Social worker: Darren John Mason
Registration number: SW34399
Fitness to Practise
Final Hearing

Dates of hearing: 16 June 2025 to 02 July 2025

Hearing venue: Remote hearing

Hearing outcome:
Fitness to practise impaired, removal order

Interim order:
Interim suspension order (18 months)

Introduction and attendees:

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

2. Mr Mason did not attend and was not represented.

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

Adjudicators	**Role**
Catherine Boyd	Chair
Louise Fox	Social worker adjudicator
Richard Weydert-Jacquard	Lay adjudicator

Hearings team/Legal adviser	**Role**
Andrew Brown	Hearings officer
Chiugo Eze	Hearings support officer
Zill-e Huma	Legal adviser

Service of notice:

4. The panel of adjudicators (hereafter "the panel") was informed by Ms Bucklow that notice of this hearing was sent to Mr Mason by email and next day delivery service to an address provided by Mr Mason (namely their registered address as it appears on the Social Work England register). Ms Bucklow submitted that the notice of this hearing had been duly served.

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

   - A copy of the notice of the final hearing dated 15 May 2025 and addressed to Mr Mason at his email and postal address which he provided to Social Work England;
   - An extract from the Social Work England Register detailing Mr Mason's registered address;
   - A copy of a signed statement of service, on behalf of Social Work England, confirming that on 15 May 2025 the writer sent by email and next day delivery service to Mr Mason at the address referred to above: notice of hearing and related documents;
   - A copy of the Royal Mail Track and Trace Document indicating "signed for" delivery to Mr Mason's address on 16 May 2025.

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

7. Having had regard to Rule 26 of the Fitness to Practise Rules ("the Rules") and all of the information before it in relation to the service of notice, the panel was satisfied that

notice of this hearing had been served on Mr Mason in accordance with Rules 26. The panel was therefore satisfied that Mr Mason had been given notice of the hearing and an opportunity to attend the same.

Proceeding in the absence of the social worker:

8. The panel heard and considered the submissions of Ms Bucklow on behalf of Social Work England. Ms Bucklow submitted that notice of the hearing had been properly served on Mr Mason in accordance with the Rules. She informed the panel that Mr Mason had provided written confirmation that he would not be attending the hearing. She further submitted that no application for an adjournment had been made, and that there was no reason to believe that adjourning today's proceedings would result in his attendance at a later date. In the absence of any good or compelling reason for his non-attendance, Ms Bucklow invited the panel to proceed in Mr Mason's absence in the interests of justice and the efficient disposal of the case.

9. The panel accepted the advice of the legal adviser in relation to the legal framework for proceeding in the absence of a registrant. The panel was advised to consider Rule 26 of the Social Work England Fitness to Practise Rules 2019, which permits a hearing to proceed in the absence of the registered social worker where notice has been properly served, and it is fair and appropriate to do so. The legal adviser referred the panel to the principles established in *R v Jones [2003] UKPC* and *General Medical Council v Adeogba [2016] EWCA Civ 162*, which emphasise that fairness and the proper administration of justice are paramount. The panel was reminded that the decision to proceed in absence is a serious one and must not be taken lightly. It should only be made where there is no good or compelling reason for the registrant's non-attendance, and where it is consistent with the public interest, including the protection of the public and maintaining confidence in the regulatory process. The panel was also advised to consider whether there was any realistic prospect that an adjournment would secure the registrant's attendance at a future date.

10. The panel considered all of the information before it, including the documentary evidence confirming proper service of the notice of hearing, and the written communication from Mr Mason in which he clearly stated that he would not be attending the hearing. The panel noted that Mr Mason had not provided any explanation for his non-attendance and had not submitted any good or compelling reason that might justify an adjournment. The panel therefore concluded that Mr Mason had made a voluntary and informed decision not to participate in the hearing.

11. The panel considered whether an adjournment would be likely to secure Mr Mason's attendance and concluded that it would not. Mr Mason had explicitly confirmed he would not be attending this hearing and did not ask for an adjournment in his communication. Therefore, the panel found no basis to believe that postponing the hearing would result in his future participation. The panel was satisfied that an adjournment would serve no practical purpose and would lead to unnecessary delay.

12. The panel noted that some of the allegations date back to 2016 and several witnesses have been called to give evidence. It concluded that any delay would cause inconvenience to the witnesses, could impact their memories and would not be in the public interest. Mr Mason has provided a response bundle for this hearing and said he would also submit a statement for the panel to consider.

13. The panel therefore concluded that it was fair, appropriate, and in the interests of justice to proceed in Mr Mason's absence. In reaching this decision, the panel carefully balanced Mr Mason's right to attend and participate in the hearing against the public interest in the timely and efficient disposal of fitness to practise matters. The panel was satisfied that Mr Mason's absence did not prevent the hearing from being conducted fairly and that proceeding would not compromise the integrity of the process.

14. Accordingly, the panel determined to proceed with the hearing in the absence of Mr Mason.

Preliminary matters:

15. Ms Bucklow applied to the panel for the discontinuance of allegations 20 to 22 concerning Child 7. Namely:

    20. *"Between March 2016 and November 2017, you were the allocated Social Worker for Child 7;*

    21. *Between March 2016 and November 2017, you failed to ensure Child 7's needs were adequately assessed and/or reviewed and/or met, in that you;*

        a) *Failed to conduct and/or record regular visits to Child 7;*

        b) *Failed to action and/or inappropriately delayed an application for direct payments in respect of Child 7;*

        c) *Failed to action and/or inappropriately delayed a referral to the Rowan Trust;*

        d) *Failed to adequately complete the relevant section of Child 7's Education, Health and Care plan;*

        e) *Failed to carry out Child in Need reviews in respect of Child 7.*

    22. *Between March 2016 and November 2017, you failed to maintain and/or record adequate communication with the family of Child 7 and/or Child 7, in that you:*

        a) *On 20 October 2017, wrongly advised Person E that direct payments would be backdated;"*

16. The application was made on the basis that, in light of new information, Social Work England submitted that there was no longer a realistic prospect of the allegations being found proven. The key witness, Person E, had confirmed that she was no longer willing to attend the hearing due to the significant passage of time and her inability to recall the relevant events. Social Work England had considered whether to issue a witness

summons or to admit her evidence as hearsay but concluded that neither option would be appropriate. Applying the principles set out in *Thorneycroft v NMC*, it was determined that admitting her evidence in her absence would be unfair, given that Mr Mason and the panel would have no opportunity to test the reliability of her account through questioning.

17. She stated in her application that Mr Mason's response had relied heavily on discussions and verbal agreements said to have taken place with Person E. In Person E's absence, those could not be confirmed or challenged, which significantly undermined the evidential basis of the allegations. Allegation 20, which stated that Mr Mason was allocated to Child 7, could be proven through case records, but this fact alone was not meaningful in the context of fitness to practise without the accompanying allegations of misconduct.

18. The panel was informed in respect of allegation 21(a), although Mr Mason accepted that he had not visited Child 7 after the initial meeting, he maintained that this had been agreed with Person E, as the case had been dormant pending identification of a respite placement. There was no evidence available to contradict this position. For allegations 21(b) and (c), while it was accepted that there had been delays in actioning direct payments and referring to the Rowan Trust, Mr Mason had provided an explanation supported by contemporaneous evidence. Without Person E's account, it could not be established that these delays amounted to misconduct.

19. Allegation 21(d), relating to the completion of the Education, Health and Care Plan, had depended entirely on Person E's claim that Mr Mason had failed to complete the relevant section. Mr Mason denied being asked to do so and stated that, had he been asked, there was little additional information he could have provided. Similarly, for allegation 21(e), although no Child in Need reviews were evidenced in the records, Mr Mason stated that he and Person E had agreed that such reviews were unnecessary until a placement became available. Again, without Person E attending, her version of events could not be tested or relied upon.

20. Allegation 22(a) concerned advice given by Mr Mason to Person E that direct payments would be backdated. This was supported by documentation, but Mr Mason had explained that he had passed on information provided to him by the finance officer and there was no evidence to suggest otherwise. Ms Bucklow submitted that if found proved Social Work England did not consider the matter serious enough to amount to misconduct.

21. Ms Bucklow further submitted that there were evidential deficiencies arising from the unavailability of Person E, whose evidence was central to the factual matrix underpinning the allegations. Additionally, Social Work England's view was that the remaining particulars in relation to Child 7 were of limited gravity and regulatory significance. Ms Bucklow submitted to the panel that it would no longer be fair, proportionate, or in the interests of justice to pursue the allegations. Accordingly, she

invited the panel to exercise its discretion under Rule 27(2) to grant the application for discontinuance of allegations 20 to 22.

22. The panel took and accepted legal advice from the legal adviser in relation to the discontinuance application under Rule 27(2) of the Fitness to Practise Rules. The panel was advised that it may exercise its discretion to discontinue one or more of the factual particulars or grounds of referral where it is satisfied that new information, which was not available to the case examiners, means that there is no longer a realistic prospect of those allegations being found proven. The panel was further advised that in applying Rule 27(2), it must consider the fairness of proceeding with the allegations in the absence of key evidence, the ability of the parties to test the reliability of the available material, and the broader public interest, including public protection and the maintenance of confidence in the regulatory process. The panel accepted this advice and applied it when reaching its decision, giving careful consideration to all relevant factors, including the evidential limitations arising from the unavailability of Person E and the implications for both procedural fairness and the regulatory objectives.

23. The panel carefully considered the application made by Ms Bucklow on behalf of Social Work England to discontinue allegations 20 to 22 concerning Child 7. The application was brought under Rule 27(2) of the Fitness to Practise Rules, which provides that adjudicators may discontinue one or more of the factual particulars and/or grounds referred by the case examiners if they are satisfied that new information means there is no longer a realistic prospect of those particulars being found proven. The panel was mindful that this rule must be exercised with caution and only where it is just and appropriate to do so.

24. The panel took into account that the key witness, Person E, who was central to the factual allegations and Mr Mason's response thereto, had indicated she was no longer willing or able to give evidence. The panel noted that Person E's unwillingness to attend was due to the significant passage of time and her resultant inability to recall the events in question. Social Work England had explored the possibility of securing her attendance by summons, but the panel concluded that this could not rectify any deficiencies in her memory. Social Work England has also considered whether her evidence could be admitted as hearsay. However, following the principles set out in *Thorneycroft v Nursing and Midwifery Council [2014] EWCA 1565 (Admin)*, it was concluded that her absence would prevent fair testing of her evidence and render it unsafe to rely upon in support of the allegations. The panel agreed with that assessment.

25. The panel was satisfied that much of Mr Mason's defence to the allegations relied on direct conversations and verbal agreements he asserted he had with Person E. In the absence of her evidence, these could not be confirmed or challenged, which significantly undermined the evidential basis of the allegations. Allegation 20, which stated that Mr Mason was the allocated social worker for Child 7 between March 2016 and November 2017, could be supported by documentary evidence. However, the panel accepted that this factual assertion, while provable, carried no regulatory

significance if not accompanied by proven failings or misconduct. The panel was therefore not satisfied that it was proportionate or necessary to proceed with this allegation in isolation.

26. The panel considered allegation 21(a) and noted that although Mr Mason accepted he had not visited Child 7 after the initial meeting, he maintained that this had been agreed with Person E on the understanding that the case remained dormant pending the identification of a respite placement. The panel found that, without Person E's evidence, this account could not be contradicted. The panel also took into account that Child in Need (CIN) visits are not mandatory and depend on the cooperation of the parent. Accordingly, the panel concluded that the allegation could not be fairly or reliably determined.

27. The panel further considered allegations 21(b) and (c), which concerned delays in the application for direct payments and referral to the Rowan Trust. Mr Mason had provided a clear explanation, supported by contemporaneous documentation, which indicated that initial delays arose due to Person E's preference for respite foster care and that once she requested direct payments, Mr Mason took action appropriately. The panel accepted that this explanation was plausible and, in the absence of evidence to the contrary, found no basis upon which to conclude that his actions amounted to misconduct.

28. The panel then turned to allegations 21(d) and (e), which related to the Education, Health and Care Plan (EHCP) and the failure to carry out CIN reviews. The panel noted that allegation 21(d) rested on Person E's claim that Mr Mason had failed to complete the relevant section of the plan, Mr Mason does not deny this but asserts that it was not requested of him and was required, a claim which Mr Mason denied. The panel accepted that without her evidence, this could not be properly assessed. With regard to 21(e), although the absence of CIN reviews was apparent from the records, Mr Mason's position was that it had been agreed with Person E that such reviews were not necessary until the case became active. Again, the panel found this explanation could not be tested in Person E's absence and the allegation was therefore not capable of fair adjudication. Furthermore, the panel has not been provided with evidence to establish a duty in relation to CIN reviews, as they are not mandatory, or to complete EHCPs.

29. The panel noted that Allegation 22(a) concerned advice given by Mr Mason to Person E that direct payments would be backdated. While this was supported by email evidence, Mr Mason stated that he had passed on information given to him by a finance officer as indicated in the email. There was no evidence to contradict this explanation. Social Work England did not consider the matter serious enough to amount to misconduct or impairment, and the panel agreed with that assessment.

30. The panel took careful account of its duty to consider the wider public interest, including the protection of the public and the need to maintain public confidence in the profession and the regulatory process. The panel concluded that in light of all the circumstances and the evidence before it, including the reasons for Person E's

unavailability and the limited seriousness of the remaining provable matters, granting the application for discontinuance would not undermine public protection or confidence in the profession or the regulatory system.

31. Accordingly, the panel was satisfied that it was fair, just, and appropriate to grant the application. The panel therefore directed that allegations 20 to 22 in relation to Child 7 be discontinued.

Application to amend:

32. Ms Bucklow made an application to amend Allegations 4, 5, and 9 to correct minor discrepancies in the dates referred to within the particulars. She submitted that these amendments were purely technical in nature, reflected the correct dates as already set out elsewhere in the evidence and documentation, and did not alter the substance of the allegations. Ms Bucklow submitted that the proposed amendments would not cause any prejudice to Mr Mason, nor affect the overall fairness of the hearing, and invited the panel to grant the application.

33. The panel took and accepted legal advice from the legal adviser in relation to the application to amend the allegations. The panel was advised that, under Rule 32 of the Social Work England Fitness to Practise Rules 2019, it has a general discretion to allow amendments to the allegations at any stage before or during the hearing, provided that doing so does not cause injustice. The legal adviser confirmed that in exercising this discretion, the panel should consider the nature and extent of the amendments, whether they are consistent with the evidence already before the panel, and whether the registrant has had a fair opportunity to understand and respond to the case. The panel was further advised that minor or technical amendments, particularly those which clarify or correct existing information without altering the substance of the allegation, are less likely to give rise to unfairness.

34. The panel granted the application to amend Allegations 4, 5, and 9. The panel was satisfied that the proposed amendments were minor and related solely to correcting dates already accurately reflected elsewhere in the evidence. The amendments did not alter the substance of the allegations or the case Mr Mason was required to meet. The panel considered the advice of the legal adviser and concluded that allowing the amendments would not cause any injustice or prejudice to Mr Mason.

Documentation

The panel was provided with the following documents:

1. Updated hearing timetable
2. Identification key

3. Preliminary application bundle
4. Statement of case
5. Statement bundle
6. Exhibit bundle
7. Social Worker's Response
8. Service and supplementary bundle
9. Closing submissions

Preliminary matters

In private

35. The panel had regard to the case management meeting decisions made on 9 May 2025. At that meeting decisions were made that:

    i. Evidence relating to Child 6, Child 5 and Child 2 and the evidence of Persons A-E should be heard in private.
    ii. The evidence of SC should be admitted as hearsay

36. Social Work England called a number of witnesses

Ms Sarah Banks

37. Ms Banks was a Team Manager in the Children's Disability Service at Staffordshire County Council ("the Council"), where she managed a team of social workers and senior family support workers responsible for delivering social care services to children with complex disabilities. She held this role for four years, from June 2015 to 2019.During the relevant period she supervised Mr Mason and had direct oversight of his practice.

Person A

38. Person A was the mother of Child 6. At the time of referral to the Council's social services, Child 6 had complex needs. Person A provided an account of her concerns about the Mr Mason's involvement with Child 6 which resulted in her complaining to the Council and subsequently to the HCPC.

Person B

39. Person B was the mother of Child 2. Child 2 was in long term foster care, but Person B still had access to Child 2 and she retained 48 % parental responsibility.

Person C

40. Person C was the mother of Child 3. Child 3 has complex health and emotional needs

Person D

41. Person D was a foster carer for Child 5 who had significant health needs.

Social Worker's evidence

42. The panel did not have direct evidence from Mr Mason. However, the panel noted the information provided by him during the course of the investigation meetings held by the Council and also information he had provided earlier in the HCPC and Social Work England investigations.

Background:

43. All concerns in this case arise from a period when Mr Darren John Mason ("Mr Mason") was employed within the Children's Disability Service at Staffordshire County Council ("the Council").

44. Mr Mason began working for the Council as an agency social worker in July 2015. On 1 November 2017, he was promoted to the role of Advanced Practitioner and made a substantive employee within the same service.

45. Mr Mason took an extended period of sick leave beginning on 5 January 2018. Upon his return to work on 5 March 2018, he was placed on suspension. His employment with the Council formally ended in June 2018.

Allegations:

46. The allegations referred by the Case Examiners on 13 July 2022 arise from two Fitness to Practise investigations, FTP-65606 and FTP-61724. The cases were joined following a Case Management Meeting on 1 February 2023. The allegations are as follows:

> ***"While registered as a social worker:***
>
> ***Child 6***
>
> ***1. You were the allocated Social Worker for Child 6 between around June 2016 and 19 October 2017;***
>
> ***2. You failed to process and/ or set up the Direct Payment Scheme in respect of Child 6, in that you:***
>
> ***a) Failed to inform Person A that 5 hours per week of Direct Payments had been agreed by the Resource Panel on 17 August 2016;***
>
> ***b) Failed to complete Form DPYP1 'Agreement for provision of services under direct payments arrangements', with Person A;***

c) Failed to obtain and/or submit a completed DPYP2 'Direct Payment Banking Form';

d) Failed to complete and/or submit a DPYP3 'Direct Payment Scheme - Data Input'.

3. You failed to adequately respond to safeguarding concerns for Child 6, in that you:

a) Failed to conduct a visit and/or arrange for another Social Worker to visit Child 6 following a Home Start Referral in/ or around May 2017;

b) Failed to consider and/or arrange a multi-agency strategy discussion in respect of Child 6 following a Home Start referral in/ or around May 2017;

c) Failed to consider and/or arrange a multi- agency strategy discussion in respect of Child 6 following an NSPCC referral in May 2017;

d) Failed to consider whether Child 6 met the threshold for a Section 47 enquiry under the Children's Act 1989 following the NSPCC referral in May 2017;

4. You failed to complete adequate Child in Need planning and/or assessments in respect of Child 6, in that you:

a) Failed to complete a Child Social Work Assessment when Child 6 was allocated to you in June 2016;

b) Failed to complete and/or review a Child in Need Plan for Child 6 between June 2016 and October 2017;

c) Failed to arrange and/or convene a Child in Need review meeting for Child 6 between June 2016 and October 2017;

d) Failed to conduct Child in Need visits at least every 4 weeks

5. You failed to maintain adequate communication with the family of Child 6, in that you;

a) Between July 2016 and February 2017 you failed to respond to telephone calls and/or text messages from Person A whilst allocated to Child 6;

b) Failed to inform Person A about the progress and/or outcome of an application to access respite care made in or around August 2016;

c) Failed to advise Person A that Independent Future Team's involvement with Child 6 would cease in or around February 2017;

6. Between July 2016 and October 2017, you failed to keep adequate records in respect of Child 6, in that you:

a) Failed to make adequate records of your communication and/or discussions with the Family of Child 6;

b) Failed to record any visits conducted by you to the Family of Child 6 and/or Child 6;

c) Failed to make adequate records of your communication and/or discussions with Child 6's school;

Child 1

7. Between 13 November 2017 and 5 January 2018 you were the allocated Social Worker for Child 1;

8. Between 13 November 2017 and 5 January 2018, you failed to make adequate case records in respect of Child 1;

9. Following Child 1's allocation to you on 13 November 2017, you failed to adequately safeguard Child 1, in that you:

a) Failed to conduct and/or record a visit to Child 1 within seven days of Child 1's referral;

b) Failed to conduct a Child Social Work Assessment in respect of Child 1;

c) Failed to convene a strategy discussion in respect of concerns raised about Child 1;

Child 2

10.Between 18 April 2017 and 5 January 2018 you were the allocated Social Worker for Child 2;

11.Between 8 August 2017 and 5 January 2018, you failed to conduct and/or record Statutory Visits to Child 2;

12.Between 8 May 2017 and 5 January 2018 you failed to keep adequate case records in respect of Child 2, in that you;

a) Failed to make adequate records of your contact with the family and/or foster carers of Child 2;

b) Failed to make adequate records of significant events and/or developments in Child 2's case;

13.Between 18 April 2017 and 5 January 2018 you failed to maintain adequate contact with the family and/or foster carers for Child 2, in that you;

a) Failed to respond to concerns and/or requests for information made by Child 2's family;

b) Advised Person B that a PEP meeting on 31 October 2017 had been cancelled, and it went ahead without their knowledge;

c) Failed to inform Person B that Child 2 had attended hospital for a leaking PEG site;

d) Failed to respond to a request by the legal representative for Person B to discharge the care order, in August 2017;

Child 3

14.Between August 2015 and 5 January 2018, you were the allocated Social Worker for Child 3;

15.You failed to adequately assess and/or review and/or meet the needs of Child 3, in that you;

a) Failed to carry out a Child in Need Review for Child 3 between June 2016 and January 2018;

b) Failed to carry out and/or record Child in Need visits to Child 3, between June 2016 and January 2018;

c) Failed to carry out an updated Child Social Work Assessment in respect of Child 3, following a supervision in December 2017;

16.You failed to record contact with the family of Child 3 and/or Child 3, in that you;

a) Made no record of the conversation you had with Child 3 regarding her views on Person C's new partner, in or around April 2017;

b) Failed to make any records in respect of a visit you made to Person C on 9 October 2017;

c) Failed to make any and/or adequate records of your conversations and communication with Person C and/or other professionals and/or agencies involved in Child 3's care, between March 2016 and January 2018;

Child 5

17.Between 23 January 2017 and 5 January 2018 you were the allocated Social Worker for Child 5;

18.Between 23 January 2017 and 5 January 2018 you failed to keep adequate case records for Child 5, in that you:

a) Failed to record a 'safe and well' visit you conducted following the arrest of Child 5's Foster Carer in December 2016;

b) Failed to record any statutory visits between 23 January 2017 and 5 January 2018;

c) Failed to record a meeting in respect of Child 5 on or around 8 May 2017;

19.Between 23 January 2017 and 5 January 2018 you failed to record adequate communication with the family and/or foster carers of Child 5 and/ or Child 5."

47. Ms Bucklow made submissions on behalf of Social Work England to find the allegations proved.

48. She stated in her submissions that Ms Banks provided clear, consistent, and credible evidence about the Council's policies and expectations. She said her evidence was supported by contemporaneous records and case documentation.

49. Ms Bucklow submitted that Mr Mason demonstrated a number of failings across multiple cases, including serious concerns in the case of Child 6. She referred to the evidence of Person A, the parent of Child 6, who she submitted gave a compelling and detailed account of her interactions with Mr Mason. Further that Person A described experiencing a significant breakdown in communication, explaining that Mr Mason failed to respond to her calls and messages during a time when she and her son were in crisis. Ms Bucklow said that Person A had recounted how she resorted to contacting other professionals and the emergency duty team in desperation and described the emotional toll this lack of support had on her, including her belief that had the situation continued, she may not have survived it.

50. Ms Bucklow highlighted that despite a Resource Panel awarding 5 hours per week of Direct Payments for Child 6 in August 2016, Person A was never informed by Mr Mason, and the necessary documentation was not completed until the case was transferred to another social worker. She also referred to Person A's oral evidence, in which she described how Mr Mason told her that Child 6 did not meet the criteria for the service, despite having only met the child once and without seeking input from other professionals. Further that Person A challenged this view and began collecting her own evidence of her son's behaviour. Ms Bucklow submitted that Person A's account was consistent, credible, and supported by the documentary evidence.

51. She also referred to the safeguarding referrals received in May 2017 from Home Start and the NSPCC, both of which raised serious concerns about Child 6's wellbeing. Ms Bucklow noted that Mr Mason took no apparent action in response. Ms Banks confirmed in her evidence that Mr Mason should have visited the child within 48 hours and arranged a strategy discussion, neither of which occurred. These omissions left Child 6 without appropriate safeguarding responses during a period of significant risk.

52. Ms Bucklow submitted that in the case of Child 1, a medically vulnerable child, Mr Mason failed to visit or assess the child after referral. Although he met the child's mother in hospital, he did not see the child or carry out the required Child Social Work Assessment. The failure to assess care arrangements or investigate safeguarding concerns was a significant omission, particularly given the child's health needs.

53. In relation to Child 2, who was a looked-after child with complex needs, Ms Bucklow stated that Mr Mason failed to conduct or record statutory visits after May 2017. She submitted that the child's mother, Person B, gave compelling evidence of being left without updates or communication about her daughter's wellbeing. She described the period as traumatic, with serious emotional consequences. These concerns were supported by the Council's own complaint findings and by Ms Banks in her oral evidence.

54. In respect of Child 3, Ms Bucklow stated that there was a total absence of recorded Child in Need reviews and visits over an 18-month period. Mr Mason was specifically directed in supervision to update records and assessments but failed to do so. His suggestion that visits had taken place but were not recorded was not supported by any documentary evidence, nor by the evidence of the child's parent.

55. For Child 5, a looked-after child with serious health needs, Mr Mason failed to record statutory visits or key meetings. Ms Bucklow submitted that although the foster carer recalled two visits, these were not documented, and no records were made of a safe and well check following a foster carer's arrest. Communication with carers and other professionals was not recorded, undermining safe care planning.

56. Ms Bucklow acknowledged Mr Mason's explanation that he used handwritten notes and lacked Care Director training. However, she submitted that this did not excuse the scale or persistence of the failures. Mr Mason was supervised and repeatedly reminded to update records. His omissions left children at risk and without the oversight necessary to ensure their safety and wellbeing.

57. In conclusion, Ms Bucklow submitted that Mr Mason's conduct represented a serious and sustained departure from professional standards, and she invited the panel to find all the allegations against Mr Mason proved.

Findings and reasons on facts

58. The panel took and accepted legal advice from the legal adviser on the key principles it must apply when making findings of fact in this Fitness to Practise hearing. The panel was advised that the burden of proof rests entirely with Social Work England and that the standard of proof is the civil standard, namely the balance of probabilities. Each allegation must be proved on its own merits, and Mr Mason is under no obligation to disprove any part of the case.

59. The panel was further advised that it must evaluate the evidence in its totality, with a focus on internal consistency, alignment with contemporaneous documentation, and corroboration from other reliable sources. In doing so, the panel should avoid relying on demeanour and instead assess the substance and coherence of each witness's evidence, as supported by relevant authorities including *R (Dutta) v GMC*.

60. In relation to hearsay, the panel was advised that such evidence is admissible under the Civil Evidence Act 1995, but it must be treated with caution. The panel must consider factors such as the circumstances in which the statement was made, whether it has been tested, and whether it is corroborated by other evidence. The panel was reminded of the authorities including *Thorneycroft v NMC* and *Ogudele v NMC*, which emphasise the need for care where hearsay evidence is central to an allegation.

61. On the issue of proceeding in absence, the panel was advised that it may do so where it is fair, and the registrant has been given proper notice. The panel was referred to *GMC v Adeogba*, which confirms that where a registrant has voluntarily chosen not to attend, the public interest may justify proceeding. If the panel is asked to draw an adverse inference from Mr Mason's absence, it must apply the criteria from *Kuzmin v GMC*, ensuring the absence is voluntary, the registrant has been notified and had opportunity to respond, and that any inference drawn is fair and proportionate.

62. The panel was further advised that its findings must be fair, reasoned, and legally consistent. Each allegation must be considered individually, with clear reasoning for why the panel found it proved or not proved. Findings must be grounded in reliable evidence, comply with the Fitness to Practise Rules and Framework, and reflect relevant professional standards. The panel's written reasons should demonstrate how the evidence was weighed and how conclusions were reached, to ensure procedural fairness and transparency.

Panel's decision on findings of fact:

63. The panel then proceeded to consider each allegation in detail, undertaking a fact-by-fact evaluation of the evidence before it. In doing so, the panel had careful regard to the oral and written testimony of the witnesses, the contemporaneous documentation, and the responses provided by Mr Mason during earlier stages of the investigation. Each factual element of the allegations was assessed on its own merits, with the panel weighing the credibility, consistency, and probative value of the evidence supporting or

refuting it.

Allegation 1

64. The panel is satisfied, on the balance of probabilities, that Allegation 1 namely "*You were the allocated Social Worker for Child 6 between around June 2016 and 19 October 2017"* is found proved. The records relating to Child 6 confirm that Mr Mason was the allocated social worker for Child 6 from approximately June 2016 until 19 October 2017. At the time of referral to the Council's social services, Child 6 had complex needs, **[PRIVATE]**

65. The panel accepted the documentary evidence and case records, which identified Mr Mason as the allocated social worker from June 2016.

    Allegation 1 is found proved.

Allegation 2

66. Ms Banks gave evidence regarding the Council's procedures and expectations for Direct Payments. Her testimony was professional and helpful in explaining the standard process and the requirements for documentation, including the completion of specific forms.

67. The panel found Person A to be a credible and reliable witness. Her evidence was consistent, detailed, and clearly presented across both her written and oral testimony. Her account was supported by contemporaneous documentation, which lent weight to her recollection. She demonstrated a coherent understanding of her interactions with Mr Mason and was clear in stating that he did not inform her of the Council's decision to award Direct Payments.

68. In respect of allegation 2a, that" *the social worker failed to inform Person A that five hours per week of Direct Payments had been agreed by the Resource Panel on 17 August 2016"*, the approval of Direct Payments was confirmed in the contemporaneous case records. Ms Banks gave evidence that the allocated social worker was expected to communicate the Resource Panel's outcome directly to the parent.

69. The evidence confirmed the Council's Resource Panel approved a Direct Payment of five hours per week on 17 August 2016 for Child 6. Despite this approval, there was no evidence that Mr Mason informed Person A of the decision or took any steps to initiate the Direct Payments process.

70. Person A gave clear and consistent evidence that she was not informed of this decision by Mr Mason and only learned of it later at the time she was making a complaint to the Council about the support given to Child 6. The panel found no documentation indicating that Mr Mason ever communicated the Resource Panel's outcome. He has not denied this omission. Taking into account the written evidence and the credible

testimony of Person A, the panel is satisfied that it is more likely than not that Mr Mason failed to inform Person A.

Allegation 2a is therefore found proved.

71. In relation to allegation 2b, that" *the social worker failed to complete Form DPYP1 'Agreement for provision of services under direct payments arrangements' with Person A"*, the panel finds this proved. This form was required under the Council's Direct Payments procedures and should have been completed at a face-to-face meeting, as confirmed in the Council's operational guidance and by Ms Banks in her oral evidence. The panel accepted Ms Banks's evidence that this step was not optional and that social workers were instructed not to post the form, but to complete it in person to ensure proper understanding.

72. Person A gave evidence that she never saw or signed any such form during Mr Mason's involvement. There is no evidence that Mr Mason attempted to complete the form, nor any record of discussion with Person A. On the balance of probabilities, the panel finds that Mr Mason failed to complete Form DPYP1.

Allegation 2b is found proved.

73. As to allegation 2c, that" *the social worker failed to obtain and/or submit a completed DPYP2 'Direct Payment Banking Form"*, the panel finds this proved. The DPYP2 form is a required part of the Direct Payments process and must be submitted in order to establish the payment mechanism. Ms Banks confirmed in her evidence that it was the social worker's responsibility to ensure this form was completed. Person A gave clear evidence that she was never asked for any banking details by Mr Mason and did not complete any such form with him. There is no indication in the records that Mr Mason made any attempt to obtain or submit the DPYP2 form.

Allegation 2c is found proved.

74. In respect of allegation 2d, that *"the social worker failed to complete and/or submit a DPYP3 'Direct Payment Scheme – Data Input' form"*, the panel finds this proved. This form is the final stage in initiating Direct Payments and must be completed for data entry into the Council's system. Ms Banks confirmed in her review that there was no evidence that this form had been completed during Mr Mason's time on the case. There are no case records to suggest this form was ever addressed by Mr Mason. On the balance of probabilities, the panel is satisfied that Mr Mason failed to complete and submit the DPYP3 form.

Allegation 2d is found proved.

Allegation 3

75. In respect of allegation 3a, that" *the social worker failed to conduct a visit and/or arrange for another social worker to visit Child 6 following a Home Start referral in or around May 2017"*, the panel finds this proved. The evidence demonstrates that a

safeguarding referral was made by Home Start on 5 May 2017 after an incident in which **[PRIVATE]**. This incident occurred in the presence of a Home Start worker, who telephoned Social Services during the visit. Person A confirmed in her oral evidence that she supported the referral and recalled being present when the call was made. The panel accepted her account as credible and consistent with the documentary evidence.

76. Ms Banks gave clear evidence that when such a referral is received, it is expected that the allocated social worker either conducts a visit within 48 hours, (ideally within 24) or ensures another social worker does so. There is no evidence in the case records that any visit took place, nor that any alternative arrangements were made by Mr Mason. The panel noted that Mr Mason has stated in interviews with the Council that in May 2017, Person A had expressed that she did not want Mr Mason to continue to be involved with Child 6 (something that is clear from the records and her complaint). His position appears to be that in those circumstances he could not visit Child 6. Ms Banks confirmed that Mr Mason could have made alternative arrangements. Person A confirmed that no one from Social Services attended and that Mr Mason did not follow up. The panel is satisfied that it is more likely than not that Mr Mason failed to conduct or arrange a visit in response to the Home Start referral.

    Allegation 3a is found proved.

77. In relation to allegation 3b, that *"the social worker failed to consider and/or arrange a multi-agency strategy discussion in respect of Child 6 following a Home Start referral in or around May 2017"*, the panel finds this proved. Ms Banks gave evidence, both in her statement and in her oral testimony, that the referral raised significant safeguarding concerns and should have prompted consideration of a strategy discussion under child protection procedures. She explained that such a meeting should involve professionals from social care, health, and education, and in this instance, it was Mr Mason's responsibility to initiate the process, irrespective of whether Person A wanted him to be the social worker for Child 6.

78. The panel accepted this as being reflective of local policy and good safeguarding practice. There is no record that Mr Mason gave any consideration to a strategy discussion or consulted with managers or other agencies in relation to the Home Start referral. Person A's evidence confirmed that no such meeting took place and that she was unaware of any safeguarding planning in response. The panel finds that Mr Mason failed to consider or arrange a multi-agency strategy discussion.

    Allegation 3b is found proved.

79. As to allegation 3c, that" *the social worker failed to consider and/or arrange a multi-agency strategy discussion in respect of Child 6 following an NSPCC referral in May 2017"*, the panel finds this proved. The evidence shows that the Council received an anonymous referral from the NSPCC on 18 May 2017. **[PRIVATE]** Ms Banks gave evidence that a strategy discussion should have been convened in response to such concerns, even though the referrer was anonymous. She confirmed in her statement

and oral evidence that it was Mr Mason's duty to arrange the strategy discussion and involve the appropriate agencies.

80. The panel noted that during supervisions with Mr Mason on 15 June 2017 and 5 July 2017, it was recorded by Ms Banks that a strategy discussion in response to the NSPCC referral was still required. Ms Banks confirmed that she continued to expect Mr Mason to organise the meeting, but there is no evidence that he did so. There is no case note, action plan, or indication that the referral was progressed in line with safeguarding procedures. In Mr Mason's investigatory interview with the Council, he said that the First Response Team who received the referral decided on taking no further action. Consequently, he argued there was no need to treat it as a safeguarding concern. Ms Banks responded in that interview that the First Response Team's decision was not to close down the safeguarding referral, rather it had been to refer it to Mr Mason to progress as he was the allocated social worker. The panel determined that this suggests Mr Mason had considered a strategy discussion but decided one was not required and therefore had failed to arrange one.

    Allegation 3c is found proved in relation to failure to arrange a multi-agency strategy discussion.

81. In respect of allegation 3d, that *"the social worker failed to consider whether Child 6 met the threshold for a Section 47 enquiry under the Children Act 1989 following the NSPCC referral in May 2017"*, the panel finds this not proved. Ms Banks gave evidence that Mr Mason was expected, as the allocated social worker, to consider whether the information in the referral indicated that Child 6 may have been suffering, or was likely to suffer, significant harm, and whether a Section 47 enquiry was required. The panel accepts that this was a necessary and important step in safeguarding practice.

82. However, Social Work England did not present any contemporaneous records, case notes, supervision documents, or any other direct evidence showing that Mr Mason failed to consider the threshold for a Section 47 enquiry. While there is no documentation demonstrating that such consideration took place, the absence of a record alone is not sufficient to discharge the burden of proof. The regulator must prove, on the balance of probabilities, that Mr Mason did not consider the threshold at all. In the absence of clear evidence that this aspect of his duty was omitted, rather than undocumented, the panel cannot be satisfied that the allegation is proved.

83. The panel recognises that failure to record a key safeguarding decision is a professional concern nevertheless the panel is not satisfied that Social Work England has established that Mr Mason failed to consider whether Child 6 met the threshold for a Section 47 enquiry. The panel noted its reason in relation to 3c and concluded that there was some evidence that he had considered the issue when deciding that a strategy discussion was not required.

    Allegation 3d found not proved.

Allegation 4

84. In respect of allegation 4a, that *"the social worker failed to complete a Child Social Work Assessment when Child 6 was allocated to him in July 2016"*, the panel finds this proved. The case records contain no evidence that Mr Mason completed such an assessment. This omission was confirmed by Ms Banks, who reviewed the case file after Mr Mason went on extended leave. In both her written and oral evidence, Ms Banks stated that the Child Social Work Assessment should have been completed at the point of allocation, as set out in the Council's assessment policy. While she accepted the version of the policy she referred to post-dated Mr Mason's involvement, she explained that the procedural requirement to assess on allocation was longstanding and standard practice. Ms Banks explained that although there was already an assessment completed by the previous social worker, Mr Mason needed to complete a new one as Child 6's circumstances had changed. Person A gave direct evidence that she never received any assessment documentation from Mr Mason, nor was she asked to participate in or sign any such assessment. She said Mr Mason had only met Child 6 twice and when she asked about the assessment, Mr Mason told her that Child 6 did not meet the criteria.

85. The panel found Person A's account to be a credible, and her evidence was corroborated by the absence of an assessment in the case records. There is no documentation suggesting that any assessment was started or completed by Mr Mason. The panel finds that Mr Mason failed to complete a Child Social Work Assessment.

    Allegation 4a is found proved.

86. In relation to allegation 4b, that *"the social worker failed to complete and/or review a Child in Need Plan for Child 6 between July 2016 and October 2017"*, the panel finds this proved. Ms Banks reviewed the records and found that the only Child in Need Plan dated during Mr Mason's allocation was completed by a colleague, not by Mr Mason himself. She explained that Child in Need Plans are essential for tracking support and interventions and must be updated and reviewed regularly. In her oral evidence, she acknowledged that the exact policy in force during Mr Mason's allocation was not available but stated that the duty to maintain and review a plan was nevertheless part of standard practice. She stated that the Child in Need reviews should be completed between every 4 to 12 weeks depending on the circumstances.

87. Person A stated that she has never seen a plan written by Mr Mason, nor was she invited to participate in a review. Her account was aligned with the records. The panel found no documentation suggesting that Mr Mason completed or reviewed a plan. Taken together, the panel is satisfied that Mr Mason did not complete or review a Child in Need Plan during his allocation.

    Allegation 4b is found proved.

88. As to allegation 4c, that *"the social worker failed to arrange and/or convene a Child in Need review meeting for Child 6 between July 2016 and October 2017"*, the panel finds this proved. Ms Banks confirmed that Mr Mason had an ongoing responsibility to convene review meetings at regular intervals, even when case closure was being considered. She explained the purpose of such meetings, including multi-agency review of the child's progress and needs. The panel considered her evidence to be knowledgeable, consistent with practice expectations, and supported by her review of the records. She was clear that there was no record of any review meeting being held. Person A's evidence was that no meetings of this nature occurred while Mr Mason was allocated to Child 6 and that she was never invited to or aware of any such reviews. She described feeling excluded from planning processes and unsupported. The panel found her account was supported by the absence of relevant documentation in the case records. The panel is therefore satisfied that Mr Mason failed to arrange or convene a Child in Need review meeting.

    Allegation 4c is found proved.

89. In respect of allegation 4d, that *"the social worker failed to conduct Child in Need visits at least every 4 weeks"*, the panel finds this not proved. Ms Banks confirmed that under the Council's procedures, visits were expected for all children subject to Child in Need planning. However, she also accepted that the frequency of visits was dependant on the specific requirements of the plan of that child and she was unable to confirm how often visits, if any, were required to be completed by Mr Mason. Therefore, the panel has found this allegation not proved because Social Work England has not established that Mr Mason had a duty to visit Child 6 every 4 weeks therefore cannot be found to have failed to do so.

    Allegation 4d is found not proved.

Allegation 5

90. In respect of allegation 5a, that *"the social worker failed to respond to telephone calls and/or text messages from Person A between July 2016 and February 2017 whilst allocated to Child 6"*, the panel finds this proved. Person A gave both oral and written evidence that she repeatedly tried to contact Mr Mason during this period and received no response. Her testimony described a pattern of communication difficulties, including failed attempts to reach him directly and through the family support worker. **[PRIVATE]**

91. The panel found Person A's oral evidence to be detailed, consistent, and compelling. It was supported by her written statement, the content of her formal complaint to the Council in February 2017, and her correspondence during the internal investigation process. Ms Banks gave corroborating evidence, based on her audit of the case in late 2017. She confirmed that there were no records or case notes indicating any sustained or responsive communication from Mr Mason during the period in question. She

described the absence of such records as inconsistent with expected social work practice, especially in a case involving a child with multiple diagnoses, safeguarding risks, and a family in crisis.

92. The corroboration between Person A's account and Ms Banks's professional review of the records reinforced the panel's confidence in the reliability of both witnesses. There was no evidence presented that contradicted Person A's account or demonstrated that Mr Mason maintained regular contact. On the balance of probabilities, the panel is satisfied that Mr Mason failed to respond to calls and messages as alleged.

    Allegation 5a is found proved.

93. In relation to allegation 5b, that *"the social worker failed to inform Person A about the progress and/or outcome of an application to access respite care made in or around August 2016"*, the panel finds this proved. The Panel noted that respite care was not granted in August 2016 because the Council's resource panel decided that Child 6 could spend more time with his father. This was not communicated to Person A in August or when he tried but failed to visit her in September when it is recorded that she was on holiday. Thereafter there is no information to suggest that Mr Mason communicated the information, although it is apparent that at some later point Person A became aware of the reason for the decision. It is clear from their response to Person A's complaint that the Council considered that Mr Mason had not taken the necessary steps to inform Person A of the outcome. This was further supported by the evidence of Ms Banks.

    Allegation 5b is found proved.

94. As to allegation 5c, that "*the social worker failed to advise Person A that the Independent Futures Team's involvement with Child 6 would cease in or around February 2017"*, the panel finds this not proved. Social Work England must establish, on the balance of probabilities, that Mr Mason was under a professional duty to provide this specific piece of information in or around February 2017 and that he failed to do so.

95. In the supervision notes of February 2017 Ms Banks wrote that Mr Mason's view was that Child 6 *'does not meet the criteria and so a service will not be offered'*. Person A said that Mr Mason has shared his view that he thought Child 6 did not meet the criteria for support from the team.

96. In her oral evidence Ms Banks said that in order to make the decision to close the case Mr Mason would have had to complete the Child Social Work Assessment which he did not do. The case was not closed in February 2017 and remained open to the team after it was transferred to a new social worker in October 2017. The panel accepted that Mr Mason thought the case should be closed in February 2017, but he did not complete the necessary steps to action this and the case remained open as further work was required. Therefore, the panel determined Mr Mason was not required to advise Person A that the team's involvement would cease in or around February 2017.

97. In the panel's view, Social Work England did not establish, on the balance of probabilities, that Mr Mason was under a clear and specific obligation to notify Person A of the end of Independent Futures Team involvement, nor did it present sufficient evidence that such communication did not take place. For these reasons, the panel is not satisfied that this allegation has been proved.

    Allegation 5c is therefore found not proved.

Allegation 6

98. In relation to allegation 6a, that "*Mr Mason failed to make adequate records of his communication and/or discussions with the family of Child 6"*, the panel finds this proved. The panel was presented with extensive case documentation and electronic case notes which contained minimal record of any ongoing communication with Person A during Mr Mason's period of allocation. Person A provided consistent, detailed and credible evidence that she experienced ongoing difficulties in communicating with Mr Mason. She described how both she and her father attempted to reach him through phone calls and messages, as well as through a Family Support Worker, but received no response from Mr Mason. Her account was clear and supported by contemporaneous documentation, including her complaint and correspondence with the Council. Ms Banks confirmed in her oral and written evidence that a review of the case records showed a significant absence of communication logs or contact notes from Mr Mason to the family.

99. The panel considered that the absence of entries in the case file, combined with the consistent account of Person A and the views of Ms Banks, provided compelling corroboration that Mr Mason failed to maintain adequate records. The panel is therefore satisfied, that Mr Mason did not meet the expected standard of recording his communications with the family.

    Allegation 6a is found proved.

100. In relation to allegation 6b, that "*Mr Mason failed to record any visits conducted by him to the family of Child 6 and/or to Child 6"*, the panel finds this proved. Person A gave clear and credible evidence that Mr Mason visited the family home only twice during the entire period he was allocated to Child 6's case. She stated that neither of those visits were recorded by Mr Mason. This was consistent with the findings of Ms Banks, who confirmed that there were no visit logs, case notes, or associated documentation to show that visits had been carried out or recorded.

101. The panel noted that Ms Banks emphasised that even minimal or infrequent visits must be recorded in accordance with the Council's policy, particularly for children on a Child in Need plan with complex behavioural and health needs. There was a total absence of visit records across a period of more than a year. Taken together, the credible oral evidence of Person A, the professional findings of Ms Banks, and the lack of any case file entries strongly supported the conclusion that Mr Mason failed to document his

visits, if any occurred. The panel finds, on the balance of probabilities, that Mr Mason failed to record visits as required.

Allegation 6b is found proved.

102. As to allegation 6c, that "*Mr Mason failed to make adequate records of his communication and/or discussions with Child 6's school"*, the panel finds this proved. The records contained no evidence of engagement between Mr Mason and Child 6's school. Mr Mason recalled that he has visited the school around May 2017 and there is no record of that visit. Ms Banks confirmed in her evidence that a review of the case file revealed no records of communication between Mr Mason and the school.

Allegation 6c is found proved.

103. The panel has carefully considered all the evidence presented in relation to Allegations 7, 8, and 9, which concern Mr Mason's conduct while allocated to Child 1. These events took place between 13 November 2017 and early January 2018. The panel took into account the oral and written evidence of Ms Banks, documentary records, internal correspondence, supervision notes, and Mr Mason's own responses during the local authority's disciplinary investigation.

104. The panel noted that Mr Mason was allocated to Child 1's case on 13 November 2017. The panel accepted that he went on leave from 20 December 2017 and was later signed off as unwell, therefore the panel confined its considerations up to 20 December 2017. While this limits the total period under review, the panel was satisfied that Mr Mason had a sufficient window over five weeks during which the essential tasks forming the basis of these allegations could and should have been carried out. The panel concluded that there was no prejudice to either party nor was there a need to amend the dates in these or the subsequent allegations with an end date of 5 January 2018.

Allegation 7

105. Turning to allegation 7*,* that *"Between 13 November 2017 and 5 January 2018 you were the allocated Social Worker for Child 1"*, the panel finds this proved. The documentary evidence clearly confirms Mr Mason's formal allocation to the case on 13 November 2017. The evidence of Ms Banks, supported by internal allocation records and supervision notes, leaves no doubt that Mr Mason was the responsible social worker throughout the relevant period. This was not contested by Mr Mason, and the panel is satisfied this allegation is proved.

Allegation 7 is found proved.

Allegation 8

106. In relation to allegation 8*,* that *"Between 13 November 2017 and 5 January 2018, you failed to make adequate case records in respect of Child 1"*, the panel finds this proved. Ms Banks gave oral evidence that only one entry was recorded by Mr Mason on the date of allocation, documenting a telephone call to a hospital nurse. No other case notes

were made, despite known professional engagement with the child's mother and at least one school visit. In documentary evidence Mr Mason later stated that he had kept handwritten notes and acknowledged during the disciplinary investigation that he had not input them into the digital Care Director system.

107. The Panel noted Ms Banks confirmed that while short-term use of handwritten notes is acceptable, they must be entered onto the digital system within seven days. The complete absence of any records beyond Mr Mason's initial contact seemed particularly unusual and lacking for a child with complex health and care needs. The panel accepted Ms Banks's evidence as reliable and consistent with the case documentation and concluded that Mr Mason failed to maintain adequate case records.

    Allegation 8 is found proved.

Allegation 9 (a) to (c)

108. As to allegation 9a, that *"Following Child 1's referral on 10 November 2017, you failed to conduct and/or record a visit to Child 1 within seven days of the referral"*, the panel is satisfied this allegation is proved. Child 1's mother was in intensive care and the school raised concerns about who was caring for Child 1 at that time. The child had complex medical conditions which required skilled support for personal care. It was unclear who had parental responsibility whilst Child 1's mother was in hospital. Child 1's aunt had reported that she and the child's grandmother were not coping with Child 1's personal care needs which could create significant health risks. The Council's expectations, as set out by Ms Banks in both oral and written evidence, required that children with safeguarding vulnerabilities be seen within seven days of referral. Mr Mason, in his disciplinary interviews confirmed that he spoke with a nurse about the mother's hospital discharge and visited the mother in hospital but did not visit Child 1 herself.

109. Mr Mason said he was satisfied having spoken to Child 1's mother, that the child's care needs were being met by relatives and as the mother was due to be discharged home soon, he did not need to visit Child 1. However, there is no record of this justification for not undertaking a visit. Ms Banks made clear that the visit to the child was still required irrespective of the mother's likely return home, given the nature of the child's needs and the lack of clarity about who was providing day-to-day care. The panel accepts this evidence and finds that Mr Mason failed to conduct or record a visit to Child 1 as required.

    Allegation 9a is found proved.

110. In respect of allegation 9b, that *"You failed to conduct a Child Social Work Assessment in respect of Child 1"*, the panel finds this proved. Mr Mason confirmed during disciplinary interviews that he did not complete a Child Social Work Assessment. He indicated he had intended to do so but was overwhelmed and experiencing stress. Nevertheless, the obligation to complete the assessment remained. Ms Banks testified

that this was a mandatory step and should have been undertaken promptly upon allocation, especially given the complex nature of Child 1's health needs, the unknown care arrangements, and the broader family context. The absence of any draft, note, or attempt to begin the assessment further confirms that this was not undertaken.

Allegation 9b is found proved.

111. In relation to allegation 9c, that *"You failed to convene a strategy discussion in respect of concerns raised about Child 1"*, the panel finds this proved. Ms Banks's evidence was that at the time of referral, the situation already presented Section 47 safeguarding concerns namely a child with complex care needs whose primary carer was in hospital and whose care arrangements were unknown. Mr Mason was tasked with identifying immediate safeguarding risks and escalating them where appropriate.

112. The panel noted that further concerns emerged following a meeting between Mr Mason and school staff on 29 November 2017, **[PRIVATE]** Ms Banks stated that the serious nature of these concerns, combined with the absence of direct contact with Child 1, should have prompted a strategy discussion. In his interviews with the Council, Mr Mason said that he did not consider that a strategy discussion was necessary and therefore he did not convene such a meeting. However, he did not document a rationale for not doing so. The panel found Ms Banks's assessment to be well-reasoned and proportionate. In her oral evidence, she explained that low-level concerns are easily distinguishable from the issues in this case that trigger safeguarding concerns.

113. The panel noted the absence of any documentation to show that such a discussion took place and accepted the oral evidence of Ms Banks. Taking this evidence together with the unchallenged factual circumstances of the case, the panel is satisfied that it is more likely than not that Mr Mason did not convene or initiate a strategy discussion when required.

Allegation 9c is found proved.

Allegation 10

114. Before addressing the individual allegations in relation to Child 2, the panel considered the oral and written evidence of the two principal witnesses: Person B (Child 2's mother) and Ms Banks. Person B gave clear, consistent, and compelling evidence. Her written statement was detailed and coherent, and her oral testimony demonstrated a strong and credible recall of events, particularly in relation to the breakdown in communication with Mr Mason, her exclusion from key aspects of her child's care, and her increasing distress due to the lack of updates and involvement. The panel found Person B to be a reliable and truthful witness, whose account was corroborated by contemporaneous records and supported by the documentary evidence, including complaint correspondence and emails.

115. The panel noted that Ms Banks's assessment of Mr Mason's casework was based on her review of the electronic case records, audit trails, and relevant policies. She

acknowledged areas where she had initially assumed Mr Mason had taken action such as assuming visits had taken place but on closer review, had concluded there were multiple failings relating to visits and record keeping.

116. With regard to allegation 10, that "*Between 18 April 2017 and 5 January 2018 you were the allocated Social Worker for Child 2*," the panel finds this allegation proved. The assignment of Mr Mason to Child 2's case is confirmed by internal electronic case management records and was not contested. He was the named social worker throughout this period and remained responsible for statutory duties and case oversight. The panel refers to its earlier decision regarding the end date of his allocation to Child 2.

    Allegation 10 is found proved.

Allegation 11

117. Turning to allegation 11, that "*Between 8 August 2017 and 5 January 2018, you failed to conduct and/or record Statutory Visits to Child 2*," the panel finds this proved. The panel had sight of the Looked After Child Visiting Guidance which states that a child who has been in foster care for over a year should have statutory visits at least every 3 months. As a child in long-term foster care, Child 2 fell into this category. Mr Mason recorded only one statutory visit, which occurred on 8 May 2017. No further visits were recorded in August or November 2017. This was confirmed by Ms Banks, who had conducted an audit of Child 2's case records and found no evidence of such visits. The panel accepted that if visits had taken place, it was Mr Mason's professional obligation to record them. In the absence of any documentation or record to suggest otherwise and based on the witness evidence and the panel finds this allegation proved.

    Allegation 11 is found proved.

Allegation 12.

118. In relation to allegation 12a, that "*Between 8 May 2017 and 5 January 2018 you failed to make adequate records of your contact with the family and/or foster carers of Child 2*," the panel finds this proved. The case file contained no records of ongoing communication between Mr Mason and either Person B or the foster carers. Person B stated in both her oral and written evidence that she had almost no direct contact with Mr Mason, and when she did attempt to reach him, her calls were unanswered. She was often forced to seek updates through duty social workers or Ms Parker (the senior family support worker). Ms Banks confirmed that there were no entries documenting regular engagement with either the mother or the foster carers during the relevant period. She also stated that as the local authority had shared parental responsibility with Person B, there should have been recorded regular communication between her and the social worker. Similarly, Child 2 had complex medical and emotional needs which were

changing during this period of time and Mr Mason failed to record his communication and contact with key adults in the child's life. The allegation is found proved.

Allegation 12a is found proved.

119. As to allegation 12b, that "*Between 8 May 2017 and 5 January 2018 you failed to make adequate records of significant events and/or developments in Child 2's case*," the panel finds this proved. The record of significant events was critically deficient. Ms Banks's evidence, supported by file audits, indicated that important occurrences such as changes to Child 2's medical and educational needs were either unrecorded or addressed only in passing by others. Person B gave evidence that she learned about key developments indirectly and long after they occurred. Ms Parker's case notes in December 2017 confirm that Mr Mason had agreed to update Person B but had failed to do so. The absence of documentation of such events significantly undermined proper case management and parental involvement.

Allegation 12b is found proved.

Allegation 13

120. Addressing allegation 13a, that "*You failed to respond to concerns and/or requests for information made by Child 2's family*," the panel finds this proved. The panel accepts Person B's evidence that Mr Mason was consistently unresponsive to her requests for information. She described calling, texting, and emailing him repeatedly, only to be met with silence. She recalled her distress was compounded by the fact that she had no direct access to the foster carers or school due to the care order in place. She was reliant on Mr Mason for information and was instead forced to rely on Ms Parker and duty workers. The panel accepted Person B's description of the anxiety and distress she experienced due to this lack of communication. This was supported by her complaint letter and consistent oral testimony. The panel concludes that Mr Mason failed in his duty to respond to a parent with parental responsibility.

Allegation 13a is found proved.

121. In relation to allegation 13b, that "*You advised Person B that a PEP meeting on 31 October 2017 had been cancelled, and it went ahead without her knowledge*," the panel finds this proved. Person B gave a clear and specific account of being informed by Mr Mason that the meeting had been cancelled due to room availability and that she would be contacted with a new date. When she later discovered, while speaking to Child 2's foster carer in a hospital car park, that the meeting had gone ahead, she was shocked and distressed. The panel noted that this account, given as sworn testimony, was specific to and consistent with the documentary evidence, including the Council's response acknowledging that the meeting had gone ahead without her knowledge. Mr Mason in the written evidence denied this version of events, claiming she had said she was unable to attend. The panel preferred Person B's evidence on this point.

Allegation 13b is found proved.

122. Turning to allegation 13c, that "*You failed to inform Person B that Child 2 had attended hospital for a leaking PEG site*," the panel finds this proved. Person B testified that she only became aware of this event weeks after it occurred. The Council's own complaint investigation acknowledged that she should have been informed and that her parental responsibility entitled her to be consulted. Email records from 18 December 2017 show that Mr Mason was aware of the issue and had informed the senior family support worker that he would update Person B. However, a case notes summary recorded by the family support worker on 23 December 2017 confirmed that no update had been provided. Mr Mason later claimed he was on leave, but the records indicate he was actively engaged with the case around the relevant dates. The panel is satisfied that he failed to notify Person B as required.

    Allegation 13c is found proved.

123. In respect of allegation 13d, that "*You failed to respond to a request by the legal representative for Person B to discharge the care order, in August 2017*," the panel finds this proved. The evidence shows that a formal request was received by Mr Mason but not responded to. In his responses throughout the Council investigation, he stated that the request should have gone to the legal department and that he would have replied eventually. Ms Banks, however, was clear in her oral evidence that Mr Mason should have acknowledged the request, advised the family accordingly, and initiated a Child Social Work Assessment to consider whether the order could be discharged. The panel concluded that even if Mr Mason could not assist, he should have advised the legal representative what the correct process was or who to contact.

    Allegation 13d is found proved.

Allegations 14 to 16

124. The panel considered the oral and written evidence of the two primary witnesses in relation to the allegations concerning Child 3: Person C (Child 3's mother) and Ms Banks.

125. The panel noted that Person C had raised concerns in a formal complaint to the Council about the absence of Child in Need meetings and a perceived lack of proactive involvement from Mr Mason in managing her child's care plan. The panel found her evidence credible and consistent with the case records, which notably lacked any regular contact, assessments, or reviews by Mr Mason.

126. Ms Banks had direct oversight of Mr Mason's work and conducted management supervision with him, including a key session in December 2017 where this case was discussed. Ms Banks was candid in acknowledging that she initially relied on Mr Mason's verbal assurances that Child in Need visits and assessments had been completed but not yet written up. However, upon reviewing Person C's complaint and the underlying case records, she revised her understanding and concluded that these activities had in fact not taken place.

127. *With regard to allegation 14*, that *"Between August 2015 and 5 January 2018, you were the allocated Social Worker for Child 3,"* the panel finds this allegation proved. This was not in dispute. Allocation records, management oversight notes, and electronic case files all confirm that Mr Mason was the allocated social worker for Child 3 from August 2015 until he went on leave and then sick leave in January 2018. The panel noted its earlier reasoning in relation to the timeframe.

    Allegation 14 found proved.

128. Turning to allegation 15a, that *"You failed to carry out a Child in Need Review for Child 3 between June 2016 and January 2018,"* the panel finds this proved. In accordance with statutory guidance and local policy, a Child in Need review should take place at least every 12 weeks for a child with disabilities. The records show that a Child in Need review was conducted in March 2016, but no further reviews are documented between that date and January 2018. Ms Banks acknowledged in oral evidence that although Mr Mason initially reported having held reviews that were not yet recorded, she came to understand following Person C's complaint and her own reassessment of the case files that no such meetings had occurred.

129. Person C described chasing the social worker about overdue reviews and receiving no response. Mr Mason, in his disciplinary response, asserted that some other meetings served as substitutes for Child in Need reviews, but the panel did not find this explanation credible or sufficient. A Child in Need review is a formal, structured meeting involving multiple professionals and documented outcomes. The panel concluded that Mr Mason failed to fulfil this core requirement.

    Allegation 15a found proved.

130. In relation to allegation 15b, that *"You failed to carry out and/or record Child in Need visits to Child 3 between June 2016 and January 2018,"* the panel finds this proved. There are no case records of Child in Need visits conducted by Mr Mason during this 18-month period. Person C stated that she could recall only one visit by Mr Mason during Child 3's extended hospitalisation, and that the nature of this interaction did not resemble a formal Child in Need meeting. Ms Banks confirmed that visits were still required even when a child was in hospital and stressed the importance of recording such contact. Mr Mason offered no documentation to show that any visits occurred or were later written up, despite claiming in supervision that he had conducted them. In the absence of any corroborating records, and based on the oral and written evidence presented, the panel is satisfied on the balance of probabilities that statutory Child in Need visits were not carried out.

    Allegation 15b is found proved.

131. Addressing allegation 15c, that *"You failed to carry out an updated Child Social Work Assessment in respect of Child 3, following a supervision in December 2017,"* the panel finds this proved. On 18 December 2017, Ms Banks conducted a supervision session with Mr Mason and recorded several urgent action points, including updating the Child

Social Work Assessment and the case chronology. Mr Mason acknowledged this supervision and the associated action points. However, there is no record of any such assessment being undertaken or even commenced. Mr Mason later attributed the lack of action to being overwhelmed by workload and backlogged handwritten notes. The panel considered that, given the length of time since the last assessment, combined with Child 3's recent surgery and changes in behaviour and mobility, a fresh assessment was not only necessary but urgent.

Allegation 15c is found proved.

132. With respect to allegation 16a, that *"You made no record of the conversation you had with Child 3 regarding her views on Person C's new partner, in or around April 2017,"* the panel finds this proved. Ms Banks documented in a management oversight record dated 19 April 2017 that Mr Mason told her he had spoken with Child 3 about her mother's new partner. However, no corresponding case note exists to record the child's views, concerns, or feelings about this development. Ms Banks explained that this omission was particularly concerning, given the need to evaluate the impact of any new adults in a child's life, especially for children with vulnerabilities. The absence of such a record meant there was no professional analysis of whether the new partner posed a safeguarding risk or was a protective factor.

Allegation 16a is found proved.

133. Turning to allegation 16b, that *"You failed to make any records in respect of a visit you made to Person C on 9 October 2017,"* the panel finds this allegation proved. Ms Parker documented in the records that Mr Mason had visited Person C on 9 October 2017 and intended to return for a joint visit on 11 October 2017. Further entries confirm this arrangement. Mr Mason, in the written evidence, later referred to this date as the time of his last known visit. Despite these references, there is no entry by Mr Mason within the electronic care records detailing what occurred during the visit, what was discussed, or whether any follow-up actions were agreed. In the absence of any contemporaneous note or post-visit summary, the panel concluded that Mr Mason failed in his duty to document this visit, which was relevant to safeguarding oversight.

Allegation 16b is found proved.

134. With regard to allegation 16c, that *"You failed to make any and/or adequate records of your conversations and communication with Person C and/or other professionals and/or agencies involved in Child 3's care, between March 2016 and January 2018,"* the panel finds this proved. The documentary record is entirely silent on any multi-agency engagement or communication led by Mr Mason during the relevant period. This is despite Child 3's complex health needs, her prolonged hospitalisation, and transition in education services. The panel finds that Mr Mason failed to meet the professional requirement to liaise with other services and to record such engagement.

Allegation 16c is found proved.

Allegations 17 to 19

135. The panel considered the oral and written evidence of two witnesses in relation to the allegations concerning Child 5: Ms Banks, and Person D.

136. Person D was the foster carer for Child 5, throughout the social worker's involvement in the case. She gave both a written statement and oral evidence about her contact with Mr Mason. In her testimony, she gave a measured and candid account of Mr Mason's practice. She noted that initially, he was communicative and responsive, but this declined over time. She was able to recall specific visits and described telephone conversations, including a phased return-to-school plan that she believed was shared with the school and supported by Mr Mason. The panel found Person D's account consistent, balanced, and credible, and her evidence helped to highlight the contrast between the verbal or practical aspects of Mr Mason's involvement and the complete lack of documentation to support those actions.

137. With regard to allegation 17, that *"Between 23 January 2017 and 5 January 2018 you were the allocated Social Worker for Child 5,"* the panel finds this allegation proved. The allocation is supported by case file records and was not disputed by Mr Mason. There is clear evidence in the documentary record, including care planning documentation and supervision notes, that Mr Mason was the assigned social worker for Child 5 during this period, although the panel noted its earlier decision in relation to the timeframe.

    Allegation 17 is found proved.

138. Turning to allegation 18a, that *"You failed to record a 'safe and well' visit you conducted following the arrest of Child 5's Foster Carer in December 2016,"* the panel finds this proved. A police referral dated 5 January 2017 detailed the arrest of Child 5's foster carer in December 2016 for being drunk and incapable. Mr Mason subsequently referenced a "safe and well" visit in a LAC Care Plan review on 24 April 2017, indicating that he had visited the placement the day after the incident and found no concerns. However, there is no case note, visit record, or observational entry corresponding to this visit in Child 5's electronic case record.

139. Ms Banks explained in her evidence that such visits must be documented particularly in the context of a safeguarding alert and that the lack of a written record leaves the local authority without verifiable evidence of the child's safety and welfare at the time. The panel accepted her evidence and concluded that Mr Mason should have made a record of the 'safe and well visit', but he failed to do so.

    Allegation 18a is found proved.

140. With respect to allegation 18b, that *"You failed to record any statutory visits between 23 January 2017 and 5 January 2018,"* the panel finds this proved. During this period, Child 5 was a looked-after child with multiple and complex needs. In accordance with statutory guidance, visits were required at a minimum every three months, and records should be created within seven working days of each visit. There is no record of any

statutory visit undertaken or recorded by Mr Mason during his period of allocation. Person D recalled two specific visits, one involving a hospital discharge and another conducted with a colleague, which may have constituted statutory visits. However, there are no entries by Mr Mason in the case file corresponding to either visit.

141. Ms Banks confirmed that without documentation, these visits could not be considered compliant with statutory or regulatory standards.

Allegation 18b is found proved.

142. Addressing allegation 18c, that *"You failed to record a meeting in respect of Child 5 on or around 8 May 2017,"* the panel finds this proved. A note written by the Senior Family Support Worker on 8 May 2017 refers to a meeting that took place with Mr Mason on or around 8 May, concerning changes to contact arrangements for Child 5's parents. Although the meeting is confirmed by a colleague, Mr Mason made no record of it. Parental contact is a core aspect of planning for children in care, and any changes must be documented, justified, and monitored. The absence of a case note undermines accountability and makes it impossible to verify what decisions were made or on what basis, given that contact decisions can affect family relationships, legal status, and emotional wellbeing.

Allegation 18c is found proved.

143. In relation to allegation 19, that *"Between 23 January 2017 and 5 January 2018 you failed to record adequate communication with the family and/or foster carers of Child 5 and/or Child 5,"* the panel finds this allegation proved. Person D gave clear oral evidence that much of her communication with Mr Mason was by telephone. She gave an example that she had emailed Mr Mason with a proposed plan for Child 5's phased return to school, and she was under the impression that he had agreed and communicated with the school. However, the case file does not contain any email correspondence, case notes, or summaries evidencing this engagement.

144. Ms Banks confirmed that all communications particularly those relating to care plans, educational needs, and health updates should have been recorded.

Allegation 19 is found proved.

Finding and reasons on grounds and impairment:

145. Ms Bucklow made submissions on behalf of Social Work England regarding the issue of misconduct and current impairment. She maintained that all of the allegations found proved amount to the statutory ground of misconduct. Ms Bucklow informed the panel that whilst Social Work England remains neutral on whether allegations 7 to 19 also amount to a lack of competence or capability, she invited the panel to conclude that the Social Worker is currently impaired by reason of his misconduct.

146. Ms Bucklow stated that misconduct is a matter of judgment, not proof, and referred the panel to the case of *Roylance v GMC*, where misconduct is described as a serious departure from professional standards. She pointed out that the seriousness of the proven allegations is central to both the misconduct and impairment assessments and invited the panel to consider the gravity and cumulative effect of the findings.

147. Ms Bucklow submitted that the panel's findings of fact engage all three limbs of the overarching objective of public protection: to protect and promote the health, safety, and well-being of the public; to maintain public confidence in social workers in England; and to promote proper professional standards. She explained that the Social Worker's conduct has not been addressed or remedied, that there is a continuing risk of repetition (engaging personal impairment), and that a finding of impairment is necessary to uphold the wider public interest in professional regulation.

148. Ms Bucklow referred to the test in *Grant v NMC* and stated that the Social Worker has in the past, and remains liable in the future, to place service users at unwarranted risk of harm, bring the profession into disrepute, and breach fundamental tenets of professional practice. She indicated that the misconduct led to actual harm in some cases and posed foreseeable risks in others, particularly where safeguarding procedures were neglected.

149. Ms Bucklow highlighted the significant consequences of the Social Worker's actions for service users. She relied on the evidence of Person A and Person B, both of whom described the emotional toll, distress, and lack of support caused by the Social Worker's failures. She also drew attention to the impact on colleagues and external professionals who were left unable to coordinate support or access key information due to the Social Worker's lack of responsiveness and documentation.

150. Ms Bucklow submitted to the panel that the Social Worker's consistent failure to keep adequate records posed a clear risk to vulnerable children. She gave specific examples where records were entirely absent in relation to visits, assessments, and safeguarding decisions. This lack of documentation, she stated, hindered oversight and undermined accountability in multi-agency contexts.

151. Turning to the issue of insight, Ms Bucklow submitted that the Social Worker has not shown any indication that he understands the seriousness of his failings or the harm they posed or caused. She recalled that although the Social Worker made some factual concessions during interviews with his employer, these were not accompanied by any acknowledgement of professional failings. Instead, he often deflected blame onto service users or denied responsibility.

152. Ms Bucklow informed the panel that the Social Worker has not engaged in reflection or shown any indication that he has learned from the events in question. She underlined that, despite the time that has passed and his access to the evidence, there has been no development in insight into his conduct or its consequences.

153. Regarding remediation, Ms Bucklow submitted that there is no evidence that the Social Worker has taken any steps to address or correct his failings. No reflective statements, relevant training, or written apologies have been submitted. She stated that in the absence of insight, remediation is unlikely, and nothing presented to the panel suggests otherwise.

154. Ms Bucklow highlighted to the panel that the risk of repetition remains high. She referenced the lack of any material showing that the Social Worker has reflected on his past practice or taken steps to improve. She also referenced the pattern of similar failings across multiple cases, including failures in communication, safeguarding, and record keeping, all of which were evident during the case reviews.

155. In conclusion, Ms Bucklow submitted that the Social Worker's fitness to practise is currently impaired by reason of misconduct. She stated that such a finding is required to protect the public, uphold confidence in the profession, and promote and maintain proper professional standards.

156. The panel took and accepted the advice of the legal adviser, who advised the panel that its primary responsibility is to protect the public. This duty extends beyond safeguarding individual service users to maintaining public confidence in the social work profession and promoting proper professional standards. The legal adviser explained that it is for the panel to exercise its own independent judgment in determining whether the facts found proved amount to misconduct. This is not a matter of proof, but a legal characterisation of conduct already found proven.

157. The legal adviser referred the panel to relevant case law, including *Roylance v GMC*, which describes misconduct as a serious act or omission that falls short of what would be proper in the circumstances. The legal adviser reminded the panel that not every failing or breach of professional standards amounts to misconduct. In line with *SRA v Day* and *Khan v BSB*, the panel must consider whether the conduct would be regarded as serious and reprehensible by competent and responsible practitioners, and whether it falls well below the standards expected of a registered social worker. Misconduct should not be found where the conduct was minor, isolated, or otherwise excusable.

158. The panel was also advised on the legal test for lack of competence and/or capability. The legal adviser referred to *Holton v GMC* and explained that this ground is distinct from misconduct and requires evidence of a fair and representative sample of the registrant's work over time that demonstrates a pattern of substandard performance. Isolated errors or one-off incidents are unlikely to meet the threshold. The panel should assess whether there were repeated failures across different aspects of practice and whether those persisted despite support or supervision.

159. In terms of capability, the panel was reminded that this can include practical and organisational failings such as an inability to manage workload, poor time management, or consistent failure to meet professional obligations. The panel should also consider any efforts made by the registrant to address the concerns and whether

those were effective. Importantly, a finding under this ground does not require a moral failing but is based on professional performance over time.

160. Turning to impairment, the legal adviser reminded the panel that this too is a matter of independent judgment. The panel must assess whether the registrant's fitness to practise is currently impaired, taking into account both the personal and public components of impairment. The personal component includes insight, remediation, and the risk of repetition. The public component concerns the need to maintain confidence in the profession and uphold professional standards.

161. The legal adviser referred the panel to *CHRE v NMC and Grant* and *Cohen v GMC*, which outline the criteria for determining current impairment. The panel should consider whether the registrant has in the past, or is liable in future, to put service users at unwarranted risk of harm, bring the profession into disrepute, breach fundamental tenets of the profession, or act dishonestly. The panel must consider whether any past failings were isolated or part of a broader pattern, how serious they were, and the likelihood of recurrence.

162. The panel was advised to consider whether the misconduct or performance concerns are easily remediable, whether they have in fact been remedied, and whether they are unlikely to be repeated. In doing so, the panel should assess the registrant's insight into their conduct, whether they have taken steps to address concerns through reflection, training or supervision, and the seriousness of the failings in light of the applicable professional standards.

163. In conclusion, the legal adviser stated that the panel must adopt a holistic and forward-looking approach. It should weigh the seriousness and persistence of the concerns found proved, the registrant's current conduct and level of insight, and the overarching need to protect service users and maintain public confidence in the profession. If the panel is not satisfied that the registrant is currently fit to practise without restriction, then it must find that their fitness to practise is impaired.

Panel decision and reasons on grounds:

164. The panel carefully considered whether the facts found proved in this case amounted to misconduct and, if so, whether Mr Mason's fitness to practise is currently impaired by reason of that misconduct. In reaching its decision, the panel had regard to the submissions made on behalf of Social Work England, the oral and documentary evidence presented throughout the hearing, the relevant legal principles, and guidance provided by the courts, including *Roylance v GMC (No.2)* [2000] 1 AC 311 and *Grant v NMC* [2011] EWHC 927 (Admin). The panel exercised its own professional judgment and kept in mind the need to protect the public, maintain public confidence in the social work profession, and uphold proper standards of conduct and performance.

165. The panel considered the facts found proved, both individually and collectively as set out below. It was satisfied that the conduct identified extended beyond isolated or

minor failings. The panel found that the conduct disclosed a sustained pattern of poor practice across multiple cases, involving several children and families. These failures occurred over a lengthy period and included repeated omissions in relation to safeguarding, communication, record keeping, assessments, and multi-agency working.

166. The panel recognised that misconduct is not defined in statute and is a matter of professional judgment. Applying the definition in *Roylance*, the panel considered whether the conduct amounted to a serious departure from the standards expected of a registered social worker. The panel accepted that not all failings amount to misconduct and that only serious misconduct, falling significantly short of expected standards, warrants regulatory intervention.

167. The panel concluded that Mr Mason's failings were serious, persistent, and widespread. It found that, in relation to multiple children and families, Mr Mason failed to carry out essential professional duties, including safeguarding vulnerable children, responding to serious concerns, maintaining communication with professionals and families, making and recording assessments, and completing statutory visits. The panel examined each allegation on its own merits and considered them cumulatively, concluding that the conduct found proved amounts to serious misconduct.

168. The panel noted that the following allegations, where the facts found proved were primarily factual in nature, confirm that Mr Mason was the allocated social worker to the child in question. These are Allegations 1, 7, 10, 14, and 17.

169. In Allegation 2, Mr Mason failed to inform Person A of an award of direct payments for Child 6 and failed to complete the necessary documentation to enable her to access this support. As a result, a family in crisis was denied vital assistance. The panel heard evidence from Person A regarding the significant emotional and practical consequences of these failings, including her account that she might not be alive today had circumstances not improved. These failures demonstrated a neglect of basic professional duties and a disregard for the family's wellbeing. Taken together, the panel finds that Allegation 2 amounts to serious misconduct.

170. In respect of Allegation 3, Mr Mason failed to act upon two safeguarding referrals relating to Child 6. These were credible and serious concerns. Mr Mason's failure to respond exposed a vulnerable child to ongoing risk. The panel considered this a gross failure to act on information that should have triggered immediate safeguarding action. This failing strikes at the core of Mr Mason's professional responsibilities and constitutes serious misconduct.

171. Allegation 4 concerns Mr Mason's failure to carry out a Child in Need assessment and to implement or review Child in Need plans in relation to Child 6. These failures extended over a significant period and meant that the child's complex needs went unaddressed. The panel considered that assessment and planning are fundamental components of supporting vulnerable children and their families and the failure to

undertake these duties represented a clear departure from professional standards. The panel finds that this constitutes serious misconduct.

172. In relation to Allegation 5, Mr Mason failed to respond to Person A's repeated attempts to contact him. This lack of communication persisted over several months and contributed to Person A's sense of isolation and lack of support. The panel noted additional evidence that other professionals encountered similar difficulties in contacting Mr Mason, which compounded the family's distress. The panel finds that this ongoing failure in communication was a serious lapse and amounts to misconduct.

173. In Allegation 6, the panel found that Mr Mason failed to maintain any records of his visits or communications concerning Child 6. Accurate and timely record keeping is a basic and essential duty of a social worker. The absence of records over such an extended period is unacceptable and undermines both continuity of care and professional accountability. The panel finds that this conduct constitutes serious misconduct.

174. Turning to Allegation 8, Mr Mason failed to make adequate case records in respect of Child 1 during a period of time when her care arrangements were unclear with her mother in hospital and when safeguarding concerns were raised. The lack of records would have limited the oversight and information sharing possible between professionals and could have hampered efforts to manage risks. Given the safeguarding context, the omission of such an important record seriously compromised multi-agency communication. The panel finds this amounts to misconduct.

175. Allegation 9 relates to Mr Mason's failure to carry out a proper assessment or convene a strategy meeting for Child 1 despite known risks. This failing left safeguarding concerns unaddressed and showed poor professional judgment. The panel considered this to be a serious breach of core safeguarding obligations and finds it constitutes misconduct.

176. In Allegation 11, Mr Mason failed to conduct or record statutory visits for Child 2 over a five-month period. Child 2 was a looked-after child with complex needs and communication difficulties. These visits were critical for monitoring welfare and safety. Mr Mason's failure placed the child at potential risk and fell significantly below the expected standards. The panel finds this amounts to serious misconduct.

177. In Allegation 12 the panel found that Mr Mason failed to make sufficient records of his contact with the family and foster carers of Child 2. Maintaining accurate and timely records of such contact is a basic and essential aspect of professional social work practice, as it ensures that care is coordinated and that all relevant professionals have access to a clear understanding of the child's progress and any concerns raised.

178. The panel also found that Mr Mason failed to adequately document significant events and developments in Child 2's case. These omissions created serious gaps in the child's case history and meant that other professionals and decision-makers were unable to rely on an accurate account of the child's circumstances, which is essential for safeguarding and effective care planning. The panel noted that the child had specific

health and care needs, and that omissions in recording key developments could have had direct consequences for the management of those needs.

179. The panel considered that these failures went beyond administrative oversight. They demonstrated a lack of attention to core social work duties and prevented proper oversight, accountability, and continuity of care. The panel was satisfied that Mr Mason's conduct in relation to Allegation 12 amounted to a significant departure from the standards expected of a registered social worker and therefore constitutes misconduct.

180. In Allegation 13 Mr Mason failed to respond to concerns and requests for information made by Child 2's family, including repeated attempts by Person B to obtain updates regarding her child's care and wellbeing. This lack of communication persisted over several months and caused significant distress to Person B, who felt excluded and uninformed. This was aggravated by the fact that Person B was not allowed to contact either Child 2's foster carers or the school. The social worker was her only point of contact to gain information about Child 2.

181. The panel also found that Mr Mason wrongly advised Person B that a Personal Education Plan (PEP) meeting scheduled for 31 October 2017 had been cancelled, when in fact it went ahead without her knowledge or participation. However, the panel bore in mind that whilst this issue was certainly sub-optimal in terms of Mr Mason's practice, that there was no evidence to suggest he had deliberately attempted to exclude person B from the meeting and rather that this was a simple mistake on his part. Consequently, the panel concluded that this omission was not serious enough to amount to misconduct.

182. Mr Mason failed to inform Person B that Child 2 had attended hospital due to a leaking PEG site, an important medical incident which any parent would reasonably expect to be told about. The panel considered this omission to be particularly concerning, given the child's complex health needs and the emotional impact such events can have on a parent.

183. In addition, the panel found that Mr Mason failed to respond to a formal request made by Person B's legal representative in August 2017 to discharge the care order relating to Child 2. This lack of response not only delayed consideration of a significant legal matter but also further demonstrated a failure to engage meaningfully with Person B and those advocating on her behalf, bringing his employer into disrepute.

184. The panel considered that this pattern of non-engagement and poor communication represented a serious dereliction of Mr Mason's professional duty to work in partnership with families. His conduct prevented effective participation by the parent in key decisions affecting her child, eroded trust in the social work process, and caused emotional harm to Person B. The panel was satisfied that the cumulative effect of these failings amounted to a significant departure from the standards expected of a registered social worker therefore amounts to misconduct.

185. Allegation 15 concerns Mr Mason's failure to adequately assess, review, or meet the needs of Child 3, a child subject to Child in Need support, between June 2016 and January 2018. The panel found that Mr Mason failed to carry out a Child in Need review for a period of approximately 18 months. During this time, there was no evidence of any formal reassessment of the child's needs or circumstances, despite Mr Mason remaining the allocated social worker.

186. The panel also found that Mr Mason failed to carry out and/or record any Child in Need visits to Child 3 during this same period. Regular Child in Need visits are a critical element of ongoing assessment and safeguarding. The absence of such visits meant that there was no structured monitoring of the child's welfare, no meaningful engagement with the family, and no opportunity to revise the support plan in response to any emerging risks or needs.

187. The panel noted Mr Mason failed to carry out an updated Child and Family Assessment following a supervision discussion in December 2017, during which it was identified that such an assessment was necessary. This was required due to significant changes in Child 3's health and behaviour. A failure to review her needs may have prevented her and her carers from accessing the support she needed. Concerns had been raised at the managerial level regarding the adequacy of the existing assessment. Mr Mason's failure to act on this supervision point reflected a disregard for managerial oversight and further delayed the appropriate review of the child's situation.

188. The panel determined that Mr Mason's failings demonstrated a prolonged neglect of fundamental safeguarding responsibilities. The absence of assessments, visits, and reviews meant that Child 3's evolving needs were not assessed nor responded to, and that planning and service provision were not kept under proper review. In the panel's judgment, these omissions placed the child at potential risk of harm and amounted to a significant departure from expected social work practice. Person C complained to the Council and told the panel that the negative impact on her mental health as she was unable to get the support her child needed.

189. The panel was therefore satisfied that Mr Mason's conduct in respect of Allegation 15 constitutes misconduct.

190. With regard to Allegation 16, Mr Mason failed to record key communications and decisions relating to Child 3 over a period of almost two years. This included failure to document discussions about a new adult in the child's life, which may have had safeguarding implications. The lack of records compromised the safeguarding process and demonstrated a failure to maintain proper professional accountability. The panel finds this amounts to misconduct.

191. Allegation 18 concerns Mr Mason's failure to maintain adequate case records for Child 5, a looked-after child with significant and complex needs, between 23 January 2017 and 5 January 2018. The panel found that Mr Mason failed to record a Safe and Well visit he conducted following the arrest of Child 5's foster carer in December 2016 which raised possible safeguarding concerns. Despite the importance of this visit, Mr Mason

did not create any record documenting the outcome of the visit or the actions taken as a result. The panel concluded that this omission represented a serious failure to safeguard and monitor a vulnerable child during a period of heightened risk.

192. The panel further found that Mr Mason failed to record any statutory visits to Child 5 during the nearly year-long period in question. The panel accepted the evidence of Person D, the child's foster carer, who confirmed that some visits did occur but were not documented by Mr Mason. In the panel's view, the absence of any records of statutory visits prevented oversight of Mr Mason's practice, disrupted continuity of care, and undermined the professional accountability that is essential in the management of looked-after children.

193. In addition, the panel found that Mr Mason failed to record a meeting concerning contact arrangements for Child 5, held on or around 8 May 2017. The panel considered this to be a serious omission, given that contact arrangements are central to a child's emotional wellbeing, legal status, and relationship with family members. The absence of any record of this meeting meant that there was no reliable account of what was discussed, what decisions were taken, or what rationale supported those decisions. This compromised transparency and hindered any future review or challenge to the decisions made.

194. The panel noted that the cumulative effect of these omissions had serious implications for Child 5's care. Record keeping is a fundamental aspect of social work practice. It enables effective multi-agency working, supports safeguarding, facilitates review, and ensures that the rationale for decisions is preserved. The panel considered that the failures in this case undermined these functions and reflected a sustained pattern of neglecting a core professional duty.

195. The panel determined that Mr Mason's failure to maintain adequate records for Child 5 over an extended period represented a serious departure from the standards expected of a registered social worker. The panel was satisfied that the conduct found proved in Allegation 18 constitutes misconduct.

196. In Allegation 19, Mr Mason failed to record adequate communication with Child 5, their family and foster carers. The panel finds that this widespread failure to record essential information over a year constitutes misconduct.

197. The panel then considered whether the facts found proved, particularly Allegations 7 to 19, amounted to a lack of competence and/or capability. It reminded itself that this ground is distinct from misconduct and concerns overall professional performance. A finding of lack of competence or capability must be based on a fair and representative sample of a practitioner's work over time, demonstrating persistent or repeated failures below the standard expected of a reasonably competent social worker.

198. Having reviewed the evidence, the panel concluded that it could not be sure that it had before it a fair sample of Mr Mason's work. There was no evidence that Mr Mason was unable to respond to supervision or support rather he just did not make his supervisor

aware of any deficiencies in his practice or barriers to him being able to fulfil his role to the required standard. The panel therefore concluded that these failings were as a result of attitudinal rather than competence issues.

199. Accordingly, the panel did not find that the statutory ground of lack of competence or capability was established. In making this assessment, the panel confirmed that its decision remained that Allegations 7 to 19 amount to misconduct.

200. In reaching its assessment as to whether the ground of misconduct had been established in this case, the panel also concluded that the following provisions of the HCPC Standards of Proficiency for Social Workers in England (2012) are engaged as a result of the facts found proved in this case. These standards represent core expectations of professional conduct and competence, and Mr Mason's repeated failings placed him in breach of them, namely:

> *"1.3 be able to undertake assessments of risk, need and capacity and respond appropriately*
>
> *1.5 be able to recognise signs of harm, abuse and neglect and know how to respond appropriately, including recognising situations which require immediate action*
>
> *2.2 understand the need to promote the best interests of service users and carers at all times*
>
> *2.3 understand the need to protect, safeguard, promote and prioritise the wellbeing of children, young people and vulnerable adults*
>
> *4.3 recognise that they are personally responsible for, and must be able to justify, their decisions and recommendations*
>
> *4.6 be able to make and receive referrals appropriately*
>
> *8.2 be able to demonstrate effective and appropriate skills in communicating advice, instruction, information and professional opinion to colleagues, service users and carers*
>
> *8.4 understand how communication skills affect the assessment of and engagement with service users and carers*
>
> *8.10 be able to listen actively to service users and carers and others*
>
> *9.1 understand the need to build and sustain professional relationships with service users, carers and colleagues as both an autonomous practitioner and collaboratively with others*
>
> *9.4 be able to support service users' and carers' rights to control their lives and make informed choices about the services they receive*
>
> *9.6 be able to work in partnership with others, including service users and carers, and those working in other agencies and roles*

10.1 be able to keep accurate, comprehensive and comprehensible records in accordance with applicable legislation, protocols and guidelines

10.2 recognise the need to manage records and all other information in accordance with applicable legislation, protocols and guidelines."

Panel decision and reasons on impairment:

201. Having determined that Mr Mason's conduct in the facts proved amounts to serious misconduct, the panel next considered whether his fitness to practise is currently impaired. In doing so, the panel applied the approach in *Grant* and considered whether Mr Mason has in the past, and is liable in the future, to place service users at unwarranted risk of harm, bring the profession into disrepute, or breach fundamental tenets of the profession. The panel concluded that all three elements were engaged.

202. The panel finds that Mr Mason's misconduct placed vulnerable children and their families at unwarranted risk of harm. He failed to act on safeguarding referrals, undertake core assessments, communicate with families and professionals, and maintain accurate records. These failures were not theoretical; the panel heard credible and compelling evidence from witnesses who described the emotional distress and practical harm resulting from Mr Mason's inaction.

203. The panel further finds that Mr Mason's conduct brought the profession into disrepute. Social workers hold a position of trust and are expected to meet high standards. A member of the public, fully informed of Mr Mason's failings, would be deeply concerned if no finding of impairment were made. A regulatory response is required to maintain confidence in the profession.

204. The panel noted that the repeated breaches of professional standards found proved in this case placed undue pressure on Mr Mason's colleagues and other agencies involved. The panel determined that, as a result of Mr Mason's persistent failures to carry out core duties such as safeguarding actions, timely assessments, record-keeping, and communication, other professionals were left to compensate for the gaps in practice. This created additional workload burdens and disrupted the effective functioning of multi-agency support for vulnerable children and families. The panel considered that this had a detrimental impact not only on service delivery but also on team dynamics and professional trust within the workplace.

205. Mr Mason also breached multiple fundamental tenets of the profession. These include acting in service users' best interests, safeguarding children, maintaining proper records, communicating effectively with others, and being accountable for professional decisions.

206. The panel finds no evidence that Mr Mason has demonstrated any meaningful insight into his failings. He has not reflected on the impact of his conduct on vulnerable service users, acknowledged the seriousness of his shortcomings, or accepted responsibility

for his actions. Where Mr Mason has responded during the course of these proceedings, his approach has been to deny the conduct, deflect blame onto others, or minimise the concerns raised. The panel considers this pattern of response to reflect a deeply embedded attitudinal issue, rather than a simple lack of understanding or isolated misjudgement.

207. While the individual elements of Mr Mason's misconduct may, in principle, be remediable, the panel finds that to date he has shown no willingness to take the necessary steps toward remediation. There is no evidence of reflection, learning, or steps taken to improve practice. In the panel's view, this entrenched failure to engage or to acknowledge the gravity of his professional failings significantly undermines any confidence that such behaviour would not be repeated. The panel considered that Mr Mason's conduct and lack of attempt to remediate is indicative of a deep-seated attitudinal issue which poses an ongoing risk to the safety of service users and to public confidence in the profession.

208. The panel noted that Mr Mason has not provided any CPD records, reflective statements, or training undertaken since the events in question. The panel considered a brief reference submitted by Mr Mason in his response bundle from his manager at a subsequent employer but gave it limited weight. The reference was not tested through evidence, nor did it not refer to the findings in this case, and provided no assurance of insight, remediation, or strengthening of Mr Mason's practice.

209. In the absence of any insight or remediation, the panel finds that the risk of repetition remains high. Mr Mason has not demonstrated that he has learned from these events or taken steps to ensure that such failures would not occur again.

210. The panel also concluded that a finding of current impairment is necessary to maintain public confidence in the profession and to declare and uphold proper standards of conduct. The seriousness and repetition of Mr Mason's misconduct, together with the lack of engagement, insight, or remediation, make a regulatory finding unavoidable.

211. The panel therefore finds that Mr Mason's fitness to practise is currently impaired by reason of his misconduct.

Finding and reasons on Sanctions:

212. Ms Bucklow made submissions on behalf of Social Work England regarding the issue of sanction. In her submissions, she said that the panel should have regard to the overriding objective, namely the protection of the public, the maintenance of public confidence in the profession, and the promotion of proper professional standards. She referred the panel to Social Work England's Sanctions Guidance updated in December 2022.

213. She submitted that the appropriate and proportionate sanction in this case was a removal order. She accepted that the purpose of a sanction is not to punish Mr Mason, but the panel should determine what sanction, if any, is required to protect the public, maintain public confidence, and uphold standards of conduct and performance.

214. She reminded the panel that they must consider sanctions in ascending order of seriousness, starting with the least restrictive. She referred to paragraph 73 of the Sanctions Guidance which requires the panel to impose the least restrictive sanction that is sufficient to meet the regulatory objectives. She submitted that taking no action, issuing advice, or issuing a warning would be insufficient and inappropriate in this case, given the panel's findings of impairment and Mr Mason's lack of engagement. Those options would not restrict Mr Mason's practice and therefore would not protect the public or meet the wider public interest.

215. Ms Bucklow submitted that the remaining sanctions capable of addressing the impairment and protecting the public were conditions of practice, suspension, or removal.

216. She accepted that the panel should consider any aggravating and mitigating factors. In terms of mitigation, she submitted that there was little of significance. Mr Mason had not attended the hearing and had not presented any account of personal circumstances that might explain his conduct. While there may be limited references in supervision records suggesting personal difficulties at the time, these had not been developed into a case for mitigation and should be treated with caution. She said there was no evidence of insight, no expression of remorse, and no remediation.

217. She submitted that contextual factors might be considered, but there was no suggestion from the evidence of Ms Banks that Mr Mason was unsupported in practice. He had regular supervision, discussed his caseload with his manager, and Ms Banks only became aware of the scale of the failings following a case audit.

218. Ms Bucklow submitted that there were significant aggravating features. Mr Mason's failings were not isolated or minor but formed a sustained pattern across multiple cases. They involved repeated omissions across several core areas of practice including safeguarding, assessment, communication, and multi-agency working. The failings affected multiple vulnerable children and families and persisted over a lengthy period of time.

219. She reminded the panel that Mr Mason had not acknowledged the concerns, had not accepted responsibility, and in earlier representations had deflected blame onto others or denied the conduct. There was no evidence of any attempt at remediation. She submitted that this amounted to a complete absence of insight and raised concerns about attitudinal or behavioural issues.

220. She submitted that harm in this case was not merely potential. There was evidence of actual and significant harm to service users. In particular, the panel heard compelling

and distressing evidence from Persons A and B, who described the long-lasting impact of Mr Mason's failures. That impact had not diminished with time.

221. Turning to conditions of practice, Ms Bucklow submitted that these would be inappropriate. She referred to paragraph 114 of the Sanctions Guidance, which sets out when conditions may be suitable. She submitted that conditions require the cooperation, insight, and willingness of a social worker to comply with them, all of which were absent in this case. She further submitted that the breadth of the failings would make it difficult to devise workable and effective conditions.

222. She submitted that as the panel may also conclude that the failings indicated a deeper attitudinal or behavioural issue, this would render conditions unworkable and unsuitable.

223. She then turned to the question of suspension and referred the panel to paragraph 137 of the Sanctions Guidance, which provides that suspension may be appropriate in cases of serious breaches of professional standards where there is some evidence of insight and a willingness or ability to remediate. However, she submitted that paragraph 138 was more directly applicable. That paragraph states that suspension is likely to be unsuitable where the social worker has not demonstrated any insight or remediation and where there is limited evidence of a willingness or ability to remediate. She submitted that those criteria were met in this case.

224. She accepted that, in principle, the underlying failings might have been capable of remediation had Mr Mason chosen to engage. However, he had not done so. He had not undertaken any training, reflection, or development work. There was no indication that he wished to return to safe and effective practice. In those circumstances, she submitted that suspension would not be sufficient to protect the public or maintain public confidence.

225. Ms Bucklow submitted that the seriousness of the misconduct was a key consideration. The panel had already found that the failings were widespread, persistent, and involved a serious dereliction of basic duties including safeguarding referrals, assessments, and Child in Need planning. Mr Mason's failures left vulnerable families unsupported, even during times of acute crisis, and caused actual harm.

226. She reminded the panel that the misconduct also had a wider impact beyond individual service users. It placed a burden on colleagues, compromised the effectiveness of the wider service, and at times brought the local authority into disrepute. She referred to the panel's earlier finding that Mr Mason failed to notify the legal department in relation to an application to discharge a care order.

227. She submitted that while the concerns may have been remediable in their infancy, Mr Mason had not remediated them and had shown no intention of doing so. There was no realistic prospect of him regaining his fitness to practise.

228. She submitted that the scale and breadth of the failings were incompatible with continued registration. In particular, she submitted that Mr Mason's unwillingness to remediate rendered it unsafe and inappropriate to impose any lesser sanction.

229. In conclusion, Ms Bucklow submitted that a removal order was the only sanction that would sufficiently protect the public, maintain public confidence, and uphold professional standards.

230. The panel took and accepted the advice from the Legal Adviser, who advised the panel that its primary responsibility at the sanction stage is to pursue the overarching objective: to protect the health, safety, and well-being of the public, to maintain public confidence in the profession, and to uphold proper professional standards. The Legal Adviser reminded the panel that sanctions are not punitive in nature but are intended to serve the public interest, and that any sanction imposed must be the minimum necessary to achieve the regulatory objectives.

231. The panel was advised that it must consider and apply the Impairment and Sanctions Guidance issued by Social Work England in December 2022 and take into account its own findings at the facts, grounds, and impairment stages. The panel must apply the principle of proportionality, balancing the interests of Mr Mason with the need to protect the public and maintain confidence in the profession. While the impact of a sanction on Mr Mason could be considered, the panel was reminded that such consequences should not outweigh the public interest in reaching a proportionate and protective outcome.

232. The Legal Adviser also advised that the panel must consider aggravating and mitigating factors and assess each sanction in ascending order of seriousness, ensuring that any decision is fair, proportionate, and consistent with the panel's previous findings.

233. The panel was further advised that under paragraph 12(3) of Schedule 2 to the Social Workers Regulations 2018, it may take no further action, issue advice, or impose a final order. A final order may, under paragraph 13, take the form of a warning, conditions of practice (up to three years), suspension (up to three years), or removal from the register. Any advice or warning issued must specify the period, one, three, or five years it is to remain on the register, in accordance with Rule 48 of the Fitness to Practise Rules.

234. The Legal Adviser summarised the guidance as to when each sanction may be appropriate, including that removal from the register is appropriate where no lesser sanction would suffice, particularly in cases involving a persistent lack of insight or an unwillingness to remediate.

235. In reaching its decision on sanction, the panel took into account all the information before it, including its findings at the facts, grounds, and impairment stages, the submissions made on behalf of Social Work England, and the legal advice provided, which it accepted and followed. The panel also has regard to Social Work England's Sanctions Guidance and approached its decision on sanction in accordance with its

statutory duty to pursue the overarching objective: to protect the health, safety, and well-being of the public, to maintain public confidence in the profession, and to uphold proper professional standards.

236. The panel reminded itself that sanctions are not intended to be punitive but must be sufficient to address the risk posed by Mr Mason's current impairment and to uphold the wider public interest. The panel applied the principle of proportionality, weighing Mr Mason's own interests against the need to protect the public and the integrity of the profession. It recognised that any sanction imposed must be the minimum necessary to meet the regulatory objectives and must be consistent with its earlier findings.

237. The panel identified a number of aggravating and mitigating features relevant to the decision on sanction.

238. The aggravating factors included the serious and persistent nature of Mr Mason's misconduct. His failings were not isolated or the result of momentary oversight. They took place over a sustained period of over 2 years and affected multiple vulnerable children and families. These were fundamental aspects of social work practice.

239. The panel also established additional aggravating features in that Mr Mason's conduct resulted in both potential and actual harm. There was a clear potential for harm arising from the failure to act on safeguarding referrals and his failure to visit, record and progress assessments for children who may have been at risk. The actual harm was evidenced by the parents and carers of service users who gave oral and written evidence. Their accounts described significant emotional distress, frustration, and a loss of confidence in social services. The harm they described was not fleeting and impacted the wider families and carers of the service users. For some, Mr Mason's failings have had a long-term impact on their willingness to engage with professionals and whether they felt or would feel supported at a time of high vulnerability.

240. A further aggravating feature that the panel determined was that Mr Mason's failings also placed additional strain on his colleagues and on multi-agency partners, who were left to fill the gaps in his practice. His dereliction of professional responsibility had a wider impact beyond his own caseload.

241. The panel noted that Mr Mason demonstrated no remorse for or insight into his failings and considered that this was a further aggravating feature. The panel considered that Mr Mason had not taken the opportunity to reflect even within the abstract on the severity of the concerns alleged against him or what their impact could have been upon service users, their families or carers, colleagues or public confidence in the profession. Where he had engaged in limited written representations, he had sought to deflect blame or downplayed the seriousness of his conduct. The panel found that this absence of insight significantly increased the risk of repetition. There was no evidence of remediation or any relevant continuing professional development. His failure to engage with the regulator or this process further demonstrated a lack of commitment to professional responsibility and accountability.

242. In considering mitigation, the panel took into account that there were brief references to personal difficulties in supervision records from the relevant period. Although this was not supported by detailed evidence, the panel acknowledged that personal or health-related challenges may have contributed to Mr Mason's difficulties at the time. The panel also noted a brief information submitted by Mr Mason from a subsequent employer, which referred to his work performance in a later role. However, the letter was not supported by oral evidence, did not address the specific failings in this case, and offered no meaningful assurance as to insight or learning. As a result, the panel gave this reference limited weight.

243. The panel accepted that Mr Mason may have experienced stress, personal strain, or other pressures in his role, which could have affected his performance. The panel also noted that Mr Mason had no prior history of regulatory concern, which it considered in his favour. However, as a practitioner of some seniority, the panel considered that Mr Mason should have been capable of identifying and flagging any difficulties he was facing, particularly where these were affecting his professional responsibilities.

244. While the panel acknowledged that the team environment may not have been functioning perfectly, there was no evidence that Mr Mason sought support, reported any difficulties, or took steps to manage the impact of these issues on his practice during the relevant period. Nor had he made any such representations during the lengthy HCPC and Social Work England investigations or these proceedings. In the absence of direct evidence from Mr Mason, including any explanation, reflective statement, or contextual information, the panel was unable to explore or assess the nature, duration, or effect of any personal mitigating circumstances. For these reasons, the panel placed only very limited weight on this mitigation.

245. The panel then turned to consider the available sanctions in ascending order of seriousness, as required by the guidance and the principle of proportionality.

246. The panel first considered whether it would be appropriate to take no further action. This is reserved for exceptional cases where a finding of impairment alone is sufficient to protect the public and uphold public confidence. Given the seriousness of Mr Mason's failings and the risk of repetition, the panel concluded that such an outcome would be wholly inadequate and would fail to meet the regulatory objectives.

247. The panel then considered whether issuing advice or a warning would be sufficient. It noted that such measures do not restrict practice and are therefore unsuitable in cases where there is an ongoing risk to the public. Mr Mason had been found to have caused actual harm and posed a future risk of harm. In those circumstances, the panel concluded that a warning or advice would not be appropriate or proportionate as it would not protect the public.

248. The panel has regard to paragraph 114 of the Sanctions Guidance and circumstances where a conditions of practice order may be appropriate. The panel accepted that the failings in this case were potentially remediable. However, the panel also has regard to the other criteria which needed to be met. The panel concluded that Mr Mason has not

shown insight and that it could not be confident that he can and will comply with the conditions. In the absence of the panel being satisfied that all of the criteria were met the panel concluded that a conditions of practice order would not be appropriate in this case.

249. The panel then considered whether a suspension order would be sufficient. Suspension is appropriate in cases of serious concern where removal is not necessary, and where there is a realistic prospect of remediation and return to safe practice. In this case, the panel found that over a sustained period of time since the first allegations arose, that Mr Mason had not demonstrated any intention to remediate his failings, had not fully engaged in the process or taken any steps to reflect on the impact of his conduct. Furthermore, that there were no indications that the issues which led to his impairment have been addressed. Consequently, the panel concluded that a suspension order would not be sufficient to protect the public or uphold the wider public interest. It would also fail to reflect the serious nature of the misconduct, the attitudinal concerns identified, and the lack of engagement.

250. The panel also had regard to paragraph 148 of the Sanctions Guidance, which states that suspension is likely to be unsuitable where there is no evidence of insight, no evidence of remediation, and where there is limited evidence to suggest that the social worker is willing or able to resolve or remediate their failings. The panel considered that all of those factors were present in this case and therefore determined that suspension was not an appropriate or proportionate sanction.

251. Having considered and rejected all lesser sanctions, the panel turned to consider whether a removal order was appropriate and proportionate. The panel recognised that removal from the register is the most serious sanction and should be reserved for cases where no lesser sanction is sufficient to protect the public or maintain public confidence in the profession. The panel noted that the Sanctions Guidance identifies removal as appropriate in cases involving a persistent lack of insight, an unwillingness or inability to remediate, and serious breaches of fundamental professional standards.

252. The panel found that these criteria were clearly met in Mr Mason's case. His misconduct was serious, repeated, and wide-ranging. It caused actual harm to vulnerable children and families and placed others at significant risk. He failed to uphold basic professional duties and demonstrated no willingness to take responsibility. The panel considered that his responses during the regulatory process, which included minimisation, and deflection of blame, reflected attitudinal concerns that went beyond mere error or lapse in competence. There was no evidence of insight, no attempt at remediation, and no indication of reflection on the impact of his conduct.

253. The panel noted that Mr Mason had consistently failed to engage with Social Work England and had not participated in the hearing process or submitted any material to demonstrate a desire or capacity to return to safe practice. His non-engagement further undermined confidence in his ability to practise safely in the future. In light of his attitudinal stance, lack of insight, and absence of remediation, the panel could not be

confident that Mr Mason would not, in the future, place service users at risk of harm, bring the profession into disrepute, or repeat the kind of conduct that led to these proceedings.

254. His continued unwillingness to take responsibility or acknowledge his failings demonstrated a fundamental incompatibility with the values and expectations of the profession. In the panel's judgment, this case fell squarely within the category of cases where a removal order is necessary to protect the public, maintain public confidence, and uphold proper standards.

255. The panel was also satisfied that public confidence in the profession and the regulatory process would be seriously undermined if a lesser sanction were imposed. A reasonable and well-informed member of the public would expect a regulator to take firm and proportionate action in the face of serious, repeated failings involving vulnerable service users, particularly where the registrant had refused to engage or demonstrate any insight.

256. Having considered all available sanctions, and applying the principles of proportionality and public protection, the panel concluded that only a removal order would be sufficient to protect the public, to maintain public confidence in the social work profession, and to uphold proper professional standards.

257. Accordingly, the panel directs that Mr Mason's name be removed from the register.

Interim order:

258. The panel next considered an application by Ms Bucklow for an interim suspension order for 18 months to cover the appeal period before the final order becomes effective.

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

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

261. The panel concluded that an interim conditions of practice order would be less restrictive but would not provide sufficient public protection for the same reasons as in its sanction determination. The panel determined therefore that an interim suspension

order was the only way to ensure the protection of the public and the wider public interest. Accordingly, the panel concluded that an 18 month interim suspension order is necessary. When the appeal period expires this interim order will come to an end unless an appeal has been filed with the High Court. If there is no appeal, the final order of removal shall take effect when the appeal period expires.

Right of appeal

262. 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.

263. 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.

264. 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.

265. 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:

266. 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

267. 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:

268. Please note that in accordance with section 29 of the National Health Service Reform and Health Care Professions Act 2002, a final decision made by Social Work England's panel of adjudicators can be referred by the Professional Standards Authority ("the PSA") to the High Court. The PSA can refer this decision to the High Court if it considers that the decision is not sufficient for the protection of the public. Further information about PSA appeals can be found on their website at: https://www.professionalstandards.org.uk/what-we-do/our-work-with-regulators/decisions-about-practitioners