



Social Worker:
Richard Mark Osguthorpe
Registration Number: SW32867
Fitness to Practise
Final Hearing:

Dates of hearing: 11 - 15 July 2022

Hearing Venue: Remote hearing

Hearing outcome: 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.
2. Mr Osguthorpe did not attend and was not represented.
3. Social Work England was represented by Ms Nutan Fatania as instructed by Capsticks LLP.

Adjudicators	Role
Eileen Carr	Chair – Lay Adjudicator
Christine Moody	Social Worker Adjudicator
Sarah McAnulty	Lay Adjudicator

Natasha Quainoo/Tom Stoker	Hearings Officer
Robyn Watts	Hearing Support Officer
Scott McDonnell	Legal Adviser

Service of Notice:

4. Mr Osguthorpe did not attend and was not represented. The panel of adjudicators (hereafter “the panel”) was informed by Ms Fatania that notice of this hearing was sent to Mr Osguthorpe through by recorded delivery and first class post to his address on Social Work Register (the Register). The notification was also sent to his personal email address. Ms Fatania 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 7 June 2022 and addressed to Mr Osguthorpe at his address as it appears on the Social Work England Register;

- An extract from the Social Work England Register detailing Mr Osguthorpe's registered address;
 - A copy of a signed Statement of Service, on behalf of Social Work England, confirming that on 7 June 2022 the writer sent by ordinary first class post and special next day delivery to Mr Osguthorpe 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 Osguthorpe's registered address at 12.35pm on 8 June 2022.
6. The panel accepted the advice of the legal adviser in relation to service of notice.
 7. Having had regard to Rules 44 and 45 and all the information before it in relation to the service of notice, the panel was satisfied that notice of this hearing had been served on Mr Osguthorpe in accordance with **Rules 44 and 45**.

Proceeding in the absence of the social worker:

8. The panel heard the submissions of Ms Fatania on behalf of Social Work England. Ms Fatania submitted that notice of this hearing had been duly served, no application for an adjournment had been made by Mr Osguthorpe and as such there was no guarantee that adjourning today's proceedings would secure his attendance. Ms Fatania also noted that Mr Osguthorpe had explicitly stated that he would not be participating in proceedings as detailed within his email of 25 May 2022. She therefore invited the panel to proceed in the interests of justice and the expeditious disposal of this hearing.
9. The panel accepted the advice of the legal adviser in relation to the factors it should take into account when considering this application. This included reference to Rule 44 and 45 of the Rules and the cases of *R v Jones [2003] UKPC; General Medical Council v Adeogba [2016] EWCA Civ 162*; and Rule 43 of the Rules.
10. The panel considered all of the information before it, together with the submissions made by Ms Fatania. The panel noted that Mr Osguthorpe had been sent notice of today's hearing and it was satisfied that he was or should be aware of today's hearing. The panel considered that Mr Osguthorpe had made his intentions clear in his email dated 25 May 2022 that he did not wish to attend.
11. The panel, therefore, concluded that Mr Osguthorpe had chosen voluntarily to absent himself. The panel had no reason to believe that an adjournment would result in Mr Osguthorpe's attendance. The panel determined that Mr Osguthorpe had voluntarily absented himself from these proceedings. Having weighed the interests of Mr Osguthorpe in regard to his attendance at the hearing with those of Social Work

England and the public interest in an expeditious disposal of this hearing, the panel determined to proceed in Mr Osguthorpe's absence.

Allegations (as amended)

12. That you, a Registered Social Worker:

1. Failed to maintain appropriate professional boundaries with the partner ('MR') of Service User WR, in that you took her on your motorbike on or around 18 July 2018.

2. Your actions at paragraph 1 posed a risk to and/ or were detrimental to Service User WR's mental health.

3. While absent from work from 19 July 2018 onwards, you continued to have contact with service users and those connected with service users, despite being instructed not to do so by your employer:

a. Service User WR's partner, 'MR'

b. Service User TD's mother, 'AD'

c. Service User AL

4. Your actions described at paragraphs 1, 2 and/ or 3 above amount to misconduct.

5. By reason of your misconduct, your fitness to practise is impaired.

Preliminary matters

13. At the outset of proceedings Ms Fatania indicated that she wished to make two applications. The first was to amend the allegations in order to particularise them in more detail to assist the panel. The second application would address the issue of hearsay evidence that Social Work England wished to rely upon.

14. Ms Fatania made her submission regarding amending the charges to provide more detail with regard to Mr Osguthorpe crossing professional boundaries by means of his conduct. The purpose of the amendments was to deliver more detail. Ms Fatania suggested that there would be no prejudice to Mr Osguthorpe.

15. The legal adviser indicated that the panel would need to consider the fairness of the proceedings and whether the amendments could be made without prejudice to Mr Osguthorpe. He advised the panel that the amendments would not bring new or fresh charges, but merely bring clarity to the case. As such, the legal adviser advised that the panel could properly consider whether the charges should be amended.
16. The panel considered that the amendments proposed would provide more detail and clarity and did not bring new or fresh charges. On that basis, the panel accepted that it was fair and agreed to the proposed amendments as set out at paragraph 12.
17. With regard to hearsay Ms Fatania referred to her written hearsay application that she had already provided within the bundle as well as relevant authorities and cases.
18. In particular the hearsay application referred to the evidence of WR, MR, AL and AD, which she wished to be placed before the panel. Ms Fatania referred to Rule 32(b)(vii) of the Fitness to Practise Rules in that the panel is able to admit evidence where it considers it fair to do so, whether or not such evidence would be admissible before the courts. Reference was also made to the weight that may be attached to such evidence, fairness to the proceedings and that there were good reasons for the witnesses not attending, namely that they were vulnerable or family members of vulnerable service users. As such, Ms Fatania submitted attendance would have a considerable adverse impact on the witnesses who were either very vulnerable service users or close members of their families.
19. The legal adviser advised the panel that when considering the application, it should be mindful of the relevance of the material and the fairness of it being included in the proceedings. The panel was also referred to the principles considered in case law including *R (Bonhoeffer) v GMC [2011] EWHC 1585 (Admin)* and *Thorneycroft v NMC [2014] EWHC 1565 (Admin)*. As indicated by Ms Fatania what is fair is fact specific. Further, the panel could consider what weight should be applied to the hearsay evidence. Another matter to address was the fact that in the current case the proposed hearsay evidence was not the only evidence that would be relied upon, but live professional and regulated witnesses would provide testimony and also provide exhibits to assist the panel.
20. Having considered the application by Ms Fatania and the advice by the legal adviser, the panel determined that the proposed hearsay evidence could properly be introduced into the proceedings and relied upon by Social Work England.
21. The reasons for the panel's decision were that it considered that the material was relevant and it would be fair to admit it. The panel took account of the detrimental effect on the witnesses if they were required to attend, noting that they were vulnerable service users who had complex mental health needs or their family

members. The panel also considered that live evidence would be heard from professional witnesses, registrants in their own right, performing a professional function within mental health services and hence they could explain how the hearsay evidence came to be provided to them in the course of their duties.

Background

22. On 24 June 2019, the Health and Care Professions Council ('the HCPC') received a referral regarding the Respondent social worker, Richard Mark Osguthorpe. The referral was made by DS, Doncaster Metropolitan Borough Council ("DMBC").
23. At the time, Mr Osguthorpe was employed by DMBC as an Approved Mental Health Professional (AMHP). He was also acting in the role of a Care Co-ordinator under the Care Programme Approach within the Rotherham Doncaster and South Humber NHS Foundation Trust ('RDaSH'). Care Co-ordinators in this role at RDaSH had to be a professionally qualified member of staff such as a social worker, occupational therapist or a community psychiatric nurse. Mr Osguthorpe worked with those who required secondary mental health services, people with mental disorders who required treatment and more intensive intervention.
24. An investigation had taken place following concerns being raised that Mr Osguthorpe had developed a friendship with one of his service users, namely Service User WR. As part of this friendship, on or around 18 July 2018, Mr Osguthorpe took Service User WR's wife/partner, 'MR', as a pillion passenger on his motorcycle. During this ride, they were involved in a road traffic accident. Upon learning of this matter, Service User WR expressed his distress to staff in the Community Mental Health Team at the nature of the relationship between Mr Osguthorpe and MR, and indicated how it had negatively affected his mental health.
25. Furthermore, DMBC became aware that Mr Osguthorpe, during a period of absence at work, had maintained contact with some service users and persons connected to service users, via text messages, despite being instructed not to do so.
26. Following the investigation undertaken by DMBC into the above matters, Mr Osguthorpe was dismissed by his employer following a disciplinary hearing on 15 August 2019 for which Mr Osguthorpe was absent.

Summary of Evidence

27. The panel heard live evidence from four witnesses and also considered material within the bundle.

28. SPC stated that she is a registered mental health nurse and is currently a Lead Investigator for RDaSH. However, at the time of the matters before the panel she was the Recovery Team Manager working as the clinical line manager to Mr Osguthorpe.
29. SPC detailed the effect on WR of him finding out that his wife/partner MR had been on Mr Osguthorpe's motorbike and had been injured in a road traffic accident on or around 18 July 2018. She stated that he was very angry, emotional and tearful. Further, he threatened to withdraw from engagement with mental health services despite requiring their continuing and ongoing support and treatment.
30. SPC also referred to professional boundaries that Mr Osguthorpe should have observed to deliver the necessary service to WR and that it was common sense that he should not have been on his motorbike with MR as a pillion passenger.
31. DS stated that he is a registered social worker with Social Work England and that he had been employed by DMBC since 2002. At the time of the matters before the panel involving Mr Osguthorpe he was a Team Leader in the Mental Health Team and did not line manage Mr Osguthorpe. This role was delegated to SPC who was a RDaSH Mental Health Team Manager. DS stated that he did see Mr Osguthorpe twice a month to discuss rotas and training. DS described Mr Osguthorpe's roles as a Care Coordinator and AMHP as very responsible and that the professional boundaries between a social worker and a service user are very clear. In particular DS described the role as powerful and that he expected boundaries to be clear. He considered Mr Osguthorpe's conduct to be well beyond what was professionally acceptable.
32. SG stated that she was a registered mental health nurse and a Care Co-ordinator within the mental health team. She visited Service User WR on 17 June 2019 and was shocked when she found out that WR and MR knew personal details about Mr Osguthorpe. She considered this to be highly unprofessional for Mr Osguthorpe to share this type of information and that it would have had an impact on the stability of WR's mental health. SG noted that WR was distressed by Mr Osguthorpe's conduct in relation to MR. She considered that WR had significant challenges due to his [PRIVATE] which required medication and support by the Recovery Team.
33. SG stated that WR had threatened to disengage from mental health services and that it was everything he should not do as there was a risk to his mental health, particularly as his medication was prescribed by a psychiatrist. She also confirmed that once Mr Osguthorpe went on sick leave in July 2018 then WR would become the responsibility of another team member.
34. RY is a registered mental health nurse who had raised concerns about Mr Osguthorpe's relationship with AL and AD, the mother of TD. She recalled seeing AL at the Jade Centre on 22 May 2019 and he had approached her saying that Mr

Osguthorpe had contacted him to let him know that Mr Osguthorpe's [PRIVATE]. RY considered that AL did not know what to do with the information passed to him by Mr Osguthorpe and felt helpless.

35. RY indicated that as Mr Osguthorpe was off sick he should not have contacted any service users, nor should he have shared personal information, but should have maintained clear professional boundaries.
36. RY confirmed that AL had [PRIVATE] and had difficulty in maintaining relationships. She was concerned by the power imbalance between AL and Mr Osguthorpe and that it was one-sided against AL.
37. With regard to TD and his mother AD, TD was a service user who had complex treatment requirements, serious needs and was in and out of treatment "all of the time" causing a stressful situation for the family.
38. Someday, prior to May 2019, RY met Service User TD's mother, AD. AD said that she had heard from Mr Osguthorpe whilst he was on sick leave and they had been exchanging text messages. AD was aware of Mr Osguthorpe's accident. RY was clear that no social worker should have contact with the family of a service user, whilst absent from work, and that should only know each other through their professional relationship.
39. Ms Fatania submitted that:
 - i) At the conclusion of the evidence it was clear with regard to the first charge that Mr Osguthorpe had crossed boundaries with MR and Mr Osguthorpe did not dispute that he had been in contact with her.
 - ii) The evidence of each witness was credible and provided by professional witnesses in the course of their roles whereby concerns had been raised about boundaries and expectations of a social worker.
 - iii) DS had described the level of Mr Osguthorpe's role, which was significant and that MR should not have been out with Mr Osguthorpe at the time of the motorbike accident. Mr Osguthorpe should not have had a "friendship" relationship with WR and MR, rather should have had clear boundaries, which had been breached in this case.
 - iv) As for the second charge there was a risk or detriment to WR's mental health. He had significant challenges and serious conditions making him fragile and vulnerable. Trust had been betrayed and there was a threat that WR would disengage from mental health services.

- v) SG described Mr Osguthorpe's actions as "terrible" and not in WR's best interests. There was a risk that WR would not access his medication and treatment.
- vi) With regard to the final charges, the panel was referred to the correspondence directing Mr Osguthorpe to not contact service users and his acceptance that he did contact MR, AD and AL.
- vii) Mr Osguthorpe did not attend proceedings and therefore the Panel did not hear from him.

Finding and reasons on facts

- 40. At the conclusion of submissions the Legal Adviser referred the Panel to the Social Work England Fitness to Practise Rules 2019, Rule 32 (c) (i) (a) which requires the panel to determine any disputed facts at the outset of the hearing. The panel heard and accepted detailed advice from the legal adviser in respect of the approach to take in determining findings of facts and the burden and standard of proof. The panel heard advice on hearsay evidence and what weight to attach to such evidence.
- 41. The panel was mindful of the fact that Mr Osguthorpe was not present or represented and therefore it was incumbent on the panel and legal adviser to ensure that they explored any weaknesses there might be in Social Work England's case.
- 42. The panel concluded that all witnesses who had given evidence had sought to assist and be helpful to the panel when answering questions.
- 43. The panel retired to reach its decision on facts.
- 44. In the circumstances, having considered all the written and oral evidence and on the balance of probabilities the panel made the following findings:

That you, a registered Social Worker:

Paragraph 1:

Failed to maintain appropriate professional boundaries with the partner ('MR') of Service User WR, in that you took her on your motorbike on or around 18 July 2018.

FOUND PROVED

- 45. The Panel relied on the evidence of DS and, a record of a meeting on 23 May 2019 with Mr Osguthorpe as part of a disciplinary investigation into his conduct. It was

explained that the purpose of the meeting was to establish the facts surrounding the motorbike accident in July 2018 involving Mr Osguthorpe and MR and to discuss concerns around professional boundaries.

46. DS told the panel that Mr Osguthorpe confirmed that he had transported MR on his motorbike as he considered her to be a friend. She had contacted him that evening on his personal phone to meet up.
47. The Panel also considered the evidence of SPC and noted in an email exchange between her and DS dated 19 July 2018, detailing a call from WR to one of her team members stating that MR was on the back of Mr Osguthorpe's motorbike when they had an accident.
48. The Panel also took account of a telephone attendance note dated 10 January 2022 provided by a Social Work England Investigator, which recounted a conversation with MR when she confirmed that she had been on the back of Mr Osguthorpe's motorbike on the day in question.
49. The panel also relied upon an email dated 12 August 2019 from Mr Osguthorpe to the DMBC, confirming that he had met with MR on the evening in question and taken her out on his motorbike. He stated that, *"I was involved in a road traffic accident on my bike on the 18 July at approx 2030hrs or about that time. This did involve my passenger MR"*. The panel also noted within the email that Mr Osguthorpe said he had built up a friendship with WR and MR during the period that he had been working with WR as his care coordinator.
50. The panel heard evidence from DS and SPC that although there was no specific training on professional boundaries, all social workers received safeguarding and domestic violence training, which would have included training on maintaining professional boundaries. Furthermore, DS explained that Mr Osguthorpe was an AMHP which required additional training and qualification and carried a higher level of responsibility and understanding of professional boundaries. Each live witness considered that Mr Osguthorpe's conduct in respect of taking MR on his motorbike was a clear breach of professional boundaries and wholly inappropriate.
51. Further, SPC stated that there were three reasons why Mr Osguthorpe should not have taken MR out on his motorbike, namely the question of insurance, the requirement for a risk assessment and finally that such actions crossed boundaries.
52. The panel therefore concluded that Mr Osguthorpe failed to maintain appropriate professional boundaries with the wife/partner (MR) of service user WR, in that he took her on his motorbike on or around 18 July 2018.

Paragraph 2:

Your actions at paragraph 1 posed a risk to and/ or were detrimental to Service User WR's mental health.

FOUND PROVED

53. The panel considered that the evidence of SG was particularly compelling. She described WR's history as a service user with the Trust, that WR was prescribed medication for his condition, namely, that he had [PRIVATE] and that he was working with the Recovery Team who provided his support and treatment.
54. The witness described a visit she made to WR on 17 June 2019, where she found him to still be very distressed regarding MR going out on Mr Osguthorpe's motorbike. She also told the panel that WR had threatened to disengage from his support and treatment. Not only was WR distressed directly after the accident, but she told the panel that it was still affecting him months later. She recalled WR saying that Mr Osguthorpe had "messed with his head".
55. SPC said that when she had spoken to WR she described him as being angry and tearful, but mostly angry regarding the events involving MR and Mr Osguthorpe.
56. The panel also noted a copy of DMBC's Safeguarding Adults Policy exhibited by DS.
57. DS told the panel that he considered that there was a risk of harm to service user WR. Further, in his statement DS stated *"His conduct significantly destabilised service users to the point that Service User WR expressed [PRIVATE] as a result of the concerns he had about Mr Osguthorpe's relationship with his partner"*.
58. The panel considered that there had been a detrimental impact on WR's mental health and therefore found paragraph 2 proved.

Paragraph 3:

While absent from work from 19 July 2018 onward, you continued to have contact with service users and those connected with service users, despite being instructed not to do so by your employer:

- a. Service User WR's partner, 'MR'
- b. Service User TD's mother, 'AD'
- c. Service User AL

FOUND PROVED IN ITS ENTIRETY

59. The Panel referred to a number of documents within the bundle and, in particular, emails and correspondence on five occasions dated between 8 August 2018 to 19 June 2019 sent to Mr Osguthorpe from DS reminding him that he should not attempt to

contact any clients. Of particular note, is correspondence dated 19 June 2019, which indicates to Mr Osguthorpe that more complaints had been received regarding him crossing professional boundaries and reinforcing to him not to contact clients.

Paragraph 3 a.

60. With regard to MR, the partner of WR, the panel noted Mr Osguthorpe had admitted in his email to the DMBC on 12 August 2019 that he had sent a "few text" to MR with details of an insurance claim and asked her about her injuries and how she was.
61. SG told the panel about a home visit to WR on 17 June 2019, which she recorded in case notes. She recorded MR told her, *"... I'm not texting him anymore I haven't since we text about the claim"*. SG told the panel in her live evidence that in her opinion it was not appropriate for Mr Osguthorpe to be sending a text to MR, the partner of WR, his service user, when he was not in *"role"*.
62. SG exhibited, a record of a home visit to WR on 10th October 2019 in which he complained that Mr Osguthorpe was still contacting MR, more than a year after the accident.
63. The panel concluded that it was more likely than not that Mr Osguthorpe had been communicating with MR whilst absent from work despite being instructed not to do so by his employer.

Paragraph 3 b.

64. The panel noted Mr Osguthorpe had admitted in his email of 12 August 2019 that he had texted AD (the mother of TD) but only in relation to being absent from work and possibly being involved in a motorbike accident.
65. With regard to AD, RY recalled AD approaching her and informing her in 2019 that Mr Osguthorpe had contacted her and that they had been exchanging text messages. She told the panel that AD was aware of Mr Osguthorpe's personal circumstances, which she felt was inappropriate. She also told the panel that TD was a very vulnerable service user with [PRIVATE] and any inappropriate communication with his mother could also have had an effect on AD.
66. The panel concluded that it was more likely than not that Mr Osguthorpe had been communicating with AD whilst absent from work despite being instructed not to do so by his employer. In coming to this conclusion, the panel accepted the evidence of RY.

Paragraph 3 c.

67. The panel noted Mr Osguthorpe had admitted in his email of 12 August 2019 that he had texted AL in response to a text from AL around the time of AL's birthday. Mr Osguthorpe said, *"I text back that I had just [PRIVATE] but was doing okay"*.
68. In relation to AL, RY described being approached by that service user on 22 May 2019, and that he was aware that Mr Osguthorpe's [PRIVATE] and he was concerned about how Mr Osguthorpe was. Such were RY's concerns that she sent an email on the same day to Mr Osguthorpe's line manager regarding these concerns.
69. RY stated that in her eyes that the interaction between Mr Osguthorpe and AL should not have happened in light of AL's [PRIVATE]. In RY's opinion, AL did not know what to do with the information given to him by Mr Osguthorpe.
70. The panel concluded that it was more likely than not that Mr Osguthorpe had been communicating with AL whilst absent from work despite being instructed not to do so by his employer.

Finding and reasons on Grounds

71. Ms Fatania submitted that the facts found proved at charges 1-3 clearly amounted to misconduct and did fall into the category of being serious, notably exposing service users to harm or the risk of harm. There had been a breach of professional boundaries, made worse by the seniority of Mr Osguthorpe.
72. Mr Osguthorpe's conduct was disgraceful and had a negative impact on the reputation of the profession and its standards. This was clear when referring to the Health and Care Professions Council (HCPC) Standards of Conduct, Performance and Ethics (2016), in place at the time, which Mr Osguthorpe had clearly breached as follows:
 - 1.7 You must keep your relationships with service users and carers professional.
 - 6.1 You must take all reasonable steps to reduce the risk of harm to service users, carers and colleague as far as possible.
 - 9.1. You must make sure that your conduct justifies the public's trust and confidence in you and your profession.
73. In addition, Ms Fatania submitted that Mr Osguthorpe's conduct was in breach of the HCPC Standards of Proficiency for Social Workers applicable at the time of the concerns, namely:

- 3.1 understand the need to maintain high standards of personal and professional conduct.
 - 3.4 be able to establish and maintain personal and professional boundaries.
74. Ms Fatania submitted that Mr Osguthorpe's conduct fell far short of these standards. These were serious matters as Mr Osguthorpe's behaviour had a serious impact on vulnerable service users and their families.
75. Ms Fatania submitted that Mr Osguthorpe's inappropriate behaviour took place over a significant period of time and had a negative impact on others. She submitted that Mr Osguthorpe's conduct posed a risk of harm to service users and had caused actual harm to service user WR. Ms Fatania drew the panel's attention to the adverse impact his conduct had had on the mental health of WR, who had threatened to withdraw from mental health services.
76. Further, Ms Fatania submitted that Mr Osguthorpe's actions were contrary to the fundamental tenets of the social work profession and, as such, would have a damaging effect on the reputation of the profession.
77. The panel heard and accepted legal advice from the legal adviser regarding misconduct. The Panel at all times had in mind the overriding objective of Social Work England which includes its duty to protect the public, promote and maintain public confidence in social workers in England and to promote and maintain proper professional standards for social workers in England.
78. The panel concluded that Mr Osguthorpe's conduct and behaviour fell far below the standards expected of a social worker. The panel considered that the behaviours and conduct of Mr Osguthorpe in relation to the proven facts in paragraphs 1-3 of the allegation amount to serious professional misconduct.
79. In coming to this conclusion, the panel considered that Mr Osguthorpe's conduct was in clear breach of all of the HCPC standards applicable at the time as set out by Ms Fatania in her submissions. It concluded that the misconduct was serious, was a fundamental departure from the standards expected and put service users at serious risk of harm and caused actual harm.
80. The panel considered that Mr Osguthorpe's breach of the professional standards identified had been made more serious by Mr Osguthorpe's level of experience and seniority of role and the vulnerability of the service users concerned. The panel considered that Mr Osguthorpe's behaviour would be considered disgraceful by members of the public and the profession. The panel was in no doubt that Mr Osguthorpe's misconduct would bring the profession into disrepute.
81. The panel therefore concluded that the facts found proved amounted to misconduct.

Finding and reasons on current impairment

82. Ms Fatania submitted that a finding of current impairment should be made on the grounds of public protection and public interest. She reminded the panel of the requirement to consider the personal and public components of impairment. Namely, that the risk of repetition puts others at risk of not having a secure professional relationship with their social worker with clear boundaries in order to obtain the support they seek.
83. Ms Fatania submitted that Mr Osguthorpe had provided no evidence to demonstrate any real insight, remorse or remediation. She submitted that during the internal disciplinary investigation, Mr Osguthorpe did not demonstrate any remorse.
84. Ms Fatania reminded the panel that Mr Osguthorpe had indicated, before these proceedings and more recently, that he seeks to remove himself from the register and has no intention to practise as a social worker. However, the panel should be mindful that if Mr Osguthorpe were to obtain further work as a social worker, there remains a risk of repetition of his misconduct.
85. In addition, Ms Fatania submitted that Mr Osguthorpe's misconduct undermines public confidence in the profession.
86. Ms Fatania submitted that the Mr Osguthorpe's fitness to practise is currently impaired on the grounds of public protection and the wider public interest.
87. The panel heard and accepted the advice of the legal adviser in relation to impairment. The panel was referred to the Social Work England guidance on fitness to practise, in particular that, *"a social worker's fitness to practise is impaired if they pose a risk to public safety, or if their conduct or performance undermines the confidence of the public is entitled to place in all social workers in England. A social worker's fitness to practise may also be impaired if their actions make it necessary to send a public message about the standards expected of social workers"*.
88. Further, the panel took into account the sanctions guidance document published by Social Work England and, in particular, pages 8 to 12, which outline the factors to be taken into account when determining current impairment. The panel is aware that a finding of current impairment is a matter for the panel's professional judgement.
89. The panel took into account that it should have regard to both the personal and public components and keep in mind the wider public interest.

90. The panel took into account all of the evidence that it had read and heard during the course of the proceedings. The panel considered whether or not Mr Osguthorpe's current fitness to practise is impaired. The panel also had regard to whether the conduct in this case is easily remediable, whether it has been remedied and whether it was highly unlikely to be repeated.
91. In relation to the misconduct, the panel had no written evidence or oral testimony that would demonstrate that Mr Osguthorpe has properly reflected and fully understood the seriousness of his misconduct. Nor, has he demonstrated that he has developed insight into the serious failings in his conduct.
92. The panel did note however, there was some evidence of his position provided by way of the information obtained during the course of the internal investigation and disciplinary proceedings carried out by DMBC. Mr Osguthorpe made some admissions as to the contact he had with the service users in question, albeit he sought to place them in context. During the disciplinary investigation Mr Osguthorpe stated *"It is easy to say there should be professional distance but it's more complicated than that. I can think of other people who are friends that I have worked with over the years. It can help with recovery dropping boundaries, there are too many boundaries."*
93. The panel considered that this indicates a lack of insight and understanding of the significance and importance of maintaining proper professional boundaries. Furthermore, contrary to Mr Osguthorpe's belief that his level of friendliness was a positive thing, the panel considered that such blurred boundaries between a service user and a social worker could be damaging to the wellbeing of that service user.
94. The panel has not had any information, from Mr Osguthorpe, which would demonstrate any remorse or remediation. The panel accepts that a failure to maintain proper professional boundaries is amenable to remediation. However, in the absence of any information from Mr Osguthorpe, the panel had to conclude that he has not remediated his misconduct. Further, there is no evidence before the panel that Mr Osguthorpe has taken any responsibility for the impact of his actions.
95. The panel considered that Mr Osguthorpe has not demonstrated any insight or understanding of how his behaviour impacted upon his employer or the wider profession. Mr Osguthorpe's conduct indicates that he poses a serious risk of harm to the public. The fact that he continued to contact service users when directed on five separate occasions not to do so by his employer demonstrates that there is a high risk of repetition.
96. The panel concluded that Mr Osguthorpe's misconduct brought the profession into disrepute and breached fundamental standards of the profession.

97. The panel therefore determined that Mr Osguthorpe's fitness to practise is impaired by reason of misconduct in relation to both public protection and the wider public interest.

Decision on sanction/warning/advice (where applicable)

98. The panel heard submissions from Ms Fatania who drew the panel's attention to the Social Work England guidance on sanctions. Ms Fatania submitted that following the panel's determination of misconduct and impairment, it was the case that Mr Osguthorpe's impairment posed a current risk to the public. It would therefore be reasonable for the panel to move beyond no action, advice/warning as these sanctions would not protect the public and would allow Mr Osguthorpe to practise unrestricted.
99. When considering each available sanction, Ms Fatania suggested that the panel should consider the harm that Mr Osguthorpe caused by taking MR, the wife/partner of service user WR as a pillion passenger on Mr Osguthorpe's motorbike, which had a significant detrimental impact on the mental well-being of WR.
100. Ms Fatania submitted that Mr Osguthorpe should have observed the standards applicable to social workers even though the incident took place outside of work. In addition, having been directed to not contact service users or their family members, Mr Osguthorpe continued to do so and he did not seem to comprehend the seriousness of this. Ms Fatania stated that Mr Osguthorpe's conduct was so serious that advice or a warning was not appropriate.
101. Ms Fatania submitted that conditions of practice would also not be appropriate as Mr Osguthorpe had indicated that he did not intend to return to work as a social worker and therefore he could not receive support within his employment.
102. Ms Fatania submitted that a suspension order would not achieve the effect of protecting the public or wider public interest. Mr Osguthorpe had occupied a privileged position, supporting very vulnerable service users, which required trust. His abuse of this privilege was serious and further, there was no evidence of any insight or remediation.
103. Ms Fatania submitted that Mr Osguthorpe's misconduct warranted a sanction of removal. She stated that there was no evidence that Mr Osguthorpe had accepted his wrongdoing and of the risk at which he had placed service users. There was no

evidence that he had used the time since the incidents to remediate and rectify his conduct.

104. The panel heard and accepted the legal advice on all the available options on sanction and considered the Social Work England 'Sanction Guidance' dated 26 November 2019. The panel was advised that it should consider any aggravating or mitigating circumstances in the case, which would be relevant to any sanction applied. The legal adviser reminded the panel that imposing a sanction was primarily about protecting the public and not punishing Mr Osguthorpe although a sanction may have a punitive effect.
105. The panel reminded itself that the purpose of any fitness to practise sanction is to protect the public, which includes maintaining confidence in the profession and upholding professional standards and that the sanction imposed should be the minimum necessary to protect the public.
106. The panel applied the principle of proportionality by weighing Mr Osguthorpe's interests with the public interest and by considering each available sanction in ascending order of severity. The panel considered the mitigating and aggravating factors in determining what sanction, if any, to impose.
107. The panel identified the following mitigating factors:
 - a. Mr Osguthorpe was of previous good character
 - b. Mr Osguthorpe had made partial admissions during the course of the DMBC investigation and in correspondence contained within the bundle.
108. The panel identified the following aggravating factors:
 - a. Mr Osguthorpe's misconduct had caused actual harm to WR.
 - b. Mr Osguthorpe abused the trust expected of a social worker.
 - c. Mr Osguthorpe had repeatedly contacted service users and family members of service users despite being directed on five separate occasions not to do so by his employer.
 - d. Mr Osguthorpe had demonstrated no insight into his behaviour and the potential consequences on service users.
 - e. there was no evidence of any remediation by Mr Osguthorpe.
 - f. Mr Osguthorpe was an experienced social worker and should have been clear about the standards required.
 - g. Mr Osguthorpe's repeated misconduct took place over an extended period of time.
 - h. Mr Osguthorpe had shown limited remorse or regret for his actions.

109. Considering the serious findings of fact, the panel decided that taking no further action, issuing advice or a warning, would not be appropriate in this case as these sanctions would not restrict Mr Osguthorpe's practice and would therefore not protect the public from the risks that had been identified.
110. The panel then considered whether a conditions of practice order would be appropriate, but decided it would not be in this case. The panel took account of the aggravating features in the case and concluded that the high level of supervision and restriction of practice that would be required to mitigate the identified risks would be impractical and unworkable, not least because the misconduct took place outside of work. The panel considered that there was no evidence that Mr Osguthorpe would comply with any conditions given his failure to engage in any meaningful way with this fitness to practise process. Further, the panel did not consider that conditions would be sufficient to mark the seriousness of the misconduct.
111. The panel then considered whether a suspension order should be imposed to protect the public and the wider public interest. The panel considered that Mr Osguthorpe's misconduct involved abuse of trust. He was an experienced social worker in a position of trust with very vulnerable service users. His primary responsibility was to safeguard their well-being. Instead, by breaching professional boundaries he put them at risk of harm, or caused them actual harm.
112. The panel considered that it is essential that members of the public can trust social workers implicitly and that any abuse of trust is serious. In this case, Mr Osguthorpe had repeatedly abused his position of trust. This led to harm or the risk of harm to vulnerable service users. By contacting them and their families, Mr Osguthorpe repeatedly ignored the explicit instructions of his employer. The panel concluded that this indicated serious attitudinal concerns that it considered were not compatible with being a social worker. The panel therefore concluded that a period of suspension would not protect the public, and would not be sufficient to protect public confidence in the profession nor to address the public interest in declaring and upholding proper standards of conduct and behaviour.
113. The panel, having decided a suspension order did not protect the public, nor meet the wider public interest, decided that the proportionate order was a removal order.
114. The panel considered that a removal order is a sanction of last resort and should be reserved for those categories of cases where there is no other means of protecting the public and the wider public interest. The panel decided that Mr Osguthorpe's case fell into this category because of the serious nature and gravity of his misconduct and the ongoing high risk of repetition. The panel was also satisfied that any lesser sanction would undermine public trust and confidence in the profession. For these reasons, the panel determined that Mr Osguthorpe's name be removed from the register.

Interim order

115. Ms Fatania made an application for the panel to make an interim order for 18 months to cover any appeal period. She stated that such an order would be compatible with the removal order that the panel had made. Further, she submitted that an interim order is necessary to protect the public, and public confidence in the profession and satisfy the public interest in light of the findings made by the panel. The panel heard and accepted the advice of the legal adviser in relation to the test for interim orders in accordance with the Social Workers Regulations 2018. To impose an interim order in the present circumstances, the panel needed to be satisfied that such an order was necessary for the protection of the public which includes the public interest.
116. The panel determined that an interim order was necessary for the protection of the public because of the nature and seriousness of the findings against Mr Osguthorpe.
117. The panel considered a member of the public would be extremely concerned if Mr Osguthorpe was able to continue to practise during the appeal period or, if an appeal was lodged, during the time it took for an appeal to be determined, in circumstances where his acts had exposed service users and others to risk of harm. Furthermore, it would be inconsistent with the panel's determination that there is an ongoing risk of repetition.
118. Therefore, the panel determined that an interim suspension order should be imposed on Mr Osguthorpe's registration.
119. The panel decided that the appropriate length of the interim order is 18 months, to cover the 28-day appeal period and the time it may take for any appeal, if made, to be determined.

Right of Appeal

1. Under paragraph 16 (1) (a) of schedule 2, part 5 of the Social Workers Regulations 2018, the Social worker may appeal to the High Court against 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.
- 2. Under paragraph 16 (2) schedule 2, part 5 of the Social Workers Regulations 2018 an appeal must be made within 28 days of the day on which the social worker is notified of the decision complained of.
- 3. Under regulation 9(4), part 3 (Registration of social workers) of the Social Workers Regulations 2018, this order can only be recorded on the register 28 days after the Social Worker was informed of the decision or, if the social worker appeals within 28 days, when that appeal is exhausted.
- 4. This notice is served in accordance with rules 44 and 45 of the Social Work England Fitness to Practice Rules 2019.

Review of final orders

- 5. Under paragraph 15 (2) and 15 (3) of schedule 2, part 4 of the Social Workers Regulations 2018:
 - 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.
- 6. Under rule 16 (aa) of Social Work England’s fitness to practise rules, a registered 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.