Social worker: Paul P Goldston
Registration number: SW25341
Fitness to Practise
Final Hearing

Dates of hearing: 13 March 2023 to 16 March 2023

Hearing venue: Remote hearing

Hearing Outcome: Removal Order

Interim order: 18 months interim suspension order (to cover the appeal period)

Introduction and attendees:

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

2. Mr Goldston did not attend the hearing and was not represented.

3. Social Work England was represented by Mr Carey case presenter instructed by Capsticks LLP.

Adjudicators	**Role**
John Walsh	Chair
Elaine Mackie	Social worker adjudicator
Moriam Bartlett	Lay adjudicator

Debra Renwick	Hearings officer
Arabella Vahey-Crossley	Hearings support officer
Catherine Bisset	Legal adviser

Service of notice:

4. Mr Goldston did not attend the hearing and was not represented. The panel of adjudicators (hereafter "the panel") was informed by Mr Carey that notice of this hearing was sent to Mr Goldston by special delivery service to Mr Goldston's registered address, as confirmed by his recorded details on the Social Work England registration system. Tracking information indicates that Mr Goldston refused to sign for the documents which were subsequently returned to sender. Mr Carey submitted that all reasonable steps had been taken to serve notice of the hearing to Mr Goldston who was willingly refusing to engage or accept service.

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

    - A copy of the notice of the final hearing dated 13 February 2023 and addressed to Mr Goldston at his home address, which he provided to Social Work England;
    - An extract from the Social Work England Register as at 13 February 2023 detailing Mr Goldston's registered address;
    - A copy of a signed statement of service, on behalf of Social Work England, confirming that on the 13 February 2023, the writer sent by special delivery to Mr Goldston 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 was attempted on the 14 February 2023 and then again on the 26 and 28 February 2023, when Mr Goldston refused to sign for the documents and they were subsequently returned to sender.

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

7. Having had regard to Rule 44 and all of the information before it in relation to the service of notice, the panel was satisfied that reasonable steps had been taken to serve notice of this hearing, which had been willingly obstructed by Mr Goldston. In these circumstances, the panel is satisfied that the rules for service have been complied with.

Proceeding in the absence of the social worker:

8. The panel heard the submissions of Mr Carey on behalf of Social Work England. Mr Carey submitted that notice of this hearing had been duly attempted to be served, no application for an adjournment had been made by Mr Goldston and as such there was no guarantee that adjourning today's proceedings would secure his attendance. Mr Carey further submitted that a documented telephone call with Mr Goldston indicated his intention to not attend this hearing or have anything to do with proceedings. Mr Carey 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 43 of the Rules and the cases of *R v Jones [2003] UKPC*; *General Medical Council v Adeogba [2016] EWCA Civ 162*. The panel also took into account Social Work England guidance 'Service of notices and proceeding in the absence of the social worker'.

10. The panel considered all of the information before it, together with the submissions made by Mr Carey on behalf of Social Work England. The panel considered that Mr Goldston had clearly indicated via the telephone that he was unwilling to attend the hearing. He had also refused to sign for two sets of documentation relating to proceedings. The panel is satisfied that reasonable attempts were made to serve Mr Goldston with notice of the hearing and concluded that his actions were a deliberate obstruction of service.

11. The panel therefore concluded that Mr Goldston had chosen voluntarily to absent himself. The panel had no reason to believe that an adjournment would result in Mr Goldston's attendance. Having weighed the interests of Mr Goldston 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 Goldston's absence.

Preliminary matters:

12. There were two preliminary matters for the panel to consider. The first was a hearsay application in respect of the evidence of AF. AF's evidence exhibits minutes from internal disciplinary proceedings in which Mr Goldston participated. Mr Carey submits that the minutes amount to business records and it would be disproportionate to require the attendance of AF to exhibit the documents which she provided in the course of her employment. Mr Carey also submits that the minutes provide Mr Goldston's only account in respect of the allegations and thus it is fair to him to admit the evidence.

13. The panel accepted the legal advice from the legal adviser and concluded that the evidence of AF amounts to business documents, provided in the course of her employment and she can offer nothing further if required to give oral evidence. The panel is satisfied that it

would be disproportionate to require AF to give evidence and considers it is fair to all parties for the evidence to be adduced as hearsay evidence as a business document.

14. A second preliminary matter was raised in respect of the evidence of VC. VC was unable to attend the hearing and Social Work England did not seek to adduce her evidence as hearsay evidence due to the late notice of her non-attendance and consequential impact upon Mr Goldston of fairness in the proceedings. Mr Carey submitted that the evidence provided by VC was available via other witnesses who were to attend or whose statements had already been admitted via the hearsay provisions.

15. Mr Carey sought permission to amend the statement of case to delete references to the evidence of VC. The panel accepted the advice of the legal adviser and in particular had regard to rule 32. The panel considered it was fair to allow the amendment of the case statement and disregarded any references to VC's evidence.

Allegations:

16. The allegations laid against Mr Goldston are as follows:

While a registered social worker working as an Approved Mental Health Professional for Westminster City Council you:

1. Did not complete work to the required standard when you:

a) Copied and pasted elements of a Community Treatment Order Review report for service user TJ on or around 12 August 2019; and

b) Completed a Social Circumstances report dated 10 July 2019 for a mental health act review tribunal for service user HE that was of poor quality.

2. Between 1 October 2018 and 27 September 2019, you failed to properly meet the needs of service users allocated to you in that you did not properly assess, review and/or maintain adequate contact with the following service users:

a) Service User JM

b) Service User JS

c) Service User NT

d) Service User PDS

e) Service User PM

3. Did not maintain adequate case records for the following service users on your caseload:

a) Service User TJ

c) Service User PDS

The matter outlined at Allegation paragraphs 1-3 amount to the statutory ground of misconduct.

By reason of misconduct, your fitness to practise is impaired

Admissions:

17. Rule 32c(i)(aa) Fitness to Practise Rules 2019 (as amended) (the 'Rules') states:

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

18. In light of Mr Goldston's non-attendance and a lack of any communication from Mr Goldston in respect of the allegations, all allegations remain contested and are for Social Work England to prove.

Summary of evidence:

19. The panel first heard evidence from SB. He explained that Mr Goldston was someone he had known in the local area as a social worker but in 2017 he became his line manager. His role at the time was as senior social worker with VC working as Mr Goldston's line manager.

20. In July 2019, Mr Goldston completed a report in respect of a service user HE. HE had a diagnosis of paranoid schizophrenia and some drug and alcohol difficulties. He was a high risk service user who was detained pursuant to section 3 of the Mental Health Act. Mr Goldston was required to provide a Social Circumstances report for the purposes of a Mental Health Tribunal. Mr Goldston was HE's care coordinator.

21. The report completed by Mr Goldston (exhibit SB8) was "pretty poor". It did not include information relevant to HE's family or medication, the risks he presents to himself and others. There should have been contact with his relatives or any significant others. Reports can be in excess of 20 pages long and 5 pages would be the minimum length.

22. With regards to another service user, JS, he was a very high risk service user with a history of violence which included use of weapons. He had numerous admissions to hospital and was subject to a community treatment order. He was taking Clozapine medication which is very effective but has medical side effects and requires monitoring of bloods and wellbeing.

23. JS lived independently but required monitoring. Mr Goldston should have had regular contact with JS including at his home to observe signs of possible relapse and seek support as appropriate.

24. A complaint was raised about Mr Goldston by a consultant Dr B who overheard Mr Goldston suggest that JS' low clozapine blood test results might be due to him having a cold. Dr B was concerned that this was minimising the low readings and could have led to JS suffering from a relapse which would increase the risks to himself and others. The low readings ought to have resulted in an immediate review and possible admission to resolve the medication levels.

25. NT was a service user with a diagnosis of paranoid schizophrenia. An indication of his ill health was poor self care which included self-neglect and he had been under the care of the home treatment team. His care needs were straightforward. He required support with his benefits and monitoring in his home to ensure it was fit for habitation and he was engaging with self care. This was described as the "bread and butter" of a mental health social worker's role.

26. NT had worked with a previous team and had been referred to a private service for floating support. The service advocates on behalf of service users to secure housing and a caseworker, LD, worked with NT with tenancy support. She raised concerns about Mr Goldston as she did not believe his flat was fit for habitation. NT then went missing from services.

27. SB and a medical consultant took to searching the streets to look for NT. He had been seen by staff on the street in an extreme state of neglect and was sufficiently unwell that he declined the assistance of social workers.

28. NT was still under the team's care which was a major concern because Mr Goldston did not appear to have provided any support to NT. A face-to-face assessment ought to have been carried out with regards to eligibility for services and in NT's case, this would have been straightforward but this had not happened which SB stated made him angry. He explained that NT's neglect should never have reached the stage it did. Prior to this, whenever he was well supported he managed well, and after Mr Goldston's involvement, he was reassigned a new social worker and again continued to do well. SB considered that Mr Goldston's actions were not a training issue but was basic work which was simply not carried out.

29. Mr Goldston was offered support when the issues were identified. He went through both formal and informal performance management. Mr Goldston was defensive but did improve with significant support mechanisms put in place. However as soon as support was withdrawn, concerns resumed as to his professional conduct.

30. PDS was a service user who was in hospital due to paranoid schizophrenia. He was moving to a less restrictive setting due to improvements in his mental health. Mr Goldston did not communicate in respect of his discharge. Funding was in place for accommodation but Mr Goldston failed to contribute to progressing PDS' move to the community. There is a lot of preparatory work to be done for discharge but Mr Goldston was not involved in this and PDS was left in hospital unnecessarily for months when he could have been discharged.

31. As a result of a complaint made by AY who was the clinical lead for placements, PDS was reallocated to another social worker as a matter of urgency. AY progressed the placement alongside VC and SB, and PDS was able to be discharged from hospital.

32. PM was another service user with a history of paranoid schizophrenia. He had a flat which Mr Goldston said was in a suitable state for discharge. SB visited PM's flat when PM was on leave from the hospital and found it was not safe or suitable for habitation. There was litter everywhere and no bedding. It was not clean and possibly verminous. SB felt that Mr Goldston had misled him by saying the flat was suitable for discharge.

33. There was no package of support in place for PM because Mr Goldston had indicated there were no obstacles to his discharge. However, this was not the case. The theme was of Mr Goldston avoiding doing his job and avoiding monitoring visits or raising concerns. If concerns were raised, Mr Goldston would be defensive and make excuses.

34. Reports prepared by Mr Goldston, plagiarising reports prepared by others, led to confusion. They fell far below the standards expected of a social worker. Mr Goldston was offered support with IT but his conduct was negligent. With support, his conduct would improve to the point he would be taken off performance management but then his performance would immediately deteriorate to an unacceptable level. Mr Goldston was an Approved Mental Health Professional (AMHP) at the time of these reports, having qualified around 12 years ago. He was later stripped of his AMHP status, a decision made by the local authority which SB stated he had never heard of happening either locally or elsewhere.

35. Mr Goldston did not accept constructive criticism related to problems with his work. He would also be very defensive if confronted and would externalise and blame others or lie to explain away situations.

36. CS also provided oral evidence to the panel. She explained that in 2019 she was the Deputy Borough Director for mental health in the local authority area where Mr Goldston worked. She knew Mr Goldston on and off for many years from when he previously worked as a support worker prior to qualifying as a social worker. When she worked as Deputy Borough Director in 2017 she knew Mr Goldston as a qualified social worker on the community team.

37. In 2017 she did not work closely with Mr Goldston until concerns were raised by SB. An investigation commenced, in which she was supported by HR advice and governed by local authority policies. A copy of her investigation report is exhibit CS11.

38. With regards to service user TJ, he was a man with a lengthy mental health history, including a risk of harm to others. He was known to services and had previously been detained in 2018. TJ was the subject of a community treatment order when he was discharged from hospital which is a legal order and represents a deprivation of liberty which is very serious. A service user with a community treatment order is an immediate concern that if they become unwell they present a risk to themselves or others.

39. Mr Goldston was required to submit a report for a Mental Health Tribunal hearing. The report he prepared was of very poor quality and did not make sense. It was dated 12 September 2019 and stated that Mr Goldston had not seen TJ for two years. If it was true that TJ had not needed intervention for 2 years then he would not need to be the subject of a community treatment order. The report was just rewording of an old report. It referred to the recent death of TJ's mother, which had in fact occurred two years earlier. The report stated "I visited TJ on the ward" but further investigation indicated that this was copied from a doctor's report, detailing an occasion that the doctor had visited TJ on the ward and not Mr Goldston himself. The investigation and records indicated that Mr Goldston had not in fact visited the service user for two years. The records documented by Mr Goldston were confusing and inaccurate and required significant unpicking to establish that Mr Goldston had in fact done nothing with regards to supporting TJ. This left the public at risk because

Mr Goldston's report made it appear that a community treatment order was unnecessary for TJ.

40. HE was a service user who was well known to services and presented a risk to himself and others when unwell. He had to be moved to a secure facility. Mr Goldston was required to prepare a Social Circumstances Report for a Mental Health Tribunal hearing. This report should have included an opinion on the likelihood of success of discharge plans. There is an expectation that in preparing such a report, a social worker would meet with the service user and relevant family members or significant others. The report should be a contemporaneous record of the service user's life and current circumstances. The report is a legal document.

41. Mr Goldston's report was not written on headed paper. CS stated it was insulting how little care had gone into the report and that she did not believe the copy she had been given was real. CS contacted the 'mental health office' for confirmation of the submitted copy. There was no reference in the report to HE's recent discharge from hospital after a 6 month admission which would indicate his community care package was insufficient. There was nothing within the report about HE's home life, management of his needs, his engagement levels or references to his family. The report contained no plans except for treatment to continue. HE had previously tried to take his own life by hanging, but this information was not included within the report. CS stated that the report was completely inadequate and would be unacceptable even for a student in their first year of study.

42. As a consequence of the poor quality report, the Mental Health Tribunal hearing was postponed. Hearings are very stressful for service users and postponements increase stress levels. Mr Goldston was on leave on the date of the Mental Health Tribunal hearing and asked a newly qualified social worker to go in his place. Ultimately a senior social worker, SB, attended but he was concerned that had the newly qualified social worker attended, she would have been in a very challenging position presenting Mr Goldston's poor quality report.

43. At Mental Health Tribunal hearings, the burden of proof rests with professionals and so there was a risk that HE could have been inappropriately discharged as a result of the report. In addition, colleagues' time was wasted in resolving issues and a newly qualified colleague was put at risk of extreme criticism and scrutiny.

44. CS explained that JM was not someone who was well known to mental health services, but he did have a long history of street homelessness and alcohol misuse. JM had a note on his records that the police had to be notified when he was to be discharged. This is exceptionally rare and would indicate there are concerns about an individual in relation to risk to others. JM was discharged from hospital on 18 December 2018 to an out of borough accommodation following a long admission. He ought to have been seen within a few days of discharge and thereafter on a weekly basis.

45. JM was only seen by Mr Goldston on 3 occasions in a 6 month period. One of these visits was not recorded in case records. The records indicate that Mr Goldston had offered to visit JM at home but JM had refused. There were no details in the documentation however of

this offer, or indeed when it was made. Even without consent, CS considers that a home visit should have been attempted. She considers that Mr Goldston was negligent in failing to ensure that JM was seen at home. JM was someone with a forensic history, issues with alcohol and a history of street homelessness but the Mr Goldston did not seem to have awareness of the importance or significance of this – had he have been so his follow-up for JM, and his remote monitoring via family would have been more comprehensive.

46. Complaints were made by JM's family in respect of his lack of support from his care co-ordinator and their concerns about his deterioration.

47. JS is a service user with a section 41 restriction. He was living in the local authority area with mental health treatment pursuant to a criminal court order. This is indicative of the fact that JS presents a significant risk to others when unwell and Home Office permission is required to change the care plan.

48. Mr Goldston was on extended leave in 2018 but returned to work in November 2018. It was expected that he would swiftly visit JS, within a week of his return to work. JS had last been seen on the 1 November 2018 and the previous social worker left a comprehensive record of their final visit. JS was told that his care coordinator had been reallocated. On the 13 November 2018, Mr Goldston returned to work. Three days later, Mr Goldston recorded that he was making arrangements to see JS but then did not until the 8 May 2019. This meant a high risk service user was without support for over 5 months. The reason a visit took place in May was because a consultant emailed Mr Goldston on the 29 April 2019 raising concerns that no visits had been recorded.

49. The role of a social worker is to see people in their own home. This is the best indicator of how someone is coping and whether they are becoming unwell. Mr Goldston never saw JS in his home. When asked why this was, Mr Goldston replied that JS refused to see him at home and would only allow visits when he came to the office for his blood to be tested. There were no records by Mr Goldston which suggested he had visited or called and visits had been declined. In August 2019 a senior nurse sent a letter to JS indicating that they were going to visit. The visit took place and they were allowed in with JS engaging well. The nurse intervened when she discovered that no home visits had taken place and recorded significant information about this visit. CS believes that Mr Goldston lied about the home visits being refused.

50. NT is a man in his middle years with a history of homelessness. He had done well under the care of his GP but in August 2019 his GP had referred for further support as he was said to be in crisis. People with a history of street homelessness often return to the streets and become lost to services. As a new service user, Mr Goldston needed to build a relationship with NT via a series of visits. He ought to speak with NT's family and follow up on concerns if there were any. NT lived less than 15 minutes' walk from the office.

51. CS's investigation indicated there was a lack of effort and care on the part of Mr Goldston. There were concerns that NT was unwell whilst Mr Goldston was on leave and SB picked up the case. There is more documented action in the 10 days when SB was engaging with NT than in the whole of Mr Goldston's time involved with NT.

52. A floating support worker raised concerns for NT, who had disengaged. CS explained that service users can disengage if they feel that no one is interested. After he went missing from services, Mr Goldston left NT unsupported for weeks without following up his presentation. CS doubts that Mr Goldston attempted to visit NT as he recorded at 13:36 that he had attempted to visit but there was no answer at 13:30. The walk to the office is more than 6 minutes and Mr Goldston's IT capabilities would not have allowed for remote recording. He had refused a smartphone capable of recording remotely.

53. There was a 43 day gap between Mr Goldston's attempted visits. This is unacceptable for someone who lives alone and requires support. Where a visit is attempted unsuccessfully, this ought to be recorded and another attempt according to the risks or circumstances of the individual. NT was well known to staff, who were not asked to flag up if they saw him.

54. PDS was a service user in his middle years. He was in a high cost placement which cost the taxpayer around £1500 per week. Such placements are significantly expensive and PDS was identified as no longer requiring the placement. There are policies requiring care to be 'close to home', both by NHS England and local guidance. There are also legal requirements to consider the least restrictive care options possible.

55. PDS was out of area in a restrictive placement and it was very important that he was moved to a lower cost service in a local area. Mr Goldston had always been PDS' care coordinator. He ought to have engaged with him every month or so but did nothing to facilitate a move to local accommodation. There were 2 recorded interactions in 9 or 10 months. One was when PDS called Mr Goldston to raise an issue and one was a record a funding panel without any detail. A nurse, AY raised concerns that Mr Goldston had not facilitated PDS' move. AY tried to contact Mr Goldston but there was no evidence that Mr Goldston had taken any action in respect of PDS.

56. In the course of the internal investigation, when questioned about PDS, Mr Goldston was unresponsive and unhelpful. This left PDS in an out of area placement for some time and represents unnecessary restriction of his liberty.

57. PM had a history of mixed engagement with services. He was last seen on the 5 November 2018 and Mr Goldston was allocated to him on the 10 November 2018. No visit was attempted until the 10 December 2018. PM was in fact unwell and his tenancy was at risk. Mr Goldston's visit was 5 weeks later than it ought to have been which CS believes gave the impression to PM that social workers were not concerned about him.

58. PM disengaged from support and attacked his neighbour. He was subsequently detained under the Mental Health Act. Mr Goldston was required to prepare a Social Circumstances Report for a Mental Health Tribunal hearing. The report was wholly inadequate and a student would fail a placement for submitting such a poor report. It wholly lacked detail or content.

59. At the time of the Mental Health Tribunal, PM had gone missing from the ward and did not attend. He was discharged from his section in his absence which is unheard of in CS' experience.

60. The Mental Health Tribunal report indicates that Mr Goldston attended the hearing and gave evidence which CS believes to be false. Mr Goldston said he had been away for the last year and PM had been given little support in that time. He indicated that with the right support, PM could be managed in the community but he had not had the right support previously. In fact, PM had been seen 7 times in 12 weeks by his previous care coordinator and became unwell despite support. The Tribunal decision was therefore based upon inaccuracies. Mr Goldston stated that he had seen PM at home the day before and the flat was in good condition but this is not recorded in notes. A consultant visited PM's home and found it in an appalling condition. Mr Goldston had indicated that the flat was habitable when in fact he had not visited it for 3 months.

61. When asked about these issues, Mr Goldston stated that the report was a rough draft. He did not accept that CS had received confirmation of the report from the mental health office. He was dismissive and defensive and displayed no ability to reflect upon his conduct.

62. Copies of the reports drafted by Mr Goldston were exhibited by CS, along with copies of complaints made by the family of JM in August and September 2019. An investigation report by PG is also exhibited.

63. Interviews conducted within the local investigations are exhibited by CS. These include an interview with Dr B who raised concerns about the care of JS. He had not been seen in an appropriate time frame and blood tests indicated that his clozapine levels were low. Dr B overheard Mr Goldston appearing to indicate that a cold may account for the low clozapine levels in the blood which he considered to be inappropriate. Dr B considers that Mr Goldston's involvement with JS fell far below the standard of care expected.

64. Mr Goldston was himself interviewed in the course of the local investigation. He explained his involvement with the service users and indicated that he understood his role and had acted appropriately in their care.

65. A statement from AY explains that he contacted Mr Goldston in respect of PDS' care as he was concerned that he had not received any communication from Mr Goldston about PDS' move.

66. A number of local authority and relevant policies are also exhibited by CS. These include the care records standards policy agreed across the local NHS trust and the Local Authority, HCPC standards of proficiency and the Mental Health Act 1983 code of practice.

67. Evidence from AF exhibited minutes from an appeal hearing on the 4 May 2020. These note that Mr Goldston qualified as a social worker in 2003. He indicated in the appeal hearing that he had been unsupported once he returned to work in 2020 and had met performance management targets.

Submissions

68. On behalf of Social Work England, Mr Carey submits that the witnesses called were credible, helpful and consistent. They gave evidence about the same events from different perspectives and were consistent.

Finding and reasons on facts:

69. The panel accepted the advice of the legal adviser in respect of burden and standard of proof, the absence of the social worker and caution with regards to hearsay evidence. The panel made the following findings.

70. The first allegation is that Mr Goldston did not complete work to the required standard when he copied and pasted elements of a community treatment order review report for TJ on or around August 2019.

71. The panel found both SB and CS to be credible and compelling witnesses. Their evidence was corroborative of each other and supported by further evidence and records. The panel accepts the evidence of SB that Mr Goldston had been an AMHP since around 2011. The panel accepts that he was an AMHP at the time of his involvement with TJ and the timeframe of all allegations against him.

72. The report prepared by Mr Goldston in respect of TJ states that "I went to see TJ on the ward on 3rd May 2018 @ 3.00pm. He was laying in his bed and would not talk to myself or the nurse. He was awake, but refusing to speak. Staff were concerned that TJ had been refusing to drink or eat and this resulted in him being put on a fluid chart and being observed closely to ensure adequate food and drink intake. I went to see TJ on Nile Ward on 17th May 2018 to discuss the coming Tribunal and to attend his ward round." It further indicates "Mother recently died (October 2017)".

73. The evidence of CS indicates that references to ward rounds were direct copies of a Doctor's record. The reference to TJ's mother was copied and pasted from the previous report as can be seen by the date being some time previously and not recent as suggested in the report.

74. The panel accepts the evidence of CS that the material appears in identical form to other documents or reports. There is no explanation put forward by Mr Goldston, either in the investigation stage or these proceedings which offers an alternative explanation for how this identical information came to be in the report prepared by Mr Goldston. The panel is therefore satisfied on the balance of probabilities that Mr Goldston copied and pasted content in the report he prepared in respect of TJ.

75. With regards to the allegation that Mr Goldston's report dated 10 July 2019 for HE was of poor quality, the panel reminds itself of the evidence of SB and CS and considered the report itself. The report is not on headed paper and is under one and a half pages in length. The report does not mention that HE had a six month hospital admission in his recent past and does not explore HE's management in the community, engagement with services or home circumstances.

76. The panel found CS to be a clear and compelling witness. Her explanation of the poor nature of the report is supported by the content of the exhibited report and in her professional opinion the report has an insulting lack of care. The panel accepts that the report was considered as unsuitable by a Mental Health Tribunal which postponed the hearing, a factor which the panel concludes is indicative of the poor quality of the report.

77. In addition, the panel accepts the evidence of SB that the report prepared by Mr Goldston was far too short and lacking in content sufficient to render it a useable document.

78. In accepting the evidence of CS and SB, and corroborating that evidence with the exhibited report, the panel concludes that the report prepared by Mr Goldston in respect of HE is of poor quality and this allegation is therefore proved.

79. The next allegation is that Mr Goldston failed to properly meet the needs of service users allocated to him in that he did not properly assess, review and/or maintain adequate contact with named service users. The panel has considered each service user in turn.

80. With regards to service user JM, the panel finds the allegation proved for the following reasons:

    a) The panel accepts the evidence of CS who was clear and compelling. She explained that JM was a high risk service user who required a visit within a week of discharge from hospital and then weekly.

    b) There is clear evidence, including via records made by Mr Goldston, that he did not visit JM at home. One purported attempted visit is not documented at all.

    c) The panel accepts the evidence of CS that a service user's refusal to accept a home visit should not be accepted at face value and attempts ought to continue to assess their wellbeing and needs. CS explains that even a doorstep visit can provide useful insight into a service user's health and it is negligent to fail to conduct home visits for JM.

    d) Concerns about JM were raised by his family. The panel considers this is indicative of the decline in JM's wellbeing. It is also evidence of Mr Goldston's lack of activity with regards to JM which was observed by others outside of the professional social work environment.

81. With regards to the service user JS, the panel finds the allegation proved for the following reasons:

    a) Mr Goldston's own records indicate that he first visited JS in May 2019. He was allocated to JS in November 2018 and the panel accept the evidence of CS that Mr Goldston ought to have visited JS within a few days or a week of his allocation.

    b) There is no explanation proffered by Mr Goldston, either at the local investigation stage or in the course of these proceedings as to why Mr Goldston waited some five months to visit JS.

c) The panel accepts the evidence of SB and CS that JS is a high risk service user with a section 41 restriction. Therefore it ought to have been obvious to Mr Goldston that JS required immediate attention.

d) The panel concludes that Mr Goldston eventually visited JS following intervention by Dr B who raised concerns that JS had not been seen previously. He was also concerned that Mr Goldston appeared to minimise low clozapine levels for JS, when in fact the results may have been indicative of poor compliance with prescribed medication and a lack of engagement on the part of JS which would necessitate further action.

e) The panel concludes that the above accepted evidence amounts to failure to assess, review and maintenance of communication between Mr Goldston with JS.

82. With regards to service user NT, the panel finds the allegation in respect of his care proven for the following reasons:

a) The panel accepts the evidence of CS that NT had a history of homelessness and such service users present a risk of returning to the streets. The panel considers it noteworthy that NT is recorded to have been managing well prior to being under the care of Mr Goldston and again after he was replaced as care coordinator.

b) The panel accepts the evidence of CS that Mr Goldston did not attempt to see NT for 10 days after he had disengaged from services and this is an unacceptable time frame. There is no explanation provided as to why Mr Goldston did not immediately visit NT.

c) The panel notes that a record was entered by Mr Goldston that he attempted to visit NT at 13:30 on the 7 May. The entry was recorded at 13:36. The panel accepts the evidence of CS that NT's address is a 15 minute walk from the office and thus Mr Goldston could not possibly have undertaken the visit and returned to the office in time to make that recording. The panel accepts the evidence received from a variety of sources, including SB and CS, that Mr Goldston's IT capabilities were incredibly poor and he was not capable of remote recording. In addition, he did not possess a smart phone capable of such recording. The panel accepts that this recorded entry by Mr Goldston is inaccurate and considers it more likely than not that Mr Goldston did not in fact attempt to visit NT at home on the 7 May.

d) The panel accepts that Mr Goldston did not attempt to visit NT for 43 days, as this was evidenced by his own recording. CS' evidence is that this is an unacceptable time frame for someone who lives alone and this contributed to NT disengaging from services.

e) The panel accepts the evidence of SB that Mr Goldston should have undertaken a Care Act Assessment to determine NT's needs and eligibility for services.

f) The panel accepts the evidence of CS and SB in respect of Mr Goldston's actions in respect of NT's care which it concludes amounts to a failure to assess, review and maintain proper contact with NT.

83. With regards to service user PDS, the panel finds the allegation proved for the following reasons:

a) Evidence in respect of Mr Goldston's lack of engagement with PDS' care arises from CS, SB and AY. All gave clear and consistent evidence of Mr Goldston's lack of engagement.

b) The panel accepts that there are only two recorded interactions in respect of PDS' care. One is when PDS telephoned Mr Goldston himself and the second was in relation to a funding panel. There is no evidence as to what is recorded about the funding panel. The panel accepts the clear evidence of CS that PDS ought to have been visited every month or two at least.

c) The panel is satisfied that PDS ought to have been moved to a local and less restrictive placement at a significantly earlier stage, as is evidenced by SB and CS.

d) The intervention of AY was necessary because of a lack of action on the part of Mr Goldston. The panel has no evidence or explanation as to why Mr Goldston did not visit PDS or progress his move back to his local area.

e) The panel concludes that the above facts which it accepts as being accurate are indicative of a failure on Mr Goldston's part to assess, review and maintain communication with PDS.

84. Finally, the panel finds the allegations in respect of PM proved for the following reasons:

a) The panel accepts the clear and convincing evidence of CS that PM had a mixed history of engagement. Records indicate that he was allocated to Mr Goldston on the 10 November 2018 but no visit was attempted until the 10 December 2018.

b) The panel accepts that PM disengaged with services and ultimately attacked a neighbour and was detained under the Mental Health Act. The panel is not satisfied that Mr Goldston's delayed visit is causative of PM's decline, however the panel concludes that PM's decline may have been noted if Mr Goldston had visited earlier.

c) The panel has reviewed the Mental Health Tribunal decision for PM. It is recorded that PM was seen at home by Mr Goldston the day before the hearing. Mr Goldston is recorded as having stated that PM's previous care coordinator had left the role some time earlier and PM had been without support for a significant period of time. The Mental Health Tribunal considered that PM had made significant progress on the basis of Mr Goldston's report of visits.

d) The panel accepts the evidence of CS that it is inaccurate to say that PM had little support over the preceding year. The panel accepts that PM had been seen 7 times in 12 weeks prior to Mr Goldston taking over his care.

e) The panel cannot reconcile the account apparently given to the Mental Health Tribunal by Mr Goldston and his records which do not reference latter visits. The panel concludes that the evidence provided by Mr Goldston was inaccurate.

f) The panel has reviewed the report provided by Mr Goldston in respect of PM and accepts the evidence of CS that the content of the report is inadequate.

g) In addition, the panel accepts the evidence of SB that Mr Goldston indicated that PM's home was suitable for discharge when his own visit revealed litter everywhere, no bedding and possible vermin. The panel accept that Mr Goldston misled other professionals about the standard of PM's home and this presented an obstacle to his safe discharge from hospital.

h) The panel concludes that the above facts, which it finds proved, amount to failures to assess and review PM.

85. The final allegations related to alleged failures to maintain adequate case records for service users TJ and PDS. The panel has considered each in turn.

86. With regards to TJ, the panel finds the allegation of failing to maintain adequate case records proved. The panel accepts the evidence of CS that the records were "inaccurate and confusing" and required a lot of "unpicking" to establish that Mr Goldston had in fact done very little. The evidence of CS is clear and supported by other evidence, such as the poor quality community treatment order report in respect of TJ. For these reasons, the panel finds the allegation in respect of record keeping for TJ proved.

87. The panel is not satisfied that the allegation in respect of the records of PDS is proved. The panel does not have sight of these records. None of the witnesses, either those who provided oral evidence or those whose statements were admitted as evidence, specifically reference the records of PDS.

88. The panel finds proved, as set out above, that Mr Goldston's actions in respect of PDS were inappropriate and unacceptable. However a lack of records could be indicative of the lack of action which the panel has found proved. There is no direct evidence of the content of PDS' records or the adequacy of said records. For this reason, the panel does not find this allegation proved.

Finding and reasons on grounds:

89. The panel accepted the advice given by the legal adviser as to what can constitute the ground of misconduct including the case of *R (on the application of Remedy UK Limited) v GMC [2010] EWHC 1245 (Admin)* which sets out that misconduct has two principal kinds: sufficiently serious misconduct in the exercise of professional practice that it can properly be described as misconduct going to fitness to practise; and morally culpable or otherwise disgraceful conduct which brings disgrace upon the profession and thereby prejudices the profession.

90. The standards relevant at the time are the HCPC Standards of Conduct, Performance and Ethics (2016) and the HCPC Standards of Proficiency (2017). On behalf of Social Work England, Mr Carey submits the following standards may have been departed from:

Standards of Conduct, Performance and Ethics (2016)

1.2: You must work in partnership with service users and carers, involving them, where appropriate in decisions about their care, treatment, or other services to be provided;

2.2: You must listen to service users and carers and take account of their needs and wishes;

6.1: You must take all reasonable steps to reduce the risk of harm to service users, carers, and colleagues as far as possible;

6.2 You must not do anything, or allow someone else to do anything, which could put the health or safety of a service user, carer, or colleague at unacceptable risk;

9.1: You must make sure that your conduct justifies the public's trust and confidence in you and your profession;

10.1: You must keep full, clear, and accurate records for everyone you care for, treat, or provide services to;

10.2: You must keep all records promptly and as soon as possible after providing care, treatment, or other services;

Standards of Proficiency (2017)

1.3 be able to undertake assessments of risk, need and capacity and respond appropriately;

2.3 understand the need to protect, safeguard, promote and prioritise the wellbeing of children, young people and vulnerable adults;

3.1 Understand the need to maintain high standards of personal and professional conduct;

4.6 be able to make and receive referrals appropriately;

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;

91. On behalf of Social Work England, Mr Carey submits that the conduct found proved is so serious it amounts to misconduct. He points to the HCPC standards as set out above and notes that the proved conduct breaches multiple standards applicable to Mr Goldston's work.

92. Mr Carey submits that the impact upon the service users was significant and included in some cases deprivations to their liberty or actual physical harm. Additionally there were risks of harm to service users and the public as a whole. There was also an impact upon Mr Goldston's colleagues who were required to step in with service users and risked unfounded criticisms and scrutiny of their conduct as a result of presenting Mr Goldston's substandard work.

93. The panel concluded that the allegations and facts found proved do amount to misconduct for the following reasons:

    a) The conduct found proved represents multiple and repeated breaches of the professional standards applicable at the time and set out above. The panel accepts the submission on behalf of Social Work England that the above standards were applicable at the relevant time.

    b) The conduct involved numerous services users and was repeated with different individuals.

    c) The conduct found proved represented failures to carry out the basic functions of a social worker. The tasks required of Mr Goldston were not tasks requiring advanced knowledge or skills but rather they were fundamental acts required of a social worker undertaking the role. The panel is satisfied that the conduct is so serious it can properly be said to be negligent professional conduct.

    d) The impact of the breaches of the above standards put service users and the public at risk of harm repeatedly and over extended periods of time.

    e) The nature of the risks caused are significant and include acts of violence by unwell service users to themselves and members of the public.

    f) The conduct was sufficiently serious to cause members of the public, who were family members of the service users, to complain.

    g) The conduct was sufficiently serious that other professionals took steps to intervene to ensure that risks to service users were minimised.

Finding and reasons on current impairment

94. The panel accepted legal advice in respect of the definition of impairment as per the Social Work England fitness to practise investigations guidance which states 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 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".*

95. The panel was reminded to look to the questions of the risk to the public posed by the conduct, the risk of repetition of the conduct, what insight the registrant has into their conduct and whether public confidence in the profession as a whole requires a finding that the registrant is impaired.

96. On behalf of Social Work England, Mr Carey submits that there is clear evidence that Mr Goldston has no insight into his misconduct and he has taken no steps towards remediating the conduct. Therefore, Mr Carey submits, there is a huge risk of repetition of the conduct given the history of repeated acts, as well as a lack of insight or remediation.

97. In its deliberations, the panel reminded itself that Social Work England's overarching objective is to protect the public.

98. The panel considered the submissions of Mr Carey and the Social Work England impairment guidance. The panel concluded that Mr Goldston is currently impaired for both personal and public interest reasons. In reaching these conclusions the panel considered the following:

    a. The panel does not accept that Mr Goldston has any insight into his conduct. He has not engaged with these proceedings and offers no evidence, either in person or writing as to his version of events or reflections upon his conduct.

    b. The panel heard evidence from both SB and CS that Mr Goldston was not willing to accept constructive criticism of his professional work and would deflect and defend his conduct. The panel considers that this is indicative of a lack of willingness to accept that his conduct amounts to misconduct and without such acknowledgment, Mr Goldston has demonstrated no insight into his misconduct.

    c. There is no evidence of any steps taken by Mr Goldston to remediate his conduct or any evidence of proactive steps taken by him to reflect upon his work.

d. The proper professional performance required of Mr Goldston to undertake his role was not complex and did not require expert knowledge. It was basic social work which Mr Goldston was capable of completing but did not complete.

e. The extended time period of the misconduct found proved and the multiple service users involved is indicative of a high risk of repeated conduct. The panel notes that Mr Goldston was able to engage productively with performance management plans for specific periods of time, but whenever he was released from such supervision, his work returned to the poor standards which are found to have amounted to misconduct. The panel is satisfied that without insight and remediation, there is an extremely high risk of repetition of misconduct from Mr Goldston.

f. Further, the panel is satisfied that Mr Goldston is impaired on public confidence grounds. Mr Goldston's proven allegations placed service users and members of the public at risk. In these circumstances the panel is wholly satisfied that public confidence in the profession as a whole is undermined by the actions or inactions of Mr Goldston.

g. The public in general, and service users in particular, are entitled to trust that social workers will undertake all tasks required of their professional roles without delay and with an appropriate level of care and professionalism. For this reason, the panel is satisfied that Mr Goldston's fitness to practise is also impaired on the public component.

Decision and reasons on sanction

99. Having reached the above conclusions in respect of misconduct and impairment, the panel next considered what sanction, if any, ought to be imposed. When considering the question of sanction, the panel took into account Social Work England's 'impairment and sanctions guidance' and the submissions of Mr Carey on behalf of Social Work England.

100. Mr Carey submitted that a removal order is appropriate in this case. He cited the panel's findings in respect of the nature and extent of the conduct, involving multiple service users over extended periods of time. Mr Carey reminded the panel that actual harm was suffered, as well as a high risk of harm to service users and the public. Mr Carey submitted that Mr Goldston's lack of insight and engagement with either his former employer or these proceedings is indicative of a lack of willingness to remediate his conduct and therefore removal from the social work register is necessary and proportionate to protect the public and public confidence in the profession.

101. The panel considers that the aggravating features in these proceedings are:

a) The number of service users whose care was impacted by the conduct of Mr Goldston;

b) The actual harm which has been proved as a result of Mr Goldston's conduct. This includes a service user disengaging from services and demonstrating self-neglect and another service user being the subject of restricted liberty at a costly placement far from his home for a period of months. The cumulative harm in the allegations found proved is actual harm as opposed to exposing service users or the public to risks of harm.

c) The misconduct had an impact upon colleagues as well as service users.

d) Public confidence in the profession as a whole was undermined in Mr Goldston's actions which resulted in complaints from members of the public, as well as professionals.

e) When local investigations commenced into the misconduct, Mr Goldston provided inaccurate information in respect of his actions.

102. The panel was unable to identify any mitigating features of Mr Goldston's conduct.

103. The panel first considered whether it would be appropriate to take no action in respect of Mr Goldston. The panel concluded that this would have no impact upon the risk to the safety of the public or risk of repetition of conduct and would not ensure public confidence in the profession, as it would enable Mr Goldston to continue to practise without restriction. Public confidence in the profession would likely diminish if no action was taken in the circumstances of the allegations, misconduct and impairment found proved.

104. The panel next considered whether advice would be an appropriate sanction. The panel concluded again that advice would have no impact upon the risk to public safety, risk of repetition of conduct and would not ensure public confidence in the profession, as Mr Goldston would be able to continue to practise without restriction. The panel reminds itself that the evidence of SB and CS was clear that Mr Goldston had been offered advice and support during informal and formal performance management procedures and such advice had not resulted in meaningful changes to Mr Goldston's professional practice. Therefore this sanction is insufficient to protect the public or inspire public confidence.

105. The panel considered whether a warning would be a proportionate sanction. The panel concluded that this would not be an adequate safeguard for the public as again it would enable Mr Goldston to continue to practise without restriction and would not address the risk of repetition of conduct, risks to public safety or public confidence in the profession. Again, the panel considered Mr Goldston's previous conduct following

formal and informal performance management to be indicative of the fact that a warning would be insufficient to bring about meaningful change sufficient to protect the public.

106. The panel therefore moved to consider sanctions which do restrict Mr Goldston's practice. The panel first considered whether conditions of practice would be a proportionate sanction and reminded itself of paragraph 114 of the sanctions guidance which states that:

"Conditions of practice may be appropriate in cases where (all of the following):

- *the social worker has demonstrated insight*
- *the failure or deficiency in practice is capable of being remedied*
- *appropriate, proportionate, and workable conditions can be put in place*
- *decision makers are confident the social worker can and will comply with the conditions*
- *the social worker does not pose a risk of harm to the public by being in restricted practice"*

107. The panel has already concluded that Mr Goldston does not demonstrate insight. He has not participated in these proceedings or offered any evidence to the panel. The panel is not confident that Mr Goldston would comply with conditions of practice, as he had previously been supported with performance management support which did not result in meaningful or lasting improvement in his conduct.

108. The panel is not satisfied that his deficiencies are capable of being remedied by conditions of practice, nor that Mr Goldston would comply with them. The panel concludes that Mr Goldston would still present a risk of harm to the public if he was able to work, even with restrictions, whilst he lacks insight. For these reasons, the panel concludes that conditions of practice are insufficient to protect the public and public confidence in the profession.

109. The panel next considered whether a suspension order is appropriate in this case. The panel considered that a suspension order would protect the public from harm and a risk of repeated conduct by preventing Mr Goldston from practising for a period of time. The panel has considered whether this is sufficient to protect the public and public confidence in the profession.

110. Paragraph 137 of the sanctions guidance states that:

"Suspension may be appropriate where (all of the following):

- *the concerns represent a serious breach of the professional standards*

- *the social worker has demonstrated some insight*
- *there is evidence to suggest the social worker is willing and able to resolve or remediate their failings"*

111. The panel has already concluded that Mr Goldston's conduct amounts to a serious breach of professional standards. However he shows no insight into his conduct and there is no evidence before this panel that suggests Mr Goldston is willing and able to resolve or remediate his failings. For this reason, the panel concludes that suspension is insufficient to protect the public and public confidence in the profession.

112. The panel therefore considered whether removal from the register of social workers is an appropriate and proportionate sanction for Mr Goldston. Paragraph 148 of the sanctions guidance states that:

"A removal order must be made where the decision makers conclude that no other outcome would be enough to (do one or more of the following):

- *protect the public*
- *maintain confidence in the profession*
- *maintain proper professional standards for social workers in England"*

113. The guidance also states at paragraph 149 that removal may be appropriate for "social workers who are unwilling and/or unable to remediate (for example, where there is clear evidence that they do not wish to practise as a social worker in the future)".

114. The panel concludes that removal from the register of social workers is an appropriate and proportionate sanction for the following reasons:

a) Mr Goldston has demonstrated no insight into his conduct and has not engaged with these proceedings. In February 2023 he indicated that he wished to be removed from the register and since that time he refused even to accept service of paperwork in relation to these proceedings;
b) The panel is satisfied that Mr Goldston will not engage in any remediation to address his conduct. The panel is satisfied that throughout investigations at a local level and beyond, Mr Goldston's view, as evidenced by SB and CS, was that there were no failings in his professional work. As a result, the panel is not satisfied that Mr Goldston is willing or able to remediate his conduct;
c) The panel has considered all sanctions which are less restrictive and concludes as set out above that each is insufficient to address the ongoing risk of harm to the public which would occur if Mr Goldston continued to work as a social worker without insight or remediation;
d) Whilst suspension would remove Mr Goldston from working as a social worker for a set period of time, the panel concludes that this would protect the public for only a limited period of time and that without remediation, the risks presented by Mr Goldston's work would remain unchanged. In circumstances where the panel finds

Mr Goldston is unwilling and unable to remediate his conduct, a suspension order is therefore insufficient to protect the public;

e) The panel considers that the conduct found proved is so serious that in order to satisfy the public confidence limb of public protection, removal from the register is required. CS described Mr Goldston's care of service users as "insulting" and the panel agrees with this assessment.

115. For these reasons, the panel concludes that a removal order is an appropriate and proportionate sanction for Mr Goldston for the reasons set out above.

Interim order

116. In light of its findings on sanction, the panel next considered an application by Mr Carey for an Interim Suspension Order to cover the appeal period before the final order becomes effective.

117. The panel was mindful of its earlier findings and decided that it would be wholly incompatible with those earlier findings if Mr Goldston were permitted unrestricted practice should an appeal against this order be submitted.

118. Accordingly, the panel concluded that an interim suspension order for a period of 18 months is necessary for the protection of the public and public confidence in the profession. 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 removal order shall take effect when the appeal period expires.

Right of appeal

119. 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.

120. 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.

121. 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.

122. 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:

123. 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

124. 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:

125. 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.