Social worker: Ntandoyakhe Ncube
Registration number: SW124787
Fitness to Practise
Final Hearing

Dates of hearing: 23 February 2026 to 10 March 2026, 14 April 2026, 16 April 2026, 15 July 2026 and 17 July 2026

Hearing venue: Remote hearing

Hearing outcome:
Fitness to practise impaired, conditions of practice order (24 months)

Interim order:
Interim conditions of practice order (18 months)

Introduction and attendees:

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

2. Ms Ncube attended and was not represented.

3. Social Work England was represented by Mr Matthew Kerruish-Jones, case presenter 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**
Debbie Hill	Chair
Beverley Blythe	Social worker adjudicator
Melissa Forbes-Murison	Lay adjudicator

Hearings team/Legal adviser	**Role**
Ruby Wade	Hearings officer
Nazia Kauser/Emma Walker	Hearings support officer
Esther Oladipo	Legal adviser

Service of notice:

5. Service of notice was not specifically addressed during the hearing. However, as Ms Ncube attended the hearing, the panel was satisfied that notice of the hearing had been properly affected in accordance with the relevant Fitness to Practise Rules.

Preliminary matters:

Preliminary issues raised by the panel:

6. At the outset of the hearing, the panel raised two preliminary issues it had identified within the documentary evidence. The panel indicated that, having reviewed the statements bundle and the exhibits bundle, it had identified matters and material within the evidence that referred to families who were not subjects within the allegations. The panel noted that where material relates to service users who are not the subject of the allegations, such material would ordinarily be redacted from the hearing documents. The panel, therefore, considered it appropriate to raise this issue at the outset to ensure that there was no potential for undercharging, that the proceedings remained focused on the matters alleged and that the panel disregarded irrelevant material.

7. Mr Kerruish-Jones thanked the panel for raising the issues and following taking instructions confirmed the allegations remained as charged. He further stated that given the logistical arrangements for the hearing and the number of witnesses due to give evidence, he suggested if permissible that, the hearing proceed with the existing

bundles with the understanding that redacted versions be provided subsequently, if required. He asked that the panel as experienced members put irrelevant information within the hearing documents out of mind for the consideration of the proceedings. The panel stated that it was happy to take this approach as its intention in raising the matter was simply to ensure that the issue was identified early in the proceedings so that it did not give rise to difficulty at a later stage. The panel confirmed that it did not wish to disrupt the progress of the hearing or risk losing witness availability if the issue could be addressed in this manner.

Application to amend Allegation 4:

8. The panel also raised a preliminary issue concerning the wording of one of the allegations. The panel noted that the date specified in Allegation 4 appeared inconsistent with the documentary evidence contained in the bundle. The allegation referred to a date of 2 September 2019, whereas the relevant documentation suggested that the correct date may be 3 September 2019. The panel referred Mr Kerruish-Jones to the relevant pages within the bundle in support of this observation.

9. Mr Kerruish-Jones responded by making an application to amend Allegation 4. He submitted that the allegation currently referred to an incident occurring on 2 September 2019, however the documentary evidence in relation to when Ms Ncube was asked to remain with Service User D to facilitate a handover to their father clearly suggests that the relevant events occurred on 3 September 2019, and therefore this appears to be an oversight. Mr Kerruish-Jones therefore applied for the allegation to be amended so that it would read *'between 2 September 2019 and 4 September 2019'* so the allegation accurately reflected Social Work England's case.

10. Ms Ncube was asked whether she objected to the proposed amendment. Ms Ncube confirmed that she did not object to the application.

11. The panel accepted the advice of the legal adviser in relation to the panel's powers to amend allegations. The legal adviser advised that under Rule 32(a) of the Fitness to Practise Rules 2019 (as amended) (the "Rules"), the panel have a broad procedural discretion to regulate their own procedure and to deal with cases fairly. This includes the power to permit amendments to allegations at any stage of the proceedings, including after a hearing has begun.

12. The legal adviser further advised that the key issue for the panel to consider when determining such an application is fairness. In particular, the panel should ensure that the proceedings remain fair to both parties and that the social worker has a fair opportunity to understand and respond to the allegation as amended. The panel was advised that relevant considerations may include the nature and extent of the proposed amendment, whether it materially alters the allegation, whether the social worker has been alerted to the amendment, and whether the social worker is present and able to respond to the amended allegation.

13. The panel considered the application to amend the allegation. The panel was mindful that the key consideration when determining such an application is fairness. The panel noted that Ms Ncube was present at the hearing and had confirmed that she had no objection to the proposed amendment. The panel further noted that the amendment sought was limited to clarifying the relevant timeframe of the allegation and did not alter the substance of the allegation or the nature of the case that Ms Ncube was required to answer. The panel was satisfied that the proposed amendment was relatively minor and that allowing the amendment would not cause any prejudice to Ms Ncube. The panel was also satisfied that Ms Ncube would still have a fair opportunity to respond to the allegation as amended. In all the circumstances, the panel determined that allowing the amendment was fair and appropriate. The panel therefore granted the application to amend Allegation 4 so that it would read *"between 2 September 2019 and 4 September 2019"*.

Hearsay Application:

14. Mr Kerruish-Jones made an application for the panel to admit certain evidence as hearsay. The application was supported by a written application which had been provided to the panel in advance of the hearing.

15. Mr Kerruish-Jones submitted that Social Work England sought to rely on parts of the evidence of Alex Cunningham relating to a discussion she had with the mother of Family B concerning a complaint about Ms Ncube's handling of a scheduled visit. In particular, Social Work England sought to rely on the account recorded in Ms Cunningham's witness statement and the contemporaneous email exhibited, which recorded a complaint from the mother of Family B that Ms Ncube had not attended a planned visit on 10 June 2019 and had not made contact until several days later.

16. Mr Kerruish-Jones submitted that Social Work England had not sought to obtain a witness statement from the mother of Family B. He explained that Social Work England had taken the view that it would not be proportionate to obtain direct evidence from the service user, particularly given that the relevant information had been contemporaneously recorded and formed part of the documentary evidence already before the panel.

17. He further submitted that hearsay evidence is admissible in proceedings where the panel considers it fair to admit such evidence. He submitted that the evidence sought to be admitted was relevant and probative, and that admitting it would not be unfair or prejudicial to Ms Ncube. Mr Kerruish-Jones also submitted that the evidence was not the sole or decisive evidence in relation to the allegation, noting that there were other documents before the panel, including Ms Ncube's own case note relating to the scheduled visit.

18. Mr Kerruish-Jones informed the panel that Ms Ncube neither consented to nor opposed the application and had adopted a neutral position in relation to the admission of the evidence. He therefore invited the panel to determine that the hearsay evidence was relevant and fair to admit in the circumstances.

19. Ms Ncube confirmed that she was neutral in relation to the application and did not wish to make any submissions or raise any objections in relation to it. Ms Ncube indicated that she wished to leave the matter for the panel to determine.

20. The panel accepted the advice of the legal adviser who explained that the evidence sought to be admitted constituted hearsay because it involved Ms Cunningham providing an account of information reported to her by the mother of Family B, who was not present to give oral evidence. The panel was advised that the relevant provision is Rule 32(b) of the Rules, which provides that the panel may admit evidence where they consider it fair to do so.

21. The panel was advised that the Rules do not prohibit hearsay evidence; however, the key consideration is whether admitting such evidence would be fair in all the circumstances. The legal adviser reminded the panel that there is no absolute right to cross-examine witnesses in professional disciplinary proceedings, but that the panel must carefully consider issues of fairness, relevance and reliability before deciding whether hearsay evidence should be admitted.

22. The legal adviser further advised the panel to have regard to the legal principles established in relevant case law, including *Bonhoeffer v GMC, Ogbonna v NMC, Thorneycroft v NMC* and *El Karout v NMC*. These authorities emphasise that the admission of hearsay evidence should not be treated as automatic and that particular caution is required where such evidence is the sole or decisive evidence supporting an allegation.

23. The panel was advised that, when determining whether it would be fair to admit hearsay evidence, it should consider a range of relevant factors. These include the reason for the absence of the original witness, the importance of the hearsay evidence to the allegation, whether it is supported by other evidence such as contemporaneous records or other witness testimony, whether the social worker has had notice of the evidence and an opportunity to respond to it, and whether there are other ways in which the reliability of the evidence can be tested. The seriousness of the allegation and the overall fairness of the proceedings to both parties should also be considered.

24. The legal adviser reminded the panel of the important distinction between admissibility and weight. The panel was advised that its task at this stage was only to determine whether it would be fair to admit the hearsay evidence. If admitted, the panel would later determine what weight, if any, should be attached to that evidence when considering the facts in the case.

25. The panel considered the application to admit hearsay evidence, in reaching its decision, the panel had regard to the written application provided by Social Work England, the oral submissions made by Mr Kerruish-Jones, and the position of Ms Ncube. The panel also accepted the advice from the legal adviser.

26. The panel considered the relevant legal principles and considered whether it would be fair in all the circumstances to admit the hearsay evidence. The panel was satisfied that

the hearsay evidence was not the sole or decisive evidence in relation to Allegation 2. The panel noted that there was other evidence within the bundle which addressed the same events, including a contemporaneous case note recorded by Ms Ncube herself indicating that the scheduled visit on 10 June 2019 had not taken place.

27. The panel also noted that there had been no substantive challenge to the content of the hearsay material and that Ms Ncube had adopted a neutral position in relation to the application. The panel further considered that there was no suggestion that Ms Cunningham had any reason to fabricate the account of the complaint and noted that the information had been recorded in the course of her professional duties as a social worker.

28. The panel also considered the reason why the mother of Family B had not been called to give evidence directly. The panel accepted the submission that it would be disproportionate in the circumstances to require the service user to provide evidence about events which had occurred some time ago, particularly where the complaint had already been recorded through the appropriate professional channels.

29. The panel was satisfied that Ms Ncube had been on notice that Social Work England intended to rely on this evidence and would therefore have a fair opportunity to respond to it during the course of the hearing.

30. Having considered all of these factors, the panel determined that it would be fair and appropriate to admit the hearsay evidence. The panel emphasised that, although the evidence would be admitted, it would determine what weight, if any, should be attached to the hearsay evidence when considering the evidence as a whole at the conclusion of the facts stage.

Privacy Application:

31. As Ms Ncube was not represented, Mr Kerruish-Jones made an application in relation to the handling of certain sensitive material during the hearing to protect Ms Ncube's private life. Mr Kerruish-Jones submitted that Social Work England did not seek for the entirety of the proceedings to be held in private and maintained that fitness to practise proceedings should ordinarily be conducted in public.

32. However, Mr Kerruish-Jones submitted that there were elements within the evidence, particularly material contained within Ms Ncube's response bundle, which related to personal and private matters concerning Ms Ncube. He indicated that those matters engaged Ms Ncube's right to respect for her private life and therefore it would be appropriate for those limited aspects of the evidence to be heard in private.

33. Mr Kerruish-Jones proposed that, rather than conducting the entirety of the hearing in private, the panel could deal with any personal or sensitive matters on an ad hoc basis as they arose during the hearing. He suggested that the panel could be alerted in advance to those parts of the evidence where private matters might arise and that those specific sections of the hearing could then be heard in private where necessary.

34. Ms Ncube was invited to respond to the application. She confirmed that she understood the application but did not wish to make any representations in relation to it and did not raise any objection.

35. The panel accepted the advice of the legal adviser who advised that the starting point is Rule 37 which provides that fitness to practise hearings should ordinarily be held in public. The panel was advised that this reflects the principle of open justice, which promotes transparency, accountability and public confidence in regulatory proceedings.

36. The panel was further advised that Rule 38(a) provides circumstances in which hearings must be held in private. These include situations where the proceedings concern the physical or mental health of the social worker, in order to protect medical confidentiality and ensure fairness.

37. The legal adviser also advised that Rule 38(b) gives the panel a discretionary power to hear all or part of a hearing in private where it considers this appropriate having regard to the vulnerability, interests or welfare of any participant, or the public interest, including the effective pursuit of Social Work England's overarching objective of protecting the public. This may include circumstances involving vulnerable individuals, children, confidential safeguarding information, or other sensitive personal matters.

38. The panel was advised that when considering whether to exercise this discretion it must undertake a balancing exercise, weighing the principle of open justice against the need to protect sensitive or confidential information. The panel was advised that, where possible, any departure from the principle of open justice should be limited to only those parts of the proceedings where it is necessary and proportionate, rather than the entirety of the hearing.

39. The panel considered the application. In reaching its decision, the panel had regard to the general principle that fitness to practise proceedings should ordinarily be held in public. The panel accepted the submission that there was no justification for the entirety of the hearing to be conducted in private. The panel recognised that elements of the evidence before it related to Ms Ncube's private life and other sensitive personal matters. The panel considered that, where such matters arose during the course of the hearing, it would be appropriate for those specific parts of the proceedings to be heard in private in order to respect Ms Ncube's right to privacy.

40. The panel therefore determined that the hearing would proceed in public, but that any parts of the evidence relating to Ms Ncube's private life or other sensitive personal matters would be heard in private where necessary. The panel indicated that this would be managed on an ad hoc basis as they arose during the course of the hearing.

Allegations:

41. The allegation, as amended, arising out of the regulatory concerns referred by the Case Examiners on 18 March 2022 is:

1. *When you attempted a visit to Family A on 29 May 2019, you:*

    a) *Did not attempt to make contact with the mother when you found she was not at home;*

    b) *Asked her son to pass on the message that you had visited.*

2. *You did not communicate effectively with Family B in that you:*

    a) *Did not attend a visit on 10 June 2019 to Family B as arranged;*

    b) *Did not make contact with Family B to explain that you would not attend the visit;*

    c) *Did not contact Family B again until 14 June 2019.*

3. *While you were the allocated social worker for Family C, you did not:*

    a) *Attend a Network meeting at Service Users CA and CB's school scheduled to take place on 24 June 2019;*

    b) *You did not contact the school to inform them that you would not be in attendance at the meeting.*

4. *Between 2 September 2019 and 4 September 2019 when asked to remain with Service User D to facilitate a handover to their father, you:*

    a) *Did not follow management instruction to remain with the service user until their father arrived to collect them;*

    b) *Left Service User D's home to attend a visit with another family;*

    c) *Did not inform your manager and/or Service User D's father that you had left;*

    d) *Were not present when the father arrived and/or did not answer his call;*

    e) *Were not contactable when your manager tried to contact you;*

    f) *Asked the parent of the second family for a lift back to Service User D's home.*

5. *While you were the allocated social worker for Service User E from around 26 February to 30 April 2020:*

    a) *In a Child in Need meeting on 24 April 2020, you did not chair the meeting effectively in that you:*

i. *Did not circulate the Child in Need plan in advance of or during the meeting;*

ii. *Did not discuss the Child in Need plan and/or the outcomes during the meeting;*

iii. *Had not progressed the action points since the previous meeting on 20 February 2020;*

iv. *Did not enquire about Service User E's living arrangements.*

b) *During a Child in Need meeting on 24 April 2020, you indicated that you did not know what a personal budget was, despite having reported on 27 March that you had made a request for one.*

c) *In an email on 23 April 2020, you requested information to enable an Education Health and Care needs assessment to be completed, despite Service User E having already been awarded an Education Health and Care Plan.*

d) *In your record of a home visit with Service User E on 16 March 2020, you did not provide analysis of their mother's mental health concerns.*

6. *While the allocated social worker for Service User F:*

a) *From 12 March to 5 April 2020, you did not follow management guidance from AB to:*

i. *Prepare a grab pack;*

ii. *Conduct a return to home interview in an appropriate setting;*

b) *Your case note dated 11 March 2020 was not clear and/or did not include adequate analysis of risks;*

c) *You did not complete a case note on 12 May 2020 regarding contact with the safeguarding officer.*

7. *In the following Child and Family assessments, your written communication was not clear and/or lacked analysis:*

a) *Child and Family Assessment for Family G dated 16 August 2019*

b) *Outreach form for Family G*

c) *Child and Family Assessment for review child protection case conference, completed on 14 April 2020 for Family H*

d) *Child and Family Assessment for review child protection case conference, completed on 19 July 2019 for Service User D*

e) *Child and Family Assessment completed on 23 March 2020 for Family I*

f) *Child and Family Assessment for review child protection case conference, completed on 28 August 2019 for Service User J*

8. *Whilst you were the allocated social worker for Service User X from 7 February to 8 September 2020, you:*

a) You took your child with you to one or more child protection visit(s) with Service User X on a date or dates unknown;

b) Took and/or allowed Service User X's mother to take one or more photos of Service User X with your own child;

c) Your actions at a and/or b above represent a failure to maintain professional boundaries

The matters outlined at 1 to 7 above amount to the statutory ground of lack of competence or capability and/ or misconduct.

The matter outlined at 8 above amounts to the statutory ground of misconduct

By reason of your misconduct and/or lack of competence or capability, your fitness to practise is impaired.

Admissions:

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

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

43. Following the reading of the allegations, the panel chair asked Ms Ncube whether she admitted any of the allegations.

44. Ms Ncube informed the panel that she admitted the following allegations: Allegation 1(b); Allegation 2(a) and 2(b); Allegation 3(a) and 3(b); Allegation 4(a), 4(b) and 4(d); Allegation 5(c) and 5(d); Allegation 6(a)(ii) and 6(c); Allegation 7(a)–(e); and Allegation 8(a)–(c) on the basis of one occasion.

45. The panel therefore found Allegation 1(b); Allegation 2(a) and 2(b); Allegation 3(a) and 3(b); Allegation 4(a), 4(b) and 4(d); Allegation 5(c) and 5(d); Allegation 6(a)(ii) and 6(c);

Allegation 7(a)–(e); and Allegation 8(a)–(c) (on the basis of one occasion) proved by way of Ms Ncube's admissions.

46. The panel noted that Ms Ncube partially admitted Allegation 4(c) in that she accepted that she did not contact Service User D's father but denied that she failed to contact her manager. Ms Ncube also partially admitted Allegation 5(b) in that she accepted that on 24 April 2020 she asked what a personal budget was but did not accept that she had previously reported on 27 March 2020 that she had made a request for one.

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

Proved Allegations:

48. Following consideration of the oral and documentary evidence, the submissions of the parties, and the panel's assessment of the witnesses and evidence as a whole, the panel found the following disputed allegations proved:

    1. Allegation 1(a);
    2. Allegation 2(c);
    3. Allegation 4(c). The panel noted that Ms Ncube partially admitted this allegation insofar as she accepted that she did not contact Service User D's father, but denied that she failed to contact her manager;
    4. Allegation 4(e);
    5. Allegation 5(a)(ii);
    6. Allegation 5(a)(iv);
    7. Allegation 6(b); and
    8. Allegation 7(f).

49. Accordingly, the allegations found proved in this case were as follows:

    1. Allegation 1(a) and 1(b);
    2. Allegation 2(a), 2(b) and 2(c);
    3. Allegation 3(a) and 3(b);
    4. Allegation 4(a), 4(b), 4(c), 4(d) and 4(e);
    5. Allegation 5(a)(ii), 5(a)(iv), 5(c) and 5(d);
    6. Allegation 6(a)(ii), 6(b) and 6(c);
    7. Allegation 7(a)–(f); and
    8. Allegation 8(a)–(c), on the basis of one occasion.

Summary of evidence:

50. The panel was provided with an updated written statement of case dated 13 January 2026, which set out the allegations and evidence upon which Social Work England relied. The supporting evidence was presented within the following documents;

- ID Key
- Statement of Case
- Statements Bundle
- Exhibits Bundles
- Social Worker's Response Bundle
- Service and Supplementary Bundle
- Hearsay application
- Social Worker's updated submission on allegations 1-8

Opening submissions on behalf of Social Work England:

51. Mr Kerruish-Jones opened the case by outlining the background to the concerns and the nature of the allegations brought against Ms Ncube. He explained that the concerns arose from a referral made to Social Work England by the London Borough of Hounslow on 14 January 2021, where Ms Ncube had been employed as a social worker between 29 April 2019 and 30 September 2020. The referral related to concerns about Ms Ncube's professional capabilities and conduct during her employment.

52. Mr Kerruish-Jones submitted that concerns regarding Ms Ncube's practice had developed over time and related to a number of fundamental areas of social work practice. These included concerns about her communication skills, both written and verbal, her implementation of management guidance and instruction, engagement with children, families and professional networks, assessment of risk, preparation for statutory meetings and supervision, and her availability and contactability during the COVID-19 lockdown period. These issues initially resulted in informal support being put in place by the employer, including a reduced caseload and management supervision, before later progressing to a formal capability process.

52. The panel was informed that the capability process formally commenced on 2 June 2020, following earlier concerns raised during supervision and appraisal processes. As part of that process, Ms Ncube was placed on a Performance Improvement Plan (PIP) designed to provide support and address concerns regarding her professional performance. However, the concerns continued. In addition to the capability process, a disciplinary investigation was initiated in September 2020 following an allegation that Ms Ncube had breached professional boundaries with a service user and their family.

53. Mr Kerruish-Jones explained that Ms Ncube had worked for the local authority for a relatively short period before going on **[PRIVATE]** leave from September 2019 until February 2020, after which she returned to office-based duties. Despite the support measures implemented by the employer, concerns regarding her performance and practice remained. Ms Ncube ultimately resigned from her position on 18 August 2020 while both the capability process and the disciplinary investigation were ongoing, and she left the local authority before those internal processes had concluded (the panel noted however, that the disciplinary process did not commence until September 2020).

54. Mr Kerruish-Jones then summarised the allegations brought by the regulator, which related to a series of incidents between May 2019 and September 2020 involving several different service users and families. He submitted that the allegations concerned a range of professional failings, including failures to communicate effectively with service users and professionals, failures to attend or appropriately manage visits and meetings, failures to follow management instructions, deficiencies in record keeping and analysis, and concerns regarding professional boundaries.

55. Mr Kerruish-Jones submitted that the allegations, if found proved, related to fundamental aspects of social work practice, including communication with service users and professionals, following management instructions, risk assessment, professional record keeping, and the maintenance of professional boundaries. He submitted that the concerns were wide-ranging, involved multiple service users, and spanned an extended period of time, and that Social Work England would invite the panel to consider whether these matters amounted to misconduct and/or lack of competence or capability, and whether Ms Ncube's fitness to practise was currently impaired.

Witness evidence:

56. All witnesses gave evidence under oath or affirmation, confirmed their witness statements were true to the best of their knowledge and belief, and were adopted as their evidence in chief.

Evidence of Deborah Davey:

57. Ms Davey confirmed that she is a registered social worker who qualified in 2008 and has several years' experience as a social work manager.

58. Ms Davey explained that on 18 September 2020 she was asked by Ms Hopper, Head of Service for Children Safeguarding, to undertake an investigation into concerns relating to Ms Ncube. Ms Davey stated that she had not previously worked with Ms Ncube and believed she was asked to conduct the investigation as she was independent from the relevant team. Her role involved receiving an investigation plan from Ms Billinge, gathering information, reviewing the concerns raised, and receiving statements from relevant members of staff, namely Ms Stacey and Ms Duniec.

59. Ms Davey explained that, as part of the investigation, she met with Ms Ncube on 29 September 2020 together with a Human Resources Adviser. During that meeting the

concerns under investigation were outlined to Ms Ncube, including concerns relating to professional boundaries arising from Ms Ncube taking her child to a child protection visit and photographs being taken of her child with a service user. Ms Davey stated that Ms Ncube accepted during the meeting that she had taken her child with her to a visit because she had been unable to arrange childcare and acknowledged that she had not informed her manager of the childcare difficulties beforehand.

60. Ms Davey further explained that Ms Ncube's responses during the meeting were brief and vague, and required prompting to obtain further explanation. In Ms Davey's view, although Ms Ncube appeared to understand the concerns that had been raised, she did not demonstrate a clear or detailed reflection on the risks associated with bringing her child to a professional visit or how her actions may have been perceived by the family. When asked what she would do differently in the future, Ms Ncube indicated that she would not repeat the behaviour but was unable to provide further explanation as to why or how she would behave differently in future. Ms Davey acknowledged that the COVID period may have resulted in a lack of understanding for Ms Ncube.

61. Ms Davey stated that following the meeting, she prepared a disciplinary investigation report with the assistance of Human Resources, bringing together the statements obtained during the investigation and Ms Ncube's responses during the interview. She explained that the internal process did not progress further because Ms Ncube resigned during the course of the investigation. However, the concerns identified during the investigation were subsequently referred to Social Work England.

Evidence of Megan Stacey:

62. Ms Stacey explained that at the relevant time she was employed by the London Borough of Hounslow as a social worker within the Safeguarding and Support Team. She stated that she worked in the same service area as Ms Ncube.

63. Ms Stacey described a conversation that took place with Ms Ncube on 1 September 2020 in which Ms Stacey and Ms Ncube discussed the case of Service User X. Ms Stacey explained that Service User X was subject to a child protection plan. The case involved daily visits due to concerns regarding unexplained bruising. Ms Stacey stated that she asked Ms Ncube how weekend visits were managed alongside childcare responsibilities and that Ms Ncube explained she sometimes took her daughter with her to visits to the family.

64. Ms Stacey also recalled that Ms Ncube showed her a photograph on her phone which depicted Ms Ncube's child and Service User X together. She stated that the photograph appeared to show the children together indoors. Ms Stacey, within her oral evidence, indicated that she could not recall with conviction that the contact was on more than one occasion.

65. Ms Stacey explained that following this conversation she considered it appropriate to raise the matter with management because of the potential safeguarding and professional boundary implications. She therefore reported the matter, which

subsequently formed part of the disciplinary investigation undertaken by the local authority.

66. In response to cross-examination Ms Stacey accepted that Ms Ncube may have mentioned childcare difficulties at the time and acknowledged that it may have been an oversight on her part that this specific explanation was not included within her written statement.

67. The panel clarified that Ms Stacey prepared her written statement approximately a week after the event and that she was not directly interviewed about this matter.

Evidence of Alison Billinge:

68. Ms Billinge explained that at the relevant time she was employed by the London Borough of Hounslow as the Team Manager within the Safeguarding and Support Team. In that role she had managerial responsibility for a number of assistant managers within the team, including Ms Ncube's manager Ms Duniec.

69. Ms Billinge's evidence addressed concerns regarding Ms Ncube's practice across several cases. She described concerns relating to communication with families and professionals, record-keeping, adherence to management instructions, and the quality of written assessments. Ms Billinge explained that concerns regarding Ms Ncube's performance developed over time and were addressed through supervision and management oversight.

70. In relation to the case involving Service User D, Ms Billinge gave evidence about an incident in early September 2019 when Ms Ncube had been instructed to remain with the child until the father arrived to collect them. Ms Billinge explained that Ms Ncube left the address before the father arrived and attended another visit. Ms Billinge stated that this caused concern because Ms Ncube had not followed the management instruction to remain with the child and had not informed either the father or her manager that she had left.

71. Ms Billinge also provided evidence regarding concerns about Ms Ncube's practise in relation to Service User F. She explained that management guidance had been provided requiring the preparation of a 'grab pack' in circumstances where a child had been reported missing. Ms Billinge described the purpose of a 'grab pack' as providing key information about the child, including identifying details and risk information, to assist agencies such as the police in locating the child. She stated that it was the responsibility of the allocated social worker to prepare and maintain this document.

72. Ms Billinge further gave evidence regarding concerns about the quality of Ms Ncube's written work, including child and family assessments. She explained that Ms Duniec had identified difficulties with the clarity of Ms Ncube's written communication and the level of professional analysis contained within assessments. In her evidence, Ms Billinge described instances where she had been advised that Ms Ncube's written work required significant managerial input or amendment.

73. Ms Billinge also addressed concerns relating to professional boundaries in relation to Service User X. She explained that she became aware of information suggesting that Ms Ncube had taken her own child with her during a visit to the family and that one photograph had been taken of the children together. Ms Billinge indicated that this raised safeguarding and professional boundary concerns which required investigation. Ms Billinge advised that she had directed Ms Ncube to delete that photograph.

74. In response to clarifying questions about her evidence relating to Service User D, Ms Billinge stated that she could not recall precisely how she had obtained the information that Ms Ncube had asked another parent for a lift, suggesting it may have been through verbal feedback or communications at the time. The panel also asked about the 'grab pack' document relating to Service User F. Ms Billinge explained that such a document is intended to contain key information to assist if a child goes missing and indicated that the issue appeared to relate to the adequacy and completeness of the information within the document rather than whether the document had been started. Ms Billinge also gave information related to the supervision, capability, and other work-related matters involving Ms Ncube.

Evidence of Maggie Faulkner:

75. Ms Faulkner explained that she is no longer employed as the deputy head teacher at the school referred to in her statement. She explained that at the relevant time she was employed as Deputy Headteacher and Designated Safeguarding Lead at a primary school. In that role she was responsible for safeguarding matters concerning pupils and for liaising with external professionals, including social workers.

76. Ms Faulkner's evidence related primarily to a network meeting held on 24 June 2019 concerning Service Users CA and CB. She explained that the meeting had been arranged as part of the ongoing safeguarding arrangements for the family. Ms Faulkner stated that Ms Ncube had been expected to attend the meeting in her role as the allocated social worker but did not attend and when contacted, Ms Ncube indicated that she had forgotten about the meeting.

77. Ms Faulkner confirmed that the school had not received any communication from Ms Ncube in advance of the meeting to indicate that she would not be attending.

78. Ms Faulkner explained that she considered that being within child protection processes is an extremely stressful time for any family. She said that her role as a safeguarding lead was to advocate for the child and the family, and that missed meetings and delayed progress prolonged what was already a difficult and stressful period for the family unnecessarily. She explained that she was dealing with the family on a day-to-day basis within the school setting and could see the worry, concern and unhappiness caused by the family remaining in the child protection arena without progress.

Evidence of Alex Cunningham:

79. Ms Cunningham explained that at the relevant time she was working as a newly qualified social worker at the London Borough of Hounslow. She outlined that she had qualified as a social worker in 2018 and worked within the same team as Ms Ncube during part of 2019, although she had limited direct involvement with Ms Ncube's cases.

80. Ms Cunningham's evidence related primarily to a complaint received from the mother of Family B. She explained that on 19 June 2019 she received a telephone call from the mother, who raised concerns regarding Ms Ncube's handling of a scheduled home visit. The mother reported that Ms Ncube had arranged to visit the family on 10 June 2019 but had not attended the visit and had not made contact at the time to explain her absence. Ms Cunningham recorded the details of this call in a contemporaneous email, which was sent to colleagues including Ms Ncube's manager.

81. Ms Cunningham stated that the information contained within the email reflected the account provided to her by the mother during that telephone call. She explained that complaints of this nature were usually raised with the duty social worker and then shared with the allocated worker's manager so that appropriate follow-up action could be taken.

82. Ms Cunningham confirmed that the concerns she described were documented in contemporaneous emails and case records exhibited to her witness statement.

Evidence of Stephanie Mullally:

83. At the relevant time, Ms Mullally was the Operations Director and Safeguarding Officer for the organisation supporting Service User E. Her evidence related primarily to the Child in Need (CIN) meeting held on 24 April 2020 and her professional involvement with the case.

84. Ms Mullally explained that Service User E had significant additional needs and was known to multiple professionals. She stated that the purpose of the CIN meeting was to review the CIN plan, assess the child's circumstances, and ensure that agreed actions were progressed through coordinated multi-agency working. Ms Mullally's evidence was that the meeting did not effectively address these objectives. She stated that the CIN plan had not been circulated in advance of the meeting and that, during the meeting itself, the plan and its outcomes were not meaningfully discussed. Instead, the discussion focused largely on administrative matters, such as funding applications, rather than on reviewing the plan and assessing the child's welfare and progress.

85. Ms Mullally further explained that, following the meeting, she sent an email on the same day to Ms Ncube's manager setting out her concerns regarding the conduct of the meeting. In that email she recorded that the CIN plan had not been referred to during the meeting and that the outcomes had not been reviewed. She also raised concerns about the lack of progress in progressing the agreed actions since the previous meeting held on 20 February 2020.

86. Ms Mullally additionally described concerns regarding Ms Ncube's understanding of aspects of the case. She recalled that during the meeting Ms Ncube asked what a personal budget was, which raised concerns because she understood that Ms Ncube had previously reported, in March 2020, that a request for a personal budget had already been made. Ms Mullally's evidence was that this caused her concern about Ms Ncube's knowledge and capabilities.

87. Ms Mullally further explained that she had concerns regarding Ms Ncube's knowledge of the case. She referred to an email sent to her on 23 April 2020, the day before the CIN meeting, in which Ms Ncube stated that she had drafted a letter requesting an Education, Health and Care (EHC) assessment and sought guidance before submitting it. Ms Mullally stated that this concerned her because the child already had an EHC plan in place and Ms Ncube had attended a review meeting relating to that plan earlier in March 2020. In her view, this indicated a lack of familiarity with the child's circumstances and the support already in place.

88. Ms Mullally stated that she raised concerns following the meeting regarding the lack of progress on the case. She explained that, in an email sent on 24 April 2020, she expressed the view that approximately 15 weeks had elapsed since the first child and family assessment and that limited progress appeared to have been made by social care during that period.

89. Ms Mullally added that, while she recognised that social workers may have demanding caseloads and may not remember every meeting in detail, she would ordinarily expect a social worker to undertake basic preparation before a meeting, including reviewing the case information and being aware of key plans and arrangements in place for the child and family. In her view, the matters she identified in the correspondence suggested that Ms Ncube had not been adequately prepared for the meeting.

90. In response to questions from the panel, Ms Mullally was asked about an email which appeared to suggest that a draft CIN plan may have been circulated prior to the CIN meeting of 24 April 2020. Ms Mullally explained that she had previously searched her records for such documentation but had been unable to locate any email attaching the plan. She stated that, although circulation of a draft plan would ordinarily assist professionals in preparing for a review meeting, it would not remove the need for Ms Ncube to have up-to-date knowledge of the case.

91. In response to the panel's questioning on whether the COVID-19 pandemic had created barriers to achieving outcomes in this case Ms Mullally stated that, although professionals were adapting to new working arrangements during that period, she had not been made aware of any specific COVID-related barriers affecting this case. She explained that professionals were generally tolerant of the challenges presented by the pandemic, but she had not been informed of any issues that would have prevented the actions required for the child from progressing.

92. Finally, Ms Mullally confirmed that, as her service was a non-statutory service, she did not have access to social care records and therefore relied on updates provided by

social care professionals or information shared by the family when seeking updates between meetings.

Evidence of Agata Duniec:

93. Ms Duniec explained that from 2019 to 2020 she worked as an Assistant Team Manager in the Safeguarding and Support Team at the London Borough of Hounslow. In that role she had managerial responsibility for supervising social workers and overseeing the quality of their casework. This included allocating cases appropriately, ensuring that assessments and interventions were progressed in a timely manner, monitoring the quality of social work practice, and supervising cases involving children in need and child protection plans. It was in this professional capacity that she came to supervise Ms Ncube, who joined the team in April 2019. Her evidence addressed a number of the allegations and concerned her supervision of Ms Ncube's work, the management guidance provided by her to Ms Ncube, and concerns identified in several cases.

94. Ms Duniec stated that concerns about Ms Ncube's practice arose over time and related to several areas of professional practice, including communication with families and professionals, record keeping, analytical reasoning within assessments, and adherence to management guidance. Ms Duniec explained Ms Ncube's support consisted of a comparatively low caseload and low complexity (where this could be controlled). She indicated a higher level of supervision, input, and oversight, as well as providing detailed quality assurance and feedback on written assessments. Ms Duniec gave a summary of formal capability processes that were implemented in relation to Ms Ncube.

95. In relation to Family A, Ms Duniec referred to Ms Ncube's case recording of a visit undertaken on 29 May 2019. She explained that the case note indicated Ms Ncube had attended the address but had not seen the children because their mother was not present. The case note recorded that Ms Ncube spoke with the adult son and asked him to pass on a message that she had visited. Ms Duniec stated that the recording did not indicate that Ms Ncube attempted to contact the mother directly following the visit. Ms Duniec indicated that leaving a note with the son was unprofessional.

96. Ms Duniec also addressed matters relating to Service User D, including an incident in September 2019 in which Ms Ncube had been instructed by Ms Duniec to remain with the child until the father arrived. Ms Duniec's evidence was that she became aware that Ms Ncube had left the address in order to attend another visit and had not informed either herself as the manager or the father that she had left. Ms Duniec explained she had directed Ms Ncube to remain with the child and mother due to the mother being too high risk to remain unsupervised with her child having recently been taken to a place of safety by the police. Ms Duniec had no recollection of being informed of Ms Ncube requesting a lift from a family during this episode.

97. Ms Duniec also addressed questions about the CIN case relating to Service User E. She explained that concerns arose following a CIN meeting held on 24 April 2020. Her evidence was that professionals involved with the family raised concerns that the

meeting had not been effectively managed and that key issues, including the CIN plan and the child's circumstances, had not been adequately discussed. She also explained that the key issue in that case appeared to be a misunderstanding regarding the child's living arrangements. Ms Ncube believed the child had moved to live with grandparents and therefore considered that further intervention was unnecessary. However, the child continued to live with the mother who was struggling with her mental health and still required support. In Ms Duniec's view the actions that should have been progressed included support for the mother, coordination with education and health services and ensuring that appropriate plans such as EHC plans were implemented.

98. Ms Duniec also gave evidence regarding Service User F, who had episodes of going missing. Ms Duniec explained that Ms Billinge had provided management guidance to Ms Ncube to prepare a safeguarding 'grab pack', such documents should contain key information to assist agencies in locating a missing child, including photographs, physical description, travel information, social media accounts and emergency contacts. After reviewing the document, she noted that important elements such as a photograph and physical description were absent from the document she reviewed and therefore considered it incomplete. She acknowledged that the 'grab pack' did have some information completed and indicated that this document would be a work in progress over time as a picture is built up over the missing episodes.

99. Ms Duniec also explained that the COVID-19 pandemic had affected working practices during the relevant period. Following Ms Ncube's return **[PRIVATE]** in early 2020, the team had to adapt to new working arrangements, including the use of remote contact with families. Virtual visits were often conducted using video calls such as WhatsApp, although face-to-face visits continued where necessary, subject to risk assessments and the availability of protective equipment. She stated that the pandemic created challenges but that safeguarding responsibilities continued throughout that period.

100. Ms Duniec was also asked about the overseas induction programme and support arrangements for internationally recruited social workers. Ms Duniec acknowledged that she could not answer this fully but offered her understanding of what had been provided. She explained that the programme included a two-week induction period, shadowing opportunities, mandatory training and the allocation of a "buddy" practitioner who could provide guidance and support. She noted that while training was provided on safeguarding issues, case recording systems and practice standards, there had not been specific training on report writing because the recruited practitioners were expected to already possess those core professional skills.

101. Finally, Ms Duniec clarified what she meant in her earlier evidence when referring to Ms Ncube's "capacity". She explained that she did not mean intentional wrongdoing but rather a concern that Ms Ncube appeared to struggle with the demands and complexity of the role. In her view, a combination of factors may have affected Ms Ncube's ability to carry out the role effectively, including communication challenges, possible language barriers, and personal circumstances such as **[PRIVATE]** adjusting to a new professional environment. She emphasised that she was not making a clinical

assessment but believed that a combination of these factors may have affected Ms Ncube's ability to process information and respond to complex safeguarding situations.

102. Ms Ncube asked whether any form of risk assessment had been undertaken in relation to her during her employment at Hounslow, particularly in light of the difficulties and issues that were occurring at that time. She specifically referred to whether a referral had been made to occupational health in respect of her circumstances. Ms Duniec responded that she did not recall any referral to occupational health having been made. She stated that she could not clearly remember why such a referral had not occurred but explained that, as far as she could recall, it had not been considered necessary at the time. She added that her understanding had been that Ms Ncube was already accessing appropriate support and had been communicating about the personal difficulties she was experiencing. For those reasons, Ms Duniec said she did not recall occupational health involvement being requested or implemented.

Social worker's case:

103. Ms Ncube provided a written response to the allegations, which she adopted as her evidence in chief before answering cross-examination questions on the outstanding allegations. In that response, she acknowledged that a significant period of time had passed since the events in question and said that, for that reason, she was unable to recall every detail with complete accuracy. She stated that, having reviewed the written accounts and documents, she believed that some matters did not reflect her recollection or were not supported by the records.

104. In relation to Allegation 1, Ms Ncube stated in her written response that she could not recall the visit of 29 May 2019 in detail but believed that the visit had been pre-arranged with the mother and that, on arrival, the mother was not present. She said that, based on her recollection of the family circumstances, the son who answered the door appeared to be of sufficient age and maturity for her to leave a brief message for the mother. She said she did not identify any safeguarding concerns that would have prevented that interaction. She added that her usual practice would have been either to follow up by telephone or to record the attempted visit in the case notes. In cross-examination, Ms Ncube accepted that the case note for that visit was her record, that it stated the visit had been "as agreed with the mother in the previous meeting", and that she spoke to an older son who informed her that the mother had gone out. She accepted that she left a message via the son for the mother to contact her. When asked directly, she accepted that the only step she took to contact the mother was leaving that message with the son, although she maintained that, from her perspective at the time, this was a reasonable attempt to make contact.

105. In relation to Allegation 2, Ms Ncube accepted in her written response that there had been shortcomings in her practice. She stated that she had attempted to attend the scheduled visit but experienced difficulty locating the address while still unfamiliar with the area, bus routes and navigation tools. She said that the weather deteriorated, that it

began to rain heavily, and that her phone battery ran out, leaving her unable to call the family or the office. She stated that, without access to her phone and unable to locate the property, she decided to return home. She accepted that she later failed to contact the family to explain what had happened **[PRIVATE]**. She acknowledged that she should have informed the family or her manager as soon as possible. In cross-examination, when taken to the contemporaneous email recording the mother's complaint that no contact had been made between 10 June and 14 June 2019, Ms Ncube accepted, on the basis of that record, that she did not contact the family again until 14 June 2019.

106. In relation to Allegation 3, Ms Ncube accepted in writing that she did not attend the network meeting on 24 June 2019 and accepted responsibility for that failure. She said that she had intended to attend but forgot the meeting due to **[PRIVATE]** difficulties she was experiencing at the time. She accepted that she had apologised by email and acknowledged that failing to attend and failing to notify the school or family was a shortcoming in her practice. **[PRIVATE]**. She advised the panel that these matters were compounded as she was also trying to manage the new systems and life in a new country without family and friends to support her.

107. In relation to Allegation 4, Ms Ncube stated in her written submissions that the relevant events occurred during a period when her **[PRIVATE]** general wellbeing were significantly affected **[PRIVATE]**. She said that in the weeks leading up to the incident she had felt under pressure because of concerns about cancelled or rearranged visits **[PRIVATE]**. **[PRIVATE]**. She said that this contributed to poor judgement and decision-making at the time. In relation to communication with her manager, she said she could not recall the precise detail of any communication attempts and noted that she had not seen phone log records to confirm what calls had or had not been answered. She accepted, however, that the pressures she was experiencing affected her ability to communicate effectively. In cross-examination, when taken to the summary document recording attempts by Ms Duniec to call and message her before Ms Ncube replied by WhatsApp, Ms Ncube said she could not recall the sequence of events, but when it was put to her on the basis of that evidence that she did not inform her manager that she had left Service User D's property, she agreed. She also accepted that she had not contacted the father. In relation to Allegation 4(f), Ms Ncube did not accept that she had asked a parent from another family for a lift. In both her written submissions and cross-examination, she maintained that her recollection was that she walked between the addresses, that the properties were close, and that she had no recollection of asking any parent for transport.

108. In relation to Allegation 5, Ms Ncube accepted in her written response that aspects of her practice at that time did not meet the expected professional standard and accepted that the quality of some of her work may not have been at its best. However, she did not accept that she had failed to circulate the CIN plan in advance, stating that the email evidence showed she had sent a draft plan to relevant professionals. In cross-examination, she maintained that she had circulated a draft plan in advance and said that she had also brought hard copies to the meeting and distributed them. When it was

put to her that she had not asked about the welfare of the child or mother, had not asked where the child was living, and that there were uncomfortable silences and inadequate progression of the meeting, Ms Ncube repeatedly stated that she could not remember. When shown the contemporaneous email sent after the meeting in which serious concerns were raised and reallocation of the case was sought, she accepted that the email recorded those concerns and that reallocation was being requested. In relation to Allegation 5(b), Ms Ncube accepted that on 24 April 2020 she asked what a personal budget was but did not accept that she had previously reported on 27 March 2020 that she had made a request for one. She said that she had checked the materials available to her and could not find minutes or meeting notes for 27 March 2020, and that without such records she could not properly confirm that the meeting had taken place or that she had reported making such a request.

109. In relation to Allegation 6, Ms Ncube stated in writing that she did not accept that she had failed to prepare a missing children and young persons 'grab pack'. She referred to documentation in the bundle which, she said, showed that a 'grab pack' had been completed and that a 'return home interview' had been conducted. She accepted that the 'return home interview' may not have taken place in the most appropriate setting and said that this was the first time she had encountered that type of situation and that she would have benefited from clearer guidance. In cross-examination, she was taken to the management email directing her to complete a 'grab pack' and to conduct and record the return home interview. She maintained that the 'grab pack' shown to her in the bundle was the relevant document and that, in her view, it had been completed on 12 March 2020. She said that, if it were being suggested that some other or further 'grab pack' was required, that would need to be demonstrated. She maintained that the document shown to her was labelled as a 'grab pack'. In relation to Allegation 6(b), Ms Ncube initially said she could not recall the case note of 11 March 2020 because she had not been able to locate it within the materials available to her. When taken to the entry and to the criticisms made of it, including that the analysis was unclear and did not adequately explain the problem or the risk, she accepted that those criticisms were fair. She accepted that simply stating that there was a problem that needed to be dealt with was insufficient without explaining what the problem was and why action was required.

110. In relation to Allegation 7, Ms Ncube accepted in her written submissions that aspects of her practice did not meet the expected standard. She attributed this to the personal pressures she was under at the time **[PRIVATE]**. She said that those pressures affected the quality of some of her work. She also said that concerns had been raised about her performance, but that supervision had not always been consistent, although she accepted that it remained her responsibility to seek support and raise concerns if her circumstances were affecting her practice. In cross-examination, when taken to the wording used in one of the child and family assessments and the criticism that the language was neither appropriate nor professional, Ms Ncube initially hesitated and said she would need to consider the language used but ultimately agreed that the language was not appropriate and not professional.

111. In relation to Allegation 8, Ms Ncube accepted in her written response that she had taken her child with her to a home visit on one occasion and accepted that this represented a breach of professional boundaries. She said that she had consistently accepted that fact but rejected any suggestion that this occurred more than once or that she had formed a personal friendship with the service user. She said that all communication with the service user had been professional and related to safeguarding matters. She explained that childcare arrangements had unexpectedly fallen through on the day of the visit, that she had attempted but failed to secure alternative support, and that she felt anxious about missing the visit in light of earlier concerns about her practice. She stated that, on reflection, the decision to proceed with the visit with her child was inappropriate. She accepted that she should have contacted her manager for guidance before proceeding.

112. Throughout her written submissions Ms Ncube placed considerable emphasis on the personal and professional challenges which she faced during the relevant period. **[PRIVATE]**. She also referred to differences between social work practice in South Africa and the United Kingdom, language and communication challenges, and what she described as inconsistent induction, training, and supervision. She stated that these matters affected her confidence, **[PRIVATE]** and professional functioning at the time. While she repeatedly said these matters were not raised as an excuse, she relied on them as contextual factors relevant to understanding her actions and the shortcomings she accepted. She acknowledged the importance of communication, supervision, professional boundaries, organisation, and seeking support at an earlier stage when personal circumstances were affecting practice.

Social Work England's closing submissions:

113. In his closing submissions, Mr Kerruish-Jones reminded the panel that the burden of proof rests with Social Work England and that it is for Social Work England to satisfy the panel that the alleged facts are proven on the balance of probabilities, namely that it is more likely than not that the alleged conduct occurred.

114. Mr Kerruish-Jones submitted that his closing submissions would be relatively brief because, in his view, many of the outstanding allegations had effectively been accepted by Ms Ncube during the course of the hearing. He noted that when Ms Ncube was taken through the documentary evidence and witness evidence in cross-examination, she broadly accepted the criticisms underlying many of the allegations. In his submission, the primary issue throughout the hearing had not been whether the conduct occurred but rather Ms Ncube's recollection of events, which he acknowledged may reasonably have been affected by the significant passage of time. Mr Kerruish-Jones reminded the panel that many of the matters under consideration occurred in 2019 and 2020, and that the hearing was taking place in 2026, meaning that a lapse in memory would not be surprising. He reiterated that the proceedings were not a memory test, and that the panel's task was instead to evaluate the contemporaneous documentary evidence and the witness evidence presented.

115. Mr Kerruish-Jones submitted that there was a substantial body of evidence supporting the allegations. He reminded the panel that they had heard evidence from multiple witnesses, whom he described as providing consistent accounts in relation to the concerns about Ms Ncube's practice. Those witnesses had adopted their witness statements and provided evidence under oath and had been subject to questioning during the hearing. Mr Kerruish-Jones submitted that the panel had before it a significant amount of witness evidence and supporting documentary material which, taken together, supported the allegations made by Social Work England.

116. Mr Kerruish-Jones indicated that, in his assessment, there appeared to be only one allegation which Ms Ncube continued to dispute in substance, namely Allegation 6(a)(i) relating to the preparation of a 'grab pack'. He acknowledged that Ms Ncube had pointed to a document within the hearing bundle which she asserted constituted a completed 'grab pack'. However, Mr Kerruish-Jones submitted that this document appeared inconsistent with the evidence given by both Ms Billinge and Ms Duniec, who had stated that the management instruction to prepare a 'grab pack' had not been properly followed. He invited the panel to consider the timing and nature of the relevant documentation, noting that the management instruction appeared to have been issued prior to 12 March, while the email referring to the absence of a 'grab pack' was dated 12 March, and the document said to represent the 'grab pack' appeared either undated or only referencing that date. Mr Kerruish-Jones submitted that the panel would therefore need to assess the adequacy and sufficiency of the document relied upon by Ms Ncube when determining whether the allegation was made out.

117. Mr Kerruish-Jones further submitted that, aside from that issue, the remaining allegations were supported by both witness testimony and documentary evidence and were, in many instances, effectively accepted by Ms Ncube during cross-examination. He submitted that when Ms Ncube was confronted with the witness evidence and relevant exhibits, she generally acknowledged the criticisms or accepted the factual position put to her. In his submission, this further supported the conclusion that the allegations were established on the evidence.

118. Accordingly, Mr Kerruish-Jones invited the panel to find that the outstanding allegations were proven on the facts. He submitted that the panel had before it sufficient evidence to conclude, on the balance of probabilities, that the factual particulars of the allegations had been established.

119. During questions from the panel, Mr Kerruish-Jones was asked to address Allegation 4(f) further. In response, he acknowledged that the evidence in relation to that allegation primarily arose from a witness account and that there was no supporting evidence other than assertion. He accepted that the evidence could be characterised as hearsay to some extent but submitted that the panel had heard the witness give evidence directly and that the weight to be attached to that evidence was a matter for the panel.

120. Mr Kerruish-Jones was also asked by Ms Ncube about the issue of circulation of the CIN plan. He acknowledged that Ms Ncube had suggested that a draft CIN plan had been circulated. However, he submitted that the evidence from witnesses suggested that the plan had not been circulated during the meeting itself. He accepted that there may be evidence that a draft document had been circulated and invited the panel to determine whether that satisfied the requirement alleged. He submitted that the panel would ultimately need to decide whether circulation of a draft plan amounted to compliance with the requirement to circulate the CIN plan in advance of or during the meeting.

121. Mr Kerruish-Jones concluded by reiterating that the panel had heard extensive evidence and inviting the panel to find that the factual allegations had been established on the balance of probabilities.

Social worker's closing submissions:

122. In her closing submissions, Ms Ncube thanked the panel for the opportunity to address them and expressed her appreciation for the time taken to hear the case. She explained that participating in the hearing had been difficult for her because it had required her to revisit a particularly challenging period in her life and career. She stated that when the proceedings began, she had been unsure whether she would be able to continue participating **[PRIVATE]**. However, she explained that she had resolved to face the process, reflect on what had occurred, and acknowledge her mistakes where appropriate. She explained that through the course of the hearing she had gained strength and had been able to recognise her shortcomings and take responsibility for aspects of her practice.

123. Addressing Allegation 1, Ms Ncube stated that although she could not recall all of the details because of the passage of time, she accepted that she conducted the home visit on the relevant date and that the mother was not at home when she attended. She said that the son answered the door and appeared sufficiently mature to receive a brief message. Ms Ncube explained that, based on her usual professional practice, she would have arranged visits in advance and would normally follow up with the parent after an unsuccessful visit. While she could not confirm whether she had contacted the mother afterwards, she said that her usual practice would have been to follow up, and she accepted responsibility for the actions she took at the time based on her professional judgment.

124. In relation to Allegation 2, Ms Ncube accepted responsibility for the shortcomings that occurred in relation to the missed visit and the lack of communication with the family. **[PRIVATE]**. She clarified that she was not presenting this as an excuse but asked the panel to consider that she had not been well on the day in question. She also explained that she had recently arrived in the country and was still becoming familiar with the local area and travel routes, which made navigating to visits more challenging. She stated that on that particular day her phone battery had run out because she had not had the opportunity to charge it **[PRIVATE]** before travelling to the visit. She recalled struggling to find her way home that day and said that her phone being without charge

meant she could not contact the family. Ms Ncube acknowledged that she should have contacted the family and her manager afterwards and accepted responsibility for failing to do so. **[PRIVATE]**.

125. Ms Ncube further acknowledged that she had missed visits and meetings on some occasions, including the meeting on 24 June 2019 which forms the basis of Allegation 3, and accepted responsibility for those failures. **[PRIVATE]**. She also explained that she had been adjusting to a new life in the UK without the support of family or an established support network. She emphasised that she was not relying on these matters as excuses, but as factors she asked the panel to consider when assessing what had occurred. She said she is not challenging the individuals who have presented the evidence to the panel and openly acknowledged missed visits and communication gaps. She recognised that this had caused inconvenience and problems for all.

126. Ms Ncube also explained that when she began working, she felt pressure to demonstrate that she could perform well in the role. She stated that she was reluctant to repeatedly inform her managers that she was struggling because she feared it might appear that she was unable to perform her duties. As a result, she tried to manage the difficulties herself, encouraging herself that she would overcome them, even though in some instances she ultimately did not succeed.

127. Turning to Allegations 4, 5 and 6, **[PRIVATE]**. She also described feeling significant pressure at work because she was approaching the end of her probationary period and was determined to succeed in the role. Ms Ncube explained that she had left her previous employment because she wanted the opportunity to work in the UK and was deeply committed to making that opportunity succeed.

128. Ms Ncube described the situation as particularly difficult because she did not have a support system in the UK. **[PRIVATE]**.

129. In relation to Allegation 6, Ms Ncube maintained her position regarding the ‘grab pack’. She stated that from the documentation she had reviewed she believed that the ‘grab pack’ had been completed on the same day that she received the management instruction. She indicated that if further evidence were presented demonstrating that it had not been completed appropriately, she would accept that but based on the documents she had seen she believed that the work had been done.

130. In relation to Allegation 7, Ms Ncube accepted the shortcomings in the quality of her assessments that she submitted and stated that the work was not up to standard.

131. Turning to Allegation 8, Ms Ncube accepted that taking her daughter on a home visit constituted a breach of professional boundaries and acknowledged that this was inappropriate. She explained that the situation arose unexpectedly due to childcare difficulties on that particular day. She said that her childcare arrangements had been working well throughout the week and she had no reason to anticipate that they would fail on that Sunday morning. When the arrangements fell through unexpectedly, she acted without properly thinking through alternative options. She accepted that she

should have contacted her manager and sought guidance or cancelled the visit instead of proceeding with the visit with her daughter. Ms Ncube also rejected any suggestion that she had developed a friendship with the service user or that there had been communication outside the professional context. She confirmed that a photograph had been taken of her daughter during the visit and that she had shown it to a colleague, and she accepted responsibility for that.

132. Ms Ncube concluded by reflecting on what she had learned from the experience. **[PRIVATE]**. She recognised the seriousness of the boundary breach and acknowledged that she should have sought managerial guidance and support earlier when she was experiencing personal difficulties. She also acknowledged that she could have strengthened her organisational and communication strategies and engaged more openly with supervision.

133. **[PRIVATE]**. She explained that she had worked hard to obtain the opportunity to practise in the UK and had applied to several countries in order to broaden her professional experience. Coming to the UK had represented a significant achievement for her, and the difficulties she experienced in Hounslow had therefore been deeply distressing. **[PRIVATE]**.

134. Ms Ncube stated that it had taken time for her to rebuild her confidence following those events. She explained that when she later obtained employment at another organisation, she began to regain confidence in her professional abilities and rediscovered enjoyment in her work. She said this experience helped her recognise that the difficulties she experienced in Hounslow were strongly connected to the health and personal challenges she faced at that time.

135. Ms Ncube invited the panel to take these circumstances into consideration when assessing the case.

Legal adviser's advice:

136. The panel accepted the advice of the legal adviser, who reminded the panel that its role at this stage was to determine the disputed facts of the case by considering the evidence before it and making findings in respect of the outstanding allegations. The panel was advised that it was responsible for assessing the reliability and weight of the evidence and deciding whether the alleged facts were established.

137. The panel was advised that where a fact had been admitted by the social worker, the panel was required to treat that admission as proof of the admitted fact in accordance with Rule 32(c)(i)(aa).

138. The legal adviser advised the panel that the burden of proof rests with Social Work England and that the social worker is under no obligation to disprove the allegations. The panel was reminded that the applicable standard of proof is the balance of probabilities, meaning that the panel must determine whether it is more likely than not that the alleged facts occurred.

139. The panel was directed to base its findings only on the evidence properly before it, including the oral testimony of witnesses, documentary exhibits, and any agreed or admitted facts. The panel was reminded that it was entitled to accept or reject parts of any witness's evidence and that it should consider factors such as consistency, plausibility, corroboration by other evidence, and the overall credibility and reliability of witnesses. The panel was also advised that contemporaneous documents, such as records and emails created at the time of events, may often be particularly persuasive when assessing the reliability of evidence.

140. In circumstances where accounts differed, the panel was advised that it was entitled to prefer one account over another provided that its conclusions were based on a proper evaluation of the evidence. The panel was also reminded that it could draw reasonable inferences from the facts it found proved but must avoid speculation.

141. The panel was also advised that some evidence before it was hearsay evidence. The panel was reminded that hearsay evidence is admissible in regulatory proceedings but that the weight attached to such evidence must be carefully considered, taking into account factors such as whether the statement was contemporaneous, whether it was supported by other evidence, and the fact that the maker of the statement may not have been available for cross-examination.

142. Finally, the legal adviser reminded the panel that its findings must be reached collectively and that it must provide clear and reasoned explanations for its conclusions. The legal adviser also explained that during the panel's private deliberations the legal adviser's role would be limited to providing independent legal advice on procedure and law, without expressing any view on the facts or the credibility of witnesses.

Finding and reasons on facts:

Allegation 1(a) – Proved:

143. The panel considered whether, on 29 May 2019, Ms Ncube did not attempt to make contact with the mother after discovering she was not at home.

144. In reaching its decision, the panel placed significant weight on the contemporaneous case note, which recorded the details of the home visit. The panel also considered the evidence of Ms Duniec who advised of the expected appropriate action in this scenario and that contemporaneous records should be inherently reliable as they are created at or near the time of the events in question. The case note contained a detailed account of the visit, including that Ms Ncube spoke with the son who answered the door. However, the panel noted that the record contained no reference to any attempt to contact the mother after it became clear that she was not present.

145. The panel also considered Ms Ncube's evidence. She accepted that she spoke to the son and left a message for the mother through the son. However, she did not state that she made any further attempt to contact the mother directly. While she indicated that

her usual practice would have been to follow up, the panel considered the contemporaneous record to be more reliable than a general description of usual practice provided several years later.

146. The panel therefore concluded that leaving a message with the son did not amount to an attempt to contact the mother directly and that no further attempt to make contact was made. Accordingly, the panel found Allegation 1(a) proved.

Allegation 2(c) – Proved:

147. The panel considered whether Ms Ncube had not communicated effectively with Family B by not contacting Family B again until 14 June 2019.

148. The panel placed weight on the contemporaneous records relating to this period. In particular, the panel noted the record from Ms Cunningham, the duty social worker, detailing a complaint on 19 June 2019, which recorded that the family had not had any contact from Ms Ncube between 10 June and 14 June 2019.The panel considered this record to be a reliable contemporaneous entry of the call that took place on that date, notwithstanding the hearsay nature of the evidence. The panel noted that the duty social worker recorded the call in the course of her role as a social worker and therefore had no reason to believe that she would have inaccurately or artificially recorded that information and therefore found this to be credible and reliable. This hearsay evidence is not sole and decisive as it is supported by the evidence of Ms Duniec and the case note referenced above.

149. The panel further noted that, during questioning, Ms Ncube ultimately accepted that there had been no contact with the family during that period. This was consistent with the documentary evidence before the panel.

150. Taking these matters together, the panel was satisfied that the evidence demonstrated that Ms Ncube did not make contact with Family B between 10 June and 14 June 2019. Accordingly, the panel found Allegation 2(c) proved.

Allegation 4(c) – Proved:

151. The panel considered the allegation that Ms Ncube did not inform the father and did not inform her manager that she had left. The panel noted that Ms Ncube accepted that she had not informed the father but stated that she could not recall whether she had informed her manager.

152. The panel considered the documentary evidence within the bundle, including the material referenced during the hearing. The panel found this to be a detailed contemporaneous summary note prepared by Ms Duniec as the supervising manager following her immediate concerns about the case. The panel considered contemporaneous records of this nature to be reliable evidence. The panel also took into account the evidence contained in the corresponding witness statement and evidence in chief of Ms Duniec, which consistently supported the account recorded in the documentary evidence.

153. The panel noted that the records did not show any attempt by Ms Ncube to contact her manager before leaving. The only evidence of communication was a later WhatsApp message in which Ms Ncube informed the manager that she had gone to cancel an appointment because someone was waiting for her. The panel considered that this communication occurred after she had already left and therefore did not amount to informing her manager beforehand.

154. The panel also noted that, during the hearing, Ms Ncube accepted that she had not spoken to the manager until that WhatsApp communication. Although she stated that she could not remember informing her manager earlier, the panel found that the documentary record and the manager's evidence clearly demonstrated that no such contact occurred prior to her leaving.

155. In light of Ms Ncube's admission that she did not inform the father and the contemporaneous documentary evidence demonstrating that she did not inform her manager before leaving, the panel was satisfied that the allegation was made out. Accordingly, the panel found Allegation 4(c) proved.

Allegation 4(e) – Proved:

156. The panel considered the evidence in relation to Allegation 4(e). In reaching its decision, the panel relied on the same documentary material and witness evidence that it had considered in relation to Allegation 4(c), in particular the contemporaneous summary note recorded by the supervising manager, together with evidence contained in the manager's witness statement and evidence in chief. The panel considered this material to be detailed and reliable as it was created at or near the time of the events and recorded the manager's concerns regarding Ms Ncube's handling of the matter.

157. The panel also noted that the evidence demonstrated that Ms Ncube asked the parent of the second family to cancel the appointment. The panel found that this was consistent with the account recorded in the documentary evidence and the manager's statement.

158. Although Ms Ncube denied the allegation on the basis of not being able to recall, the panel concluded that the contemporaneous records and supporting witness evidence were more reliable and persuasive. Accordingly, the panel found Allegation 4(e) proved.

Allegation 4(f) - Not Proved:

159. The panel considered the evidence in relation to Allegation 4(f). The panel carefully reviewed the witness evidence and the documentary material relied upon in support of the allegation.

160. The panel noted that the allegation appeared to rely primarily on the evidence of Ms Billinge. However, the panel observed that Ms Billinge was not directly involved in the relevant events and that her evidence on this point appeared to derive from information reportedly provided by Ms Duniec. The panel therefore considered the extent to which this evidence was supported by other material.

161. When Ms Billinge was questioned about this issue, the panel noted that she was unable to provide clear details regarding the circumstances in which the information had arisen. She was unable to recall who had provided the information or the source of the allegation. The panel also considered the highly detailed contemporaneous evidence of Ms Duniec, namely the summary incident record, and noted that her evidence does not mention this matter at all and therefore did not clearly support the assertion that Ms Ncube had asked a parent for transport.

162. The panel also considered Ms Ncube's evidence. She stated that she recalled the properties being close to each other and that she walked between them. The panel found her evidence on this point to be clear and credible.

163. In light of the absence of reliable contemporaneous documentation, the hearsay nature of the evidence relied upon, and the credible evidence provided by Ms Ncube, the panel concluded that the allegation was not supported by sufficient evidence. Accordingly, the panel found Allegation 4(f) not proved.

Allegation 5(a)(i) - Not proved:

164. The panel considered that the allegation that Ms Ncube did not circulate the CIN plan in advance of, or during, the relevant meeting. The panel reviewed the documentary evidence and the witness evidence relied upon in support of the allegation.

165. The panel noted the email correspondence within the exhibits bundle whereby on 13 March at 11.52am, Ms Ncube has sent an email which indicates the draft CIN plan was attached. Ms Bell acknowledged receipt of this. The panel observed that this email appeared to form part of a wider email chain and that other professionals involved in the network meeting were copied into the correspondence and in their responses supported that this plan was circulated to the professional network.

166. The panel further took into account the evidence given during the hearing that the circulation of a draft CIN plan prior to a meeting would be acceptable practice, as such plans are often circulated in draft form and then amended following discussion at the meeting. The panel noted that Ms Ncube had always maintained that she had circulated the plan.

167. The panel was satisfied that the available evidence demonstrated that the plan had been circulated to the network prior to the meeting. On that basis, the panel could not be satisfied that the allegation, as framed, had been made out. Accordingly, the panel found Allegation 5(a)(i) not proved.

Allegation 5(a)(ii) – Proved:

168. The panel considered the allegation that the CIN plan and/or the outcomes were not referred to during the meeting. The panel reviewed the documentary evidence and the witness evidence relevant to this allegation.

169. The panel noted that the principal evidence on this point came from the email sent by Ms Mullally following the CIN meeting. The panel placed weight on this email because it was written contemporaneously on 24 April, immediately after the meeting had taken place. The panel considered contemporaneous communications of this nature to be reliable evidence of professional concerns at the time.

170. In her email, Ms Mullally expressed concerns about the conduct and quality of the meeting and specifically stated that the CIN plan was not referred to during the discussion and that the outcomes were not discussed or reviewed. The panel considered that this email demonstrated that the meeting had not addressed the CIN plan as expected. The panel also noted that the email was sent directly to the team manager, which indicated that the concerns were considered sufficiently serious to be raised promptly following the meeting.

171. The panel acknowledged that they had not been directed to any formal minutes of the meeting available which might otherwise have recorded the discussion. However, the panel considered that the contemporaneous email from a professional who attended the meeting provided sufficiently reliable evidence regarding what had occurred. In addition, the panel noted that Ms Ncube could not recall this meeting in any detail.

172. In light of the contemporaneous concerns raised by Ms Mullally about the absence of discussion of the CIN plan, the panel was satisfied that the allegation had been established. Accordingly, the panel found Allegation 5(a)(ii) proved.

Allegation 5(a)(iii) - Not proved:

173. The panel considered the evidence in relation to Allegation 5(a)(iii). The panel noted that the principal evidence relied upon in support of this allegation was the email sent by Ms Mullally following the meeting.

174. The panel noted that the email was written shortly after the meeting and raised concerns about the conduct and quality of the meeting. However, the panel observed that the email indicated that the discussion during the meeting had been based on action points rather than the CIN plan itself. The panel considered that while this email suggested that the plan may not have been specifically referred to during the meeting, it also indicated that relevant matters were nevertheless discussed through the action points. The panel noted within the service user's case notes that they showed action and progress by Ms Ncube on multiple areas for this family and gave evidence of why referrals could not be progressed during the COVID period.

175. The panel noted that Ms Mullally, when questioned, advised that she would not have had access to the local authority case notes where these actions and progress would have been recorded.

176. The panel therefore considered that the available evidence demonstrated some clear actions and rationale for lack of progress on this case and therefore, the alleged conduct did not occur on the balance of probabilities. Accordingly, the panel found Allegation 5(a)(iii) not proved.

Allegation 5(a)(iv) – Proved:

177. The panel considered the evidence relating to Allegation 5(a)(iv). In reaching its decision, the panel took into account the documentary evidence and the witness evidence presented during the hearing.

178. The panel placed weight on the email sent by Ms Mullally to Ms Duniec immediately following the meeting, in which Ms Mullally raised concerns about the handling of the case and the matters discussed during the meeting. The panel considered this email to be a contemporaneous record of a professional raising concerns shortly after the relevant events, which the panel regarded as reliable evidence.

179. The panel also considered Ms Mullally's witness statement, which supported the concerns raised in the email. The panel found that this evidence was consistent with the issues identified in the contemporaneous correspondence.

180. In addition, the panel noted the case note recorded by the subsequent social worker following a conversation with the mother. The panel considered that this record further indicated that relevant enquiries had not been made at the time.

181. The panel also had regard to Ms Ncube's evidence. When questioned about the circumstances, Ms Ncube indicated that she could not recall the details of the matter. The panel noted that she did not provide an alternative explanation or evidence to contradict the concerns recorded in the contemporaneous documentation.

182. Taking these matters together, the panel was satisfied that the documentary evidence demonstrated that the relevant enquiry had not been made. Accordingly, the panel found Allegation 5(a)(iv) proved.

Allegation 5(b) - Not proved:

183. The panel considered the allegation that, during a meeting on 24 April 2020, Ms Ncube indicated that she did not know what a personal budget was despite having reported on 27 March 2020 that she had made a request for one.

184. The panel noted that Ms Ncube accepted that, during the meeting on 24 April 2020, she had asked what a personal budget was. However, she did not accept that she had previously reported on 27 March 2020 that she had requested a personal budget.

185. The panel carefully considered the documentary evidence relied upon in support of this allegation. The panel noted that the evidence indicated that the issue of a personal budget had been discussed previously at a CIN meeting on 20 February 2020 when the case was allocated to a different social worker. The panel found that the documentation from that earlier meeting demonstrated that the concept of a personal budget had been identified as an outcome at that time. However, the panel did not identify any contemporaneous documentary evidence confirming that Ms Ncube herself had reported on 27 March 2020 that she had made such a request.

186. The panel also considered the evidence of Ms Mullally, who raised concerns regarding Ms Ncube's knowledge of the personal budget. However, the panel noted that Ms Mullally's email related specifically to the meeting held on 24 April 2020. The panel did not have minutes from the meeting on 27 March 2020, or any other contemporaneous documentation, which demonstrated that Ms Ncube had previously stated that she had personally requested a personal budget.

187. The panel therefore concluded that while Ms Ncube accepted that she did not know what a personal budget was at the time of the meeting on 24 April 2020, the available evidence did not establish that she had earlier reported making such a request on 27 March 2020 and indicated this outcome had been requested whilst this case had been held by another social worker. The panel considered that the allegation depended on that sequence of events, and in the absence of evidence establishing the earlier report, the allegation could not be made out. Accordingly, the panel found Allegation 5(b) not proved.

Allegation 6(a)(i) - Not proved:

188. The panel considered the allegation that Ms Ncube did not follow management guidance from Ms Billinge to prepare a 'grab pack'. In reaching its decision, the panel carefully reviewed the documentary evidence and the oral evidence given during the hearing.

189. The panel noted that there was a document within the bundle which was titled 'missing persons and child grab pack' and appeared to be a 'grab pack' relating to the relevant case. The only date on the document was 12 March 2020, and the document appeared to have been completed by Ms Ncube. When this document was put to Ms Duniec during the hearing, she acknowledged that the document shown was indeed a 'grab pack'. The panel considered this acknowledgement to be significant.

190. The panel also took into account that the allegation was Ms Ncube did not follow management guidance from Ms Billinge to prepare a 'grab pack', rather than an allegation concerning the adequacy or completeness of the document. The panel noted that evidence given by witnesses indicated that 'grab packs' are documents that are developed over time and may be added to as further information becomes available. The panel therefore considered that the fact the document may nimpairmot have been fully completed or completed well did not mean that a 'grab pack' had not been prepared.

191. The panel further noted that the documentary evidence demonstrated that a 'grab pack' had been created on or around 12 March 2020. Although submissions were made suggesting that it may not have been completed in a timely manner, the panel observed that the allegation itself did not relate to timeliness or adequacy but simply to whether a 'grab pack' had been prepared. Ms Ncube had maintained throughout her denial of this allegation.

192. In light of the contemporaneous document showing that a 'grab pack' had been prepared, the panel was not satisfied that the allegation had been established. Accordingly, the panel found Allegation 6(a)(i) not proved.

Allegation 6(b) – Proved:

193. The panel considered Allegation 6(b), namely that Ms Ncube's written record was not clear and/or did not include adequate analysis of risk. The panel had particular regard to the relevant contemporaneous case note, which the panel considered to be the best evidence of what was recorded at the time. Having reviewed the entry, the panel found that the 'analysis' section contained only a brief statement to the effect that there was 'a problem that needs to be dealt with', without identifying what the problem was, why it amounted to a safeguarding concern, or what risks arose for the child. The panel also found that parts of the wording were unclear, including references such as an 'agent discussion' with a manager and 'action points', which were not explained and did not convey a coherent assessment of risk.

194. The panel further took into account Ms Ncube's evidence under affirmation during cross-examination. Although she initially indicated that she could not recall the case note or locate it, when taken to the entry she accepted that the criticisms advanced by Ms Duniec were fair. In particular, she accepted that the note lacked clarity and contained no meaningful analysis of risk and accepted that it was not sufficient merely to state that there was a 'problem' without explaining what it was and why it required action. The panel considered Ms Ncube's acceptance to be significant and consistent with the panel's own assessment of the document.

195. In light of the limited and unclear content of the case note, Ms Duniec's valid criticism of the quality of the document, and Ms Ncube's acknowledgment that the record did not set out the risk issues or analysis required, the panel was satisfied that the allegation was established. Accordingly, the panel found Allegation 6(b) proved.

Allegation 7(f) – Proved:

196. The panel considered Allegation 7(f), namely that following child and family assessments Ms Ncube's written communication was not clear and lacked analysis. The panel reviewed the relevant Child and Family Assessment completed on 28 August 2019 for Service User J.

197. The panel noted that this contemporaneous document formed the primary evidence for this allegation. In reviewing the assessment, the panel observed that aspects of the written communication lacked clarity and contained wording that was confusing and inappropriate. In particular, the panel noted the reference to the child being "emotional[ly] slower than her age mates", which the panel considered to be poorly expressed and not professionally framed. The panel also considered that the document consisted largely of narrative description and did not include a clear analysis of risk or a structured professional evaluation of the information recorded.

198. The panel accepted the evidence of Ms Duniec, who raised concerns not only about the language used in the assessment but also about the absence of professional analysis. Ultimately, Ms Ncube accepted the allegation.

199. Having considered the document and the supporting witness evidence, the panel concluded that the written communication within the assessment lacked clarity and lacked analysis. Accordingly, the panel found Allegation 7(f) proved.

Allegation 8 – Proved:

200. The panel considered Allegation 8, namely that Ms Ncube took her child with her to one or more visits. The panel noted that the only matter in dispute was that Ms Ncube accepted that she had taken her child with her on only one occasion.

201. The panel reviewed the evidence relied upon in support of this allegation. The panel noted especially that the contemporaneous evidence of Ms Stacey indicated that the incident occurred on more than one occasion. Ms Ncube however, maintained her position consistently throughout the proceedings, including during cross-examination and within her written responses to the regulator.

202. The panel noted that Ms Stacey's statement was prepared close in time to the events in question and she had had the conversation directly with Ms Ncube. This statement throughout identified a conversation that indicated that Ms Ncube took her child on more than one occasion on child protection visits. Although when giving oral evidence, Ms Stacey could not "recall with conviction", due to the passage of time, that this was more than one occasion, the panel placed greater weight on her contemporaneous account.

203. Ms Ncube's admission that she took her child to a visit on one occasion was clear and consistent with her contemporaneous evidence for the investigation process. However, the panel accepted that the conduct occurred on more than one occasion based on the contemporaneous evidence of Ms Stacey. The panel assessed that Ms Stacey had no known motive to fabricate her concerns and determined that as she was raising these issues with management, she would likely have taken care to ensure their accuracy. Therefore, the panel preferred the evidence of Ms Stacey over Ms Ncube in relation to this point.

204. Accordingly, the panel found Allegation 8 proved on the basis that it occurred on more than one occasion.

Summary of submissions on grounds and Impairment:

Social Work England submissions on grounds:

205. Mr Kerruish-Jones submitted that the panel was required, pursuant to Regulation 25(2) of the Social Workers Regulations 2018, to determine whether the facts found proved amounted to misconduct and/or lack of competence or capability. He reminded the panel that this stage involved an evaluative judgment rather than a question of proof.

He clarified that Allegations 1 to 7 were advanced on the basis that they could amount to misconduct and/or lack of competence or capability, whereas the boundary breaches arising from Allegation 8, including Ms Ncube taking her child to a visit involving Service User X, was advanced solely on the basis of misconduct.

206. In relation to lack of competence, Mr Kerruish-Jones referred the panel to the authority of *Calhaem v General Medical Council [2007] EWHC 2606 (Admin)*, submitting that lack of competence suggests a standard of professional performance which is unacceptably low and which, save in exceptional circumstances, should be demonstrated by reference to a fair sample of the practitioner's work. He submitted that the allegations found proved, taken together, provided a fair and representative sample of the social worker's practice over an extended period between approximately May 2019 and May 2020. He submitted that the concerns demonstrated persistent deficiencies across a range of core social work functions, notwithstanding the support, supervision, informal guidance, and subsequent performance improvement plan provided by the local authority.

207. Mr Kerruish-Jones submitted that the concerns established by the panel related to fundamental aspects of social work practice, including communication with families and professionals, professional boundaries, risk assessment and analysis, safeguarding practice, preparation for statutory meetings, compliance with management direction, and maintenance of accurate and appropriate records. He submitted that the concerns were wide-ranging and demonstrated that Ms Ncube had worked at an unacceptably low standard over a sustained period of time.

208. In relation to misconduct, Mr Kerruish-Jones referred the panel to the principles set out in *Roylance v General Medical Council (No.2) [2000] 1 AC 311*, namely that misconduct involves an act or omission falling short of what would be proper in the circumstances. He reminded the panel that not every failing would amount to misconduct and that any misconduct must be sufficiently serious. He submitted, however, that the conduct found proved in this case, both individually and cumulatively, represented serious departures from the standards expected of a registered social worker and therefore met the threshold for misconduct.

209. Mr Kerruish-Jones further submitted that, although some of the allegations pre-dated the introduction of the Social Work England Professional Standards in December 2019 and therefore fell under the HCPC 'Standards of Conduct, Performance and Ethics' then in force, the relevant standards under both frameworks were broadly aligned. He identified, in particular, standards concerning working within the limits of knowledge and skills, managing risk, maintaining professional boundaries, communicating appropriately and effectively, maintaining accurate records, analysing risk, and using supervision appropriately. He submitted that Ms Ncube's conduct engaged and breached a number of these professional standards.

210. Finally, Mr Kerruish-Jones submitted that the concerns found proved placed vulnerable service users at potential risk of harm and represented serious departures from

expected professional standards. He invited the panel to conclude that the statutory grounds of misconduct and/or lack of competence were established.

Social Work England's submissions on impairment:

211. Mr Kerruish-Jones submitted that if the panel were to find a statutory ground established, the panel was then required to determine whether Ms Ncube's fitness to practise is currently impaired, having regard to both the personal and public components of impairment. He referred the panel to Social Work England's guidance on impairment and submitted that the panel should consider whether the concerns identified were remediable, whether they had in fact been remedied, and whether there remained a risk of repetition.

212. Mr Kerruish-Jones referred the panel to the principles set out in *Cohen v General Medical Council [2008] EWHC 581 (Admin)*, submitting that the assessment of impairment must take account both of the need to protect the public and the collective need to maintain confidence in the profession and uphold proper professional standards. He submitted that the relevant considerations included whether the conduct was remediable, whether it had been remedied, and whether repetition was highly unlikely.

213. He also referred the panel to the approach set out in *CHRE v NMC and Grant*, namely whether the social worker had in the past acted, or remained liable in the future to act, in a manner liable to place service users at unwarranted risk of harm, bring the profession into disrepute, or breach fundamental tenets of the profession. Mr Kerruish-Jones submitted that the concerns found proved in this case engaged each of those considerations, save for dishonesty, which was not an issue in this case.

214. In relation to the personal component of impairment, Mr Kerruish-Jones acknowledged that Ms Ncube had engaged with the regulatory proceedings throughout and had provided reflective pieces and testimonials. He submitted that Ms Ncube had generally accepted responsibility for many of the concerns and apologised for aspects of her conduct. He further acknowledged that Ms Ncube had undertaken steps intended to improve her communication skills, including completion of an English language course, and had undertaken employment outside social work, including work as a carer and housing support worker.

215. However, Mr Kerruish-Jones submitted that the concerns identified were extensive, fundamental, and persisted over a prolonged period of approximately 12 months despite supervision, management oversight, informal support, and the implementation of a performance improvement plan. He submitted that the concerns related to basic and fundamental aspects of social work practice, including safeguarding, communication, professional boundaries, risk assessment and analysis, preparation for statutory meetings, record keeping, compliance with management direction, and engagement with service users and professionals.

216. Mr Kerruish-Jones submitted that, whilst the concerns were theoretically remediable through training and practice, Ms Ncube's insight and remediation remained insufficient to fully address the regulatory concerns or to minimise the risk of repetition. In particular, he submitted that although Ms Ncube had demonstrated some reflection, her insight remained limited because it did not sufficiently address the impact of her conduct on the service users concerned. He submitted that the breadth of the concerns, the number of service users affected, and the sustained nature of the failings demonstrated ongoing regulatory concerns regarding her fitness to practise.

217. Mr Kerruish-Jones also invited the panel to consider the weight to be attached to the testimonials provided on behalf of Ms Ncube, noting that it was unclear whether the authors had been made aware of the nature of the allegations and findings in these proceedings when providing their references.

218. In relation to the wider public interest, Mr Kerruish-Jones submitted that the failings found proved represented significant departures from the standards expected of registered social workers and had the potential to undermine public confidence in the profession and the regulatory process. He submitted that the concerns involved fundamental tenets of the profession and included matters directly affecting the safety and wellbeing of vulnerable service users.

219. Accordingly, Social Work England submitted that a finding of current impairment was required on both personal and public interest grounds in order to protect the public, maintain confidence in the profession, and uphold proper professional standards for social workers in England.

Social Worker's submissions on grounds and impairment:

220. Ms Ncube did not make formal submissions. Instead, she relied upon a detailed reflective statement and supporting testimonials she had provided, and her oral evidence. However, Ms Ncube answered questions from Mr Kerruish-Jones and the panel regarding the allegations, her reflective evidence, insight, remediation, current circumstances, and risk of repetition.

221. Ms Ncube stated that the concerns arose during a period in which she was experiencing significant personal vulnerability, including **[PRIVATE]** difficulties adjusting to life and work in a new country. **[PRIVATE].**

222. Ms Ncube accepted that the concerns identified in the allegations reflected failings in her professional practice. She stated that, with hindsight, she recognised that she had not communicated effectively when struggling, had failed to escalate concerns appropriately, and had not prioritised safe practice sufficiently **[PRIVATE]**. She stated that she now understood the importance of maintaining professional boundaries, timely communication, accurate recording, thorough preparation, and seeking support at an early stage when experiencing difficulties.

223. In relation to insight, Ms Ncube stated that she accepted that her actions had negatively affected service users, families, and the local authority. She acknowledged

that service users relied upon social workers for support and safeguarding intervention and accepted that the quality of her work had not met the standard expected. She stated that the quality of some of her reports and assessments failed to provide a clear or accurate picture of families' circumstances, which could have affected continuity of support and required matters to be revisited by other professionals. She acknowledged that this may have caused distress or frustration to vulnerable service users who were required to repeat difficult or traumatic information. She also accepted that she had "let down" both service users and the local authority which had employed her.

224. Ms Ncube further stated that she understood the seriousness of the concerns and had reflected significantly upon the matters found proved. She explained that through reflection and learning she had developed greater emotional resilience, improved self-awareness, and a clearer understanding of professional boundaries and safe practice. She stated that she now practised in a more stable and reflective manner and had learned the importance of escalating concerns, maintaining professional boundaries, and communicating openly when struggling.

225. Ms Ncube also addressed remediation and current practice. She stated that since leaving social work employment she had undertaken work as a care assistant and in housing support roles, where she had continued to work with vulnerable individuals and families. She described carrying out risk assessments within housing services, including assessments relating to safeguarding concerns, fire risks, domestic abuse, substance misuse, financial vulnerability, and risks associated with tenancy loss. She explained that she had developed her understanding of risk assessment through both formal training and practical experience and described making referrals to appropriate support agencies where risks were identified.

226. She also stated that she had undertaken report writing and assessment work in housing support settings and had participated in mentoring newer staff members, including providing guidance regarding report writing, policies, safeguarding, lone working, and professional procedures. She explained that she had supported colleagues in understanding local procedures and risk management practices and had assisted with induction and workplace guidance.

227. Ms Ncube stated that she had undertaken further reading, training, and professional development since the events giving rise to the allegations. She referred to engaging with online social work learning resources, Social Work England training materials, safeguarding-related reading, and wider reading relating to community work, social policy, risk assessment, and social impact assessment. She also stated that she had completed training courses and an English language course aimed at improving her communication skills.

228. In relation to professional boundaries, Ms Ncube provided examples from her more recent work in housing support settings where she said she had maintained appropriate professional boundaries with vulnerable service users despite attempts by some service users to establish more informal relationships or seek preferential treatment.

She stated that she had learned the importance of treating service users consistently, maintaining objectivity, and ensuring that professional relationships remained appropriate at all times.

229. **[PRIVATE]**.

230. **[PRIVATE]**.

231. In relation to supervision and support at Hounslow, Ms Ncube **[PRIVATE]** stated that she did not recall a formal return-to-work process **[PRIVATE]**.

232. Ms Ncube further described the induction process for internationally recruited social workers. She explained that the induction primarily consisted of online training, system training, and shadowing opportunities with experienced practitioners. She stated that she did not recall receiving extensive training specifically regarding English legislation or statutory social work practice and explained that the transition to working in a new country had occurred quickly **[PRIVATE]**.

233. Ms Ncube also provided evidence regarding her current support systems and personal stability. She stated that she now had stable childcare arrangements available should she return to work, together with support from her church, peer networks, community contacts, and voluntary work. She explained that she had become involved in charity and community work, including assisting in the establishment of a charitable organisation and volunteering within a charity retail setting. She described participating in community projects and organisational development work, including safeguarding-related responsibilities within that charitable context.

234. Overall, Ms Ncube's stated that the concerns arose during a uniquely difficult period in her life characterised by **[PRIVATE]**, unfamiliarity with UK practice, isolation, and insufficient coping strategies. She accepted that aspects of her practice had fallen below expected standards and stated that she had since reflected extensively, developed insight, undertaken learning and training, strengthened her professional boundaries and communication skills, and developed safer working practices which, in her view, reduced the risk of repetition.

Legal advice:

235. The panel accepted the legal advice provided by the legal adviser. At this stage, the panel must assess whether the proved facts fall within one or more of the statutory grounds for concern under Regulation 25(2) of The Social Workers Regulations 2018. The relevant statutory grounds to consider in this case are misconduct and lack of competence or capability and then go on to determine the issue of current impairment. The panel reminded itself that the question of whether the facts found proved amounted to misconduct and/or lack of competence or capability was ultimately a matter for its own independent professional judgment. The panel was advised that misconduct and lack of competence are distinct statutory grounds and that it was necessary to carefully distinguish between serious professional wrongdoing and deficient professional performance.

236. In relation to misconduct, the panel was advised that there is no statutory definition of misconduct, but that the applicable legal principles derive from *Roylance v General Medical Council (No. 2)*, namely that misconduct involves conduct falling short of what would be proper in the circumstances. The panel was reminded that not every breach of professional standards amounts to misconduct and that misconduct must represent a serious departure from the standards expected of a registered social worker. The panel was advised to consider the seriousness of the conduct, whether it undermined or had the potential to undermine safe practice or public confidence, and whether the conduct was more properly characterised as serious professional wrongdoing rather than poor performance or isolated error. The panel was further advised that repeated failings could properly be considered cumulatively when determining whether the threshold for misconduct had been met.

237. In relation to lack of competence or capability, the panel was advised that the relevant legal principles derive principally from *Calhaem v GMC*. The panel was advised that lack of competence concerns an unacceptably low standard of professional performance ordinarily demonstrated by reference to a fair sample of the social worker's work. The focus is upon deficiencies in professional skill, knowledge, judgement, or ability, rather than attitudinal concerns or deliberate wrongdoing. The panel was advised that not every error or isolated failing would amount to lack of competence and that it was necessary to consider whether the concerns demonstrated persistent or systemic deficiencies in core areas of social work practice, such as safeguarding, assessment, communication, decision-making, professional judgement, and record keeping. The panel was also advised that contextual matters, including workplace pressures, support, and level of experience, could be considered, although such factors would not necessarily negate a finding of lack of competence if the overall standard of practice remained unacceptably low.

238. The panel was advised that, if a statutory ground was established, it must then go on separately to consider whether the social worker's fitness to practise is currently impaired. The panel was reminded that the purpose of fitness to practise proceedings is not punitive, but rather the protection of the public, the maintenance of public confidence in the profession, and the upholding of proper professional standards, consistent with the principles set out in *Meadow v GMC*.

239. The panel was advised that impairment involves consideration of both the personal and public components of impairment, each carrying equal importance. The panel was referred to *CHRE v NMC and Grant* and the questions derived from the Fifth Shipman Report, namely whether the social worker had in the past acted, or remained liable in the future to act, so as to place service users at unwarranted risk of harm, bring the profession into disrepute, breach fundamental tenets of the profession, or act dishonestly. The panel was reminded that these principles assist in assessing both future risk and the wider public interest.

240. In considering the personal component of impairment, the panel was advised to consider the factors identified in *Cohen v GMC*, namely whether the concerns were

remediable, whether they had been remedied, and whether repetition was highly unlikely. The panel was advised to assess issues including insight, remediation, risk of repetition, harm or risk of harm, admissions, and testimonials. The panel was reminded that genuine insight requires more than expressions of regret and should involve an understanding of what went wrong, why it was wrong, the impact upon service users and the profession, and what would be done differently in future. The panel was further advised that remediation is best demonstrated through objective evidence such as relevant training, supervision, reflective practice, and evidence of improved practice.

241. The panel was also advised that testimonials should be considered carefully, including whether the authors were aware of the regulatory concerns and whether the testimonials addressed the matters relevant to the proceedings.

242. In relation to the public component of impairment, the panel was advised that, even in the absence of a continuing personal risk, a finding of impairment may still be required in order to maintain public confidence in the profession and uphold proper professional standards. The panel was reminded of the principles in *Bolton v Law Society* and *Yeong v GMC*, namely that the reputation of the profession and confidence in the regulatory process are important public interest considerations. The panel was advised to consider whether a fully informed member of the public would be concerned if no finding of impairment were made and whether the absence of such a finding would fail adequately to mark the seriousness of the conduct or uphold the standards expected of registered social workers.

Finding and reasons on grounds:

243. The panel accepted the advice of the legal adviser and considered the submissions made on behalf of Social Work England and by Ms Ncube. The panel reminded itself that the question of whether the facts found proved amount to misconduct and/or lack of competence is a matter for the panel's professional judgement.

244. The panel considered the relevant statutory grounds pursuant to the Social Workers Regulations 2018. In determining whether the facts found proved amounted to misconduct and/or lack of competence, the panel had regard to the relevant case law, including *Roylance v General Medical Council* and *Calhaem v General Medical Council*. The panel reminded itself that misconduct is behaviour which falls seriously short of the standards expected of a registered professional, whilst lack of competence concerns a standard of professional performance which is unacceptably low and ordinarily demonstrated by a fair sample of work.

245. The panel also had regard to the professional standards applicable at the relevant time, which included the HCPC 'Standards of Conduct, Performance and Ethics', the HCPC 'Standards of Proficiency for Social Workers in England', and the Social Work England Professional Standards. The panel found that the following professional standards were breached by Ms Ncube's conduct:

HCPC Standards of Conduct, Performance and Ethics

- 6.1 You must take all reasonable steps to reduce the risk of harm to service users, carers and colleagues as far as possible.
- 6.2 You must not do anything, or allow someone else to do anything, which could put the health or safety of a service user, carer or colleague at unacceptable risk.

HCPC Standards of Proficiency for Social Workers in England

- 1.3 Be able to undertake assessments of risk, need and capacity and respond appropriately.
- 1.4 Be able to recognise and respond appropriately to unexpected situations and manage uncertainty.
- 1.5 Be able to recognise signs of harm, abuse and neglect and know how to respond appropriately.
- 2.3 Understand the need to protect, safeguard, promote and prioritise the wellbeing of children, young people and vulnerable adults.
- 2.5 Be able to manage and weigh up competing or conflicting values or interests to make reasoned professional judgements.
- 4.1 Be able to assess a situation, determine the nature and severity of the problem and call upon the required knowledge and experience to deal with it.
- 8.2 Be able to demonstrate effective and appropriate skills in communicating advice, instruction, information and professional opinion to colleagues, service users and carers.
- 8.9 Be able to engage in inter-professional and inter-agency communication.
- 9.1 Understand the need to build and sustain professional relationships with service users, carers and colleagues.
- 9.6 Be able to work in partnership with others, including service users and carers, and those working in other agencies and roles.
- 14.1 Be able to gather, analyse, critically evaluate and use information and knowledge to make recommendations or modify practice.

Social Work England Professional Standards

- 2.3 Maintain professional relationships with people and ensure that they understand the role of a social worker in their lives.
- 2.7 Consider where conflicts of interest may arise, declare conflicts as early as possible and agree a course of action.

- 3.2 Use information from a range of appropriate sources, including supervision, to inform assessments, analyse risk, and make professional decisions.
- 3.4 Recognise the risk indicators of different forms of abuse and neglect and their impact on people, their families and support networks.
- 3.11 Maintain clear, accurate, legible and up to date records documenting how decisions are reached.
- 3.12 Use assessment skills to respond quickly to dangerous situations and take necessary protective action.
- 4.4 Demonstrate good subject knowledge on key aspects of social work practice and develop knowledge of current issues in society and social policies impacting social work.

246. The panel first considered Allegations 1(a) and 1(b). Whilst the panel found these factual particulars proved, the panel did not consider that the conduct reached the threshold of either misconduct or lack of competence. The panel accepted that Ms Ncube's actions were limited and fell below best practice. However, the panel considered that the conduct represented relatively low-level failing which did not amount to a serious departure from professional standards. The panel was not satisfied that these matters demonstrated an unacceptably low standard of professional performance or conduct sufficiently serious to amount to misconduct.

247. In relation to Allegations 2(a), 2(b), and 2(c), the panel concluded that the matters amounted to misconduct. Ms Ncube did not attend a planned home visit, did not appropriately communicate with the family or her manager, and did not make contact again for several days. The panel considered that this conduct related to fundamental safeguarding responsibilities which would have been known to Ms Ncube. The panel considered that effective communication, reliability, and follow-up are basic and essential components of safe social work practice, particularly where children and families are subject to safeguarding involvement. Whilst the panel accepted that Ms Ncube had referred to personal difficulties and health issues at the time, the panel was satisfied that the conduct represented a serious departure from the standards expected of a registered social worker and therefore amounted to misconduct.

248. In relation to Allegation 3(a) and 3(b), the panel determined that the conduct amounted to misconduct. Ms Ncube did not attend a network meeting and did not appropriately notify relevant professionals and the family. The panel considered that Ms Ncube would have been aware that attendance and participation in multi-agency meetings are a fundamental component of safeguarding practice and coordinated child protection planning. The panel considered that social workers are required to engage effectively and that Ms Ncube would have been aware of the requirement to communicate non-attendance. The panel concluded that the conduct represented a serious falling short

of expected professional standards and therefore amounted to misconduct rather than a mere lapse in performance.

249. In relation to Allegation 4, including particulars 4(a), 4(b), 4(c), 4(d) and 4(e), the panel concluded that the conduct amounted to misconduct. The panel considered the concerns cumulatively. Ms Ncube left a vulnerable child before the father arrived despite clear management instructions to remain, did not appropriately communicate with her manager, did not contact the father, and took inappropriate steps in managing the visits. The panel considered that this demonstrated poor professional judgement in circumstances where clear management direction had been given. The panel considered it particularly serious that the conduct occurred within an active safeguarding context where risk management and adherence to management instructions were essential. The panel was satisfied that the conduct constituted a serious breach of professional obligations. The panel therefore concluded that the conduct amounted to misconduct.

250. In relation to Allegation 5(a)(ii) and 5(a)(iv), the panel concluded that the matters amounted to lack of competence. The panel considered that the evidence demonstrated deficiencies in Ms Ncube's ability to effectively organise, manage, and progress core statutory social work functions in relation to Service User E. Ms Ncube did not effectively chair and manage the Child in Need meeting and did not adequately explore and clarify the child's living arrangements and welfare circumstances. The panel considered that these concerns demonstrated deficiencies in core social work competencies, professional skill, judgement, and capability. The panel was satisfied that the concerns related to fundamental aspects of social work practice and formed part of a broader pattern of deficient professional performance demonstrated across a fair sample of Ms Ncube's work.

251. In relation to Allegation 5(c) and 5(d), the panel concluded that the matters amounted to lack of competence. Ms Ncube demonstrated inadequate understanding and analysis in relation to the service user's educational and safeguarding needs and failed adequately to analyse concerns regarding maternal mental health. The panel considered that Ms Ncube's difficulties in understanding and progressing these issues reflected deficiencies in professional judgement, analytical ability, safeguarding assessment, and understanding of statutory processes. The panel accepted that the concerns demonstrated an inability to consistently exercise the level of professional skill and judgement expected of a reasonably competent social worker. The panel was satisfied that these failings concerned fundamental aspects of social work practice and demonstrated an unacceptably low standard of professional performance amounting to lack of competence.

252. In relation to Allegation 6(a)(ii), the panel concluded that the conduct amounted to misconduct. The panel considered that Ms Ncube did not adequately follow clear management direction regarding safeguarding procedures for a missing child and did not appropriately progress safeguarding actions that had been expressly identified to her. The panel considered that compliance with safeguarding procedures and

management instructions is a fundamental professional responsibility, particularly in circumstances involving a child at potential risk of harm. The panel was satisfied that the conduct represented a serious departure from expected professional standards and involved a significant failure to respond appropriately to safeguarding concerns. The panel therefore concluded that the conduct crossed the threshold into misconduct.

253. In relation to Allegation 6(b), the panel concluded that the matter amounted to lack of competence. The panel considered that Ms Ncube's case recording and risk analysis demonstrated significant deficiencies in clarity, analysis, professional reasoning, and safeguarding assessment. The concerns related to Ms Ncube's ability to appropriately to analyse safeguarding information and to record coherent, child-focused professional assessments capable of being understood and relied upon by other professionals. The panel accepted that the evidence demonstrated deficiencies in professional capability and judgement. The panel concluded that the concerns reflected deficient professional performance in a core area of social work practice and therefore amounted to lack of competence.

254. In relation to Allegation 6(c), whilst the factual particular was proved, the panel did not consider that the matter amounted to either misconduct or lack of competence or capability. The panel accepted that there were shortcomings in relation to the document concerned. However, the panel considered that the evidence demonstrated that some work had been undertaken in relation to the 'grab pack' and that the issue related more properly to adequacy and completeness rather than a wholesale failure to act. The panel concluded that the conduct did not reach the threshold required for either misconduct or lack of competence.

255. In relation to Allegation 7(a)–(f), the panel concluded that the matters amounted to lack of competence. The panel accepted that Ms Ncube's written communication, assessments, and recordings repeatedly lacked clarity, structure, and appropriate professional analysis. The panel considered that these failings related primarily to deficiencies in professional skill, analysis, communication, organisation, and report writing, which are core components of competent social work practice. The panel was satisfied that the concerns demonstrated recurring deficits in fundamental social work competencies over a sustained period of time and across multiple cases. The panel concluded that the concerns reflected an unacceptably low standard of professional performance demonstrated across a fair sample of Ms Ncube's work. The panel therefore concluded that Allegation 7 amounted to lack of competence.

256. In relation to Allegation 8(a)–(c), the panel concluded that the conduct amounted to misconduct. The panel considered that Ms Ncube taking her child to a home visit involving a service user represented a clear failure to maintain appropriate professional boundaries. The panel accepted that Ms Ncube had acknowledged the conduct, apologised, and provided context **[PRIVATE]**. However, the panel considered that maintaining clear professional boundaries is a fundamental tenet of the social work profession and essential to safe safeguarding practice. The panel was satisfied that the

conduct represented a serious departure from the standards expected of a registered social worker and therefore amounted to misconduct.

257. Having considered the evidence as a whole, the panel found that the statutory ground of misconduct was established in relation to Allegations 2(a)-(c), 3(a)-(b), 4(a)-(e), 6(a)(ii), and 8(a)-(c). The panel found that the statutory ground of lack of competence was established in relation to Allegations 5(a)(ii), 5(a)(iv), 5(c), 5(d), 6(b), and 7(a)-(f). The paanel found that Allegations 1(a)-(b) and 6(c), whilst proved factually, did not amount to either misconduct or lack of competence or capability.

Finding and reasons on current impairment:

258. The panel next considered whether Ms Ncube's fitness to practise is currently impaired by reason of the statutory grounds found established. In reaching its decision, the panel took into account the submissions made by Mr Kerruish-Jones, the evidence and reflective material provided by Ms Ncube, her oral evidence before the panel, the testimonials submitted on her behalf, the advice of the legal adviser, and the relevant legal authorities and guidance, including *CHRE v NMC and Grant*, *Cohen v GMC*, and Social Work England's 'Impairment and Sanctions' guidance.

259. The panel reminded itself that the purpose of fitness to practise proceedings is not to punish the social worker for past failings, but to protect the public, maintain public confidence in the profession, and uphold proper professional standards. The panel recognised that impairment is a forward-looking exercise, considering Ms Ncube's past and present circumstances to assess whether Ms Ncube's fitness to practise is currently impaired at the time of the hearing.

260. The panel considered both the personal and public components of impairment. In doing so, the panel had regard to the factors identified in *Cohen*, namely whether the concerns are remediable, whether they have been remedied, and whether they are highly unlikely to be repeated. The panel also considered the questions derived from *Grant*, including whether Ms Ncube had in the past acted, and/or remained liable in the future to act, so as to place service users at unwarranted risk of harm; whether she had brought the profession into disrepute; and whether she had breached fundamental tenets of the profession.

261. The panel first considered the issue of insight. The panel accepted that Ms Ncube had engaged with the regulatory process throughout and had provided reflective material. The panel noted that she had admitted a number of the factual allegations at an early stage and had demonstrated some willingness to acknowledge failings in her practice. The panel also accepted that Ms Ncube had reflected upon aspects of her conduct, including failures in communication, professional boundaries, emotional resilience, and professional judgement.

262. The panel accepted that Ms Ncube had demonstrated some developing insight into the circumstances that contributed to the concerns. In particular, the panel accepted that she had reflected upon the impact of **[PRIVATE]**, the impact of the pandemic, and

workplace pressures during the relevant period. The panel also accepted that she had acknowledged that she had not appropriately sought support and escalated concerns when she was struggling professionally.

263. However, the panel concluded that Ms Ncube's insight remained incomplete and insufficiently developed. The panel considered that, whilst Ms Ncube was able to identify some of the factual failings and acknowledge that her conduct fell below professional standards, her reflections remained largely focused upon the circumstances affecting her personally rather than upon the impact of her conduct upon vulnerable service users, safeguarding processes, colleagues, and the wider public.

264. The panel was particularly concerned that Ms Ncube struggled to articulate clearly the safeguarding risks arising from her failings. Whilst she acknowledged in general terms that service users had been "let down", the panel considered that her understanding of the potential consequences for children and vulnerable families remained underdeveloped. The panel noted that, when questioned directly, Ms Ncube was only able to identify limited examples of how her failings may have affected service users and did not demonstrate a sufficiently developed understanding of the broader safeguarding implications of inadequate assessments, poor communication, deficient risk analysis, and unclear recording.

265. The panel further considered that Ms Ncube's reflections demonstrated only limited acceptance of her own professional responsibility in relation to maintaining competence and seeking appropriate professional development. Whilst the panel accepted that workplace and personal pressures were relevant contextual factors, the panel considered that Ms Ncube continued to place significant emphasis upon external factors and had not yet demonstrated a sufficiently developed understanding of her personal responsibility as a social worker to maintain safe and effective practice notwithstanding such pressures.

266. The panel next considered remediation. The panel accepted that the concerns identified are capable of remediation. The panel also accepted that Ms Ncube had taken some steps towards remediation. The panel noted that she had undertaken some training, engaged in reflective exercises, undertaken work in non-social work support roles, and sought to improve aspects of her communication and professional practice. The panel also accepted that she had demonstrated some positive personal development and greater emotional stability since the events in question.

267. The panel further accepted that there was evidence suggesting improvement in certain limited areas. In particular, the panel considered that there was some evidence that Ms Ncube had become more reliable and organised in relation to attendance, punctuality, and professional engagement. The panel also accepted that the risk of repetition in relation to the professional boundary issue underlying Allegation 8 appeared significantly reduced, given Ms Ncube's reflections regarding childcare arrangements, professional boundaries, and the inappropriateness of taking her child to visits.

268. However, the panel concluded that remediation remained incomplete. The panel was not satisfied that Ms Ncube had demonstrated sufficient remediation of the core concerns relating to safeguarding analysis, risk assessment, professional judgement, report writing, prioritisation, recording, and analytical social work practice. The panel considered that the evidence before it did not demonstrate that Ms Ncube had sufficiently developed or tested the professional skills required for safe autonomous social work practice.

269. The panel noted that much of the evidence relied upon by Ms Ncube related to support work and housing-based roles. Whilst the panel accepted that those roles involved transferable skills and some degree of responsibility, the panel considered that they did not provide sufficient evidence that Ms Ncube had remediated the deficiencies identified in relation to safeguarding assessment, statutory intervention, analytical decision-making, and risk management within a statutory social work environment.

270. The panel was also concerned by the absence of objective evidence demonstrating remediation of the specific competency concerns identified by the panel. The panel noted that Ms Ncube referred generally to undertaking training and learning activities, including safeguarding-related learning. However, the panel considered that the evidence provided lacked sufficient detail and specificity. The panel was not provided with sufficiently detailed evidence demonstrating targeted continuing professional development directed at the particular deficiencies identified in these proceedings. Nor was the panel provided with objective evidence, such as supervisory reports, assessed work, or professional evaluations, demonstrating that Ms Ncube had successfully applied and embedded that learning within professional practice.

271. The panel also considered the testimonials provided on behalf of Ms Ncube. The panel accepted that the testimonials spoke positively of her character, reliability, and commitment. However, the panel attached limited weight to those testimonials in relation to the issue of impairment. The panel noted that the authors of the testimonials had not been informed of the regulatory allegations or the nature of the concerns before the panel. The panel, therefore, considered that the testimonials did not meaningfully address the specific issues relevant to the panel's assessment of impairment and remediation. The panel's approach was consistent with Social Work England's guidance that limited weight should normally be attached to testimonials where the authors are unaware of the underlying regulatory concerns.

272. The panel next considered the risk of repetition. The panel accepted that certain aspects of Ms Ncube's failings appeared less likely to be repeated, particularly those relating to professional reliability and professional boundaries. However, the panel remained concerned that there continued to be a risk of repetition in relation to the more fundamental concerns regarding safeguarding analysis, risk assessment, prioritisation, professional judgement, and analytical social work practice.

273. The panel considered that Ms Ncube's incomplete insight and incomplete remediation meant that the risk of repetition remained more than minimal. The panel was not

satisfied that Ms Ncube had yet demonstrated a sufficiently developed understanding of the safeguarding implications of her failings or that she had fully addressed the deficiencies in her practice. The panel considered that, were Ms Ncube to return to unrestricted social work practice at this stage, there remained a risk that similar failings could recur, particularly in pressured safeguarding environments involving autonomous decision-making and competing demands. The panel therefore concluded that Ms Ncube remains currently impaired on the personal component.

274. The panel then considered the public component of impairment. The panel concluded that the public component of impairment was clearly engaged in this case. The concerns found proved were serious, wide-ranging, and persisted over a significant period of time. The panel had found both misconduct and lack of competence established in relation to fundamental aspects of social work practice, including safeguarding, risk assessment, professional communication, professional boundaries, case recording, professional judgement, and interagency working.

275. The panel considered that Ms Ncube's failings had the potential to place vulnerable children and families at unwarranted risk of harm. The concerns related directly to core safeguarding responsibilities expected of registered social workers. The panel further considered that the failings represented significant departures from the professional standards expected of social workers and breached fundamental tenets of the profession.

276. The panel concluded that informed members of the public would be seriously concerned if a finding of current impairment were not made in circumstances where a social worker had demonstrated repeated failings across a fair sample of work involving safeguarding responsibilities over an extended period. The panel considered that public confidence in the profession and in the regulatory process would be undermined if a finding of impairment were not made.

277. The panel was also satisfied that a finding of impairment is necessary to uphold and declare proper professional standards. The panel considered it essential that social workers understand the importance of maintaining safe safeguarding practice, effective risk assessment, clear professional boundaries, accurate recording, and effective professional communication when working with vulnerable service users.

278. Accordingly, having considered all of the evidence and information before it, the panel concluded that Ms Ncube's fitness to practise is currently impaired on both the personal and public components.

Summary of submissions on sanction:

Social Work England's submissions on sanction:

279. Mr Kerruish-Jones submitted that the panel should consider the available sanctions in ascending order of seriousness and impose the least restrictive sanction capable of adequately protecting the public and addressing the wider public interest. He

described the appropriate outcome as finely balanced but submitted that an 18-month conditions of practice order was the regulator's primary position.

280. Mr Kerruish-Jones acknowledged that Ms Ncube had admitted a number of the allegations, albeit at a relatively late stage, and had demonstrated a willingness to recognise failings in her practice. He referred to the panel's findings that Ms Ncube had undertaken reflection and had demonstrated developing insight. However, he submitted that her insight remained incomplete, particularly because she had experienced difficulty clearly articulating the safeguarding risks arising from her admitted and proved failings.

281. He acknowledged that the panel had found the risk of repetition relating to the professional-boundary concerns in Allegation 8 to be significantly reduced. However, he submitted that a continuing risk remained in relation to the more fundamental practice concerns, including safeguarding analysis, risk assessment, prioritisation, professional judgement, communication, case recording, and compliance with management direction. In light of Ms Ncube's incomplete insight and remediation, he submitted that the overall risk of repetition remained more than minimal and required restriction of her practice.

282. Mr Kerruish-Jones submitted that the concerns were capable of remediation and that Ms Ncube had demonstrated a willingness to engage with the regulatory process and to improve her practice. He relied upon the absence of evidence that any service user had suffered actual harm, the reduced risk of repetition concerning professional boundaries, and the absence of any indication that Ms Ncube would be unwilling or unable to comply with conditions. He submitted that appropriately formulated conditions would provide her with a structured opportunity to address the outstanding concerns while protecting the public. Any failure to comply or demonstrate sufficient improvement could be considered by a reviewing panel, including whether a more restrictive order had become necessary.

283. Mr Kerruish-Jones referred to the 'Impairment and sanctions guidance' concerning conditions of practice. He submitted that the relevant considerations were substantially met. Ms Ncube had demonstrated some insight; the identified deficiencies were capable of remediation; appropriate, proportionate, and workable conditions could be formulated; there was reason to believe she would comply; and any risks could be managed through restricted and supervised practice.

284. He proposed conditions directed at the areas of concern identified by the panel. These included the appointment of a nominated reporter and the provision of regular reports to Social Work England. If employed in a role requiring registration, Ms Ncube should be required to formulate and implement a Personal Development Plan (PDP) addressing safeguarding and risk analysis, the conduct of visits, communication with service users and colleagues, compliance with management direction, prioritisation, professional boundaries, case recording, and written communication. The plan should be agreed

with her employer, provided to Social Work England within a specified period, and updated before any review.

285. Mr Kerruish-Jones further proposed that Ms Ncube should practise under the direct supervision of a registered workplace supervisor approved by Social Work England, with regular supervisory reports provided to the regulator. He submitted that Ms Ncube should not supervise other social workers or students, practise independently, undertake agency or locum work, or perform out-of-hours or on-call duties. She should work only in an establishment where other social workers were employed.

286. He also proposed that Ms Ncube should read and reflect upon Social Work England's Professional Standards, provide a written reflective account addressing the conduct found proved and what she should have done differently, and undertake relevant continuing professional development. Evidence of that learning and development should be supplied to Social Work England within the timescales specified by the panel.

287. As an alternative, Mr Kerruish-Jones submitted that, if the panel concluded that workable conditions could not be formulated or that conditions would not adequately address the identified risks, a suspension order would be appropriate. He referred to the seriousness of the breaches, while also recognising Ms Ncube's engagement, general acceptance of responsibility, work in health and support roles, and stated intention to return to social work practice. He submitted that these matters indicated that the concerns were not fundamentally incompatible with eventual return to the profession and that removal would not be required. In those circumstances, Social Work England would invite the panel to impose a suspension order for 12 months.

288. In response to questions from the panel, Mr Kerruish-Jones submitted that there were no specific aggravating factors beyond the findings already made. In mitigation, he relied upon Ms Ncube's admissions, her engagement with the proceedings, and the absence of any other disciplinary history brought to the panel's attention.

Social worker's submissions on sanction:

289. Ms Ncube did not make any substantive submissions regarding the appropriate sanction and indicated that she would leave the decision to the panel.

290. In response to a question from the panel, Ms Ncube confirmed that, if the panel imposed a conditions of practice order, she would be willing to comply with the conditions.

Legal advice:

291. The panel accepted the advice of the legal adviser in relation to sanction. The panel was advised that, having found Ms Ncube's fitness to practise currently impaired, it was required to determine what, if any, sanction was necessary. The purpose of a sanction was not to punish Ms Ncube for past conduct, although it might have a punitive effect,

but to protect the public, maintain public confidence in the social work profession and uphold proper professional standards.

292. The panel was reminded of the principle in *Bolton v Law Society* that the reputation of the profession and the maintenance of public confidence may require a sanction notwithstanding the consequences for the individual professional. The panel was advised that any sanction must be necessary, proportionate and no more restrictive than was required to achieve the regulatory objectives.

293. The panel was advised to consider the available outcomes in ascending order of seriousness, beginning with the least restrictive, and to identify the first outcome sufficient to protect the public and address the wider public interest. It was required to explain why each lesser outcome was insufficient. The panel was also reminded that its decision on sanction should be consistent with its findings on impairment. In particular, where a current risk to the public had been identified, an outcome that did not restrict practice would ordinarily be inconsistent with that finding.

294. The panel was advised to take account of all relevant aggravating and mitigating factors. Potential mitigating factors included insight, remorse, admissions, objective evidence of remediation, relevant training and reflection, personal or health circumstances, the level of workplace support, previous good character and informed testimonials. Potential aggravating factors included repeated or prolonged concerns, actual or potential harm, relevant regulatory history, limited insight, incomplete remediation and a continuing risk of repetition. Although personal circumstances and hardship were relevant to proportionality, they could not override the need for public protection or the maintenance of confidence in the profession.

295. In relation to the available sanctions, the panel was advised that taking no further action following a finding of impairment would be rare and would only be appropriate where the impairment finding itself was sufficient and there was no continuing risk. Advice and warning orders did not restrict practice and were generally appropriate only where the concerns were limited, the risk of repetition was low and sufficient insight and remediation had been demonstrated. Where the panel had found current impairment on the personal component, a non-restrictive outcome would rarely provide sufficient public protection.

296. The panel was advised that a conditions of practice order may be appropriate where the deficiencies were capable of remediation, the social worker had demonstrated sufficient insight, workable and proportionate conditions could be formulated, and the panel was satisfied that the social worker was willing and able to comply. Conditions were commonly appropriate in cases involving lack of competence or capability. However, they had to be clear, workable, measurable, verifiable, enforceable and capable of being monitored by Social Work England. They also had to provide adequate public protection without being so restrictive as to amount in practice to suspension. A conditions of practice order could be imposed for up to 3 years and would be reviewed before its expiry.

297. The panel was advised that suspension may be appropriate where the concerns were serious and temporary removal from practice was required, but there remained a realistic prospect of remediation and eventual return to practice. Suspension would ordinarily be appropriate where workable conditions could not be formulated or would not sufficiently protect the public or wider public interest. When determining the duration of a suspension order, the panel should balance the need for public protection and the maintenance of professional standards against the risk of the social worker becoming deskilled.

298. A removal order was the most restrictive sanction and should only be imposed where no lesser outcome would adequately protect the public, maintain public confidence or uphold proper professional standards. It was generally reserved for the most serious cases, including serious dishonesty, abuse of trust, violence, sexual misconduct, serious criminal offending, persistent lack of insight, or an unwillingness or inability to remediate. The panel would be required to explain clearly why suspension or any other lesser sanction was insufficient before imposing removal.

299. The panel was further advised that there was a public interest in supporting a trained professional to return to safe and effective practice where this could be achieved without compromising public protection. This could support the imposition of workable conditions, or a time-limited suspension with review, rather than removal in an appropriate case. However, the interests of the social worker could not take precedence over public safety.

300. Finally, the panel was advised to conduct an express proportionality assessment and to provide clear and structured reasons identifying why the selected sanction was the minimum necessary. Its reasons should explain why lesser and more restrictive sanctions were rejected, why the chosen duration was appropriate, and how the order addressed the specific risks and public interest concerns identified in its impairment decision.

Decision and reasons on sanction:

301. In reaching its decision on sanction, the panel accepted the advice of the legal adviser and had careful regard to the 'Impairment and sanctions guidance' published by Social Work England. The panel took account of Social Work England's overarching objective of protecting, promoting and maintaining the health, safety and wellbeing of the public, maintaining public confidence in the social work profession, and promoting and maintaining proper professional standards.

302. The panel reminded itself that the purpose of a sanction is not to punish Ms Ncube, although a sanction may have a punitive effect. It considered the available sanctions in ascending order of seriousness and sought to identify the least restrictive sanction sufficient to protect the public and address the wider public interest. The panel had regard to the submissions made by Mr Kerruish-Jones and Ms Ncube's willingness to comply with any order, together with its earlier findings on facts, grounds and current impairment.

303. The panel identified the following aggravating factor:

- The concerns did not arise from a single or isolated incident. They involved repeated poor-quality practice over a prolonged period and extended across a number of fundamental areas of social work practice.

304. The panel identified the following mitigating factors:

- Ms Ncube was experiencing significant health and personal difficulties during the relevant period, supported by documentary evidence **[PRIVATE]**.
- Some of the events occurred during the COVID-19 pandemic, when Ms Ncube was considered to be at increased risk and was working in particularly difficult circumstances.
- There were relevant contextual issues arising from Ms Ncube's recruitment as an overseas-qualified social worker and a lack of clarity concerning the nature and effectiveness of the induction and support provided to overseas-qualified social workers in her position.
- Ms Ncube admitted a number of allegations and particulars, including some at an early stage, and those admissions reduced the areas requiring determination by the panel.
- Ms Ncube demonstrated some remorse for her failings.
- She engaged fully with the regulatory proceedings and remained engaged throughout a lengthy hearing.
- She had undertaken some continuing professional development, training and reflective exercises directed towards improving her practice.
- There was no previous regulatory or disciplinary history before the panel.

No further action, advice or warning order:

305. The panel first considered whether it would be sufficient to take no further action or to impose advice or a warning order.

306. The panel concluded that none of those outcomes would be appropriate. The concerns involved both misconduct and lack of competence across a number of fundamental areas of social work practice. They included safeguarding analysis, risk assessment, professional judgement, prioritisation, communication, case recording, compliance with management direction and professional boundaries.

307. The panel had also found Ms Ncube's fitness to practise impaired on both the personal and public components. In particular, it had found that her insight and remediation remained incomplete and that there continued to be a risk of repetition in relation to the core practice concerns.

308. Taking no further action would provide no protection against that risk and would fail adequately to mark the seriousness and breadth of the findings. It would also undermine public confidence in the profession and fail to uphold proper professional standards.

309. Advice or a warning order would similarly be insufficient. Those outcomes would not restrict Ms Ncube's practice and would permit her to return immediately to unrestricted social work. The panel considered that this would be inconsistent with its finding that there remained a current risk to service users if Ms Ncube were to return to unrestricted practice at this time.

Conditions of practice order:

310. The panel next considered whether a conditions of practice order could adequately protect the public and address the wider public interest.

311. The panel considered this issue with particular care because the findings were wide-ranging and concerned a number of core social work competencies. It recognised that any conditions imposed would need to be sufficiently comprehensive to address those concerns, while remaining workable and not becoming so restrictive as to amount in practice to suspension.

312. The panel concluded that the deficiencies identified were capable of remediation. They related principally to professional knowledge, skill, analysis, judgement, organisation and communication rather than to dishonesty, violence, discrimination, abuse of trust or deep-seated attitudinal concerns. There is a realistic prospect that, with appropriate training, supervision, reflection and supported practice, Ms Ncube could develop the skills required to return safely to unrestricted social work practice.

313. The panel also considered that Ms Ncube had demonstrated sufficient developing insight to make conditions workable. Although her insight was not yet complete, it had developed during the proceedings. Ms Ncube had engaged consistently with the hearing, had reflected upon aspects of her practice and had undertaken some relevant training. She had also expressly confirmed that she would comply with a conditions of practice order.

314. The panel was satisfied that Ms Ncube was willing and capable of complying with conditions. There was no evidence that she had deliberately disregarded regulatory requirements or that she would seek to evade the restrictions imposed upon her practice. Her sustained engagement with the proceedings gave the panel confidence that she would engage with supervision, training, reporting and reflective requirements.

315. The panel was also satisfied that workable, measurable and verifiable conditions could be formulated. The conditions could require Ms Ncube to practise only within a structured employment setting and under supervision, prevent her from practising independently or undertaking roles involving unsupported practice, and restrict her from supervising other social workers or students.

316. The conditions could further require a PDP and targeted continuing professional development addressing the particular deficiencies identified, including safeguarding and risk analysis, undertaking visits, communication with service users and professionals, compliance with management direction, prioritisation, professional boundaries, case recording and written communication. Compliance and progress could be monitored through reports from an approved workplace supervisor and nominated reporter and through the provision of documentary evidence to Social Work England.

317. The panel concluded that such conditions would provide substantial safeguards. Ms Ncube would not be permitted to return to unrestricted practice or to undertake autonomous social work without appropriate oversight. The conditions would enable her competence and professional judgement to be observed, assessed and developed within practice while ensuring that responsibility for complex work and decision-making was appropriately supervised.

318. The panel recognised that Ms Ncube was not currently working as a registered social worker and that securing suitable employment subject to conditions might be difficult. However, it did not consider that the absence of current social work employment made conditions unworkable. The conditions would take effect whenever she obtained a role requiring registration/use of her social work skills, and she would remain responsible for informing prospective employers and Social Work England of her circumstances.

319. The panel considered the likely effect of a conditions of practice order upon Ms Ncube. It recognised that the order would restrict the roles she could undertake, require disclosure to prospective employers and may make it more difficult for her to secure social work employment. The conditions would also impose significant obligations in relation to supervision, training, reflection, reporting and professional development.

320. The panel balanced those consequences against the seriousness and breadth of the findings, the continuing risk of repetition and the need to protect vulnerable service users. It also took account of the need to maintain public confidence in the profession and uphold the standards expected of registered social workers.

321. A conditions of practice order would protect the public through supervision and restrictions on Ms Ncube's practice while giving Ms Ncube an opportunity to demonstrate remediation.

322. The panel therefore concluded that a conditions of practice order could adequately manage the identified risks, protect service users, maintain public confidence and uphold proper professional standards. The panel concluded that the impact of the order upon Ms Ncube was justified and proportionate to the risks and concerns identified.

Suspension order:

323. For completeness, the panel went on to consider whether a suspension order was required. It considered this to be a finely balanced issue in view of the number and

nature of the concerns, the range of fundamental practice areas affected, and its finding that Ms Ncube remained impaired on both the personal and public components.

324. The panel recognised that suspension would provide immediate and complete protection by preventing Ms Ncube from practising as a social worker. It also acknowledged that suspension may be appropriate where the concerns represent serious breaches of professional standards and where workable conditions cannot be formulated.

325. However, the panel had been able to formulate conditions which it considered workable, measurable and sufficient to protect the public. The identified deficiencies were remediable, Ms Ncube had demonstrated some insight and a willingness to improve, and there was a realistic prospect of her returning to safe and effective practice. The panel noted that the 'Impairment and sanctions guidance' states it is in the public interest to support a trained and skilled social worker to return to practice, if this can be achieved safely.

326. The panel placed particular weight upon Ms Ncube's sustained engagement with the proceedings, her developing insight and her expressed willingness to comply with conditions. It considered that she had the potential to become a safe and competent practitioner if provided with a structured opportunity to demonstrate and consolidate improvement.

327. The panel concluded that suspension would be more restrictive than was presently necessary. It would prevent Ms Ncube from undertaking the supervised practice through which the outstanding deficiencies could most effectively be tested and remediated. The panel was satisfied that the public could be protected without entirely excluding her from the profession. The panel therefore determined that suspension would be disproportionate at this stage.

328. The panel next considered the appropriate duration of the order carefully. Social Work England had proposed a period of 18 months. However, the panel concluded that a period of 2 years was necessary and proportionate.

329. The panel had identified deficiencies across a substantial number of core areas of social work practice. Meaningful remediation would require targeted training, reflection, the preparation and implementation of a PDP, and a period of supervised practice during which Ms Ncube could demonstrate sustained and consistent improvement.

330. The panel also recognised that Ms Ncube was not currently employed as a registered social worker and might require a significant period to obtain a suitable role in which the conditions could operate. A period of 2 years would provide sufficient time for Ms Ncube to obtain suitable employment, undertake the required learning, apply that learning in supervised practice and produce objective evidence of improvement. It would also provide an appropriate period of public protection.

331. The panel determined that the appropriate and proportionate sanction was a conditions of practice order for a period of 2 years. The order will be reviewed before it expires. For a period of two years from the date on which this order takes effect, Ms Ncube's registration will be subject to the following conditions.

Conditions:

332. The conditions imposed by the panel are set out below:

Condition 1

You must notify Social Work England at any time you are employed in a role, or provide social work services, which require you to be registered with Social Work England. You must provide Social Work England with the contact details of your employer, agency, or any organisation with which you have a contract or arrangement to provide social work services, whether paid or voluntary.

Condition 2

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

Condition 3

a. At any time you are employed in a role, or provide social work services, which require you to be registered with Social Work England, you must agree to the appointment of a reporter nominated by you and approved by Social Work England. The reporter must be registered with Social Work England and may be the same person as your workplace supervisor.

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

Condition 4

You must arrange for your reporter to provide reports to Social Work England every 4 months and at least 14 days before any review of this order. Social Work England will make these reports available, upon request, to any workplace supervisor referred to in these conditions.

Condition 5

You must inform Social Work England within 7 days of receiving notice of any formal disciplinary proceedings taken against you while these conditions are in effect.

Condition 6

You must inform Social Work England within 7 days of receiving notice of any investigation or complaint made against you while these conditions are in effect.

Condition 7

You must inform Social Work England if you apply for social work employment or self-employment, whether paid or voluntary, outside England. You must do so within 7 days of the date of the application.

Condition 8

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

Condition 9

a. At any time you are employed in a role, or provide social work services, which require you to be registered with Social Work England, you must formulate a Personal Development Plan specifically designed to address the identified shortfalls in the following areas of your practice:

i. Safeguarding;

ii. Analysis of risk;

iii. Undertaking visits;

iv. Communication with colleagues and service users;

v. Following management direction;

vi. Prioritisation;

vii. Professional boundaries;

viii. Case recording;

ix. Written communication; and

x. Assessment skills.

b. Your Personal Development Plan must be approved and signed by your employer, if you are employed.

Condition 10

You must provide Social Work England with a copy of your Personal Development Plan within 8 weeks of the date these conditions take effect. You must provide an updated copy to Social Work England at least 2 weeks before any review of this order.

Condition 11

a. At any time you are employed in a role, or provide social work services, which require you to be registered with Social Work England, you must place yourself and remain under the close supervision of a workplace supervisor nominated by you and approved by Social Work England. The workplace supervisor must be registered with Social Work England and may be the same person as your reporter.

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

Condition 12

You must arrange for your workplace supervisor to provide reports to Social Work England every 3 months and at least 14 days before any review of this order. Social Work England will make these reports available, upon request, to any reporter referred to in these conditions.

Condition 13

You must only work as a social worker at an establishment where at least two other social workers are employed and working on a daily basis.

Condition 14

You must not supervise the work of any other social worker or student social worker.

Condition 15

You must not be responsible for the work of any other social worker or student social worker.

Condition 16

You must not work as an independent social worker. You must only work as a social worker at an establishment where other social workers are employed.

Condition 17

You must only engage in social work practice at an establishment that you do not own, where another social worker is working at the same time as you and with whom you have made personal contact before you begin work each day.

Condition 18

You must not undertake any agency, locum, out-of-hours, or on-call duties.

Condition 19

You must read Social Work England's 'Professional Standards' (July 2019), and provide a written reflection to Social Work England 4 months after these conditions take effect, focusing on how your conduct, for matters relating to this

case was below the accepted standard of a social worker, outlining what you should have done differently.

Address the conduct and practice concerns arising from this case in relation to:

xi. safeguarding;

xii. analysis of risk;

xiii. undertaking visits;

xiv. communication with colleagues and service users;

xv. following management direction;

xvi. prioritisation;

xvii. professional boundaries;

xviii. case recording;

xix. written communication; and

xx. assessment skills;

b. Explain how your conduct and practice fell below the standards expected of a registered social worker; and

c. Identify what you should have done differently.

Condition 20

a. You must undertake 35 hours of continuing professional development in relation to safeguarding, risk analysis, communication skills, professional boundaries, and assessment skills.

b. You must provide evidence of the continuing professional development undertaken to Social Work England within 6 months of the date these conditions take effect.

Condition 21

You must provide a written copy of your conditions, within 7 days from the date these conditions take effect, to the following parties confirming that your registration is subject to the conditions listed at 1 to 20, above:

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

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

- Any organisation, agency or employer where you are using your social work qualification/knowledge/skills in a non-qualified social work role, whether paid or voluntary (at time of application).

You must forward written evidence of your compliance with this condition to Social Work England within 14 days from the date these conditions take effect.

Interim order:

333. In light of its findings on sanction, the panel next considered an application by Mr Kerruish-Jones for a 2 year interim conditions of practice order to cover the appeal period before the final order becomes effective. Mr Kerruish-Jones also invited the panel to revoke the interim suspension order that had been put in place in preparation for this hearing.

334. The panel considered whether to impose an interim order. It was mindful of its earlier findings and the risk to the public if no order is in place and decided that it would be wholly incompatible with those earlier findings to permit Ms Ncube to practice unrestricted during the appeal period.

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

336. The panel accepted the submissions of Social Work England and noted that the interim order imposed on 18 June 2021 is no longer necessary as the public are adequately protected by the final order today on 17 July 2026. Ms Ncube is in agreement with this course of action.

337. The purpose of the interim order has now been superseded by the final order imposed on 17 July 2026. Ms Ncube is now subject to a conditions of practise final order for a period of 2 years, which has been imposed following a finding of impairment. In addition, an interim conditions of practise order for a period of 18 months is in place to ensure public protection during the appeal period.

338. Accordingly, the panel has decided to revoke the interim order imposed on 18 June 2021 under Schedule 2, paragraph 8 of the Social Workers Regulations 2018 (as amended). The interim suspension order imposed on 18 June 2021 is revoked.

Right of appeal:

339. 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.

340. 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.

341. 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.

342. 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:

343. 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

344. 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:

345. 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-regulaors/decisions-about-practitioners.