57. During Ms Ebiegbe's first formal supervision with Ms Hodson on 21 October 2019, it was recorded that she felt she was settling into the role. However, a number of actions were identified across multiple cases. These included ensuring case notes were up to date and completing Care Act Assessments in relation to Service Users 4, 5, 6, 7 and 3. In relation to the more recent allocations of Service Users 1 and 2, actions were agreed to undertake Care Act Assessments.

58. At the subsequent supervision on 18 November 2019, actions identified at the previous supervision remained outstanding. The same action points persisted in relation to Service Users 4, 5 and 7. Draft assessments had been produced in relation to Service Users 6 and 3, but amendments were required and not all actions had been progressed. Although visits had been undertaken to Service Users 1 and 2, Care Act Assessments had still not been completed.

59. By the supervision of 23 December 2019, due to ongoing concerns about Ms Ebiegbe's work, she was placed on an informal action plan. She was encouraged to speak up if she was struggling and to consult with her line manager and management team where required. The action plan set out specific tasks for each service user to be completed by 8 January 2020, and it was reviewed at supervision on 22 January 2020. Ms Atkin submitted that this demonstrated that support and structured guidance were provided.

60. Ms Atkin submitted that the concerns did not resolve. When Ms Ebiegbe went on leave in or around February 2020, Ms Hodson undertook audits of the eight remaining cases allocated to her. Following her return from leave, Ms Ebiegbe was suspended on or around 9 March 2020 pending investigation into concerns that she had failed to adequately fulfil her duties and responsibilities as a social worker. A formal probation hearing took place on 31 July 2020, and her last working day at the Council was confirmed as 3 August 2020.

61. Turning to the substance of the allegations, Ms Atkin structured her submissions around the eight service users whose cases underpin the factual particulars. She submitted that across the majority of those cases common themes emerged: failure to progress reviews and Care Act Assessments adequately or in a timely manner; failure to maintain sufficiently detailed and up-to-date case records; failure to appropriately involve service users in assessments and care planning; failure to consider and document mental capacity and best interests decision-making where required; and lack of independent initiative.

62. In relation to Service Users 4 and 5, both residing in supported accommodation, Ms Atkin submitted that the work required was described as non-complex review work. Despite assessment visits being undertaken, the visits were not written up for a significant period and draft assessments required improvement due to insufficient detail. There was limited recorded evidence of meaningful involvement of the service users.

63. For Service Users 6 and 3, who presented with issues including homelessness risk, substance misuse, financial vulnerability and mental health concerns, Ms Atkin submitted that assessments were not properly progressed, case notes were not entered contemporaneously, and there was no evidence of appropriate consideration of mental capacity despite the presenting circumstances.

64. In relation to Service User 7, Ms Atkin submitted that there was a delay in completing an assessment following allocation. It was later acknowledged that the delay represented a missed opportunity to put support in place which may have prevented deterioration. There were also concerns that discharge arrangements were progressed without reassessment, without adequate involvement of the service user, and without mental capacity consideration.

65. For Service User 1, recently discharged from hospital, and Service User 2, where there were concerns of self-neglect and fire risk, Ms Atkin submitted that there were delays in completing Care Act Assessments, inadequate documentation, and failures to consider the requirements of the Mental Capacity Act. In relation to Service User 2, despite safeguarding concerns and joint visits, assessments were incomplete and engagement was not sufficiently pursued.

66. In relation to Service User 8, Ms Atkin submitted that the concern centred on lack of independent decision-making and initiative in progressing a safeguarding enquiry. Ms Hodson's evidence was that actions were taken only following instruction and prompting, and that Ms Ebiegbe appeared ready to close the case without sufficient engagement.

67. Ms Atkin submitted that these cases represented the majority of Ms Ebiegbe's caseload during the relevant period and demonstrated a pattern of inadequate progression of assessments and reviews, insufficient analysis and response to risk, poor recording, and lack of independent initiative. She further submitted that Ms Ebiegbe failed to establish and maintain sufficient knowledge and skill in using the Council's IT recording system, evidenced by delayed uploads, incomplete records and rejected draft assessments.

68. Ms Atkin invited the panel to take into account that, whilst Ms Ebiegbe had not formally admitted each allegation, her reflective piece of June 2025 contained general acceptance of failings. In that reflection she acknowledged concerns about timeliness, communication, record keeping, consent, independent decision-making and risk assessment. Social Work England submitted that this supported the credibility of Ms Hodson's evidence and the contemporaneous documentation.

69. Ms Atkin emphasised the importance of contemporaneous service user records, supervision notes and audit findings, created close in time to events, and submitted that these should be afforded significant weight. She also reminded the panel that draft versions of assessments were not retained on the system, and that adequacy must

therefore be assessed by reference to audit evidence, supervisory feedback and case notes.

70. **[Private]**

71. In conclusion, Ms Atkin submitted that the chronology of supervision, action planning, audit and suspension, together with the contemporaneous documentary record and supervisory evidence, establish on the balance of probabilities that Ms Ebiegbe failed to adequately progress assessments and reviews, failed to maintain sufficient records, failed to involve service users appropriately, failed to consider mental capacity where required, and demonstrated insufficient independent initiative and IT competence. She invited the panel to find all the factual allegations proved on balance of probabilities and to conclude that those facts amount to lack of competence or capability.

Social worker's submissions:

72. The panel noted that it did not receive any submissions from Ms Ebiegbe for the purposes of this hearing. However, the panel acknowledged and took into careful consideration all previous correspondence received from Ms Ebiegbe throughout the regulatory process, including her written responses, reflective statement and evidence of engagement. The panel was satisfied that it had regard to her earlier representations and participation when reaching its findings, and ensured that her position, insofar as it had been articulated in prior communications, was properly considered in the determination.

Legal advice:

73. The panel heard and accepted the advice of the Legal Adviser in relation to its approach to findings of fact. The panel recognised that the advice was provided to assist it in applying the correct legal framework and that the responsibility for determining the facts remained entirely a matter for the panel's independent judgment.

74. The Legal Adviser reminded the panel that the burden of proof rests at all times on Social Work England. It is not for the registrant to prove or disprove any allegation. The applicable standard is the civil standard, namely the balance of probabilities. The panel must be satisfied that it is more likely than not that the alleged conduct occurred before making any finding of fact.

75. The panel was advised that each particular must be considered separately and on its own merits, whilst also evaluating the totality of the evidence. No allegation can be found proved unless, following a rigorous evaluation, the panel is satisfied that the evidence is cogent, reliable and sufficient to meet the civil standard.

76. The Legal Adviser further advised that in assessing the evidence the panel must consider all material before it, including oral testimony, written statements and contemporaneous documentary records. Particular weight may properly be attached to contemporaneous documents and objective records where available. The panel was

reminded to exercise caution when assessing witness demeanour and not to place undue reliance on confidence or presentation.

77. Finally, the Legal Adviser reminded the panel that its reasoning must be clear, logical and transparent, identifying the evidence relied upon and explaining the evaluative pathway to its conclusions, in accordance with principles of fairness and natural justice.

Finding and reasons on facts:

78. In reaching its findings of fact, the panel had regard to all of the evidence before it. This included the documentary exhibits provided by Social Work England, the oral evidence of the witness, the submissions made on behalf of Social Work England, and the correspondence and reflective material submitted by Ms Ebiegbe. The panel carefully considered the credibility and reliability of the witness, the consistency of the documentary evidence, and the context in which the events were said to have occurred. It applied the civil standard of proof, namely the balance of probabilities, and reached its conclusions only after a thorough evaluation of the totality of the evidence, ensuring that each particular was determined on its own merits and in light of the evidence as a whole.

79. The panel carefully assessed the evidence of Ms Hodson, (Jayne Hodson, Advanced Practitioner with the Council called by Social Work England). Taking into account both her detailed written statement and her oral testimony. The panel found Ms Hodson to be a credible and reliable witness. She gave her evidence in a clear, measured and cogent manner, and was able to respond directly and thoughtfully to the panel's questions. The panel did not discern any indication of exaggeration, defensiveness, or an improper motive. Her evidence was consistent with the contemporaneous documentation, including supervision records, audits and correspondence, and she was prepared to acknowledge contextual factors where appropriate. The panel was satisfied that Ms Hodson had undertaken thorough audits, had followed established processes, and had directed Ms Ebiegbe to opportunities for support and improvement. Overall, the panel considered Ms Hodson's written and oral evidence to be balanced, professional and grounded in the documentary record, and it attached significant weight to her account when reaching its findings.

80. The panel reminded itself that the burden of proof rested on Social Work England and that the standard was the balance of probabilities.

Allegation 1(a)(i) - service user 4

81. The panel had regard to the oral and written evidence of Ms Hodson, the contemporaneous supervision records, the case notes entered by Ms Ebiegbe, the informal action plan documentation, and the audit findings completed in February 2020.

82. Service User 4 was allocated to Ms Ebiegbe on 5 September 2019 for the purpose of conducting a review of existing support and updating the Care Act assessment. The evidence established that this was described as a non-complex piece of work. It required arranging a review with the provider, involving family or an advocate as appropriate, confirming whether the support continued to meet the service user's needs, and completing the necessary review documentation and updated assessment on the system. The panel accepted Ms Hodson's evidence that work of this nature was frequently allocated to non-qualified staff and could ordinarily be completed within a relatively short timeframe.

83. The panel found that although an initial attempt to arrange a visit was recorded on 19 September 2019 and a visit took place on 30 September 2019, the case note recording that visit was not entered until 18 November 2019. The panel considered that a delay of approximately seven weeks in recording a review visit was significant and fell below the standard expected of a reasonably competent social worker, particularly where accurate and contemporaneous record keeping was a basic professional requirement.

84. The panel further found that supervision on 21 October 2019 identified that the review and Care Act assessment had not been typed up and uploaded, and that case notes were not up to date. Similar concerns were recorded at supervision on 18 November 2019, at which point the assessment had been commenced but remained incomplete. The panel noted that the supervision records reflected repeated advice and clear action points, including the need to block out time to complete paperwork and prevent backlog. The repetition of these actions supported the conclusion that the work was not being progressed in a timely manner.

85. The panel also considered the content and quality of the assessment. The audit evidence demonstrated that the Care Act assessment was rejected due to insufficient detail, lack of flow, and failure to provide meaningful insight into the service user. Amendments were required, including adding further detail to the background section. Even after amendment and resubmission, the assessment was rejected again because of contradictory information regarding whether Service User 4 could be left alone safely. The panel noted that supervision records had previously stated that the service user could not be left alone due to safety concerns, whereas Ms Ebiegbe's case note stated that he could be left alone for a few hours each day. This inconsistency was material and required further clarification.

86. The panel accepted that Ms Ebiegbe later contacted the accommodation manager to clarify how long Service User 4 could be left alone and resubmitted the assessment. However, the overall chronology demonstrated that the review visit took place on 30 September 2019, yet the Care Act assessment was not written up and finalised on the system until early December 2019, and further work remained outstanding into January 2020. The audit also identified that required processes relating to transfer, closure and review scheduling had not been completed, necessitating intervention by Ms Hodson.

87. The panel considered Ms Hodson's evidence that although Service User 4 resided in supported living and there were no immediate unmet care needs, the statutory requirement to complete and record the review in a timely manner had not been met. The panel accepted that the delay of approximately three months between visit and completion of the assessment created a risk that changes in needs could have gone unidentified. The panel also accepted that the failure to complete the work resulted in additional workload for colleagues.

88. Having considered the totality of the evidence, the panel was satisfied on the balance of probabilities that Ms Ebiegbe did not progress the review and Care Act assessment of Service User 4 adequately and in a timely way. The delay in recording the visit, the repeated failure to complete and upload the assessment despite supervision and an action plan, the insufficient detail in draft assessments, and the contradictory information regarding the service user's ability to be left alone collectively demonstrated both inadequate progression and lack of timeliness.

89. **Accordingly, the panel found allegation 1(a)(i) proved on the balance of probabilities.**

Allegation 1(a)(ii)

90. The panel considered the contemporaneous case records, the supervision notes, the audit evidence and the written and oral evidence of Ms Hodson. The panel reminded itself that accurate and timely record keeping was a fundamental professional obligation for social workers and was essential to ensure continuity of care, accountability and safeguarding.

91. Service User 4 was allocated to Ms Ebiegbe on 5 September 2019. The first entry made by Ms Ebiegbe following allocation was dated 19 September 2019 and recorded an attempt to arrange a visit. The evidence established that a visit took place on 30 September 2019. However, the panel found that the case note documenting that visit was not entered onto the recording system until 18 November 2019. This represented a delay of approximately seven weeks, or around 50 days.

92. The panel accepted Ms Hodson's evidence that case notes should ordinarily be recorded within 48 hours and that a delay of this magnitude was significant. The panel found that such a delay undermined the reliability and usefulness of the record and fell below the standard expected of a reasonably competent social worker.

93. The panel further noted that during supervision on 21 October 2019, Ms Ebiegbe was specifically reminded to ensure that case notes following visits, discussions and meetings were uploaded with the relevant dates and times. Despite this clear action point, the visit of 30 September 2019 remained unrecorded until 18 November 2019, almost a month after the supervision discussion. The panel considered that this demonstrated not only a delay but a failure to act on direct managerial instruction.

94. In addition, the panel considered the content of the case note eventually entered. The record provided limited detail about the assessment discussion and lacked depth and analysis. The panel accepted the submission that the entry did not contain sufficient detail to demonstrate a comprehensive review of needs, particularly given the purpose of the visit was to update the Care Act assessment.

95. The panel therefore found that the case records were not maintained in a timely manner and were not sufficiently detailed. The delay in recording the visit, combined with the limited substance of the entry and the failure to comply with supervision directions, amounted to a failure to maintain sufficiently detailed and up to date case records.

96. **Accordingly, the panel found allegation 1(a)(ii) proved on the balance of probabilities.**

Allegation 1(b)(i) – Service User 5

97. The panel carefully considered the oral and documentary evidence relating to Service User 5.

98. Service User 5 was allocated to Ms Ebiegbe on 5 September 2019 for the purpose of conducting a care plan review and updating the Care Act assessment. Service User 5 resided in supported living accommodation and had learning disabilities. The evidence of Ms Hodson was that this was a non-complex piece of work. It required arranging and undertaking a review visit, involving relevant parties including the care provider and family where appropriate, and completing an updated assessment on the recording system. On the evidence before the panel, this was work that could reasonably have been completed within a short timeframe, particularly where no significant changes to support arrangements were anticipated.

99. The panel found that there was a delay in progressing the review following allocation. Although contact was initiated on 19 September 2019, the review visit did not take place until 30 September 2019, some 21 days after allocation. The panel accepted Ms Hodson's evidence that this was not in itself an acceptable timeframe for work of this nature, particularly given that the review was routine and non-complex.

100. More significantly, the panel found that there was a substantial delay in writing up the assessment. Although the review visit took place on 30 September 2019, the case note of that visit was not entered until 18 November 2019, and the Care Act assessment was not written up on the system until 23 December 2019. The panel accepted the evidence that the assessment should have been completed within approximately two weeks of the review visit. The three-month period taken to complete and record the assessment represented, in the panel's judgment, a significant and unjustified delay.

101. The panel also found that the assessment was not progressed adequately. The evidence demonstrated that the assessment was rejected due to insufficient detail and the need for additional information to provide a fuller picture of the service user's

background, strengths and needs. The panel accepted the evidence that further amendments were required before the assessment met the required standard. The panel also noted that, despite a recorded entry in January 2020 stating that the assessment had been updated and professional involvement would be ended, a subsequent entry in March 2020 indicated that the assessment was still in the process of being finalised. This inconsistency supported the conclusion that the work had not been progressed in a clear, complete or satisfactory manner.

102. The panel further accepted the evidence that there was no recorded evidence of meaningful attempts to involve Service User 5 in the review process. Given the statutory framework and professional standards requiring partnership working and involvement of the individual in their own care planning, the absence of evidence of such involvement supported the conclusion that the review was not progressed adequately.

103. The panel considered whether these failings might have been characterised as minor or administrative in nature. However, the cumulative effect of the delay in undertaking the review, the extended delay in writing up the assessment, the rejection of the draft for lack of detail, and the absence of evidence of service user involvement demonstrated a pattern of inadequate progression. The panel found that this was not an isolated oversight but a failure to complete allocated statutory work within a reasonable and professionally acceptable timeframe and standard.

104. Having weighed the totality of the evidence, including the contemporaneous case records, supervision notes and audit findings, the panel was satisfied that the evidence was cogent and reliable. The panel was satisfied on the balance of probabilities that Ms Ebiegbe did not progress the review/assessment of Service User 5 adequately and in a timely way.

105. **Accordingly, the panel found allegation 1(b)(i) proved on the balance of probabilities.**

Allegation 1(b)(ii)

106. The panel considered the contemporaneous case notes, the supervision records, the audit findings and the oral and written evidence of Ms Hodson. The panel reminded itself that accurate, contemporaneous and sufficiently detailed record keeping is a core professional obligation. Proper records ensure continuity of care, enable oversight and supervision, support safeguarding, and provide accountability for decision-making.

107. Service User 5 was allocated to Ms Ebiegbe on 5 September 2019. The first case note entered following allocation was dated 19 September 2019 and recorded an attempt to arrange a visit. The evidence established that a visit was subsequently arranged and took place on 30 September 2019. However, the panel found that the case note documenting that visit was not entered onto the system until 18 November 2019. This amounted to a delay of approximately 50 days.

108. The panel accepted the evidence that such a delay was significantly outside the expected timeframe for recording a statutory review visit. Case notes should ordinarily be recorded promptly, and certainly within a matter of days rather than weeks. A delay of this magnitude undermines the reliability and usefulness of the record, particularly where the visit formed part of a statutory Care Act review. The panel found that the record had not been kept up to date by Ms Ebiegbe.

109. The panel also considered the content of the case note eventually entered. It accepted the submission that the entry lacked sufficient detail to evidence a thorough review of Service User 5's needs. The note did not provide comprehensive analysis or demonstrate meaningful engagement with the service user's circumstances. Given that the purpose of the visit was to conduct a review and inform an updated assessment, the level of detail recorded fell below that expected of a reasonably competent social worker.

110. The panel further noted that during supervision on 21 October 2019, Service User 5's case was specifically discussed. Ms Ebiegbe was given a clear action to ensure that case notes following visits, discussions and meetings were uploaded onto the system with the relevant dates and times. Despite this explicit direction, the case note relating to the visit of 30 September 2019 remained outstanding until 18 November 2019, almost a month after that supervision session. The panel considered that this demonstrated not only a delay but a failure to act on clear managerial instruction.

111. The panel considered whether these shortcomings could properly be characterised as minor administrative oversights. It concluded that they could not. The delay was substantial, the record lacked sufficient detail, and the failure to update the system persisted despite supervision and clear action points. Taken together, these matters demonstrated that the case records were neither maintained in a timely manner nor sufficiently detailed to meet professional standards.

112. Having weighed the totality of the evidence, the panel was satisfied that the evidence was cogent and reliable. The panel was satisfied on the balance of probabilities that, in respect of Service User 5, Ms Ebiegbe did not maintain sufficiently detailed and/or up to date case records.

113. **Accordingly, the panel found allegation 1(b)(ii) proved on the balance of probabilities.**

Allegation 1(b)(iii)

114. The panel carefully considered the evidence relating to the involvement of Service User 5 in the review and assessment process.

115. The panel first considered the evidence of the review visit which took place on 30 September 2019. The case note subsequently entered indicated that Service User 5 was present and that some information was recorded about her communication needs, including that she used a notebook and had limited verbal communication. The panel

accepted that this demonstrated that Service User 5 was physically present during the visit and that there was at least some level of interaction.

116. In those circumstances, the panel was not satisfied that Social Work England had proved, on the balance of probabilities, that Ms Ebiegbe did not involve Service User 5 at all in the review or assessment. The documentation did not support a finding of complete absence of involvement. There was some reference to her communication and circumstances, and the panel could not properly conclude that there was no involvement whatsoever.

117. The panel then went on to consider whether Ms Ebiegbe involved Service User 5 adequately in the review and assessment of her care and support needs.

118. The panel noted that the case record of the visit was limited in content and did not clearly demonstrate how Service User 5's views were sought, how her communication needs were actively facilitated, or how her wishes and feelings informed the assessment. The record largely reflected information provided by staff and general descriptions of her care arrangements. There was no clear documentation of structured attempts to ascertain her views in a person-centred manner, nor was there evidence of advocacy involvement or exploration of how best to enable her participation, notwithstanding her limited verbal communication.

119. The panel also took into account that, after the visit on 30 September 2019, there was no recorded evidence of any further direct contact with Service User 5 for several months. The absence of any subsequent engagement or follow-up weighed significantly in the panel's assessment. The panel considered that involvement in assessment was not a single, isolated event but an ongoing process which should reflect meaningful engagement with the individual whose needs were being reviewed. The prolonged absence of further contact undermined any suggestion that Service User 5 had been adequately involved in the assessment process.

120. The panel considered the evidence of Ms Hodson, who stated that there was no evidence on file of attempts to involve Service User 5 and that the assessment process should have included working in partnership with the service user. The panel approached that opinion evidence with appropriate scrutiny but accepted that it was consistent with the documentary record, which lacked clear, contemporaneous evidence of meaningful engagement.

121. The panel also considered the submission that the documentation was limited and ambiguous. Although what could be considered "adequate" had not been expressly defined by Social Work England, the panel was satisfied that adequate involvement, particularly for a service user with learning disabilities and limited verbal communication, would reasonably have required clear documentation of how views were sought, how communication was facilitated, and how those views informed the assessment. That evidence was absent in this case.

122. The panel therefore concluded that, while there had been some minimal level of contact, Ms Ebiegbe did not involve Service User 5 in the review and assessment of her care and support needs in an adequate manner.

123. **Accordingly, the panel found allegation 1(b)(iii) proved on the basis that Ms Ebiegbe did not involve Service User 5 adequately in the review or assessment of her care and support needs. The panel did not find proved the alternative assertion that she did not involve Service User 5 at all.**

Allegation 1(c)(i) – Service User 6

124. The panel carefully considered the evidence relating to Service User 6.

125. The panel found that Service User 6 was allocated to Ms Ebiegbe in late September 2019 to complete a Care Act assessment and to explore support needs. At the point of allocation, the service user was residing beyond the permitted period at his accommodation and was at risk of becoming street homeless. There were additional concerns regarding substance use, housing options, and physical and mental health. The panel considered that this was therefore a case involving clear and potentially escalating risks which required timely and careful assessment.

126. The panel noted that an initial visit took place in early October 2019. However, the contemporaneous record of that visit contained no meaningful detail of what had been discussed, who was present, what risks had been identified, or what action plan was formulated. The absence of substantive recording at that stage significantly undermined the panel's confidence that the assessment process had been progressed adequately from the outset.

127. The panel further noted that, despite the urgency of the circumstances, the period from allocation to the assessment being sent for initial authorisation was approximately seven weeks. The assessment was subsequently rejected on two occasions before being authorised in early December 2019. The panel considered that a delay of this magnitude, in a case involving risk of homelessness and multiple vulnerabilities, was significant.

128. The panel accepted the evidence that the assessment drafts were rejected because they were not tailored to the individual needs of Service User 6. The information recorded was described as generalised, repetitive across domains, and in some instances left blank. There was a lack of personalisation and insufficient exploration of the relevant Care Act domains. The panel found that this demonstrated that the assessment did not sufficiently analyse the service user's specific risks, needs, strengths and outcomes. The fact that sections were left blank and information appeared copied or insufficiently individualised supported a finding that the assessment was not progressed adequately.

129. The panel also placed weight on the evidence that the case had been explicitly identified as requiring prioritisation due to Service User 6's risk of homelessness.

Despite this, there were delays in typing up the assessment, in progressing housing liaison, and in exploring care packages. Even after the assessment was authorised, further deficiencies arose in progressing the care plan, including incomplete documentation and delays in activating services.

130. The panel further noted that there was no evidence of further meaningful contact with Service User 6 after the initial visit in October 2019, nor clear documentation demonstrating that proposed support arrangements had been discussed with him or that consent had been obtained. In the panel's view, this reinforced the conclusion that the assessment process was not handled in a sufficiently thorough or person-centred manner.

131. The panel carefully considered whether these failings were solely matters of delay or whether they also reflected inadequacy. It concluded that they reflected both. The seven-week delay before initial authorisation, in the context of identified homelessness risk, was not reasonable. Moreover, the repeated rejection of the assessment drafts for lack of personalisation, insufficient exploration of risks and support needs, and incomplete sections demonstrated inadequacy in the quality of the assessment work.

132. The panel was satisfied that, taken together, the delays, the repeated rejection of draft assessments, the lack of detailed recording of risk exploration, and the absence of evidence of sufficient exploration of support needs established that Ms Ebiegbe did not progress the assessment of Service User 6 adequately and/or in a timely way.

133. **Accordingly, the panel found allegation 1(c)(i) proved on the balance of probabilities.**

Allegation 1(c)(ii)

134. The panel carefully considered the evidence relating to the maintenance of case records for Service User 6.

135. The panel found that an assessment visit to Service User 6 took place in early October 2019. However, Ms Ebiegbe did not record a substantive case note of that visit until later in October. When the entry was eventually made, it lacked sufficient detail. It did not clearly identify who was present at the visit, what was discussed, what risks were identified, what decisions were made, or what actions were agreed. The panel considered that these are fundamental elements of a contemporaneous social work record, particularly in a case involving risk of homelessness and complex needs.

136. The panel further noted that the case record did not demonstrate whether the proposed care and support arrangements had been discussed with Service User 6 or whether consent had been obtained in respect of the duration and frequency of support. The absence of such documentation was significant. In a statutory assessment under the Care Act, clear recording of the individual's involvement, the exploration of options, and the agreed plan is essential.

137. The panel also took into account that Ms Ebiegbe had been reminded on multiple occasions during supervision of the requirement to ensure that case notes were up to date. Despite those reminders, no additional detailed entry was made to properly reflect the content of the assessment visit. The audit evidence confirmed that there were no case notes adequately reflecting the assessment visit, including who was present, a summary of discussions, and an action plan moving forward. The panel considered that this demonstrated a sustained failure to maintain adequate records rather than an isolated oversight.

138. The panel placed weight on the further evidence that certain case notes appeared to mirror those of another service user residing in the same accommodation, with minimal alteration beyond a change of name. The panel regarded this as particularly concerning. Social work records must be individualised, accurate, and reflective of the specific circumstances of the person concerned. The replication of entries undermined confidence that the records were sufficiently detailed, tailored, or contemporaneous.

139. Having considered the totality of the evidence, the panel was satisfied that the case records in relation to Service User 6 were neither sufficiently detailed nor adequately maintained in a timely manner. The deficiencies were material and went to the substance of professional record-keeping obligations.

140. **Accordingly, the panel found allegation 1(c)(ii) proved on the balance of probabilities.**

Allegation 1(c)(iii)

141. The panel carefully considered the evidence relating to the involvement of Service User 6 in decisions about his care and support.

142. The panel first considered whether Ms Ebiegbe had failed to involve Service User 6 at all. The evidence established that Ms Ebiegbe undertook an initial visit in early October 2019. The panel was satisfied that this visit constituted some level of direct contact. In addition, Ms Ebiegbe accepted during the investigation that she had attempted to communicate with Service User 6, albeit often via the supported accommodation and his support worker. In those circumstances, the panel was not satisfied that Social Work England had proved that Service User 6 was not involved at all. There was some degree of contact and engagement, however limited.

143. The panel then turned to consider whether Service User 6 had been involved adequately.

144. The panel noted that the assessment documentation was criticised as lacking personalisation, containing repeated information across domains, and leaving sections incomplete. The assessment did not clearly articulate Service User 6's wishes, feelings, or desired outcomes. The panel accepted that a Care Act assessment must be person-centred and strengths-based, particularly where the service user presents with significant risks, including potential homelessness, substance misuse, and physical

and mental health concerns. The absence of tailored, individualised content undermined confidence that Service User 6's views had been meaningfully sought or reflected.

145. The panel also attached weight to the evidence that, following the initial visit in October 2019, there was no recorded direct contact between Ms Ebiegbe and Service User 6 for several months. During that period, key developments occurred, including the formulation of proposed support arrangements. The records indicated that Ms Ebiegbe sought information from a support worker, but there was no documentary evidence that she discussed the proposed care package directly with Service User 6, nor that she obtained or recorded his consent to the nature, frequency, or duration of the proposed support. The panel regarded this as a significant omission.

146. The panel further noted that the audit findings described Service User 6 as not being fully involved and identified deficiencies in recording his views, wishes and feelings. The scoring of the assessment as inadequate in that respect was consistent with the documentary record before the panel. While the panel approached that opinion evidence with appropriate scrutiny, it found it aligned with the absence of clear, contemporaneous evidence demonstrating meaningful engagement.

147. The panel took into account Ms Ebiegbe's explanation that communication was difficult because Service User 6 did not have his own mobile phone and that she therefore dealt with matters through his support worker. The panel accepted that practical difficulties may arise in engaging service users. However, the statutory framework requires active efforts to involve the individual in decisions affecting their care and support. The reliance on third parties, without clear documentation of attempts to facilitate direct engagement or to ascertain and record the service user's wishes, did not meet that standard.

148. The panel therefore concluded that, although there had been some limited contact with Service User 6, the evidence demonstrated that Ms Ebiegbe did not involve him adequately in decisions about his care and support.

149. **Accordingly, the panel found allegation 1(c)(iii) proved on the basis that the involvement was not adequate. The panel did not find proved the alternative assertion that Service User 6 was not involved at all.**

Allegation 1(c)(iv)

150. The panel carefully considered the evidence relating to the issue of mental capacity and best interests in respect of Service User 6.

151. The panel reminded itself that a social worker is expected to understand and apply the principles of the Mental Capacity Act 2005. Where there is evidence suggesting that a person may lack capacity in relation to a particular decision, a capacity assessment should be undertaken and clearly recorded, with a reasoned professional rationale. If a

person is found to lack capacity, any subsequent decision must be taken in their best interests and properly documented.

152. The panel noted that Service User 6 presented with a range of vulnerabilities at the point of allocation, including risk of homelessness, substance misuse, historical mental health difficulties including paranoid schizophrenia, and anxiety and depression. There were also concerns relating to financial management, including expenditure on alcohol and drugs. The panel considered that these matters were capable of engaging the need to consider mental capacity, particularly in relation to the management of finances and decisions about accommodation and care arrangements.

153. The panel further noted that, at allocation, mental capacity assessment in relation to finances had been identified as a matter for consideration. Despite this, there was no documented mental capacity assessment completed by Ms Ebiegbe. There was no recorded analysis of Service User 6's ability to understand, retain, weigh or communicate information relevant to specific decisions. Nor was there any documented rationale explaining why a capacity assessment was not required.

154. The panel also considered whether best interests decision-making had been addressed. It accepted that best interests considerations only arise where a person is assessed as lacking capacity in relation to a specific decision. However, the absence of any recorded consideration of capacity meant that there was no evidential basis upon which best interests reasoning could properly follow. The documentation did not demonstrate that Ms Ebiegbe had engaged with the statutory framework in any structured or reasoned way.

155. The panel took into account the discussion regarding Ms Ebiegbe's level of experience as a newly qualified social worker. It accepted that her knowledge may have been at a basic level. However, the panel was satisfied that even at a foundational level, a social worker would be expected to identify when mental capacity might require consideration, particularly in circumstances involving financial concerns, substance misuse, significant vulnerability, and proposed care interventions. The panel also noted that Ms Ebiegbe had been directed to consider this issue and had access to relevant policy and supervision support.

156. There was no evidence before the panel that Ms Ebiegbe undertook a mental capacity assessment, recorded a structured consideration of capacity, or documented any best interests analysis. The absence of any such documentation, in circumstances where the issue had been flagged and where the service user's presentation gave rise to legitimate questions about decision-making ability, led the panel to conclude that the statutory requirements had not been addressed.

157. The panel therefore found, on the balance of probabilities, that Ms Ebiegbe did not consider mental capacity and/or best interest decision making in respect of Service User 6.

158. **Accordingly, the panel found allegation 1(c)(iv) proved on the balance of probabilities.**

Allegation 1(d)(i) – Service User 7

159. The panel carefully considered the evidence relating to Ms Ebiegbe's management of Service User 7's case.

160. The panel noted that Service User 7 was allocated to Ms Ebiegbe following a request for an assessment from his GP. The information available at allocation indicated significant concerns, including a diagnosis of dementia, regular alcohol intake, risk of falls, potential financial exploitation, and concerns expressed by family members. The panel accepted that these were serious matters requiring timely and structured assessment.

161. The evidence demonstrated that Ms Ebiegbe undertook a home visit on 16 October 2019. However, she did not record that visit or write up the Care Act assessment until 2 December 2019, more than six weeks later. During that period, there was no recorded evidence of meaningful case progression. The panel found that such a delay in documenting and progressing an assessment in a case involving dementia, falls risk and safeguarding concerns was unacceptable and fell below the standard expected.

162. The panel further noted that during supervision sessions in October and November 2019, Ms Ebiegbe was reminded of the need to complete the assessment and progress referrals, including consideration of reablement services and assistive technology. Despite this guidance, the agreed actions remained outstanding.

163. On 2 December 2019, the same day the assessment was written up, Ms Ebiegbe was informed that Service User 7 had been admitted to hospital and that his health had significantly deteriorated. The panel considered that this development materially altered the circumstances and required urgent reassessment and active discharge planning. However, the evidence demonstrated that no timely reassessment was undertaken. Ms Ebiegbe did not visit the hospital to reassess Service User 7's needs prior to discharge.

164. The panel was particularly concerned by the evidence that Service User 7 was discharged to a care home placement sourced by Ms Ebiegbe without her undertaking a hospital visit to reassess his needs. The evidence showed that the assessment on the system did not reflect his updated condition, and that no updated Care Act assessment had been completed. The panel accepted the evidence that discharge planning is a fundamental statutory responsibility and requires active reassessment, consultation and authorisation processes.

165. The panel also took into account that, at supervision in late December 2019, Ms Ebiegbe was explicitly directed to update the assessment, contact the ward, liaise with family, and ascertain what Service User 7 wanted. Despite this, she did not visit Service

User 7 until 21 January 2020. By the time of audit in early February 2020, an updated assessment had still not been completed.

166. The panel was satisfied that the cumulative effect of these delays was significant. There was a prolonged period between allocation and the first completed assessment; a further failure to act promptly when the service user's needs changed due to hospital admission; a delay in undertaking reassessment; and a failure to complete an updated assessment in accordance with statutory and internal requirements.

167. The panel accepted the evidence that Service User 7's needs had deteriorated and that earlier assessment and intervention may have mitigated risk. It found that Ms Ebiegbe did not take timely or adequate steps to assess and respond to those needs. The pattern demonstrated not a single isolated delay, but repeated failures to progress the case appropriately despite supervision, reminders and clear risk indicators.

168. Accordingly, the panel concluded that Ms Ebiegbe did not progress the assessment of Service User 7 adequately or in a timely way.

169. **The panel therefore found allegation 1(d)(i) proved on the balance of probabilities.**

Allegation 1(d)(ii)

170. The panel carefully considered the documentary evidence relating to Ms Ebiegbe's record keeping in respect of Service User 7.

171. The panel found that Ms Ebiegbe undertook a home visit to Service User 7 on 16 October 2019. However, she did not record that visit or complete the Care Act assessment until 2 December 2019, a delay of more than six weeks. During that period, the case notes contained no detailed contemporaneous account of the visit, the discussions held, the risks identified, or the actions proposed.

172. The panel noted that during supervision sessions in October and November 2019, Ms Ebiegbe had been specifically reminded to write up the Care Act assessment and progress the case. Despite these reminders, no timely or adequate entry was made. The eventual entry recorded in December 2019 did not provide a clear outcome of the home visit, did not set out a structured action plan, and did not clearly identify next steps.

173. The panel accepted the evidence of Ms Hodson that the case notes were assessed as inadequate against core professional standards of record keeping, because of their lack of clarity, explanation of actions taken or rationale, or identification of what would happen next. The panel was satisfied that the documentation did not clearly explain what had been done, by whom, or why. Nor did it provide a coherent and forward-looking plan.

174. The panel further noted that there was a period between early December and late December 2019 during which no entries were made by Ms Ebiegbe, notwithstanding

that Service User 7 had been admitted to hospital and that discharge planning was under consideration. Given the significant change in circumstances and the complexity of the case, the absence of contemporaneous recording during this period was particularly concerning.

175. When entries were made around late December, they did not clearly articulate Ms Ebiegbe's overall plan. It was not apparent from the case notes whether discharge home or to a care home was being pursued as the primary option, nor was there a clear record of structured decision-making. The lack of clarity in the documentation meant that another professional reviewing the file would not have had a coherent understanding of the rationale, decision-making process, or intended outcomes.

176. The panel considered that accurate, timely and detailed record keeping is a fundamental requirement of social work practice, particularly in cases involving dementia, safeguarding concerns, hospital admission and discharge planning. The deficiencies identified were not minor omissions but reflected sustained failures to maintain up to date and sufficiently detailed records.

177. Accordingly, the panel concluded that Ms Ebiegbe did not maintain sufficiently detailed and/or up to date case records in respect of Service User 7.

178. **The panel therefore found allegation 1(d)(ii) proved on the balance of probabilities.**

Allegation 1(d)(iii)

179. The panel carefully considered the evidence relating to Service User 7's involvement in decisions concerning his care, support and accommodation.

180. The panel accepted that assessments in adult social care must be person-centred and service user led. Proper practice requires the social worker to ascertain and record the individual's wishes, feelings, beliefs and preferences, and to ensure that those views inform decision-making, particularly in circumstances involving hospital admission and discharge planning.

181. The evidence demonstrated that following the home visit on 16 October 2019, Ms Ebiegbe did not maintain meaningful contact with Service User 7 for a substantial period. No contact or attempted contact was recorded between mid-October and late December 2019. During that time, Service User 7's needs escalated significantly, including admission to hospital in early December 2019.

182. The panel found that critical decisions were made during the hospital admission period, including discharge to a care home, extension of his stay, and subsequent discharge arrangements. The evidence showed that these decisions were made without Ms Ebiegbe undertaking a hospital visit to reassess his needs and without clear evidence that she had ascertained his wishes directly.

183. Although there was a record of a telephone call in late December 2019 in which Ms Ebiegbe spoke to Service User 7, the content of that conversation was limited to general matters such as his wellbeing. There was no documented evidence that she discussed with him his preferences regarding discharge, accommodation, or ongoing care arrangements. Nor was there any clear record that she sought to explore his views about returning home, notwithstanding that his family had indicated that he had previously expressed such a wish.

184. The panel noted that there was no recorded consideration of how Service User 7's dementia and fluctuating health may have impacted his ability to participate in decision-making, nor was there any documented attempt to assess or clarify his capacity in relation to accommodation and care decisions at the relevant time. The panel accepted that meaningful engagement in such circumstances would ordinarily require direct discussion, and, where necessary, facilitation through hospital staff or other professionals if face-to-face access was difficult.

185. The panel was satisfied that Ms Ebiegbe had not taken sufficient steps to ensure that Service User 7's voice was central to the decision-making process. The absence of timely reassessment, the failure to conduct a hospital visit prior to discharge decisions, and the lack of documented consultation about his wishes demonstrated that his involvement was neither structured nor substantive.

186. The panel considered whether there had been any involvement at all. While there was evidence of limited contact in late December 2019, that contact did not address the key decisions being made about accommodation and care. The panel concluded that, in practical terms, Service User 7 was excluded from meaningful participation in decisions affecting his care and support.

187. Accordingly, the panel found that Ms Ebiegbe did not involve Service User 7 in decisions about his care and/or support.

188. The panel therefore found allegation 1(d)(iii) proved on the balance of probabilities.

Allegation 1(d)(iv)

189. The panel considered all of the evidence relating to the application of the Mental Capacity Act 2005 in respect of Service User 7.

190. The panel accepted that where there are concerns about a service user's cognitive functioning, understanding or exposure to risk, there is a statutory obligation to consider and apply the Mental Capacity Act 2005. Capacity is decision-specific and must be assessed where there is reason to doubt an individual's ability to understand, retain, weigh and communicate relevant information. Where a person lacks capacity in relation to a particular decision, any decision made on their behalf must follow the best interests framework and be properly documented.

191. The panel accepted the evidence of Ms Hodson that these principles are fundamental to social work practice and that Ms Ebiegbe, as a qualified social worker, would have been expected to understand and apply them. Ms Hodson stated that Ms Ebiegbe had access to local authority policy and guidance and that, in circumstances such as these, the Mental Capacity Act framework should have been actively considered and recorded.

192. The evidence demonstrated that Ms Ebiegbe was aware that Service User 7 had a diagnosis of Alzheimer's disease and experienced poor memory. The assessment also identified dementia, concerns about falls, alcohol misuse, vulnerability and potential financial exploitation. The panel was satisfied that these were clear indicators requiring active and recorded consideration of mental capacity, particularly in relation to decisions about hospital discharge, accommodation and care planning.

193. The panel found no evidence that Ms Ebiegbe undertook a mental capacity assessment in relation to Service User 7's accommodation, care arrangements or discharge from hospital. There was no documented professional rationale addressing whether he had capacity to decide where he should live or whether he understood and consented to placement in a care home. There was similarly no evidence that a best interests process was undertaken. Decisions were made to discharge Service User 7 to a care home and to extend his stay without reference to the statutory best interests framework, without recorded balancing of his wishes and feelings against identified risks, and without documented consideration of the relevant statutory factors.

194. The panel accepted Ms Hodson's evidence that the Mental Capacity Act should have been applied in these circumstances and found her evidence to be clear, consistent and supported by the documentary record. The absence of any reference to capacity assessment or best interests reasoning was not consistent with statutory compliance.

195. The panel was satisfied that this was not merely a case of inadequate documentation of a process that had occurred. Rather, the documentary record contained no indication that the statutory framework had been considered or applied at all.

196. In those circumstances, the panel concluded that Ms Ebiegbe did not consider mental capacity and/or best interest decision making in respect of Service User 7.

197. **The panel therefore found allegation 1(d)(iv) proved on the balance of probabilities**.

Allegation 1(e)(i) – Service User 3

198. The panel carefully considered all of the evidence relating to the progression of the Care Act assessment for Service User 3.

199. The panel found that Service User 3 was allocated to Ms Ebiegbe on 26 September 2019 to complete a Care Act assessment. Service User 3 was described as a vulnerable adult residing in supported accommodation, at risk of financial abuse, with additional concerns relating to drug and alcohol use and poor mental health. The panel accepted

that this was a case requiring timely and focused assessment, given the identified safeguarding risks and the potential risk of homelessness.

200. The evidence demonstrated that Ms Ebiegbe made initial contact on 4 October 2019 and she made a visit on 9 October 2019. However, the assessment was not uploaded for managerial approval until 12 November 2019, approximately five weeks after the visit. The panel noted that during this period there were repeated prompts and supervision discussions identifying the need to complete the Care Act assessment, write up case notes and undertake a Mental Capacity Assessment for finances. On 1 November 2019, Ms Ebiegbe was specifically asked to prioritise the case following concerns raised by external professionals about potential homelessness.

201. Despite these clear prompts and the recognised urgency of the situation, the assessment was not progressed promptly. The panel considered that a five-week delay in uploading the assessment, particularly in a case involving risk of homelessness and financial vulnerability, was excessive and not consistent with reasonable professional standards.

202. The panel further found that when the assessment was eventually submitted, it was rejected by Ms Hodson. The evidence of Ms Hodson, which the panel accepted as clear and credible, was that the assessment was basic, lacked person-centred detail, contained information that appeared to be copied and pasted, and did not clearly demonstrate that care and support options had been discussed with the service user. The assessment required amendment following managerial feedback. Supervision records indicated that Ms Hodson had to sit with Ms Ebiegbe and provide detailed guidance about what was expected.

203. The panel found that these deficiencies went beyond minor drafting issues. The lack of tailored, individualised content and the apparent replication of material from another service user's assessment demonstrated inadequate exploration of Service User 3's specific risks and support needs. In a case involving potential financial abuse, substance misuse and mental health concerns, a thorough, person-centred assessment was essential to inform safe and effective support planning.

204. Although the assessment was eventually approved in mid-December 2019, the panel noted that further delays occurred in progressing the care package. As at late December 2019, care agencies were only just being explored. The case audit identified that, despite completion of the assessment, Ms Ebiegbe was still consulting the key worker about what support was required, suggesting that the service user's needs had not been clearly identified through her own assessment. Subsequent entries demonstrated that care plans required amendment and were rejected due to incomplete cost and eligibility documentation. Ultimately, the case had to be reallocated for completion, and a full review was required because the level of support needed was not clear from the work undertaken by Ms Ebiegbe.

205. The panel accepted Ms Hodson's evidence that the delay in assessment, delay in support provision and delay in recording were significant factors in this case, particularly given the service user's vulnerability and risk of homelessness. The panel found that the pattern of delay, rejection of assessments for lack of adequate detail, and the need for substantial managerial intervention demonstrated that the assessment had not been progressed either adequately or in a timely way.

206. Taking all of the evidence together, the panel was satisfied that Social Work England had proved on the balance of probabilities that Ms Ebiegbe did not progress the assessment of Service User 3 adequately and/or in a timely way.

207. **Accordingly, the panel found allegation 1(e)(i) proved on the balance of probabilities.**

Allegation 1(e)(ii)

208. The panel carefully considered all of the evidence relating to the standard and timeliness of Ms Ebiegbe's record keeping in respect of Service User 3.

209. The evidence established that Ms Ebiegbe undertook a Care Act assessment visit with Service User 3 on 9 October 2019. An entry was made on 11 October 2019. However, that entry did not set out what had occurred during the visit. It did not record who was present, what was discussed, what risks were identified, what views were expressed by the service user, or what actions were agreed. The entry contained no substantive summary of the assessment discussion.

210. The panel accepted Ms Hodson's evidence that case notes should ordinarily be recorded within 48 hours of contact, in accordance with case recording policy. Although an entry was made shortly after the visit, the panel found that the content of that entry was so lacking in detail that it did not amount to an adequate record of the visit. The mere fact that a note was entered did not satisfy the requirement to maintain sufficiently detailed records.

211. The panel further noted that, despite supervision discussions on multiple occasions in October, November and December 2019 reminding Ms Ebiegbe of the need to ensure case notes were up to date, no further entry was made to expand upon or properly document the outcome of the 9 October 2019 visit. There remained no clear record of the assessment findings or agreed next steps. The absence of any substantive follow-up documentation, despite explicit managerial direction, reinforced the panel's conclusion that the records were not sufficiently detailed.

212. The panel also considered the audit findings which described the case notes as unclear and difficult to follow. That assessment was consistent with the panel's own review of the chronology and content of the records. The lack of clarity as to what had been done, by whom, and why, undermined the integrity of the case management process and impeded continuity of care.

213. In addition, the panel took into account the evidence that certain case notes relating to Service User 3 appeared to mirror those of another service user residing in the same accommodation, with minimal differentiation beyond a change of name. The panel found that this raised further concerns about the quality and individualisation of the record keeping. Case recording should be person-centred and specific to the individual circumstances of each service user. The mirroring of entries suggested a lack of tailored documentation and diminished confidence that the records accurately reflected the work undertaken.

214. Taking all of this evidence together, the panel was satisfied that Ms Ebiegbe did not maintain sufficiently detailed case records in relation to Service User 3. The records did not adequately capture the content or outcome of key visits, were not meaningfully updated despite repeated managerial direction, and lacked clarity and person-centred detail.

215. **Accordingly, the panel found allegation 1(e)(ii) proved on the balance of probabilities.**

Allegation 1(e)(iii)

216. The panel carefully considered the evidence relating to Ms Ebiegbe's involvement of Service User 3 in decisions concerning his care and support.

217. The panel noted that Service User 3 was described as a vulnerable adult residing in supported accommodation, with identified risks including financial exploitation, substance misuse and poor mental health. In such circumstances, meaningful and person-centred involvement in assessment and care planning was a fundamental aspect of safe and lawful practice.

218. The panel accepted Ms Hodson's evidence that the Care Act assessment prepared by Ms Ebiegbe was very basic, lacked specific and person-centred information, and appeared to contain material copied and pasted from other assessments. The panel found this evidence to be consistent with the documentary record. The assessment did not clearly demonstrate that care and support options had been discussed with Service User 3, nor did it record his wishes and preferences in any structured or personalised way.

219. The panel further noted Ms Hodson's evidence that there was little indication that Ms Ebiegbe re-visited Service User 3 or maintained ongoing contact with him. The case records showed that following the initial visit in October 2019, there was no evidence of direct contact or attempted contact with Service User 3 up to February 2020. Instead, information was sought predominantly through his support worker. The panel considered that while consultation with support staff may form part of good practice, it cannot substitute for direct engagement with the individual whose care and support are being determined, particularly in the absence of documented reasons why direct involvement was not possible.

220. The panel also found that there was no evidence that Ms Ebiegbe discussed with Service User 3 the proposal that he would receive support from a particular care provider, nor was there evidence that he was consulted about the frequency or timing of that support. The fact that Service User 3 was later recorded as being unaware that a provider would be visiting him strongly supported the conclusion that he had not been meaningfully involved in those decisions.

221. The panel took into account Ms Ebiegbe's response during the investigation, in which she stated that communication had been difficult and that she had resorted to dealing with Service User 3 through his support worker. The panel accepted that practical difficulties may arise in community practice. However, such challenges do not displace the statutory and professional obligation to involve service users in decisions about their own care. The panel was satisfied that reliance on intermediaries, without evidence of structured attempts to engage Service User 3 directly or to document efforts made to facilitate his involvement, fell below the standard required.

222. The panel also accepted Ms Hodson's audit findings that Service User 3 was not fully involved and that the recording failed to clearly state his views, wishes, feelings and beliefs. The audit scoring indicated that significant elements of person-centred practice were missing. The panel found that assessment to be consistent with the absence of documented engagement and the mirrored nature of the case notes.

223. The panel was not satisfied that Social Work England had proved that Service User 3 was not involved at all, as an initial visit did take place and there was some level of contact at that stage. However, the panel was satisfied that the involvement was not adequate. The absence of sustained contact, the failure to document Service User 3's views in a meaningful way, the reliance on support staff without recorded justification, and the lack of consultation regarding care arrangements collectively demonstrated that Ms Ebiegbe did not work in partnership with him in decisions about his care and support.

224. **Accordingly, the panel found allegation 1(e)(iii) proved on the balance of probabilities**.

Allegation 1(e)(iv)

225. The panel considered all of the evidence relating to whether Ms Ebiegbe addressed issues of mental capacity and best interests in respect of Service User 3.

226. The panel accepted the unchallenged evidence of Ms Hodson that where there are concerns regarding a service user's understanding and exposure to risk, it is a statutory duty to apply the legislative framework of the Mental Capacity Act 2005. Ms Hodson explained that capacity is decision-specific and that, where there is reason to doubt a person's ability to understand, retain, weigh and communicate relevant information, a formal assessment must be undertaken and clearly recorded. If a person is found to lack capacity in relation to a specific decision, any decision made on their behalf must

follow the best interests framework. The panel accepted her evidence that these principles are fundamental aspects of social work practice and that Ms Ebiegbe would have been expected to understand them upon qualification and through access to local authority policy and supervision.

227. The panel noted that Service User 3 was identified as a vulnerable adult with concerns relating to financial exploitation, substance misuse, poor mental health and reported threats of suicide. The panel considered that these were clear indicators that capacity, particularly in relation to management of finances and personal safety, required active consideration. The evidence demonstrated that Ms Ebiegbe was expressly advised during supervision to complete a Mental Capacity Assessment in relation to finances. This instruction was reiterated on more than one occasion.

228. Despite those explicit prompts and the identified risks, the panel found no evidence within the case records that Ms Ebiegbe undertook a Mental Capacity Assessment in relation to Service User 3. There was no documented exploration of his understanding of financial management, no recorded analysis of his ability to make decisions regarding his care and support, and no professional rationale addressing whether he had or lacked capacity in relation to any specific decision.

229. The panel also found no evidence that a best interests process was initiated or considered. In circumstances where concerns had been raised about financial abuse and vulnerability, and where a Mental Capacity Assessment had been specifically advised, the absence of any documented application of the statutory framework was significant. The audit evidence confirmed that there was no recorded consideration of mental capacity and no reference to the required process, despite this having been discussed in supervision.

230. The panel was satisfied that this was not merely a matter of incomplete recording. The repeated supervisory instructions to complete an MCA, coupled with the absence of any corresponding assessment or recorded rationale, demonstrated that the statutory framework had not been applied in practice.

231. In those circumstances, the panel concluded that Ms Ebiegbe did not consider mental capacity and/or best interest decision making in respect of Service User 3.

232. **Accordingly, the panel found allegation 1(e)(iv) proved on the balance of probabilities.**

Allegation 1(f)(i) – Service User 1

233. The panel considered all of the evidence relating to the progression of the assessment for Service User 1.

234. The panel found that Service User 1's case was allocated to Ms Ebiegbe on 3 October 2019 for the purpose of completing a Care Act assessment to determine eligibility for care and support. At the time of allocation, Service User 1 had recently been

discharged from hospital. The information available at allocation identified that she had dementia, that her condition had worsened following infection, that she had fallen since discharge, and that her savings had reduced below the funding threshold. There were therefore both care and financial considerations requiring timely assessment and progression.

235. Ms Ebiegbe arranged a visit for late October 2019, which took place. However, the panel found that no detailed record of that visit was entered contemporaneously. There was no substantive case note between late October and early December 2019. The written Care Act assessment was not completed and uploaded until early December 2019, more than five weeks after the visit and approximately two months after allocation.

236. The panel accepted the evidence of Ms Hodson that, in supervision on 21 October 2019, Ms Ebiegbe had been advised to complete the visit, write up the assessment and send it for approval. By the next supervision on 18 November 2019, the Care Act assessment and Eligibility Letter remained outstanding. Ms Ebiegbe was advised to undertake a further home visit if required, maintain contact with Service User 1 and her daughter, and initiate a referral to the Assessments and Benefits Team given that Service User 1 was no longer able to self-fund.

237. Despite these clear instructions, the panel found that the assessment was not written up until early December 2019. Furthermore, following completion of the assessment, the further actions identified in supervision were not progressed in a timely manner. There was no evidence of maintained contact with Service User 1 or her daughter until the end of December 2019. The referral to the Assessments and Benefits Team was not initiated until early January 2020, and the eligibility letter remained in draft form when Ms Ebiegbe's involvement ceased.

238. The panel accepted Ms Hodson's evidence that there was a significant delay in assessing Service User 1's needs and completing the written documentation. The panel considered that this was not a minor administrative delay but a prolonged failure to progress a case involving a vulnerable adult with dementia, recent hospital discharge, financial uncertainty and a history of falls.

239. The panel further accepted Ms Hodson's evidence as to impact. The delay created a risk of financial detriment, including potential debt accumulation and deprivation of assets, and delayed the formal confirmation of eligibility and support arrangements. The panel noted that when the case was reallocated, the outstanding work was completed within a short period, which underscored that the tasks could reasonably have been progressed more promptly.

240. Taking all of the evidence together, the panel was satisfied that Ms Ebiegbe did not prepare the assessment until approximately two months after allocation and did not write up the assessment until more than five weeks after the visit. The panel concluded that the assessment was not progressed adequately or in a timely manner.

241. **Accordingly, the panel found allegation 1(f)(i) proved on the balance of probabilities.**

Allegation 1(f)(ii)

242. The panel considered all of the evidence relating to Ms Ebiegbe's recording in respect of Service User 1.

243. The panel found that although Ms Ebiegbe undertook a home visit to Service User 1 in late October 2019, no detailed case note of that visit was recorded until early December 2019. This represented a delay of several weeks between the visit and the creation of any substantive written record.

244. The panel accepted the evidence that, during supervision on 21 October 2019 and again on 18 November 2019, Ms Ebiegbe had been reminded of the need to ensure that case notes were kept up to date. Although those reminders arose in discussion of other service users, the obligation to maintain contemporaneous and accurate records applied equally across her caseload. The panel was satisfied that Ms Ebiegbe was aware of the expectation that recording should be timely and comprehensive.

245. When the case note and Care Act assessment were eventually uploaded in early December 2019, the documentation was described as very brief and lacking in detail. The panel's own review of the evidence supported that characterisation. The entry did not provide a clear, structured account of what had occurred during the home visit, what information had been gathered, what analysis had been undertaken, or what actions were proposed. It did not demonstrate a comprehensive account of discussions with Service User 1 or her daughter, nor did it provide a sufficiently detailed rationale for decisions taken.

246. The panel considered that timely and detailed recording is a fundamental aspect of safe social work practice. It ensures continuity of care, supports transparency in decision-making, and provides an audit trail in circumstances where a service user's needs may change. In this case, Service User 1 had dementia, had recently been discharged from hospital, and faced financial uncertainty. The absence of prompt and detailed recording in such circumstances was of particular concern.

247. The panel was satisfied that the delay of several weeks before recording the visit, coupled with the brevity and lack of detail in the eventual entry, demonstrated that Ms Ebiegbe did not maintain sufficiently detailed and/or up to date case records in respect of Service User 1.

248. **Accordingly, the panel found allegation 1(f)(ii) proved on the balance of probabilities.**

Allegation 1(f)(iii)

249. The panel considered all of the evidence relating to the extent to which Ms Ebiegbe involved Service User 1 in the assessment process.

250. The panel accepted that meaningful involvement of a service user in the assessment of care and support needs is a fundamental aspect of social work practice. This includes working in partnership with the individual, and where appropriate their family or next of kin, ensuring that the person's views, wishes and feelings are clearly ascertained and recorded, and considering whether mental capacity issues require exploration. The panel accepted Ms Hodson's evidence that it was paramount that Service User 1's needs were met appropriately and that her human rights were respected throughout the process.

251. The panel noted that Ms Ebiegbe conducted one home visit to Service User 1 in October 2019. However, the record of that visit was limited and did not clearly demonstrate the extent to which Service User 1's own views were sought, as opposed to reliance being placed primarily on information provided by her daughter. The documentation did not clearly articulate Service User 1's wishes, feelings or understanding of her circumstances.

252. The panel further found that there was no evidence of any further direct contact with Service User 1 between the initial visit and January 2020. Although Ms Ebiegbe was advised during supervision in November 2019 to undertake an additional home visit if necessary and to maintain contact with Service User 1 and her daughter, there was no evidence that such contact occurred until the end of December 2019, and that contact was with the daughter rather than Service User 1 herself.

253. The panel accepted Ms Hodson's audit findings that there had been only one visit, no consistent communication, and no clear reference to Service User 1's views, wishes and feelings within the records. The panel noted that Ms Hodson assessed this area as requiring improvement, indicating that whilst there was some limited involvement, significant aspects were missing or incomplete. The panel found that this assessment was consistent with the documentary evidence.

254. The panel was satisfied that adequate involvement would have required sustained engagement with Service User 1, clear documentation of her views and preferences, and continued communication during a period when her needs were changing and her financial situation was deteriorating. The absence of further direct contact, coupled with the limited and largely second-hand recording of information, demonstrated that Ms Ebiegbe did not adequately involve Service User 1 in the assessment of her care and support needs.

255. **Accordingly, the panel found allegation 1(f)(iii) proved on the balance of probabilities.**

Allegation 1(f)(iv)

256. The panel considered all of the evidence relating to the application of the Mental Capacity Act 2005 in respect of Service User 1.

257. The panel accepted the evidence of Ms Hodson that where there are concerns regarding a service user's understanding and exposure to risk, it is a statutory duty to consider and, where appropriate, apply the Mental Capacity Act framework. Capacity is decision-specific and requires an assessment where there is reason to doubt an individual's ability to understand, retain, weigh and communicate relevant information. If a person lacks capacity in relation to a particular decision, any decision taken on their behalf must follow the best interests framework. The panel further accepted that Ms Ebiegbe, as a qualified social worker, would have been expected to understand these requirements and had access to relevant policy and guidance.

258. The panel noted that at the point of allocation it was recorded that Service User 1 had dementia and that her condition had worsened following a recent infection. Ms Ebiegbe referred to the dementia during her visit. The panel considered that this information, coupled with the fact that significant decisions were required regarding care, funding and ongoing support, constituted a clear trigger for consideration of mental capacity in relation to care and accommodation decisions.

259. The panel found no evidence within the case records that Ms Ebiegbe undertook a mental capacity assessment in respect of Service User 1. There was no recorded analysis of whether Service User 1 was able to understand and make decisions about her long-term care arrangements, her finances, or the transition from self-funding to local authority support. There was similarly no documentation evidencing any professional rationale for concluding that a formal assessment was not required.

260. The panel also found no evidence that a best interests framework was applied. There was no recorded balancing of Service User 1's wishes, feelings, beliefs and values against identified risks, nor any structured decision-making process in circumstances where capacity may have been in doubt. The audit findings expressly identified no consideration of mental capacity or best interests, and the panel found that assessment to be consistent with the documentary record.

261. The panel attached weight to the fact that, once the case was reallocated, a mental capacity assessment and best interests process were undertaken by another social worker within a short period. The fact that capacity was subsequently formally assessed reinforced the panel's conclusion that consideration of the Mental Capacity Act had been required during Ms Ebiegbe's involvement. The panel did not accept that this was merely a matter of incomplete recording; rather, the absence of documentation indicated that the statutory framework had not been applied.

262. In those circumstances, the panel concluded that Ms Ebiegbe did not consider mental capacity and/or best interest decision making in respect of Service User 1.

263. **Accordingly, the panel found allegation 1(f)(iv) proved on the balance of probabilities.**

Allegation 1(g)(i) – Service User 2

264. The panel considered all of the evidence relating to Ms Ebiegbe's management of Service User 2's assessment.

265. The panel noted that Service User 2's case involved clear safeguarding concerns. Prior to formal allocation, Ms Ebiegbe had been directed to liaise with professionals due to the level of concern raised. The recorded management decision identified that urgent intervention from adult care might be required. The concerns included significant self-neglect and the condition of the property.

266. Ms Ebiegbe attempted a welfare visit on 9 October 2019 and recorded that Service User 2 was not at home. She observed through the window that the property was very unkempt, cluttered, and smoke-stained. These observations indicated potential fire risk and environmental neglect. The panel considered that such circumstances required prompt and structured assessment.

267. The case was formally allocated to Ms Ebiegbe on 10 October 2019 for completion of a Care Act assessment and consideration of a multi-agency approach. A further visit took place on 30 October 2019. Ms Ebiegbe recorded signs of neglect and expressed concerns regarding fire hazard due to clutter, although she noted that Service User 2 stated he was managing and agreed to be supported.

268. The panel found that despite the seriousness of the concerns, no typed Care Act assessment was recorded on the system until early December 2019. The assessment visit occurred on 30 October 2019, yet the written assessment was not uploaded for over a month. During supervision on 18 November 2019, Ms Ebiegbe was reminded that the Care Act assessment required writing up and that further steps could only be taken once the assessment was properly recorded.

269. The panel attached weight to Ms Hodson's evidence that, given the risks highlighted regarding the property condition and self-neglect, there was a lack of proactiveness and prioritisation. The panel accepted that while there was some contact with charities and support services, this did not substitute for a timely and comprehensive Care Act assessment. Without a completed and authorised assessment, risks could not be formally analysed, eligibility determined, or structured support put in place.

270. The panel further found that when the assessment was eventually submitted, it lacked sufficient detail. Ms Hodson rejected the assessment on the basis that it did not sufficiently reflect the information obtained during the visit, did not adequately explore Service User 2's background, strengths, and difficulties, and did not provide the level of detail required. The panel accepted that approval could not be granted where sections were incomplete or insufficiently detailed. Amendments were required before the assessment was eventually approved in January 2020.

271. In considering timeliness, the panel was aware that there was a delay of approximately two months from allocation to a completed and approvable assessment. In circumstances involving self-neglect and potential fire hazard, the panel considered that this delay was significant. The need for a multi-agency response had been identified early, yet progression was dependent upon a properly completed assessment, which was not achieved within a reasonable timeframe.

272. In considering adequacy, the panel accepted Ms Hodson's evidence that the initial draft lacked detail, used basic phrasing, and failed to embed the substance of what had been observed and discussed during the home visit. The panel found that this was not a minor drafting issue but reflected a failure to fully analyse and record the risks and support needs identified.

273. Taking all of the evidence together, the panel was satisfied that Ms Ebiegbe did not progress the assessment of Service User 2 adequately and/or in a timely way.

274. **Accordingly, the panel found allegation 1(g)(i) proved on the balance of probabilities.**

Allegation 1(g)(ii) – Service User 2

275. The panel considered all of the evidence relating to the quality and sufficiency of Ms Ebiegbe's case recording for Service User 2.

276. The panel noted that the concerns relating to Service User 2 were serious and included self-neglect, significant clutter within the home, and potential fire hazards. In such circumstances, accurate, detailed and analytical case recording was essential to ensure that risks were properly identified, monitored and managed, and that decision-making could be understood and scrutinised.

277. The audit undertaken by Ms Hodson assessed the quality of Ms Ebiegbe's recording against a number of professional criteria. Ms Ebiegbe was scored at a level indicating that improvement was required in respect of explaining what had been done and why, ensuring that entries were based on fact rather than opinion, and ensuring that records were logical and concise. Ms Hodson explained that such a score reflected that significant aspects of recording were missing or incomplete, even if the record was not wholly unsatisfactory.

278. The panel attached weight to Ms Hodson's evidence that the case notes contained very brief references to actions taken, with limited explanation of the rationale for those actions. The panel accepted that in a case involving safeguarding concerns and environmental risk, it was not sufficient to record observations in isolation. The professional reasoning underpinning decisions, next steps, and planned interventions required clear articulation.

279. The panel further noted the evidence that the case notes were brief and required more detail, including clearer summaries of next actions and the practitioner's plan moving

forward. The absence of structured forward planning within the record reduced transparency and undermined the ability of colleagues or managers to understand the trajectory of the case.

280. Whilst there was some evidence of engagement and some recording of observed conditions within the property, the panel was satisfied that Ms Ebiegbe's recording did not sufficiently explain why particular actions were taken, how risks were being evaluated, or what the intended outcomes were. The panel considered that this fell below the standard expected of a reasonably competent social worker managing a case involving self-neglect and potential fire hazard.

281. Taking the evidence as a whole, the panel concluded that Ms Ebiegbe did not maintain sufficiently detailed case records in respect of Service User 2.

282. **Accordingly, the panel found allegation 1(g)(ii) proved on the balance of probabilities.**

Allegation 1(g)(iii)

283. The panel considered all of the evidence relating to Ms Ebiegbe's involvement of Service User 2 in the assessment process.

284. The panel accepted that Service User 2 presented with significant concerns, including self-neglect, environmental hazards within the property and potential fire risk. In such circumstances, meaningful and sustained engagement was essential to ensure that his wishes, understanding, and capacity to manage risk were properly explored, and that any intervention was proportionate and person-centred.

285. The evidence demonstrated that a home visit took place on 30 October 2019, during which Service User 2 agreed to be supported, notwithstanding his stated view that he was managing well. Subsequent entries showed that he engaged in further contact, including asking for assistance with obtaining a hoover, signing an authorisation letter, and permitting technical officers to attend his home. The panel therefore accepted that there was some level of engagement and that this was not a case of complete absence of involvement.

286. However, the panel found that engagement was not maintained or developed in a manner consistent with the level of risk identified. Ms Hodson's evidence was that, given the concerns about the condition of the property and the risks arising from it, there should have been further attempts to engage Service User 2 and to progress a multi-disciplinary approach. She advised that a professionals' meeting would have been beneficial to explore how risks could be managed. The panel accepted that evidence as measured, reasonable and consistent with good practice in safeguarding and self-neglect cases.

287. The panel noted that on 4 December 2019, Service User 2 stated that he did not want anybody coming into his home to "bother him" and that he could manage by himself.

The panel accepted that resistance to intervention can arise in self-neglect cases. However, the panel considered that a statement of this nature did not absolve Ms Ebiegbe of the responsibility to continue proportionate attempts at engagement, particularly where previously the service user had shown willingness to accept some support.

288. The panel attached weight to the evidence that there were no further attempts by Ms Ebiegbe to contact or re-engage Service User 2 between early December 2019 and early February 2020. In the context of identified environmental risk and concerns about self-neglect, the absence of further contact demonstrated a lack of persistence and partnership working. The panel accepted Ms Hodson's evidence that failure to undertake further attempts to engage amounted to a failure to work in partnership with the service user.

289. The panel was satisfied that adequate involvement required more than a single visit and limited follow-up. It required sustained engagement, exploration of ambivalence, and appropriate escalation where risks persisted. The evidence demonstrated that this did not occur.

290. Taking the evidence as a whole, the panel concluded that Ms Ebiegbe did not adequately involve Service User 2 in the assessment of his care and support needs.

291. **Accordingly, the panel found allegation 1(g)(iii) proved on the balance of probabilities.**

Allegation 1(h)(i) – Service User 8

292. The panel considered all of the evidence relating to Ms Ebiegbe's handling of the safeguarding enquiry concerning Service User 8.

293. The panel accepted that Service User 8 was allocated to Ms Ebiegbe on 12 December 2019 to undertake a Section 42 safeguarding enquiry in relation to concerns about frequent falls. The panel noted that this was Ms Ebiegbe's first safeguarding enquiry.

294. The panel carefully considered Ms Hodson's evidence that she was required to provide direction to Ms Ebiegbe at each stage of the enquiry. Ms Hodson stated that she had to instruct Ms Ebiegbe to make contact with the family and the care home, to gather relevant documentation, and to ascertain what safeguarding measures were in place. She further described sitting with Ms Ebiegbe to provide step-by-step guidance on completing the safeguarding action plan, risk assessment, chronology and protection planning documentation. The panel accepted that the documentary record demonstrated a high level of managerial instruction and oversight in progressing the enquiry.

295. The panel also considered the email sent by Ms Ebiegbe on 16 December 2019 in which she sought clarification regarding next steps, including whether to arrange a visit, whether she needed to undertake her own mental capacity assessment, and whether

to contact the service user's son. The panel regarded this email as demonstrating engagement with the case and a willingness to seek guidance. It did not interpret the request for support, in itself, as evidence of a lack of initiative. Indeed, in the context of a first safeguarding enquiry, seeking clarification was not unreasonable.

296. However, the panel distinguished between initiative and independent decision-making. While Ms Ebiegbe raised appropriate questions and followed instructions once given, the evidence demonstrated that key actions were largely prompted by her manager rather than identified and progressed autonomously. The safeguarding action plan, risk summary, and documentation were completed with direct managerial guidance as to what should be included. The panel was satisfied that the enquiry progressed primarily through directed instruction rather than through Ms Ebiegbe exercising her own professional judgement as to next steps.

297. The panel therefore concluded that, on the balance of probabilities, Ms Ebiegbe did not demonstrate independent decision-making when progressing the safeguarding enquiry.

298. In relation to initiative, however, the panel was not satisfied that the allegation was made out. The panel found that Ms Ebiegbe did take steps by sending an email to Ms Hodson seeking advice. She proposed contact with relevant parties, reviewed safeguarding information and sought clarification about capacity issues. In the context of her first safeguarding enquiry and her newly qualified status, the panel did not consider that the evidence established a failure of initiative. Rather, it demonstrated a need for support and supervision.

299. **Accordingly, the panel found allegation 1(h)(i) proved in relation to the absence of independent decision-making, but not proved in relation to a lack of initiative, on the balance of probabilities**.

Allegation 1(h)(ii)

300. The panel considered all of the evidence relating to Ms Ebiegbe's engagement with Service User 8 during the safeguarding enquiry.

301. The panel accepted that Service User 8 was allocated to Ms Ebiegbe on 12 December 2019 to undertake a safeguarding enquiry concerning frequent falls. The panel noted that, shortly after allocation, Ms Ebiegbe made contact with Service User 8 and recorded that she had spoken with her on 17 December 2019. On that occasion, Service User 8 stated that she was fine and happy at the home but was too sleepy to talk further. The panel accepted that this constituted an attempt to involve Service User 8 in the enquiry.

302. The panel further noted that there was no recorded further direct contact between 17 December 2019 and mid-January 2020, when Ms Ebiegbe indicated an intention to close the case. The panel recognised that there was then managerial oversight, following which Ms Ebiegbe arranged a further visit and attended on 3 February 2020.

During that visit, she attempted to engage Service User 8 again, but recorded that Service User 8 was unable to provide meaningful responses.

303. The panel carefully considered Ms Hodson's evidence, including her view that it would have been good practice for Ms Ebiegbe to have revisited Service User 8 sooner, potentially on an alternative day, to explore her presentation and understanding in more depth before progressing closure. The panel accepted that such further attempts may well have represented best practice in safeguarding work.

304. However, the panel was mindful that the allegation required it to determine whether Ms Ebiegbe had failed to take sufficient steps to involve Service User 8. The panel did not have before it any specific safeguarding policy, protocol, or prescribed timescale demonstrating that further contact within a defined period was mandatory. Nor was there evidence of an explicit managerial instruction requiring a further visit within a particular timeframe that was not complied with.

305. The panel was also satisfied that Ms Ebiegbe had taken a number of steps during the early stage of the enquiry, including liaising with relevant parties and making at least one direct attempt to speak with Service User 8. When concerns were raised by her manager in late January 2020, she acted upon that feedback and arranged a further visit. The evidence did not establish that she wholly failed to attempt involvement, but rather that her level of engagement may have fallen short of optimal or ideal practice.

306. The panel considered that there is a distinction between what would have been good or preferable practice and what amounts to a failure to take sufficient steps. In the absence of clear evidence that specific required actions were omitted, or that Ms Ebiegbe disregarded explicit instructions to engage further within the relevant period, the panel was not satisfied that Social Work England had discharged the burden of proving this particular on the balance of probabilities.

307. **Accordingly, the panel found allegation 1(h)(ii) not proved on the balance of probabilities.**

Allegation 2

You failed to analyse and/or respond to risk(s) to one or more service users by your conduct at 1(a)(i), and/or 1(c)(i), and/or 1(d)(i), and/or 1(e)(i), and/or 1(f)(i) and/or 1(g)(i).

308. The panel has considered with care the documentary and oral evidence, including the case audits and supervisory evidence of Ms Hodson, together with Ms Ebiegbe's reflective statement dated 22 June 2025.

309. The issue for the panel was whether the established failures to progress assessments and reviews adequately and/or in a timely manner amounted to a failure to analyse and/or respond to risk in respect of one or more service users. The panel is satisfied that they did.

310. The panel attached weight to Ms Ebiegbe's reflective statement in which she provided an acknowledgement and acceptance of shortcomings in relation to risk. She recognised that she did not always assess or respond to risk effectively or promptly and accepted that this could have resulted in delays in safeguarding interventions. She further acknowledged that her ability to assess and respond to risk did not meet the standard required to ensure that service users were fully protected. The panel did not treat these reflections as determinative of the facts; however, they are consistent with and supportive of the documentary and supervisory evidence before it.

311. In relation to Service User 4, the assessment completed by Ms Ebiegbe was rejected because it contained contradictory information regarding whether the individual could safely be left alone. The panel considers that internal inconsistency on a central safeguarding issue demonstrates a failure to analyse risk adequately. A risk assessment which presents conflicting conclusions about a service user's safety cannot properly inform care planning or risk mitigation. The failure to reconcile that contradiction and to produce a clear, coherent analysis amounted to a failure to analyse and respond appropriately to risk.

312. In respect of Service User 6, there were significant delays in assessment, recording and the provision of care and support. Evidence identified a risk of homelessness arising from those delays. The panel accepts that homelessness constitutes a serious and foreseeable harm. In circumstances where such a risk is present, a social worker is required to explore relevant assessment domains thoroughly and to progress intervention in a timely and proportionate manner. The failure to do so meant that the identified risk was neither properly analysed nor addressed, thereby prolonging exposure to potential harm.

313. With regard to Service User 7, care and support needs relating to maintaining a habitable home, nutritional needs and personal hygiene were identified, yet no timely action followed. Once such fundamental needs are recognised, there is a professional obligation to consider the associated risks and to take appropriate steps to mitigate them. The absence of follow-up action resulted in delay and deterioration. The panel finds that this amounted to a failure to respond to identified risks.

314. In the case of Service User 3, the matter required reallocation to the duty team because the level of support required had not been clearly determined during Ms Ebiegbe's involvement. There were delays in assessment, recording and provision of care, together with an identified risk of homelessness. The panel considers that where the required level of support cannot be discerned from the assessment and record, risk has not been adequately analysed. The delay in clarifying needs and progressing support meant that emerging risks were not mitigated in a timely manner.

315. In respect of Service User 1, there were significant delays in assessing needs and completing documentation. During that period, risks arose including financial deprivation and the accumulation of debt. Financial safeguarding is a core aspect of social work practice. The failure to progress the assessment and documentation

promptly meant that the service user's changing circumstances were not addressed in a timely way, leaving risks insufficiently mitigated. This constituted a failure to respond appropriately to risk.

316. In relation to Service User 2, risks concerning the condition of the property were identified, yet there was a delay of over a month between the home visit and the assessment being recorded on the system. During that time there was no completed Care Act assessment articulating the service user's level of need. The panel accepts that in social care practice information can rapidly become outdated and that delay increases the likelihood that risks go unaddressed. In circumstances where the service user was subsequently identified as having complex needs requiring substantial support, the failure to analyse, record and progress the assessment in a timely manner exposed the service user to unmitigated risk.

317. The panel acknowledges that there was evidence to suggest Ms Ebiegbe was at times familiar with aspects of certain cases. However, professional standards require that risk analysis is clearly articulated, recorded and translated into timely action. Risk management in statutory practice cannot depend upon unrecorded knowledge. Accurate recording and timely progression are essential to ensure continuity of care, enable multi-agency working and safeguard vulnerable individuals. The absence of clear analysis and documented action significantly increases risk because other professionals cannot identify, understand or respond to emerging concerns.

318. The risks identified across the cases were varied, including homelessness, deterioration in living conditions, financial harm and unmet care needs. The common feature was delay and a failure to translate identified concerns into structured, timely intervention. Risk in social work is dynamic. Failure to progress assessments adequately and without undue delay undermines effective risk analysis and response and compounds the potential for harm.

319. Having considered the totality of the evidence, including Ms Ebiegbe's acknowledgement and acceptance of shortcomings in relation to risk, the contemporaneous records and the supervisory evidence, the panel is satisfied on the balance of probabilities that Ms Ebiegbe failed to analyse and/or respond to risks in respect of one or more of the identified service users.

320. **Accordingly, the panel found allegation 2 proved on the balance of probabilities.**

Allegation 3

You did not establish, and/or maintain, sufficient knowledge and skills with respect to the Council's 'ALLIS' system.

321. The panel considered all of the documentary and oral evidence relating to Ms Ebiegbe's competence in using the Council's electronic case management system, known as ALLIS (Liquid Logic).

322. The panel was required to determine whether Ms Ebiegbe failed to establish and/or maintain sufficient knowledge and skills in respect of ALLIS during the period in question.

323. The evidence demonstrated that a structured induction programme had been prepared in advance of Ms Ebiegbe joining the team. Ms Hodson described a standard induction process which included ICT training, mandatory e-learning, and familiarisation with policies and procedures before commencing ALLIS-specific training. A personalised induction plan had been prepared for Ms Ebiegbe. The evidence showed that she attended ALLIS training sessions covering demographics, assessments and action plans, support plans, reviews, closures, and safeguarding. The training records produced confirmed that most of these sessions had been completed between September and November 2019, however the closures and safeguarding session had not been completed by Ms Ebiegbe.

324. The panel was satisfied that appropriate initial training had been made available to Ms Ebiegbe. There was no evidence that additional specific learning needs had been identified at the outset beyond those applicable to all practitioners. The evidence of Ms Hodson was that social workers were expected to take responsibility for their own continuing professional development, to identify gaps in knowledge, and to seek further training or raise issues within supervision. The panel accepted that as an accurate reflection of professional expectations.

325. The evidence further demonstrated that when difficulties arose, Ms Ebiegbe was repeatedly advised to seek one-to-one support from the ALLIS systems training team. Supervision records from October 2019 onwards confirmed that she had been reminded of the availability of 1:1 sessions. The informal action plan letter dated 23 December 2019 again signposted one-to-one support with the User Support Officer. Subsequent supervision notes in January 2020 recorded that a 1:1 session had been cancelled and rescheduled, and that Ms Ebiegbe reported difficulty finding time within her working week to attend further sessions.

326. The panel noted Ms Hodson's evidence that Ms Ebiegbe had struggled with IT generally, including basic system access. Audits had identified practice issues linked to use of ALLIS, including failure to set pend dates, incomplete closure processes, difficulty locating contact details, and delayed uploading of case notes. In some cases, Ms Ebiegbe had not followed system processes relating to care plan reviews, transfer summaries, or next actions. Ms Hodson expressly linked some of the deficiencies in case recording to Ms Ebiegbe's difficulty in using ALLIS.

327. The panel also considered the email from the ALLIS User Support Officer indicating that Ms Ebiegbe had been "finding it difficult" and that her part-time working pattern may have made it harder to retain learning. During the probation hearing in July 2020, Ms Ebiegbe herself expressed ongoing issues with IT and reported that she had not been familiar with the ALLIS system, notwithstanding that she had attended the relevant training.

328. The panel carefully considered whether these difficulties had been attributable to inadequate employer support. It acknowledged that electronic recording systems could be complex and that many practitioners experienced initial difficulty adapting to new systems. However, the evidence in this case demonstrated that structured induction training had been provided, multiple ALLIS modules had been completed, supervision had repeatedly addressed the issue, and one-to-one support had been offered and facilitated. While there was evidence of some engagement with additional support, the difficulties had persisted over a sustained period.

329. The panel accepted that Ms Ebiegbe had been able, on occasion, to complete documents and input case notes onto ALLIS. However, the issue was not whether she could use the system at all, but whether she had established and maintained sufficient knowledge and skills to use it competently and consistently in the execution of her duties. The repeated audit findings, incomplete processes, delays in uploading records, and expressed lack of familiarity with the system demonstrated that her competence in using ALLIS had not reached the level required for safe and effective practice.

330. The panel was satisfied that the deficiencies in ALLIS usage had not been isolated or transient. They had been identified across multiple cases and had persisted despite training and supervisory intervention. As a registered social worker, Ms Ebiegbe bore professional responsibility to maintain adequate competence in core systems integral to statutory practice. ALLIS was the primary mechanism for recording assessments, safeguarding activity, support plans and case progression. Inability to use it effectively had had a direct impact on record keeping, case management and risk monitoring.

331. Taking the totality of the evidence into account, the panel was satisfied on the balance of probabilities that Ms Ebiegbe did not establish and/or maintain sufficient knowledge and skills with respect to the Council's ALLIS system.

332. **Accordingly, the panel found allegation 3 proved on the balance of probabilities.**

Finding and reasons on grounds and current impairment:

Submissions:

Social work England:

333. Ms Atkin, on behalf of Social Work England, made submissions to the panel on both the statutory ground and the issue of current impairment. She relied upon the written Statement of Case and supplemented those submissions orally by reference to the panel's findings of fact.

334. Ms Atkin submitted that whether the facts found proved amount to the statutory ground of lack of competence or capability is a matter of judgement for the panel. She reminded the panel that the Social Workers Regulations do not provide a statutory definition of lack of competence. However, she submitted that the panel is assisted by Social Work England's published Impairment and Sanctions Guidance, which explains

that lack of competence or capability is distinct from misconduct and denotes an unacceptably low standard of professional performance. She submitted that such a finding suggests a deficit in the knowledge and skills required to practise safely and effectively.

335. She further submitted that the guidance makes clear that lack of competence will ordinarily be demonstrated by reference to a fair sample of the registrant's work over a period of time. She relied upon *Calhaem v General Medical Council [2007] EWHC 2601 (Admin)*, as cited in the Statement of Case, which confirms that deficient professional performance indicates a standard which is unacceptably low and is ordinarily established by reference to a representative body of work rather than isolated incidents.

336. Ms Atkin submitted that the panel's findings clearly established such a fair sample. She submitted that the panel had found the vast majority of the allegations proved and that those findings demonstrated repeated and sustained failures across more than half of Ms Ebiegbe's caseload over a significant period. She submitted that the panel had found failures to progress assessments and reviews adequately or in a timely manner; failures to maintain sufficiently detailed and up-to-date case records; failures to involve service users adequately in assessments and decisions about their care and support; failures to properly consider mental capacity and best interests; failures to identify, analyse and respond appropriately to risk; and failures to demonstrate sufficient knowledge and skill in the use of the Council's systems.

337. Ms Atkin submitted that these findings concerned fundamental aspects of social work practice. She reminded the panel that it had already determined that these were not minor errors but fell below the standard expected. She submitted that Ms Ebiegbe had a reduced caseload and access to supervision, policy guidance and an informal action plan, yet meaningful and sustained improvement was not demonstrated.

338. She further submitted that the conduct was inconsistent with core professional standards governing safe practice. Ms Ebiegbe failed to promote and protect the rights and wellbeing of service users, failed to work in partnership with them and involve them appropriately in decision-making, failed to identify and minimise risk and reduce the risk of harm, failed to practise safely and effectively within her scope of practice, failed to exercise appropriate professional judgement and personal responsibility for decisions, and failed to maintain clear, accurate and comprehensive records. She submitted that Ms Ebiegbe also failed to use supervision and professional guidance effectively to inform assessments and develop her competence.

339. Ms Atkin submitted that, taken together, the panel's findings demonstrated a sustained and unacceptably low standard of professional performance across a representative sample of Ms Ebiegbe's work. She submitted that the deficiencies reflected a lack of competence rather than isolated misconduct and invited the panel to find that the statutory ground was made out.

340. Turning to impairment, Ms Atkin submitted that the panel must determine whether Ms Ebiegbe's fitness to practise is currently impaired. She relied upon the legal framework set out in *Cohen v General Medical Council [2008] EWHC 581 (Admin) and CHRE v NMC and Grant*, submitting that the panel must consider the need to protect service users, maintain public confidence in the profession and uphold proper professional standards.

341. Ms Atkin submitted that, in competence cases, the panel should consider a number of key factors when assessing personal impairment: the harm caused or risk of harm arising from the deficient performance; the likelihood of repetition; any relevant previous history; and the extent of Ms Ebiegbe's insight and remediation.

342. In relation to harm and risk of harm, Ms Atkin submitted that the panel's findings clearly demonstrated that Ms Ebiegbe's deficient performance gave rise to significant risk. She referred to the panel's findings that in relation to Service User 6 there was a failure properly to address the identified risk of homelessness and exposure to harm; that in relation to Service User 7 the absence of follow-up actions resulted in delay and deterioration; that in relation to Service User 3 safeguarding risks were not mitigated in a timely manner; that in relation to Service User 1 risks of financial deprivation were insufficiently addressed; and that in relation to Service User 2 delay in progressing assessments exposed the service user to ongoing risk. She submitted that even in the absence of established actual harm, the existence of real and avoidable risk is sufficient to engage impairment.

343. In relation to likelihood of repetition, Ms Atkin submitted that the shortcomings were not isolated. She submitted that the panel's findings demonstrated a pattern of repeated deficiencies affecting core aspects of practice over a sustained period. She submitted that despite supervision, guidance and an informal action plan, the concerns persisted. She submitted that the pattern and duration of the failings support the conclusion that there remains a real risk of repetition.

344. In relation to previous history, Ms Atkin acknowledged that Ms Ebiegbe had no prior regulatory findings. However, she submitted that this carried limited weight in circumstances where the concerns arose at the outset of Ms Ebiegbe's career and persisted despite structured support. She submitted that the absence of previous findings does not negate the seriousness of the pattern identified.

345. In relation to insight and remediation, Ms Atkin submitted that although Ms Ebiegbe had produced reflective pieces acknowledging shortcomings, her insight remained limited. She submitted that Ms Ebiegbe appeared to attribute her difficulties, at least in part, to inadequate support, whereas the panel's findings did not support that assertion. She submitted that this demonstrated incomplete acceptance of responsibility and insufficient appreciation of the potential impact of her failings on service users.

346. Ms Atkin further submitted that while Ms Ebiegbe had undertaken further training and produced certificates, there was no independent evidence demonstrating how that

training had translated into safe and effective practice. She submitted that there were no employer references, supervisor reports, supervised practice assessments or up-to-date testimonials confirming improved competence. She submitted that in the absence of objective and independent evidence of remediation, the panel could not be satisfied that the deficiencies had been addressed or that the risk of repetition was low.

347. Ms Atkin submitted that when these factors are considered together, namely; the risk of harm, the repeated nature of the deficiencies, the limited insight and the absence of independent evidence of remediation, Ms Ebiegbe's fitness to practise remains impaired on personal grounds.

348. Finally, Ms Atkin submitted that impairment is also required on public interest grounds. She submitted that the failings identified relate to core elements of safe social work practice, including assessment, risk management, record keeping, professional judgement and service user engagement. She submitted that a finding of no impairment would undermine public confidence in the profession and fail to uphold proper professional standards.

349. Ms Atkin therefore invited the panel to find that Ms Ebiegbe's fitness to practise is currently impaired on both personal and public interest grounds.

Social Worker:

350. The panel noted that Ms Ebiegbe did not submit any written submissions addressing the statutory ground or current impairment for the purposes of this hearing. The panel did not treat the absence of further submissions as determinative of those issues and reached its decision solely on the basis of the evidence before it and the applicable legal framework. The panel took into account the written material previously provided by Ms Ebiegbe, including her reflective statement and supporting documentation submitted prior to this hearing, and considered that material carefully when assessing both the statutory ground and the question of current impairment.

Legal advice:

351. The panel heard and accepted the advice of the legal adviser in relation to the statutory ground and impairment.

352. The legal adviser advised the panel that it must determine whether the facts found proved amounted to the statutory ground of lack of competence or capability. Lack of competence concerns a standard of professional performance falling below that expected of a reasonably competent social worker. It is not concerned with a single minor error or isolated lapse. Ordinarily, it requires evidence of a pattern of deficiencies or a fair sample of work demonstrating that the registrant's performance was seriously deficient.

353. The legal adviser advised the panel to consider whether the failings demonstrated a pattern over time and whether they established an inability to practise safely and

effectively to the standard expected of a reasonably competent social worker at the relevant stage of career.

354. If satisfied that the registrant's performance represented a fair sample of unacceptably low professional performance reflecting deficits in knowledge, skill or judgement, the panel could properly conclude that the statutory ground of lack of competence or capability was made out.

355. Turning to impairment, the legal adviser advised that a finding of a statutory ground did not automatically result in a finding of impairment. Impairment is a separate and distinct stage. It is forward-looking and concerned with current fitness to practise, public protection and public confidence. It is not punitive but regulatory in nature.

356. The panel was advised that it must consider both the personal and public elements of impairment and provide clear reasons for its conclusions on each.

357. In relation to the personal element, the legal adviser advised the panel to consider the extent of harm caused or risk of harm arising from the deficiencies; whether the shortcomings were isolated or formed part of a pattern; whether there was a likelihood of repetition; any relevant previous history; and the extent of the registrant's insight and remediation. These factors were interrelated and required a holistic evaluation.

358. The panel was advised to consider whether the deficiencies were capable of remediation, whether meaningful remediation had occurred, and whether the risk of repetition remained. The question was whether, at the date of the hearing, the registrant could practise safely and effectively without restriction. If the panel was satisfied that the deficiencies had been fully addressed and that the risk of repetition was highly unlikely, that could weigh against a finding of personal impairment. Conversely, if meaningful remediation had not been demonstrated or a real risk of repetition persisted, that would support a finding of personal impairment.

359. The panel was further advised that it must consider the public element of impairment separately. This required consideration of whether a finding of impairment was necessary to maintain public confidence in the profession and in the regulatory process, and to uphold proper professional standards. Even in circumstances where personal risk was reduced, a finding of impairment might still be required where the failings were serious, involved fundamental aspects of professional practice, or were such that a fully informed member of the public would expect a regulatory finding.

360. In assessing both elements, the panel was advised to consider the seriousness and breadth of the failings, the potential for harm if the registrant were to practise without restriction, and any evidence of insight, remediation or mitigation. The panel was reminded that its determination must be reasoned, balanced and evidence-based, demonstrating that it had considered all relevant factors and reached its conclusion through an evaluative judgement.

361. In summary, the legal adviser advised that impairment required a careful, structured and forward-looking assessment. The panel was required to determine whether there remained a current risk to service users and/or whether a finding was required in the public interest to uphold standards and maintain confidence.

The panel's decision on grounds:

362. The panel considered whether the facts found proved amounted to the statutory ground of lack of competence. The panel reminded itself that lack of competence concerns a standard of professional performance which falls below that expected of a reasonably competent social worker. It is not concerned with a single error, minor lapse, or momentary oversight. Ordinarily, it requires evidence of a fair sample of work demonstrating that the registrant's performance was seriously deficient and reflected deficits in knowledge, skill or professional judgement rather than attitudinal or deliberate wrongdoing.

363. The panel first examined the scope and pattern of the proven facts. The deficiencies were identified across multiple service users, engaged different domains of practice, and persisted over a period of approximately six months. They included failures in assessment, risk analysis, capacity consideration, recording, service user involvement, and timely progression of statutory duties. The panel was satisfied that this constituted a broad and representative body of work rather than isolated incidents. The repetition of similar deficiencies across unrelated cases demonstrated a pattern rather than coincidence.

364. In evaluating the seriousness of the failings, the panel considered the professional standards in force at the relevant time. It noted that at the relevant time, regulation of social workers transitioned from the Health and Care Professions Council (HCPC) to Social Work England, and therefore the applicable standards changed.

365. The panel first considered the HCPC Standards of Conduct, Performance and Ethics. Standard 1.2 requires a registrant to work in partnership with service users and carers, involving them appropriately in decisions about care and support. Standard 1.3 requires registrants to empower and enable service users to play a part in maintaining their own health and wellbeing and to support them in making informed decisions. The panel found that in multiple cases there was insufficient evidence that service users' wishes, feelings and preferences were actively explored or meaningfully incorporated into assessments and care planning. In respect of Service Users 3, 5 and 7, documentation did not demonstrate structured discussion about proposed interventions or evidence that options were explained so that informed choices could be made. In the case of Service User 7, significant discharge and placement decisions were progressed without clear documentation of consultation regarding his preferences. In relation to Service User 5, whose communication needs required careful engagement, involvement was minimal and inadequately evidenced. These were not merely recording deficiencies; they demonstrated an absence of structured

partnership working. The panel was satisfied that this reflected a deficit in applying core social work principles of empowerment and collaborative practice.

366. The panel then considered Standard 6.1, which requires a registrant to take all reasonable steps to reduce the risk of harm to service users. The evidence demonstrated repeated failures to analyse, escalate and respond proportionately to identified risks. In the case of Service User 6, there was a clear risk of homelessness combined with substance misuse and mental health vulnerability. The assessment was delayed, repeatedly rejected for insufficient detail and lack of personalisation, and not progressed with the urgency required by the presenting risks. In respect of Service User 7, known risks associated with dementia and falls were not promptly reassessed following hospital admission, and discharge planning proceeded without an updated, robust analysis. In the case of Service User 2, serious concerns regarding self-neglect and environmental fire hazards were identified but the Care Act assessment was not completed within a reasonable timeframe. In relation to Service User 1, delay in progressing financial assessment created foreseeable risk of financial detriment. The panel concluded that these repeated failures demonstrated a deficit in structured risk analysis and prioritisation.

367. The panel also considered Standard 7.6, which requires registrants to acknowledge and act on concerns raised. Supervision records demonstrated repeated identification of delays, incomplete assessments, and the need to consider mental capacity. Despite clear supervisory direction and action planning, required steps were not completed within reasonable timescales. In cases such as Service Users 3 and 6, supervision explicitly identified the need to consider or undertake a Mental Capacity Assessment, yet no assessment was undertaken and no clear rationale documented. The panel was satisfied that this demonstrated difficulty translating supervisory guidance into improved practice.

368. Turning to the HCPC Standards of Proficiency, the panel considered Standard 1.2, requiring effective management of workload and resources. Ms Ebiegbe was allocated a reduced caseload and worked part-time hours. Notwithstanding that support, statutory assessments remained incomplete for extended periods; visits were not written up contemporaneously; and key documentation was delayed. The repetition of delay across multiple cases demonstrated difficulty in prioritisation and workload organisation beyond what could reasonably be attributed to pressure or complexity.

369. Standard 1.3 requires social workers to undertake assessments of risk, need and capacity and respond appropriately. The panel's findings demonstrated repeated inadequacy in assessment quality. Assessments were rejected for lack of analytical depth, insufficient exploration of domains and absence of personalisation. In cases involving dementia, financial vulnerability and substance misuse, there was no structured or documented consideration of mental capacity despite clear triggers. The panel was satisfied that this reflected a deficit in understanding when and how to apply

the Mental Capacity Act 2005 framework, and an inability to embed statutory requirements into practice.

370. Standard 3.1 requires maintenance of high standards of personal and professional conduct. The sustained pattern of delayed progression, repeated rejection of work and failure to implement supervisory advice demonstrated that the expected professional standards were not consistently maintained.

371. Standard 4.1 requires a registrant to assess situations, determine the nature and severity of problems and draw upon appropriate knowledge and experience. Standard 4.3 requires recognition of personal responsibility for decisions and recommendations. The panel found that assessments were frequently lacking in structured analysis and occasionally contained contradictory information. In the case of Service User 4, contradictory statements regarding safety and supervision demonstrated insufficient critical evaluation. In the safeguarding enquiry concerning Service User 8, independent professional judgement was not clearly evidenced, and progression of the case relied heavily on managerial direction. The panel concluded that these findings reflected deficits in analytical reasoning and autonomous decision-making.

372. Standard 10.1 requires accurate, comprehensive and contemporaneous record keeping. Across multiple cases, visits were recorded weeks after they occurred; assessments were uploaded significantly later than the visits to which they related; and case notes lacked clarity or analytical structure. Some entries mirrored other service users' entries without sufficient individualisation. In cases involving hospital discharge and safeguarding, the absence of timely recording had potential implications for continuity and accountability. The panel was satisfied that this represented a repeated failure to meet fundamental record-keeping requirements.

373. The panel also considered Standards 14.1, 14.2 and 14.3, which require social workers to draw on appropriate knowledge and skills to inform practice, including gathering, analysing and critically evaluating information; selecting and using appropriate assessment tools; and preparing, implementing and reviewing plans to meet needs in conjunction with service users and carers. The panel found that assessments were repeatedly rejected for insufficient exploration of relevant risk domains, incomplete sections and lack of personalisation. In several cases, the documentation did not clearly demonstrate how identified needs and risks had been analysed or how professional judgement had been applied to reach reasoned conclusions. The panel was satisfied that this reflected deficiencies in gathering, critically evaluating and using information to inform recommendations, contrary to Standard 14.1.

374. In addition, the panel found that Ms Ebiegbe did not consistently or competently use the Council's mandatory assessment and recording system (ALLIS), which constituted the primary assessment tool through which statutory Care Act assessments, safeguarding documentation and care plans were completed and progressed. The repeated audit findings, incomplete processes, delayed uploads and expressed lack of

familiarity with the system demonstrated difficulty in selecting and using the required assessment framework effectively in practice, engaging Standard 14.2.

375. The panel further found that care plans were delayed, amended or required reallocation because the assessment work did not provide a sufficiently clear, structured or analytical foundation for decision-making. The absence of timely, robust assessments necessarily impeded the preparation, implementation and review of plans to meet service users' needs, engaging Standard 14.3. Taken together, the panel concluded that these matters demonstrated deficits in core assessment and planning skills central to competent statutory practice rather than isolated drafting or administrative errors.

376. The panel then considered the Social Work England Professional Standards and assessed how the facts found proved demonstrated that those standards were not met during the relevant period.

377. Standard 1.3 requires social workers to work in partnership with people to promote wellbeing and achieve best outcomes. The panel found that in a number of cases there was insufficient evidence within the records that service users' wishes, feelings and preferences had been clearly explored and documented as part of the assessment and decision-making process. In particular, in cases including Service Users 3, 5 and 7, significant decisions regarding care planning and support arrangements were progressed without clear recording of structured consultation or documentation demonstrating how the service user's views informed the outcome. The panel was satisfied that this reflected inadequately evidenced partnership working within the assessment process.

378. Standard 2.4 requires social workers to practise in ways that demonstrate professional confidence and capability. The panel found that assessments were repeatedly returned for further work due to lack of detail, insufficient analysis and incomplete sections. Despite induction, supervision and feedback, similar deficiencies were identified across multiple cases during the review period. The panel was satisfied that the persistent inability to produce assessments to the required standard, notwithstanding support, demonstrated limited consolidation of core competencies expected of a social worker practising within supported employment.

379. Standard 2.5 requires social workers to actively listen and use appropriate communication methods to build relationships and enable participation. In cases where service users presented with vulnerabilities, cognitive impairment or communication needs, there was limited evidence within the records of adapted communication strategies or structured efforts to ensure meaningful engagement. The panel was satisfied that the documentation did not consistently demonstrate purposeful and responsive communication tailored to individual needs.

380. Standard 3.1 requires social workers to work within legal and ethical frameworks. The panel found that in more than one case the need to consider mental capacity was identified in supervision, yet no formal Mental Capacity Assessment was undertaken

and no clear rationale was recorded explaining why it was unnecessary. In circumstances where dementia, financial vulnerability or significant risk were present, the Mental Capacity Act 2005 framework was clearly engaged. The panel was satisfied that this demonstrated difficulty in embedding statutory requirements within assessment practice.

381. Standard 3.2 requires the use of information from supervision and other appropriate sources to inform assessments, analyse risk and make professional decisions. Supervision records demonstrated that concerns regarding delay, assessment quality and the need to consider capacity were repeatedly raised. Although guidance and examples were provided, similar deficiencies continued to arise across subsequent cases. The panel concluded that supervisory feedback was not consistently translated into sustained and measurable improvement in practice during the relevant period.

382. Standard 3.3 requires social workers to apply knowledge and skills to address social care needs arising from physical or mental ill health, substance misuse, abuse, neglect and vulnerability. The cases considered by the panel involved precisely such issues, including dementia, self-neglect, environmental fire risk, homelessness risk and safeguarding concerns. The panel found that assessments did not consistently demonstrate robust analysis of these risks or clear articulation of how professional knowledge informed decision-making. The repetition of incomplete or insufficiently analytical assessments indicated difficulty applying core professional knowledge within common adult social care scenarios.

383. Standard 3.8 requires clarity regarding accountability for delegated work. The responsibility for progressing assessments, completing reviews and recording visits lay with Ms Ebiegbe. The panel found that statutory tasks were not consistently completed within expected timeframes and that key documents remained incomplete at the point of reallocation. The panel was satisfied that accountability for progressing cases was not consistently discharged.

384. Standard 3.11 requires maintaining clear, accurate and up-to-date records documenting how decisions are reached. The panel found that visits were not consistently recorded contemporaneously; assessments were uploaded significantly after visits; and entries often lacked sufficient analytical depth. In some cases, records required substantial amendment or were returned for further work. The panel was satisfied that the standard of recording fell below that expected and did not consistently provide a clear evidential basis for decision-making.

385. Standard 3.12 requires social workers to use assessment skills to respond quickly to dangerous situations and take protective action where necessary. The panel found that in cases involving homelessness risk, environmental fire hazard, hospital discharge and safeguarding concerns, assessments and care planning were delayed and did not progress with appropriate urgency. The panel was satisfied that identified risks were not consistently translated into timely statutory intervention.

386. Standard 3.13 requires the provision of, or support for access to, tailored advice and services based on evidence. The panel found that delayed and incomplete assessments limited the timely identification of eligible needs and the progression of appropriate services. Without a robust and timely evidential assessment, care planning and service provision were necessarily delayed or required reallocation. The panel was satisfied that this demonstrated difficulty in ensuring that advice and services were consistently tailored and progressed in a timely manner.

387. Standard 4.2 requires social workers to use supervision and feedback to critically reflect and identify learning needs. Although supervision occurred regularly and concerns were clearly identified, the panel found limited evidence of sustained improvement across the review period. Similar issues re-emerged in later cases notwithstanding earlier feedback. The panel concluded that supervision was not consistently integrated into practice development in a way that resulted in measurable and sustained enhancement of performance.

388. The panel recognised that Ms Ebiegbe was newly qualified and at an early stage of her career. It took into account that she had a reduced caseload and access to supervisory support, although the panel determined that some aspects of support could have been better tailored. However, the deficiencies identified concerned fundamental elements of statutory social work practice rather than matters of advanced discretionary judgement. The panel was satisfied that a reasonably competent newly qualified social worker, working within a supported practice environment, would be expected to complete assessments within appropriate timescales, undertake structured risk analysis, consider mental capacity where triggered, maintain accurate and contemporaneous records, and meaningfully involve service users in decision-making.

389. Against that context, the panel was satisfied that the proved facts demonstrated substantive deficiencies across core areas of statutory social work practice, including assessment, risk analysis, capacity consideration, recording and service user involvement. These were not minor or technical shortcomings but reflected underlying deficits in knowledge, skill, prioritisation and professional judgement. The concerns were broad in scope, arose across multiple cases during the relevant period, and persisted notwithstanding supervision and support. Taken cumulatively, they constituted a fair and representative sample of Ms Ebiegbe's work and demonstrated a sustained and unacceptably low standard of professional performance.

390. **Accordingly, the panel concluded that the statutory ground of lack of competence was established.**

The panel's decision on current impairment:

391. The panel next considered whether, in light of the facts found proved, Ms Ebiegbe's fitness to practise was currently impaired. The panel reminded itself that a finding of lack of competence did not of itself mean that impairment must follow. The panel was required to exercise its judgement as to current impairment, having regard to the need

to protect the public, to maintain public confidence in the profession, and to declare and uphold proper professional standards. In doing so, the panel took account of the past conduct and performance it had found proved, because that provided the context in which to assess present risk and the extent to which the concerns had been addressed.

392. The panel approached impairment by considering both the personal component and the public component. In relation to the personal component, the panel considered, in particular, the degree of harm caused or risk of harm; the likelihood of repetition; any relevant previous history; and the extent of insight and remediation. The panel treated these factors as interrelated and assessed them holistically rather than in isolation.

393. In relation to harm and risk of harm, the panel was satisfied that the deficiencies it had found proved in Ms Ebiegbe's practice carried a significant risk of harm, even where actual harm was not established. The proven facts included repeated delay and inadequacy in statutory assessments and reviews, failures to maintain adequate and timely records, failures to involve service users adequately in decisions about their care and support, failures to consider capacity and best interests where the circumstances clearly triggered that consideration, and failures to analyse and respond to risk. The panel had found proved that risks across multiple cases were not mitigated in a timely or structured way.

394. The panel had found proved, among other matters, that Service User 6 faced a risk of homelessness and vulnerability, which was prolonged by delayed and inadequate assessment and care planning; that Service User 7's deteriorating needs following hospital admission were not promptly reassessed and discharge planning proceeded without an updated assessment; that Service User 2 presented with self-neglect and environmental hazards including fire risk, yet assessment and progression were delayed; and that Service User 1 faced foreseeable risk of financial detriment arising from delay in progressing eligibility and associated actions. The panel was satisfied that these matters demonstrated a real and avoidable risk of harm arising from Ms Ebiegbe's deficient professional performance, and that this factor weighed significantly in favour of a finding of current impairment.

395. In relation to repetition, the panel considered whether the deficiencies were isolated or instead demonstrated a pattern and whether there was credible evidence that the risk of repetition had been sufficiently addressed. The panel had found that the failings were repeated across multiple unrelated service users over a sustained period of approximately six months and engaged fundamental areas of statutory social work practice. The panel had accepted that Ms Ebiegbe was newly qualified and that there were contextual issues, including that she worked part-time, and that some aspects of support could have been better tailored. However, the panel was satisfied that the breadth and persistence of the deficiencies, and the fact that similar concerns arose across multiple cases notwithstanding supervision, guidance, action planning and reduced caseload, indicated a continuing risk of repetition unless there was clear

evidence of remediation and sustained improvement. The panel was also mindful that the deficiencies were not confined to one discrete skill, but extended across assessment quality, timeliness, risk analysis, recording, service user involvement and application of legal frameworks, which together increased the regulatory significance of repetition.

396. In relation to previous history, the panel noted that Ms Ebiegbe had no prior regulatory findings. The panel considered that the absence of previous history did not materially reduce the risk in this case because the concerns arose at the outset of her career and persisted despite support and intervention. The panel therefore treated the absence of previous regulatory history as a neutral factor, rather than one carrying significant weight against impairment.

397. The panel then considered insight. The panel had before it a reflective statement and written material in which Ms Ebiegbe acknowledged shortcomings in areas including risk, recording, prioritisation, communication and partnership working, and she articulated, in general terms, the potential impact upon service users, colleagues and multi-agency working. The panel accepted that the reflective material demonstrated some appreciation, at least at a theoretical level, of why the concerns mattered and how they could affect others. However, the panel was not satisfied that insight was full, developed and reliable. The panel placed weight on the fact that the reflective material was self-reported, untested by oral evidence, and was not supported by independent professional endorsement demonstrating that Ms Ebiegbe had translated reflection into consistently safe and effective practice.

398. The panel also considered that elements of Ms Ebiegbe's account tended to focus on contextual difficulties and shortcomings in support, whereas the panel's findings on the proved facts were that she had received supervision, guidance and clear instruction and that the deficiencies persisted across the review period. The panel therefore concluded that insight was developing but remained incomplete, particularly in terms of a demonstrated, practice-based understanding of the seriousness of the risk created by repeated delay and inadequate statutory intervention.

399. The panel next considered remediation. The panel noted that Ms Ebiegbe had undertaken some training and produced limited certificates. The panel accepted that completing training can be a positive step. However, the panel was not satisfied that the evidence demonstrated meaningful remediation of the competence concerns identified. The panel was concerned that there was limited detail as to the scope, duration and rigour of the training, and limited reflection showing what had been learned in a way that directly addressed the specific deficiencies found proved, such as timely progression of assessments, robust risk analysis, application of the Mental Capacity Act 2005 where triggered, and maintenance of clear, contemporaneous and individualised records.

400. The panel also considered that Ms Ebiegbe referred, in general terms, to putting systems in place, such as grids or organisational tools, but the panel was not satisfied

that this amounted to robust evidence that she could now practise safely and effectively to the required standard. The panel recognised that there can be difficulties in a social worker who is not currently in practice being able to provide independent evidence of steps taken. However, the panel placed significant weight on the absence of independent evidence of remediation, such as a supervisor's report or a peer's feedback, an employer reference, an assessment from a placement or reflective supervisor, evidence of supervised practice, or up-to-date testimonials attesting to safe and competent performance since the concerns arose. The panel also noted that there was no independent evidence addressing the concerns about IT competence and the use of core recording systems, which had been found proved and were integral to safe statutory practice.

401. The panel also noted Ms Ebiegbe's non-attendance at the hearing. The panel did not treat non-attendance as an aggravating factor in itself or rely upon it in reaching its findings. However, the panel considered that her absence meant that her insight and remediation could not be explored or tested, and it reduced the panel's ability to be satisfied that the concerns had been fully understood, accepted and addressed. The panel concluded that the absence of oral evidence and the lack of independent corroboration materially limited the weight it could place on the written reflective material and training certificates when assessing current impairment.

402. Drawing these matters together, the panel concluded that the personal component of impairment was established. The panel was satisfied that the proven deficiencies created a significant risk of harm, that the failings were repeated and wide-ranging, that insight was incomplete, and that there was insufficient independent evidence of remediation to satisfy the panel that the risk of repetition was low. The panel was therefore not satisfied that Ms Ebiegbe could presently practise safely and effectively without restriction.

403. The panel then considered the public component of impairment. The panel was satisfied that the findings in this case concerned fundamental aspects of statutory social work practice, including timely assessment and review, risk assessment and mitigation, lawful decision-making where capacity issues arise, adequate record keeping, and meaningful involvement of service users in decisions about their care and support.

404. The panel considered that these are core competencies expected of a social worker, including one newly qualified and working within supported practice. The panel concluded that a finding of no current impairment, in circumstances where the panel had found a sustained and significant pattern of deficient performance and where remediation was not independently evidenced, would undermine public confidence in the profession and in the regulatory process and would fail to uphold proper professional standards.

405. **Accordingly, the panel determined that Ms Ebiegbe's fitness to practise is currently impaired on both the personal and the public components.**

Decision and reasons on sanction:

Submissions:

Social Work England:

406. Ms Atkin, on behalf of Social Work England, made submissions to the panel on sanction. She reminded the panel that the purpose of a sanction in fitness to practise proceedings is not to punish the registrant but to protect the public, to maintain public confidence in the profession, and to uphold proper professional standards. Ms Atkin submitted that the panel must apply the Sanctions Guidance, move through the available outcomes in ascending order, and ensure that any order imposed is proportionate and no more restrictive than is necessary to achieve the regulatory objectives. Any decision on sanction must be consistent with the panel's findings on facts, statutory ground and current impairment.

407. Ms Atkin submitted that taking no further action would be wholly inappropriate in circumstances where the panel had found current impairment, particularly on the personal component. She reminded the panel of its findings that there had been a real and avoidable risk of harm across multiple cases; that the deficiencies were broad in scope and persisted over time; that similar concerns arose notwithstanding supervision, guidance, action planning and a reduced caseload; and that there remained a risk of repetition. In those circumstances, she submitted that a finding of impairment alone would not sufficiently protect the public or maintain confidence in the profession.

408. She further submitted that advice or a warning would not be appropriate. Those outcomes do not restrict practice and are unsuitable where there is a current risk to the public. She referred the panel to the Sanctions Guidance, which makes clear that where a social worker poses a current risk to public safety, it will ordinarily be reasonable to move beyond outcomes such as no action, advice or warning, because such measures do not address the risk. In her submission, the breadth and persistence of the competence concerns, together with incomplete insight and limited evidence of remediation, meant that a non-restrictive outcome would fail to protect the public.

409. Turning to a conditions of practice order, Ms Atkin acknowledged that such an order can be appropriate in cases of lack of competence where the deficiencies are capable of remediation, the registrant has demonstrated insight, workable and proportionate conditions can be formulated, and there is confidence that the registrant will comply. However, she submitted that those criteria were not met in this case. Although Ms Ebiegbe had demonstrated a degree of developing insight in her reflective material, that insight remained incomplete and untested. There was no independent testimonial evidence, no corroboration from an employer or supervisor, and no objective evidence demonstrating that the identified deficiencies had been remedied in practice.

410. The concerns were not confined to a single discrete skill but extended across assessment quality, timeliness, risk analysis, recording, service user involvement and application of legal frameworks. In her submission, it would not be realistic or sufficient to seek to address such wide-ranging and fundamental deficiencies through conditions at this stage, nor would it be reasonable to expect an employer to carry the level of oversight that would be required to mitigate the risk.

411. Ms Atkin therefore invited the panel to impose a suspension order. She submitted that suspension would be appropriate where workable conditions cannot be formulated to protect the public, but the case does not require removal from the register, which is not available as an option in a case of lack of competence. She submitted that suspension would appropriately mark the seriousness of the deficiencies, protect the public from ongoing risk, and maintain confidence in the profession, while allowing Ms Ebiegbe a defined period in which to demonstrate meaningful remediation and fully developed insight.

412. In relation to length, Ms Atkin invited the panel to impose a period of suspension of not less than two years. She submitted that the concerns were fundamental and basic in nature and would require sustained effort and objective evidence to remediate. She reminded the panel that suspension orders are subject to review and that a period which is too short may not allow sufficient time for meaningful remediation to be demonstrated. She also submitted that, in light of Ms Ebiegbe's indication that she was not currently practising and had referenced health concerns, it may be proportionate to allow a longer period before review so as to avoid unnecessary stress and to provide a realistic opportunity for reflection, retraining and the gathering of independent evidence.

413. In conclusion, Ms Atkin submitted that a suspension order was the minimum necessary and proportionate sanction to protect the public and the wider public interest in this case.

Social worker:

414. The panel noted that Ms Ebiegbe did not submit any written representations in relation to sanction for this hearing. In determining the appropriate sanction, the panel nevertheless considered the written material she had previously provided during the course of the proceedings, including her reflective statement and evidence of training, and weighed that material alongside the submissions made on behalf of Social Work England, legal advice and the applicable sanctions guidance.

Legal advice:

415. The panel heard and accepted the advice of the legal adviser in relation to sanction. The panel was reminded that its overarching objective is the protection of the public, the maintenance of public confidence in the profession, and the upholding of proper professional standards. Sanctions are not punitive but protective in nature. The panel

was advised to take account of the Impairment and Sanctions Guidance and its earlier findings on facts, grounds and impairment, and to apply the principle of proportionality, ensuring that any sanction imposed is the minimum necessary to meet the regulatory objectives. The panel was further advised that while the impact of a sanction on the social worker may be considered, personal consequences should not ordinarily outweigh the public interest.

416. The panel was advised to consider aggravating and mitigating factors and to approach the available sanctions in ascending order of severity. The available outcomes included taking no further action, issuing advice, making a warning order, imposing a conditions of practice order for up to three years, or imposing a suspension order for up to three years. Removal was not available in this case given the statutory ground of lack of competence.

417. The panel was advised that no further action, advice or a warning would only be appropriate where the public was sufficiently protected without restriction, and would not be suitable where there remains a current risk to the public. Conditions of practice may be appropriate in cases of lack of competence where the failings are remediable, insight has been demonstrated, workable and proportionate conditions can be formulated, compliance can be monitored, and there is no ongoing risk of harm from restricted practice. Suspension may be appropriate where conditions are not workable but the case does not warrant removal, particularly where there has been a serious breach of standards but some insight and potential for remediation remain.

The panel's reasons and decision on sanction:

418. The panel proceeded to consider sanction. The panel reminded itself that the purpose of sanction in fitness to practise proceedings is not to punish, but to protect the public, maintain public confidence in the profession and uphold proper professional standards. The panel had regard to Social Work England's Sanctions Guidance and to its earlier findings on facts, grounds and impairment. The panel applied the principle of proportionality, bearing in mind that any sanction imposed must be the minimum necessary to achieve the regulatory objectives and must be consistent with its findings.

419. The panel noted that Ms Ebiegbe did not provide written submissions on sanction for this hearing. In reaching its decision, the panel nevertheless took into account the written material previously provided by her during the proceedings, including her reflective statement and training certificates, and considered those alongside the submissions made on behalf of Social Work England and the relevant guidance.

420. The panel identified the aggravating and mitigating factors.

421. In aggravation, the panel found that the competence deficiencies were not isolated but formed a pattern across multiple service users over a sustained period of approximately six months. The concerns engaged fundamental aspects of statutory social work practice, including assessment quality, risk analysis, timeliness, record

keeping, service user involvement and application of statutory frameworks. The failings persisted despite supervision, guidance, action planning and a reduced caseload. The repetition and breadth of the deficiencies increased their seriousness. The panel also found that insight remained developing and incomplete and that remediation had not been demonstrated by independent or objective evidence. There were no testimonials, professional references or supervisory reports evidencing improved competence. Accordingly, the risk of repetition remained.

422. In mitigation, the panel recognised that Ms Ebiegbe was newly qualified and at the beginning of her professional career when the concerns arose. The panel accepted that she experienced challenging personal circumstances during her employment, including health difficulties and financial and childcare pressures, together with practical transport challenges. These matters were taken into account as contextual mitigation. The panel also recognised that some degree of insight was demonstrated in her written reflections. She acknowledged shortcomings and expressed some remorse. She had undertaken limited training and described systems she sought to implement to prevent recurrence. The panel further noted that she had engaged with the regulatory process by returning documentation when required.

423. The panel carefully considered whether the level of workplace support constituted mitigation. The evidence demonstrated that a structured induction was provided, supervision was arranged on a regular basis, action plans were implemented, and the registrant's caseload was reduced. The panel did not find evidence of systemic failure or absence of support by the employer. However, the panel recognised that Ms Ebiegbe was newly qualified at the time and was adjusting to the demands of statutory practice. It accepted that she may have required a higher degree of structured guidance than some practitioners and that there may have been a mismatch between the level of support she required and that which was reasonably available within the service. The panel also noted that supervision sessions were at times rearranged (partly due to Ms Ebiegbe's availability) and that the working relationship appeared to involve mutual frustration. Nonetheless, the panel was satisfied that support mechanisms were in place and that ultimate responsibility for meeting professional standards and progressing allocated work remained with Ms Ebiegbe. The issue before the panel was not the adequacy of employer systems but the registrant's ability to demonstrate the competence required for safe and effective practice.

424. The panel noted that Ms Ebiegbe had no previous regulatory findings. However, as the concerns arose at the very start of her professional career, this factor carried limited weight

425. The panel did not treat Ms Ebiegbe's non-attendance as an aggravating factor and drew no adverse inference from her absence. However, in the absence of oral evidence, the panel was unable to explore or test her current insight, remediation and circumstances. As a result, the panel was limited to the written material before it when assessing whether the concerns had been fully addressed.

426. Weighing these matters together, the panel concluded that while there were identifiable mitigating and contextual factors, they did not outweigh the seriousness, breadth and persistence of the competence deficiencies found proved.

427. The panel then considered the available sanctions in ascending order of severity.

428. The panel determined that taking no further action would be wholly inappropriate. A finding of impairment alone would not sufficiently protect the public nor maintain confidence in the profession given the ongoing risk of repetition identified.

429. The panel next considered whether to issue advice or a warning. The panel concluded that these outcomes would not be sufficient. Advice or a warning would not restrict practice and would not address the continuing risk arising from the panel's finding of personal impairment. Given the breadth of the deficiencies and the absence of demonstrated remediation, such outcomes would not adequately protect the public or uphold proper standards.

430. The panel then considered a Conditions of Practice Order. The panel recognised that conditions are often appropriate in cases of lack of competence where failings are remediable, workable conditions can be formulated, and there is confidence that the registrant will comply. The panel carefully considered whether conditions could be drafted to address the identified deficiencies, which spanned assessment quality, risk analysis, application of statutory frameworks, record keeping, prioritisation and service user involvement.

431. However, the panel was not satisfied that workable, proportionate and monitorable conditions could be formulated at this stage. The deficiencies were broad and fundamental, affecting core aspects of practice rather than a discrete or technical area. The panel was not satisfied, in the absence of independent evidence of remediation or oral evidence from Ms Ebiegbe, that she had demonstrated sufficient development of her competence to practise safely even under restriction. The panel also considered the practical implications for any employer, noting that conditions would likely require intensive oversight beyond what is realistically sustainable and may in effect amount to suspension by another means. In these circumstances, the panel concluded that a Conditions of Practice Order would not provide sufficient protection to the public.

432. The panel therefore considered whether a Suspension Order was appropriate. The panel was satisfied that the case fell short of removal from the register, which is not available at this stage in a case of lack of competence unless specific statutory criteria are met. The panel noted that there was some developing insight and some limited evidence of engagement with training. The panel considered that a period of suspension would protect the public while affording Ms Ebiegbe an opportunity to demonstrate meaningful remediation and strengthened insight.

433. In determining the length of suspension, the panel balanced the need to protect the public and uphold confidence in the profession against the risk of further deskilling. The

panel also took into account the time that had elapsed since the concerns arose and the limited progress demonstrated over that period. The panel concluded that a period of two years was proportionate. A shorter period would be insufficient to allow meaningful remediation given the breadth of the deficiencies and the absence of demonstrated practical improvement. A two-year period would provide adequate time for Ms Ebiegbe to undertake relevant training, develop transferable skills, reflect in detail on the findings, and obtain independent evidence of improved competence.

434. The panel determined that prior to any review, the future panel would be assisted by evidence demonstrating Ms Ebiegbe's detailed reflection addressing each area of deficiency found proved, including the impact on service users, colleagues and public confidence; evidence of relevant and substantive training with reflective learning outcomes; evidence of how learning has translated into practice or transferable skills, including record-keeping and application of statutory frameworks; testimonials or professional references addressing competence, reliability and insight; and information relating to any health matters she considers relevant to her ability to practise safely.

435. The panel emphasised that suspension is a temporary and protective measure. Its purpose is to allow Ms Ebiegbe a meaningful opportunity to address the deficiencies identified and to demonstrate strengthened insight, remediation and safe practice. The order will be subject to review prior to its expiry. At that review, a future panel will consider whether Ms Ebiegbe's fitness to practise remains impaired and whether she has sufficiently addressed the concerns found proved. If a future panel is not satisfied that the deficiencies have been remedied or that the risk to the public has been adequately addressed, it may consider a more restrictive outcome, including removal from the register, if appropriate and in accordance with the statutory framework. The responsibility rests with Ms Ebiegbe to demonstrate that she is fit to return to practice. Importantly, if Ms Ebiegbe considers that she has addressed these issues, and can evidence this within a shorter time period, she can request an early review.

436. For these reasons, the panel determined that a Suspension Order for a period of two years is necessary and proportionate to protect the public, maintain public confidence in the profession and uphold proper professional standards.

437. **Accordingly, the panel imposed a Suspension Order for a period of two years.**

Interim order:

438. In light of its earlier findings, the panel next considered an application by Ms Atkin, on behalf of Social Work England, for an interim suspension order for 18 months to cover the appeal period before the final order becomes effective. Ms Atkin informed the panel that there was an existing interim order in place; however, it was not sufficient in length to cover the appeal period following the substantive decision.

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

440. The panel also considered whether it should revoke or vary the existing interim order. The panel noted that Ms Ebiegbe had not waived her right to the statutory appeal period and was not present at the hearing to do so. The panel further noted that it had not been put on notice by Social Work England that such a waiver would be sought. In those circumstances, and in order to preserve the integrity of the statutory framework governing the appeal period, the panel determined that it was neither appropriate nor lawful to revoke or vary the existing interim order at this stage.

441. The panel was mindful of its earlier findings and decided that it would be wholly incompatible with those findings not to impose an interim order. The panel considered paragraph 207 of the Impairment and Sanctions Guidance, which highlights that "*an interim order may be necessary where the adjudicators have decided that a final order is required, which restricts or removes the ability for the social worker to practise…without an interim order, the social worker will be able to practise unrestricted until the order takes effect. This goes against our overarching objective of public protection.*" The panel had identified a risk of repetition if Ms Ebiegbe were permitted to practise without restriction.

442. The panel concluded that an interim suspension order was the most appropriate and proportionate measure to ensure the protection of the public and the wider public interest during the appeal period. Accordingly, the panel determined that an interim suspension order for a period of 18 months is necessary.

443. When the appeal period expires, this interim order will come to an end unless an appeal has been lodged with the High Court. If no appeal is filed, the substantive suspension order will take effect upon expiry of the appeal period.

Right of appeal:

444. Under Paragraph 16(1)(a) of Schedule 2 of the regulations, the social worker may appeal to the High Court against the decision of adjudicators:

a. the decision of adjudicators:

   i. to make an interim order, other than an interim order made at the same time as a final order under Paragraph 11(1)(b),

   ii. not to revoke or vary such an order,

   iii. to make a final order.

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

445. 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.

446. 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.

447. 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:

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

- 15(1) The regulator must review a suspension order or a conditions of practice order, before its expiry
- 15(2) The regulator may review a final order where new evidence relevant to the order has become available after the making of the order, or when requested to do so by the social worker
- 15(3) A request by the social worker under sub-paragraph (2) must be made within such period as the regulator determines in rules made under Regulation 25(5), and a final order does not have effect until after the expiry of that period

449. 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:

450. 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.