Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
1, 4, 5, 6, 7, 11, 12, 13, 14, 18, 19 and 20 April 2022

Virtual Hearing

Name of registrant:	Terence Paul Golden
NMC PIN:	83H1517E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – (April 1987) Registered Midwife Midwifery – (May 1990)
Area of registered address:	New Zealand
Type of case:	Misconduct
Panel members:	John Vellacott (Chair – Lay member) Seamus Magee (Lay member) Linda Tapson (Registrant member)
Legal Assessor:	Oliver Wise
Hearings Coordinator:	Vicky Green
Nursing and Midwifery Council:	Represented by Scott Smith, Case Presenter
Mr Golden:	Not present and not represented in his absence
Adjournment application:	Not granted
Facts proved:	All
Facts not proved:	None
Fitness to practise:	Impaired
Sanction:	Striking off order
Interim order:	Interim suspension order – 18 months

Day one of the hearing

Given Mr Golden's prior engagement in previous hearings and active communication with the Nursing and Midwifery Council (NMC), his attendance was expected at this hearing, although this had not been confirmed by Mr Golden.

Prior to the hearing starting, Mr Golden was sent an email inviting him to attend a pre-hearing meeting with the hearing's coordinator, the case presenter and legal assessor at 9am. Mr Golden did not join the meeting at 9am and the hearing's coordinator sent an email to him at 9:07am with the details of the meeting and offering support if he was experiencing any technical difficulties.

There was no response to the email and two further emails were sent by the hearings coordinator to Mr Golden, one at 9:35am and another at 10:15am. Telephone contact was also attempted but unsuccessful.

The panel was informed of the above and it decided to proceed to consider service and whether to proceed in the absence of Mr Golden.

Decision and reasons on service of Notice of Hearing

In response to the COVID-19 crisis, emergency changes were made to the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended (the Rules). The emergency changes allow for the Notice of Hearing (the Notice) to be sent by the Nursing and Midwifery Council (NMC) by email instead of by recorded delivery post. This email must be sent securely to a registered email address for the registrant and/or representative.

At the outset of this hearing the panel was informed that Mr Golden was not in attendance and that the Notice was emailed to his registered email address on 6 December 2021.

Mr Smith, on behalf of the NMC, submitted that it had complied with the requirements of the Rules.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice provided details of the hearing, the time, dates and the nature of the hearing and set out the charges in full. It also contained, amongst other things, information about Mr Golden's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

In the light of all the information available, the panel was satisfied that Mr Golden has been served with the Notice in accordance with the requirements of Rules 8 and 34, and in accordance with the emergency changes to the Rules.

Decision and reasons on proceeding in the absence of Mr Golden

The panel next considered whether it should proceed in the absence of Mr Golden. It had regard to Rule 21 and heard the submissions of Mr Smith who invited the panel to continue in the absence of Mr Golden.

Mr Smith drew the panel's attention to the Proceeding in Absence bundle which contained a number of emails from Mr Golden to the NMC. Mr Smith submitted that Mr Golden has engaged with the NMC throughout these proceedings and he sent a number of emails to the NMC using the email address that the Notice was sent to. Mr Smith informed the panel that Mr Golden attended a recent interim order hearing by video link without confirming his attendance prior to the hearing.

Mr Smith drew the panel's attention to the following document sent by Mr Golden to the NMC dated 18 March 2022:

'Objection to final hearing dates

Lack of notice to allow sufficient time to arrange human and administrative resources.

It only now appears that notice is given to the registrant that the final hearing is take place in two weeks time. This is a unilateral rather than bilateral agreement. It is usual with two parties in a case to agree dates and witnesses except where the NMC are concern as they completely ignore fairness reasonableness etc.

This fails to meet the legal requirements for fairness reasonableness or proportionality.

This recent confirmation of the final hearing dates from the NMC lawyer Matthew Ccassells still does not answer the questions raised recently (and in fact over the last couple of years) by the registrants to the NMC in particular including the following:

Witness lists
Who are the NMC calling as witnesses
Will the complainant be a witness

The registrant has previously and repeatedly indicated the requirement for witnesses from the NMC.

These are required to include:
*case managers both current and previous (Megan brown & Sylvia***)*
Executive management
Head of legal Libby Lamont

The NMC objecting to witnesses is like objecting to having a fair hearing. The witnesses will show how there is no credible evidence the allegations themselves

are not clear and the NMC have not entered into any meaningful explanations or responses.

Disability

The registrant requires reasonable adjustments and not to be treated less favourably for to disability.

This includes sufficient notice to gain support and assistance with the final hearing.

Impecuniosity

This has been outlined in various documents including recently to the NMC. The panel is required to recruit these along with along documentation by the registrant in this case.'

Mr Smith also drew the panel's attention to the case management form that was sent to Mr Golden on 23 August 2021. He submitted that Mr Golden was asked to provide the NMC with any dates to avoid when scheduling this substantive hearing but he did not respond. Mr Smith submitted that Mr Golden did not respond to or request alternative dates after the Notice was sent to him on 6 December 2021.

Mr Smith drew the panel's attention to a letter from Mr Golden dated 25 March 2022 in which he raised a number of administrative questions. He also referred the panel to the NMC's response to Mr Golden's questions.

Mr Smith submitted that there is no good reason to adjourn this hearing today. Mr Smith submitted that Mr Golden is aware of the hearing dates, he has been given reasonable notice in that the Notice was sent on 6 December 2021 and a reminder email was sent by the NMC to Mr Golden on 14 February 2022. Mr Smith submitted that Mr Golden was further reminded of the dates of this hearing on 1 and 10 March 2022. He submitted that

Mr Golden has chosen to voluntarily absent himself. Mr Smith referred the panel to the case of *General Medical Council v Adeogba* [2016] EWCA Civ 162.

Mr Smith invited the panel to exercise its discretion and proceed in the absence of Mr Golden. Mr Smith submitted that there is a public interest in the expeditious disposal of this case given that the charges arose over two years ago, they are serious and raise public protection concerns. He submitted that NMC witnesses have been put on notice to give evidence and an adjournment may inconvenience them.

Furthermore, Mr Smith submitted that Mr Golden has had ample time to make arrangements, to obtain any support and to draft submissions in preparation for this hearing.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised 'with the utmost care and caution' as referred to in the case of *R v Jones (Anthony William) (No.2) [2002] UKHL 5*.

The panel has decided to proceed in the absence of Mr Golden. In reaching this decision, the panel has considered the submissions of Mr Smith and the advice of the legal assessor. It has had particular regard to the following considerations:

- Mr Golden has been provided with sufficient notice and his challenge to the hearing dates has come at a late stage.
- Three witnesses have made themselves available to give live evidence during this hearing.
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services.

- Further delay may have an adverse effect on the ability of witnesses accurately to recall events.
- There is a strong public interest in the expeditious disposal of the case.

The panel noted that there may be some disadvantage to Mr Golden in proceeding in his absence. Whilst the evidence upon which the NMC relies will have been sent to Mr Golden, he will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on his own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowances for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mr Golden's decision to absent himself from the hearing, waive his rights to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

The panel also noted that Mr Golden had been sent the Case Management Form (CMF) that includes a section which invites a response to the charges and requests information about whether any adjustments are necessary to enable him to participate in the hearing. The panel noted that, to date, no response has been submitted by Mr Golden to the NMC.

In these circumstances, the panel has decided that it is fair, appropriate and proportionate to proceed in the absence of Mr Golden. The panel will draw no adverse inference from his absence in its findings of fact.

Details of charge (as read)

That you, a registered nurse and midwife

1. Did not complete a full risk assessment during Patient A's initial appointment with you or, in the alternative, did not make any record of the risk assessment you had performed in Patient A's notes.

2. Following Patient A reporting a suspected rupture of membranes to you:

a. did not record the suspected rupture of membranes in Patient A's notes.

b. did not advise Patient A that she should allow you to exam her to confirm whether her membranes had ruptured or, in the alternative, did make any record of your advice to Patient A and her response in Patient A's notes

3. Did not provide information to Patient A concerning:

a. the risks that would arise if her pregnancy lasted longer than 42 weeks.

b. the types of clinical intervention which she should consider and which you would recommend if her pregnancy lasted longer than 42 weeks or, in the alternative, did not make any record of the information you provided and the discussion you had in Patient A's notes.

4. In addition to the matters set out in charges 1-3 above, did not complete any records in respect of the care you provided to Patient A.

5. Did not store Ocytocin appropriately in that you stored it in a communal fridge and took no steps to secure it.

6. Did not attempt to handover Patient A's care to another midwife and/or obstetrician when it would have been appropriate to do so in view of your decision that you would no longer act as her midwife and the late stage of her pregnancy.

7. Delegated Patient A's care to Person A when it was inappropriate to do so in view of her not being a healthcare professional.

8. Practised midwifery in France without requesting leave to provide midwifery services from the French Order of Midwives.

9. Practised midwifery in France without having in place appropriate insurance.

10. In practising without leave from the French Order of Midwives and/or without insurance you acted without integrity in that you knew you were not entitled to practise midwifery in France but did so anyway.

11. In failing to keep records of Patient A's care you acted without integrity in that by doing so you intended to minimise the risk of your unregistered and/or uninsured practice coming to the attention of the French authorities.

AND in light of the above, your fitness to practise is impaired by reason of your misconduct.

Decision and reasons on application to amend charges 2.b and 5

After the charges were read, Mr Smith made an application to amend the wording of charges 2.b and 5. He submitted that both of the amendments were to correct typographical errors.

Charge 2.b. currently reads as follows:

2. Following Patient A reporting a suspected rupture of membranes to you:

b. did not advise Patient A that she should allow you to exam her to confirm whether her membranes had ruptured or, in the alternative, did make any record of your advice to Patient A and her response in Patient A's notes

The proposed amendment to charge 2.b. is as follows:

2. Following Patient A reporting a suspected rupture of membranes to you:

b. did not advise Patient A that she should allow you to examine her to confirm whether her membranes had ruptured or, in the alternative, did make any record of your advice to Patient A and her response in Patient A's notes

Charge 5 currently reads as follows:

5. Did not store Ocytocin appropriately in that you stored it in a communal fridge and took no steps to secure it.

The proposed amendment to charge 5 is as follows:

5. Did not store Oxytocin appropriately in that you stored it in a communal fridge and took no steps to secure it.

Mr Smith submitted that the proposed amendment in respect of charge 2.b. was to correct a grammatical error and the proposed amendment in respect of charge 5. was to correct a spelling error. He submitted that the proposed amendments do not change the substance of the charge and would therefore cause no injustice to Mr Golden if the amendments were made.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel was of the view that such amendments, as applied for, were in the interest of justice. The panel was satisfied that there would be no prejudice to Mr Golden and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendments, as applied for, to ensure clarity and accuracy.

Decision and reasons on application to admit hearsay evidence

Mr Smith made an application for the evidence of Person A to be admitted into evidence as hearsay pursuant to Rule 31 of the Rules. He referred the panel to the case of *Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin).*

Mr Smith submitted that despite the NMC's best efforts, it has been unable to secure Person A's attendance to give live evidence at this hearing. He submitted that Person A has provided no reason for her lack of engagement and the NMC is unable to compel her to attend and give evidence.

Mr Smith submitted that Person A's evidence is clearly relevant to the charges. He submitted that whilst relevant, Person A's evidence was not sole and decisive, and it was corroborated by the evidence of Patient A.

With regard to fairness, Mr Smith submitted that Mr Golden had been notified of the NMC's intention to make this application. He submitted that Mr Golden was made aware of Person A's witness statement in July 2020 and he has not challenged it. Mr Smith submitted that Mr Golden was notified of this application in the evening on 1 April 2022, and there was no response from him to the notice from the NMC of its intention to apply to admit Person A's evidence as hearsay, and he has not formally challenged any of Person A's evidence. Mr Smith submitted that taking all of the above into account, the evidence of Person A should be admitted into evidence as hearsay.

The panel accepted the advice of the legal assessor, who took the panel to considerations set out in *Thorneycroft.* He pointed out that the NMC did not give notice of this application to Mr Golden before the evening of 1 April 2022. It was relevant that Mr Golden would not be attending to cross examine Person A due to his non-attendance, but the panel would be deprived of the opportunity of testing Person A's evidence by questioning her.

The panel considered that Person A's evidence is relevant as it goes to charges 3, 5 and 7. It first considered whether Person A's evidence was the sole and decisive evidence in respect of these charges. The panel had regard to all of the evidence before it and found that there was evidence from Patient A to corroborate the evidence of Person A in respect of charges 3 and 5. With regard to charge 7, the panel noted a communication from Mr Golden to Patient A in which he suggested delegating her care. The panel therefore concluded that the evidence of Person A is neither sole nor decisive in respect of the charges her evidence relates to.

The panel went on to consider whether it would be fair to admit the witness statement of Person A into evidence as hearsay evidence. The panel was of the view that the NMC made all reasonable efforts to secure Person A's attendance in the circumstances. The panel noted that Mr Golden had previously been sent Person A's witness statement and he had recently been notified of this application. The panel also noted that Mr Golden had not contested the contents of Person A's witness statement and he had not responded to the notification of this application.

Taking all of the above into account, the panel determined that it would be fair to admit the witness statement of Person A into evidence as hearsay, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on application to adjourn

On day three of the hearing (5 April 2022) the panel was made aware of an email that had been sent from Mr Golden's email address. Mr Smith drew the panel's attention to the letter that was contained within the email, in particular the following:

> *'What are the options in this case?*
> *Can the case be adjorned [sic] / postponed until there is proper engagement with written responses by the NMC?'*

In the light of this, the panel treated this as an application to adjourn this hearing pursuant to Rule 32 of the Rules and invited submissions from Mr Smith.

Mr Smith drew the panel's attention to the NMC's response to this letter. He submitted that Mr Golden was provided with ample notice of the hearing and he has chosen to not attend. He submitted that the questions put forward by Mr Golden are repetitive and he appears to be attempting to derail the hearing process. Mr Smith submitted that there is no good reason to adjourn and that it remains in the public interest to continue with this hearing. Mr Smith submitted that the application should be declined and that the hearing should continue.

The panel accepted the advice of the legal assessor, who referred the panel to the considerations in Rule 32:

> *'Rule 32 (2) A practice committee considering an allegation may, of its own motion or upon the application of a party, adjourn the proceedings at any stage, provided that –*
> *No injustice is caused to the parties and (b) that the decision is made after hearing representations from the parties (where present) and taking advice from the legal assessor…*
>
> *(4) In considering whether or not to grant a request for… adjournment, the… practice committee shall, amongst other matters, have regard to –*
> *(a) the public interest in the expeditious disposal of the case;*
> *(b) the potential inconvenience caused to a party or any witnesses to be called by that party; and*
> *(c) fairness to the registrant.'*

The panel gave careful consideration to Mr Golden's application to adjourn this hearing.

Further to its previous determination in respect of service of notice, the panel found that Mr Golden had been provided with sufficient notice of this hearing and ample time to prepare and to seek legal representation if he wished to do so. The panel was of the view that Mr Golden has been encouraged to attend the hearing and offered support in order to facilitate his attendance at this hearing.

The panel found that there was no new information from Mr Golden and no good reason has been provided by him to support his application for an adjournment. The panel was aware of Mr Golden's contact with the NMC, raising procedural questions and continuing to not participate in this hearing. The panel was mindful of the public interest in the expeditious disposal of cases and that another NMC witness is due to give live evidence.

Having regard to all of the above, the panel decided to refuse Mr Golden's application for an adjournment.

Whilst the panel did not accede to Mr Golden's adjournment application, it decided to pause the hearing until 1:30pm on day four. In addition, the panel asked the NMC to correspond with Mr Golden inviting him to submit further information including any rebuttals to the charges which he referred to in his most recent communication to the NMC. The panel also asked for the NMC to send a reminder to Mr Golden that he, or any representative, could attend the hearing either virtually or by telephone. This delay also facilitated the NMC as its next witness was not currently available and may become available on day 4.

[This hearing resumed on day 4 at 1:30pm]

When the hearing resumed the panel noted that Mr Golden was not in attendance and asked Mr Smith for an update about whether the NMC had received any further communication or written responses to the charges from him.

Mr Smith told the panel that NMC had sent Mr Golden an email advising him of the panel's decision. He confirmed that Mr Golden had not provided any written submissions or responses to the charges.

Decisions and reasons on amendment to charge 2b

Before the panel made its determination on the facts, it noted that there was a typographical error in charge 2.b.

Charge 2.b. currently reads as follows:

> 2. Following Patient A reporting a suspected rupture of membranes to you:
>
> b. did not advise Patient A that she should allow you to examine her to confirm whether her membranes had ruptured or, in the alternative, did make any record of your advice to Patient A and her response in Patient A's notes

The proposed amendment to charge 2.b. is set out below:

> 2. Following Patient A reporting a suspected rupture of membranes to you:
>
> b. did not advise Patient A that she should allow you to examine her to confirm whether her membranes had ruptured or, in the alternative, did **not** make any record of your advice to Patient A and her response in Patient A's notes

In accordance with Rule 28 of the Rules, the panel invited submissions from Mr Smith and legal advice from the legal assessor.

Mr Smith agreed with the proposed amendment and submitted that it was a typographical error. He submitted that the NMC case has been put on the basis that Mr Golden 'did not' make any records and therefore the amendment would cause him no injustice.

The panel accepted the advice of the legal assessor.

The panel determined that the amendment would correct the obvious omission of the word *'not'*. Given that Mr Golden is aware of the NMC case the panel was of the view that there would be no injustice to him if this amendment was made. The panel therefore decided to make the amendment as set out above.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Smith on behalf of the NMC. Before making any decisions on the facts, the panel asked for the NMC to check to see whether any rebuttal evidence had been provided by Mr Golden. Mr Smith confirmed that no rebuttal evidence or submissions had been provided by Mr Golden for the panel's consideration.

The panel has drawn no adverse inference from the non-attendance of Mr Golden.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

The panel heard live evidence from the following witnesses called on behalf of the NMC:

- Patient A: Patient A.

- Ms 1: Registered Midwife – expert witness.

- Mr 2: EU Public Affairs Manager at the French Order of Midwives.

The panel also considered the witness statement and hearsay evidence of:

- Person A: Friend of Patient A.

Background

On 28 October 2019 Patient A referred Mr Golden to the NMC. At the time that the charges arose, Patient A was an expectant mother who was residing in France. It is alleged that Patient A entered into a contract with Mr Golden and there was an agreement that he would provide private midwifery services and assist with her home birth and the delivery of her baby, due on 9 September 2019.

In her referral, Patient A raised a number of concerns about the level of care provided to her by Mr Golden. Concerns were also raised about Mr Golden practising in France without the required registration or insurance.

The panel then considered each of the charges and made the following findings.

Charge 1

> 1. Did not complete a full risk assessment during Patient A's initial appointment with you or, in the alternative, did not make any record of the risk assessment you had performed in Patient A's notes.

This charge is found proved.

In reaching this decision, the panel had regard to the evidence of Patient A and Ms 1.

The panel considered the evidence of Patient A, who, in her witness statement stated the following:

> *'During the time I was under Paul's care he did not complete any documentation that I knew of. He printed off a maternity record and never completed this. I exhibit the blank Maternity Record provided by Paul as* ***Exhibit IB/4.*** *Up until nearing the end of my pregnancy the support he provided was by email/WhatsApp. When he came over to France near the end of my pregnancy he did complete examinations checking the baby's position. He would do this by placing his hands on my belly and feel where he believed the baby's head and bottom were. For quite a while baby's head was not dropping down and was not engaged. I did not see Paul write any notes down after the examination. He also checked the baby's heart rate and my blood pressure but again I did not see him write anything down.'*

In her oral evidence, Patient A told the panel that she had not had any antenatal blood tests as she was not keen to have them and requested limited intervention. However, she confirmed there was no discussion with Mr Golden, and she was not offered any blood tests. She stated that when Mr Golden first met with her he did not carry out a full antenatal risk assessment.

The panel had sight of the blank Maternity Record referred to by Patient A in her witness statement.

The panel had regard to the expert evidence of Ms 1 and her expert report. The panel noted that having had sight of all of the evidence, Ms 1 concluded that Mr Golden's actions did not constitute a full and thorough risk assessment.

The panel found the evidence of Patient A to be clear and consistent with her witness statement and contemporaneous documentation. The panel noted that if Patient A could not answer a question she would not speculate and it also noted that she recognised her own responsibility in respect of knowing about Mr Golden's registration and insurance

status in France. The panel found Patient A to be a balanced and fair witness who did her best to assist the panel. The panel therefore determined that Patient A was a credible and reliable witness and concluded that it was safe to rely on her evidence.

The panel found Ms 1 to be a credible and reliable expert witness. The panel noted that Ms 1 is an expert in midwifery services and she provided objective and clear evidence.

Having found the evidence of Patient A and Ms 1 to be credible and reliable and having had sight of the blank Maternity Record, the panel was of the view that it was more likely than not that Mr Golden did not complete a full risk assessment during Patient A's initial appointment and did not make any record of the risk assessment he had performed in Patient A's notes. The panel therefore found this charge proved.

Charge 2.a.

2. Following Patient A reporting a suspected rupture of membranes to you:

a. did not record the suspected rupture of membranes in Patient A's notes.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms 1 and Patient A.

In her witness statement Patient A stated the following:

'Paul arrived at about 39-40 weeks and I informed him that I had felt a little gush of water. He did not really acknowledge this and said the baby was still very high and he did not think the birth was imminent…

…There was no conversation about the 'little gush of water' I had experienced. Paul felt very dismissive, it was as if he brushed it under the carpet.'

The panel considered that an expectant mother reporting this to any competent midwife would cause the midwife to suspect and investigate in detail whether the membranes have actually ruptured. Furthermore, this information should have been recorded in the notes, regardless of whether Mr Golden suspected they were ruptured or not. Ms 1, in her expert report, stated the following:

> *'…if a mother reports that her membranes may have ruptured, an internal examination with a spectrum[sic], or the use of a swab to detect amniotic fluid, should be completed in order to confirm whether the membranes have ruptured. NICE (2008b) guidance advises that in the event of ruptured membranes, induction or labour can be offered immediately, otherwise expectant management of 24 hours should be recommended. The risk of not identifying spontaneous rupture of membranes can result in the increased risk of infection to both the mother and the baby.'*

The panel had sight of Patient A's Maternity Record and noted that Mr Golden had not made any record of anything, including the suspected rupture of membranes. The panel therefore found this charge proved.

Charge 2.b.

> b. did not advise Patient A that she should allow you to examine her to confirm whether her membranes had ruptured or, in the alternative, did not make any record of your advice to Patient A and her response in Patient A's notes

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Patient A and Ms 1.

The panel had regard to the evidence of Patient A, who, in her witness statement, stated the following:

> *'Paul arrived at about 39-40 weeks and I informed him that I had felt a little gush of water. He did not really acknowledge this and said the baby was still very high and he did not think the birth was imminent.'*

In her evidence, Patient A told the panel that after reporting the *'gush of water'* Mr Golden completed a number of examinations, including checking heart rate and feeling the position of the baby. Patient A could not recall whether Mr Golden suggested any further examinations or checks specific to address the history of the possibility of a rupture of membranes; neither did he initiate any discussion about this. In light of this uncertainty, the panel concluded it could not find that Mr Golden did not advise Patient A regarding further investigations to confirm or discount ruptured membranes. Therefore, the panel found the first alternative in this charge not proved.

The panel then went on to consider the second alternative in this charge, the failure to make a record of any advice given to Patient A and her response. Patient A provided evidence of her Maternity Record in which there were no entries. The panel therefore found this charge proved in the second alternative.

Charge 3.a.

3. Did not provide information to Patient A concerning:

    a. the risks that would arise if her pregnancy lasted longer than 42 weeks.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Patient A and Ms 1.

The panel had regard to the evidence of Ms 1 and her expert report in which she stated the following:

> *'10.3.1 At standard 6.1 of this report, NICE (2008a) recommend that pregnant mothers should be advised that most women will labour spontaneously by 42 weeks. From 38 weeks, they should be offered information about the risks with pregnancies lasting longer than 42 weeks. This discussion should include information on membrane sweeps (internal vaginal examination where the baby's membranes are separated from the cervix), induction of labour between 41-42 weeks, or expectant management. They should be informed that the risk of compromise to the baby or stillbirth rises steeply after 42 weeks, though this is from a low baseline. From 42 weeks, women who decline induction of labour should be offered increased monitoring to include recommending continuous fetal monitoring at least twice a week, and an ultrasound to assess the estimation of amniotic fluid levels.'*

The panel had sight of a number of emails sent by Patient A to Mr Golden and it noted that there was no record of him advising her of the risks associated with a pregnancy that lasts longer than 42 weeks. The panel had particular regard to an email from Patient A to Mr Golden dated 24 October 2019:

> *'at 42+ weeks pregnant (whether that was the exact term or not) there are many risks and advice plus regular monitoring which are recommended, especially for a first time mother. I reached out to you a number of times to ask for some guidance and support, as a healthcare professional I believe this is part of the role which I was paying you for, although you seem to have diminished your responsibility here.'*

The panel also had regard to evidence in the form of a number of messages from Patient A to another midwife. In these messages Patient A was attempting to get advice, as Mr Golden had discharged Patient A from his care.

In her evidence Patient A told the panel that Mr Golden did not advise her of the risks that would arise if her pregnancy lasted longer than 42 weeks. The panel noted that there were no patient records.

Having regard to the above, the panel determined that it was more likely than not that Mr Golden did not provide Patient A with information about the risks that would arise if her pregnancy lasted longer than 42 weeks. The panel therefore found this charge proved.

Charge 3.b.

3. Did not provide information to Patient A concerning:

b. the types of clinical intervention which she should consider and which you would recommend if her pregnancy lasted longer than 42 weeks or, in the alternative, did not make any record of the information you provided and the discussion you had in Patient A's notes.

The panel found this charge proved.

In reaching this decision the panel had regard to the evidence of Patient A and Ms 1.

The panel had regard to the expert evidence of Ms 1 who, in her expert report, explained the types of clinical intervention available if a pregnancy lasted longer than 42 weeks (as set out above under charge 3.a).

The panel had sight of an email from Patient A to Mr Golden dated 24 October 2019 in which she stated that she had reached out to Mr Golden on a number of times to ask for guidance and support as she was concerned about what options were available to her. The panel noted that Mr Golden did not set out what options were available to her and he stated that their contract ended on 8 October 2019 and he was no longer providing any midwifery services to her.

Having regard to all of the evidence before it, the panel determined that it was more likely than not that Mr Golden did not provide information to Patient A about the types of clinical intervention available or recommended if her pregnancy lasted longer than 42 weeks. The panel also found that there was no record of a discussion taking place in Patient A's notes. Accordingly, the panel found this charge proved.

Charge 4.

> 4. In addition to the matters set out in charges 1-3 above, did not complete any records in respect of the care you provided to Patient A.

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it which included the evidence of Patient A and her Maternity Record.

The panel had sight of an email from Patient A to Mr Golden dated 24 October 2019 in which she stated the following:

> *'It dawned on me that you never actually made any notes about my case or any notes about the baby's heartbeat etc.'*

In her oral evidence Patient A told the panel that Mr Golden did not make any handwritten notes during assessments and he did not make any notes on a laptop or any other electronic device. The panel had sight of Patient A's Maternity Record which contained no entries by Mr Golden.

The panel also had sight of Person A's witness statement in which she stated the following:

‘I am all for a more holistic approach to midwifery however the lack of note taking and lack of medical records concerned me.’

The panel had regard to the expert evidence of Ms 1 who stated that every interaction between Mr Golden and Patient A should have been documented and given to Patient A and a copy of the notes retained by Mr Golden. She stated that emails were not a sufficient record of care.

Having regard to all of the above, the panel found that there was no recognised professional record of care provided to Patient A. Accordingly, the panel found this charge proved.

Charge 5.

5. Did not store Oxytocin appropriately in that you stored it in a communal fridge and took no steps to secure it.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Patient A, Person A and Ms 1.

In her witness statement Patient A stated the following:

‘He left his medical kit, some of his clothes and Oxytocin in my house.’

The panel had sight of an email from Patient A to Mr Golden dated 8 October 2019, in particular:

'You were negligent in misplacing drugs and I also now have a box of this left in my fridge along with other medical equipment which you have left here, with no way of disposing of the items.'

The panel also had sight of some photographs of the Oxytocin that were taken by Patient A which was still in her house at the time of the referral to the NMC.

In her expert evidence, Ms 1 told the panel that Oxytocin should not be left at a Patient's house, unless it was for a short period of time and stored securely.

Having regard to all of the above the panel found that Mr Golden did not store the Oxytocin appropriately. The panel therefore found this charge proved.

Charge 6.

6. Did not attempt to handover Patient A's care to another midwife and/or obstetrician when it would have been appropriate to do so in view of your decision that you would no longer act as her midwife and the late stage of her pregnancy.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Patient A, Ms 1 and Person A.

The panel had regard to the witness statement of Patient A in which she stated the following:

'I was aware he had contact with other midwives in France and I asked him for their contact details, if he could not be there could he recommend anyone else. He gave me the details for one Midwife [Ms 4]... Paul would not give me the details of the

other midwives he said he would ask them to contact me. I had to keep chasing him about these and he never got back to me.'

The panel had sight of an email from Mr Golden to in response to an email from Patient A raising concerns about handing over her care to another midwife dated 8 October 2019 in which he stated the following:

'I trust with time you accept the realities of time and distance and that the agreement ended which mean [sic] that I am not your midwife.'

Albeit, Mr Golden gave details of another healthcare professional to Patient A, he placed the onus on her to establish contact with another midwife or other healthcare professionals and did not attempt to handover Patient A's care. The panel had sight of an email from Mr Golden to Patient A dated 5 October 2019:

'The way forward. I suggest talking with local midwife to see what information and options they can offer.'

The panel also had sight of another email from Patient A to Mr Golden dated 24 October 2019:

'I asked you whether I could be seen by the midwife in either St Yrieix or Gueret and you said one refused and the other you never responded about.'

Patient A later attended hospital on the recommendation of another healthcare professional following a scan. The panel noted that there was no attempt by Mr Golden to handover to the hospital staff and Patient A had no notes to assist.

The panel found that that there was no evidence that Mr Golden attempted to handover Patient A's care to another midwife when he ceased to care for her. The panel was of the view that Mr Golden appeared to attempt to absolve himself of any responsibility when the

contract ended, and put the onus of finding a new midwife on to Patient A which the panel considered to be inappropriate, especially in the absence of any record of care.

Charge 7.

> 7. Delegated Patient A's care to Person A when it was inappropriate to do so in view of her not being a healthcare professional.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Patient A and Person A.

In her evidence Patient A told the panel that Person A informed her that Mr Golden had delegated care to her.

In her evidence, Patient A stated that Mr Golden often made reference to the fact that she had support, in the event of him not arriving in time to provide care in labour. She stated that she thought initially, this was said in the tone of a joke, but further stated she felt he was serious after her friend (Person A) and planned birth partner had advised her that he said the same thing to her and the impression she gained was that he was serious. This was confirmed in an email on 5 October 2019 from Mr Golden to Patient A when he stated *'you have support for early labour and even the birth, if this happens without a midwife.'*

The panel had sight of the witness statement of Person A and noted that she is not a registered healthcare professional. In her witness statement Person A stated the following:

'[Patient A] was having a difficult time towards the end of her pregnancy, he[sic] was very upset and she was overdue but Paul was quite flippant saying "everything will be fine". His style was not to interfere which is what [Patient A] wanted but he was very laid back and said "it'[sic] fine if I'm not here I'll support her over the phone". He said I would be fine to deliver the baby. I am not a healthcare professional.'

The panel concluded that, whatever was the position before 5 October 2019, on that date it was clear that Mr Golden was serious about delegating care of Patient A to Person A in his absence. The panel therefore found this charge proved.

Charge 8.

8. Practised midwifery in France without requesting leave to provide midwifery services from the French Order of Midwives.

This charge is found proved.

In reaching its decision the panel had regard to the contract dated 24 May 2019 and the evidence of Mr 2.

The panel noted that in the contract, Mr Golden had written that he was a registered nurse and midwife, insured to provide midwifery care in the UK and provided his NMC PIN, but provided no information about requesting leave from the French Order of Midwifes.

The panel had sight of Mr 2's witness statement in which he stated the following:

'The Midwife involved in this NMC investigation was not registered with the French Order of Midwives. Every midwife who is allowed to practice in France has to be registered. This data is collected on an electronic table software. When the

NMC approached the French Order of Midwives for assistance with their investigation a search was carried out on the Midwifes name and no results came up. If they were on the table they would have a national number which allows them to prescribe and work as a midwife. The French Order of Midwives completed this search and no results came up.'

The panel had sight of a print-out of the search which showed that Mr Golden was not registered with the French Order of Midwives. The panel also heard live evidence from Mr 2 when he confirmed that he had undertaken a check of the register for the requisite period of 2019 and 2020 and there was no record of Mr Golden being registered.

The panel found Mr 2 to be an independent and professional witness who was able to assist the panel with the requirements of registrations at the French Order of Midwives. The panel found the evidence of Mr 2 to be credible and reliable.

Having regard to the above, the panel found that Mr Golden practised midwifery in France without requesting leave to provide midwifery services from the French Order of Midwives. Accordingly, the panel found this charge proved.

Charge 9.

9. Practised midwifery in France without having in place appropriate insurance.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Patient A and Mr 2.

In her witness statement Patient A stated the following:

*‘He sent me through the contract. I exhibit this contract as **Exhibit IB/3**. Before signing the contact Paul did inform me that he would not be insured to deliver the baby in France where I live. He informed me that his insurance only covers the UK.’*

The panel had sight of a letter of contract from Mr Golden to Patient A dated 24 May 2019. The panel noted that Mr Golden had written that he only had professional indemnity insurance for the UK.

Having regard to the above, the panel found that it was more likely than not that Mr Golden practised midwifery in France without having in place appropriate insurance. The panel therefore found this charge proved.

Charge 10.

10. In practising without leave from the French Order of Midwives and/or without insurance you acted without integrity in that you knew you were not entitled to practise midwifery in France but did so anyway.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Patient A and the contract dated 24 May 2019.

The panel had regard to its findings at charges 8 and 9, that Mr Golden had practised without leave from the French Order of Midwives and without insurance.

The panel had regard to Patient A’s witness statement in which she stated the following:

‘Before signing the contract Paul did inform me that he would not be insured to deliver the baby in France where I live. He informed me that his insurance only covers the UK.’

The panel noted that Mr Golden made Patient A aware that he was not insured to practise in France but continued to practise and provide midwifery services in France without insurance. The panel was of the view that in practising without insurance in France, Mr Golden acted without integrity.

The panel concluded that it would be highly unlikely for a midwife practising in the UK not to know that there is a responsibility to register in another country before providing midwifery services. In consequence, they would be aware that if they wished to practise overseas they would need to check to confirm what the practice requirements were for that particular country. The panel considered that as a registered nurse and midwife in the UK, Mr Golden would have been aware of the NMC Code which requires nurses and midwives to adhere to the laws of the country that they are practising in. The panel determined that it was more likely than not that Mr Golden knew that he needed leave from the French Order of Midwives to practise as a midwife in France. The panel also determined that in practising without leave from the French Order of Midwives Mr Golden acted without integrity.

Having regard to all of the above the panel found this charge proved on both limbs.

Charge 11.

> 11. In failing to keep records of Patient A's care you acted without integrity in that by doing so you intended to minimise the risk of your unregistered and/or uninsured practice coming to the attention of the French authorities.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Patient A.

The panel had regard to the witness statement of Patient A in which she stated the following:

> *'In my NMC referral form I noted that Paul informed me that he would not be able to complete any formal paperwork if he attended my birth as he was not insured to deliver a baby in France so I would have been unable to ascertain the correct birth certificate for my baby. I was aware he was uninsured however the part about paperwork was only told to me once he arrived in France. In France if you have a homebirth the midwife must complete documentation and submit it to the Mayor. There is an official piece of paper that needs to be filled in with details such as the name of the mother, place of birth, weight, time, date etc and signed by the midwife. When Paul arrived in France he refused to complete this as he was not insured. This would have meant I would not have been able to get a birth certificate for my daughter.'*

In the light of the above, the panel determined that it was more likely than not that in failing to keep records of Patient A's care, Mr Golden intended to conceal that he was providing care without insurance and without being registered with the French Order of Midwives. In doing so, the panel found that Mr Golden acted without integrity and found this charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mr Golden's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Mr Golden's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Mr Smith provided detailed submissions in respect of misconduct. He identified the specific and relevant standards where, in the NMC's view, Mr Golden's actions fell short of what is expected of a registered midwife. He took the panel through each charge and identified the parts of The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) that had been breached. Mr Smith submitted that the charges found proved demonstrate a series of decisions, omissions and failings made by Mr Golden over a period of several months. He submitted that the charges found proved individually, and collectively, amounted to misconduct.

Submissions on impairment

Mr Smith moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Smith also provided detailed submissions on the question of whether Mr Golden is currently impaired. Mr Smith referred the panel to two references provided by Mr Golden. He submitted that the following limbs of the test set out in *Grant* are engaged:

a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; …*

Mr Smith submitted that the lack of any evidence of insight, remorse, reflection or remediation, that Mr Golden's fitness to practise is currently impaired. He therefore invited the panel to find Mr Golden's fitness to practise impaired by reason of his misconduct on both public protection and public interest grounds.

The panel accepted the advice of the legal assessor.

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code.

The panel was of the view that Mr Golden's actions did fall significantly short of the standards expected of a registered midwife, and that his actions amounted to a breach of the Code. Specifically:

> *'**1.2** make sure you deliver the fundamentals of care effectively*
>
> ***2.3** encourage and empower people to share in decisions about their treatment and care*
>
> ***2.5** respect, support and document a person's right to accept or refuse care and treatment*
>
> ***3.3** act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it*
>
> ***6.1** make sure that any information or advice given is evidence-based including information relating to using any health and care products or services*
>
> ***8.5** work with colleagues to preserve the safety of those receiving care*
>
> ***8.6** share information to identify and reduce risk*
>
> ***10.1** complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event*
>
> ***10.2** identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need*

10.4 *attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation*

11.1 *only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions*

13.2 *make a timely referral to another practitioner when any action, care or treatment is required*

18.4 *take all steps to keep medicines stored securely*

20.1 *keep to and uphold the standards and values set out in the Code*

20.2 *act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment*

20.4 *keep to the laws of the country in which you are practising'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that all of the charges found proved both individually, and collectively, amounted to misconduct.

In considering whether each of the charges amounted to misconduct, the panel had regard to the National Institute of Clinical Excellence (NICE) guidelines on maternity care and the expert report.

In respect of charge 1, the panel determined that the failure to carry out an adequate risk assessment during his initial appointment with Patient A fell seriously short of the standards expected of a midwife. An adequate risk assessment would include a full family

history, past medical/surgical history, previous obstetric history and a bio-physical assessment. This risk assessment forms a baseline record informing the planning and implementation of care and ongoing risk assessment. In failing to undertake this, Mr Golden exposed Patient A and her unborn baby to an unwarranted risk of harm.

The panel found that Mr Golden's actions in respect of charge 2 amounted to misconduct. As set out in its decision on facts, the panel was of the view that Mr Golden, as a registered midwife, should have been aware of and acted in accordance with the guidance on suspected ruptured membranes. In failing to make a note of the suspected rupture and taking the appropriate steps, the panel determined that Mr Golden demonstrated a disregard for patient safety. The panel was of the view that in failing to record the suspected ruptured membranes, Mr Golden deprived any future healthcare professionals of having a full record of Patient A's history which could have had potentially catastrophic consequences for Patient A and her baby including sepsis and still birth.

Furthermore, the panel noted that when Patient A raised concerns about what could have been ruptured membranes, Mr Golden did not acknowledge her concerns or advise her appropriately. The panel determined that Mr Golden's lack of advice to Patient A resulted in her not seeking medical intervention in a timely manner.

In respect of charge 3, the panel found that Mr Golden's actions and omissions amounted to misconduct. As set out in its decision on facts, the panel noted the NICE guidance on what is expected of a midwife in providing advice about a pregnancy which lasts longer than 42 weeks. The panel determined that in failing to provide this information to Patient A, he deprived her of being able to make a fully informed choice about her options if her pregnancy lasted longer than 42 weeks.

The panel found that Mr Golden's lack of records in respect of the care he provided to Patient A, as set out in charge 4, amounted to misconduct. The panel considered that the lack of a record of care was a serious departure of the standards expected of a midwife and could have had potentially serious consequences for Patient A and her baby. The lack

of maternity records could have caused delays to Patient A and her baby receiving appropriate treatment from other healthcare professionals when she attended hospital.

In respect of charge 5, the panel found that in storing medication in Patient A's house, Mr Golden showed a complete disregard for safety. The panel noted that if Oxytocin was used inappropriately by a pregnant woman it could result in separation of the placenta resulting in intrauterine death. The panel was of the view that Mr Golden should have taken all reasonable steps to ensure that any medication in his possession was stored securely in a locked box or bag. The panel therefore found that Mr Golden's actions amounted to misconduct in respect of this charge.

In respect of charge 6, the panel determined that Mr Golden's actions in not attempting to handover Patient A's care to another qualified healthcare professional amounted to misconduct. The panel had regard to its findings in respect of this charge and the expert report in which it was stated that there was no clinical justification for Mr Golden to discharge Patient A. The panel found that Mr Golden appeared to absolve himself of any responsibility once he considered the contract had ended. The panel was of the view that Mr Golden's actions in not attempting to handover Patient A's care caused distress to her and her partner, which she communicated to him and he did not respond. Without a proper handover, the panel was of the view that Patient A and her baby were put at risk as healthcare professionals would not be able to assess what interventions had previously taken place, or assess previous clinical indicators. The panel therefore determined that Mr Golden's lack of handover in respect of Patient A's care amounted to misconduct.

Having regard to its findings at charge 7, the panel was of the view that Mr Golden's actions in delegating Patient A's care to an unqualified person was extremely serious and amounted to misconduct. The panel considered that as an experienced midwife, Mr Golden would have been fully aware that it is illegal in the UK for someone to act as a midwife if they are not qualified. In advising Person A that she was able to care for Patient A during labour, the panel found that Mr Golden's actions fell seriously short of what is

expected of a midwife. The panel was of the view that this was exacerbated by Mr Golden's knowledge of the heightened potential risks for a baby born after 42 weeks.

In respect of charges 8 and 9, the panel found that in practising in France without the required registration or indemnity insurance, Mr Golden's actions amounted to misconduct. The panel noted that in practising as a midwife in France without registration with the French Order of Midwives is a criminal offence. The panel also considered that in practising without indemnity insurance could have had serious implications for Patient A and her baby if complications arose during childbirth resulting in injury that required ongoing and specialist support.

With regard to charges 10 and 11, the panel was of the view that Mr Golden's lack of integrity by practising without the required registration or insurance over a period of months and in a clandestine manner. The panel was therefore of the view that this amounted to misconduct.

Having regard to all of the above, the panel concluded that Mr Golden's behaviour fell significantly below the standard required of a registered midwife and therefore amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mr Golden's fitness to practise is currently impaired.

Midwives occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust midwives with their lives and the lives of their loved ones. To justify that trust, midwives must be transparent and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'*

In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's "test" which reads as follows:

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:*
>
> a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> d) *...'*

The panel found limbs a, b and c engaged in this case.

The panel determined that Mr Golden's actions and omissions placed Patient A and her baby at an unwarranted risk of harm. The panel found that in discharging Patient A without clinical justification, and in not ensuring that her care was handed over to a qualified midwife or other healthcare professional, Mr Golden acted without compassion and caused both Patient A and her partner emotional distress. The panel found that Mr Golden's actions brought the profession into disrepute and he breached fundamental tenets of the profession. The panel found that in practising without indemnity insurance and the required registration, Mr Golden demonstrated a flagrant disregard for the rules of the country he was practising and for the welfare of Patient A and her baby.

The panel had sight of two references provided by Mr Golden. The panel had regard to a reference dated 13 August 2020 in which the following was stated:

> *'Statement regarding Terence Paul Golden Midwife*
>
> *I […] make the following true statement regarding Terence Paul Golden I worked as a midwife for many years.*
>
> *I met Paul Golden about three years ago. We are working together on some projects for teaching. We engage in professional supervision together.*
> *Paul teaches communication, mediation and law. He is very committed and dedicated to women and the midwifery profession. He supports human rights for women. He is kind, compassionate and if necessary he 'goes the extra mile'.*
> *Paul and I were together the day he was called back to France for the birth there. He instantly booked the flight from Venice to Bordeaux. I took him to the train station in Klagenfurt. He was on his way to her because she said, she was in labor. Her partner was messaging Paul that he should be coming. So Paul went. But he returned after the woman told him, that he should not to come.*

In September he had left France because the woman also asked him to leave then. That was after being there three weeks waiting for the birth. It seems likely that the date for the birth may be wrong. I know that Paul had cancelled work commitments in September to provide care to the woman in France.

Paul was clearly dedicated to this woman and he recommended she should contact the local midwife and hospital and arrange a scan (when she asked him to leave).'

The panel also had regard to another reference dated 13 August 2020 in which the following was stated:

'I chose Paul to be my midwife for my fifth child two years ago in the UK. Since then Paul and I have collaborated with workshops related to birth education, mediation and human rights in childbirth.

I understand he has a charge of not making notes.

Everything about Paul is focused on women's choices. It is unimaginable that he would not make notes or do anything that was not woman centred.
In my case, we went through the various perceived risks (age (44), vba2c multiparity etc). Paul and I discussed and documented all my choices. He stayed with us throughout the antenatal period, labour and postpartum period until I was ready for him to leave.

I have a record of my pregnancy and birth notes. We wrote some documents together showing I gave informed consent. Paul works in true partnership with women. He was totally committed to me and my family receiving the best care possible.'

The panel had regard to the two references that attest to Mr Golden's clinical competency and dedication to providing collaborative and compassionate midwifery care. However,

they do not address the majority of the matters that have arisen in this case. Therefore, the panel determined that it could attach little weight to these references in relation to current impairment.

The panel went on to consider whether the Mr Golden's misconduct was remediable and, if so, whether it had been remedied. The panel determined that Mr Golden's misconduct raises serious attitudinal concerns. The panel determined that in not keeping maternity records, Mr Golden was attempting to avoid leaving an audit trail because he knew he was acting unlawfully in practising without the required registration and insurance. The panel found that Mr Golden prioritised financial gain over the emotional and physical needs of Patient A and her baby which demonstrated serious attitudinal concerns. The panel also found that Mr Golden's actions in leaving Patient A *'high and dry'* because he believed that his contractual obligations were fulfilled, were serious and was not the conduct that is expected of a caring midwife. The panel noted communications from Patient A to Mr Golden in which she was clearly distressed and asking for help, and even in the face of a distressed expectant mother who had placed trust in him, he demonstrated a complete disregard for her wellbeing and provided no emotional or clinical support. The panel therefore concluded that the misconduct in this case is difficult to remediate.

In respect of Mr Golden's insight into his misconduct, the panel noted that he has not provided any responses to the charges against him or a reflective statement for the panel's consideration. Conversely, the panel noted his only engagement in this hearing has been in an attempt to divert attention to what he asserted to be flaws in the NMC process. The panel therefore found that Mr Golden had no insight into his misconduct. The panel also considered that Mr Golden has demonstrated no remorse for his actions, instead he appears to attempt to deflect any responsibility on to Patient A.

The panel went on to consider whether Mr Golden had taken steps to remediate and strengthen his practice. The panel noted that there was no evidence of any remediation. The panel had particular regard to the following statement in the reference dated 13 August 2020 and noted the following:

‘I met Paul Golden about three years ago. We are working together on some projects for teaching. We engage in professional supervision together. Paul teaches communication, mediation and law. He is very committed and dedicated to women and the midwifery profession. He supports human rights for women. He is kind, compassionate and if necessary he ‘goes the extra mile’.’

The panel was concerned that Mr Golden having specialist knowledge in teaching communication, mediation and law, acted unlawfully, without integrity and showed a disregard for Patient A, even when she was communicating that she was distressed and asking for help.

The panel was of the view that in light of all of the above, the likelihood of Mr Golden repeating his misconduct was high. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that a finding of impairment on public interest grounds is required because a member of the public would be shocked if a finding was not made in the circumstances of this case.

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Mr Golden’s fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mr Golden's fitness to practise is currently impaired.

19 April 2022

On the morning of 19 April 2022 the panel was informed that Mr Golden had sent an email to the NMC with some additional documents attached during the bank holiday weekend. This further documentation was provided after the panel had announced its decision on impairment of fitness to practise and after it had heard the NMC submissions on sanction, but before it had handed down its decision on sanction. The email from Mr Golden referred to a number of documents which were served at various interim hearings. These were provided to the panel and the panel took some time to read and properly consider the same. When the panel were reading these documents, the NMC received an email from Mr Golden containing an application for a 'Mis-trial or to abandon this case'. The panel went on to consider this application.

Decision and reasons on application for a 'Mis-trial or to abandon this case'

Mr Golden's application is set out below:

'Application for a Mis-trial or to abandon this case

1. *This case failed to meet any reasonable or proper process.*

2. *There is no bundle provided in physical form and all electronic documentation has been sent in an inaccessible way with passwords / encryption that prevents access.*

3. *Today the online hearing was inaccessible to the defence and to the public.*

4. *The Defence has been told by the NMC case manager […] today that the panel are postponing the hearing without notice to read defence documents. Why they have not been read before begs the question is this a fit and proper panel.*

5. *Any questions arising from the defence documents are required to be in writing for a proper time to consider (seek advice) and respond.*

6. *The panel have not demonstrated that they are a fit and proper panel.*

7. *Now there are doubts about mental capacity of the panel members.*

8. *The panel all get paid as we understand with a daily amount plus expenses (around £500 per day) including for all the times the panel delay or postpone or simply fail to read documents that are required by any fit and proper panel. That appears to meet the threshold for the criminal act of fraud.*

9. *A referral to the police will be made for this and other cases where the abuse of process appears to reach the standard of proof for criminal investigation. This brings into question the NMC leadership or lack of and the complicatedness even by failing to act.*

10. *This 'hearing' failed to satisfy legal requirements and therefore should be either abandoned completely or declared a mis-trail or whatever the correct terminology is.*

11. *This registrant is self-representing. Has no access to online facilities and yet managed to access the hearing today as arranged with the nmc case manager only to find no current hearing.*

Paul Golden
For the defence / registrant

1150 hours on 19 April 2022

The panel invited submissions from Mr Smith on behalf of the NMC. Mr Smith submitted that there was no proper basis on which this application could be founded. He submitted that this case has been conducted in accordance with proper processes pursuant to the Rules. Mr Smith submitted that Mr Golden has been provided with all of the documents related to this case from the outset of the NMC investigation. He submitted that Mr Golden refers to some of the NMC evidence in his responses which he could have only had access to if he had received the bundles.

In respect of the question of accessibility of the hearing, Mr Smith drew the panel's attention to an email sent by Mr Golden to the NMC on 19 April 2022 at 11:12 in which he said he was able to access the hearing link. Mr Smith also drew the panel's attention to an email from the NMC to Mr Golden in which he was advised the following:

'Dear Paul,

The panel are currently reading the documents the [sic] you provided and will resume at 12:00. The hearing link is below.'

Mr Smith submitted that the hearing was not inaccessible to the defence or the public and Mr Golden was informed of when to join the hearing and he chose not to. Mr Smith further submitted, as set out above, Mr Golden was told that the panel was in private session in order to read Mr Golden's further submissions and he had been told that the hearing would resume at 12pm.

In respect of point 6, Mr Smith submitted that there are no grounds for the hearing to be abandoned on the basis that the panel is not *'fit and proper'.* He submitted that the panel is a professional and experienced panel, who are independent of the NMC.

In respect of point 11, Mr Smith drew the panel's attention to an email sent by Mr Golden to the NMC on 19 April 2022 at 11:12 in which he confirmed that he had managed to log in to the hearing link. Mr Smith submitted that Mr Golden has been provided with information on how to join the hearing either by web access or by dialling in using a telephone. Mr Smith also submitted that Mr Golden has been kept informed and encouraged to join the hearing at each stage of these proceedings. Mr Smith submitted that there is no reason that would cause this hearing to be abandoned or reconsidered and invited the panel to refuse this application.

The panel accepted the advice of the legal assessor, who advised that in his opinion, there was no good reason to abandon the case. In respect of point 2 of Mr Golden's application, he pointed out that it would have been impossible for the NMC to send a paper bundle to Mr Golden as he had not provided an address where one could be sent.

The panel considered the submissions made by Mr Smith and gave careful consideration to each of the points raised by Mr Golden.

As set out in this determination the panel has taken the necessary and repeated steps to give Mr Golden an opportunity to engage, including delaying the start of the hearing on day 1 on 1 April 2022. The panel, throughout this hearing, has encouraged engagement from Mr Golden and ensured that both web and dial in details have been provided to him. The panel noted that on Mr Golden's account he had the facility to join the hearing by web access earlier on 19 April 2022. The panel was not in open session at that time, because he had sent further documents, the panel could not proceed with the hearing until it had read all of these documents in fairness to him. An email was sent to Mr Golden to advise him that the hearing would resume at 12pm once the panel had finished reading his documents. Mr Golden did not join the hearing at 12pm and the panel waited for him until 12:10pm, at which point the panel was informed instead of joining the hearing, Mr Golden had sent his application for 'Mis-trial or to abandon this case'. The panel considered Mr Golden's assertions about accessibility of the hearing and communication about how and when to join to be unfounded.

The panel noted Mr Golden's assertions that this hearing has *'failed to meet any reasonable or proper process'* and that this hearing *'has failed to satisfy legal requirements*'. The panel is assisted by an independent legal assessor who provides legal advice to ensure that proceedings are carried out in a fair and legal manner in accordance with the rules. The panel considered that it has followed the correct process and procedures and that this hearing has been conducted in accordance with the rules and legal requirements.

In respect of Mr Golden's assertion that this is not a *'fit and proper'* panel, the panel determined that this is unfounded and there is no basis for it to recuse itself. The panel has had at the forefront of its mind the question of fairness to Mr Golden and encouraged his engagement throughout these proceedings. The panel was also of the view that it is a professional panel, acting independently of the NMC and there is nothing raised by Mr Golden that would undermine this.

Having regard to all of the above, the panel decided to refuse Mr Golden's application and proceed to the sanction stage.

Additional documents

Having received additional documentation at this very late stage of the hearing, the panel invited submissions from Mr Smith.

Mr Smith drew the panel's attention to the case of *TZ v General Medical Council [2015] EWHC 1001 (Admin) (TZ)*, in particular paras 75-82. He submitted that the panel has the discretion to allow these additional documents into evidence, however, he submitted that any decisions that have been announced should not be revisited in the light of the new documentation. Mr Smith submitted that Mr Golden has had ample opportunity prior to, and during this hearing, to produce documents for the panel's consideration. Mr Smith further submitted that the contents of the documents are limited in respect of the charges

in this case. He submitted that in these documents Mr Golden continues to show no acceptance of the charges or insight into his misconduct and therefore a risk of repetition and consequent risk of harm to the public remains.

The panel accepted the advice of the legal assessor. He drew the panel's attention to parts of Mr Golden's skeleton argument that he considered to be particularly relevant to the panel's deliberations on sanction. He referred to the passage in Mr Golden's skeleton argument which identified specific conditions for the panel considering an interim order, which might also be relevant to a substantive case on sanction. He referred to the case of *Kamberova v NMC [2016] EWCA 2955* in which Dingemans J held that if proceedings are long delayed and a person is subject to suspension in the interim period, that period of suspension may affect the proportionality of the length of the subsequent period of suspension. Whether it has that effect is for the committee to determine. If the appropriate sanction is one of striking off, then the fact that there has been an interim suspension order may be of no relevant effect. Finally, the legal assessor referred to Mr Golden's argument that he had had a long career in which he had demonstrated a good character.

Having regard to all of the above, and after having read all of the additional documentation provided by Mr Golden, the panel decided to accept it into evidence to assist with its deliberations on sanction. The panel found no grounds to revisit its determination on facts and impairment.

Application by Mr Golden on 20 April 2022 to adduce further evidence

On 20 April 2022 Mr Golden made a written application indicating that he wished to rely on the evidence of supporting witnesses which included video evidence. The only specific document he provided consisted of a character reference from an expert in hypnobirthing. He did not identify any specific witnesses except this expert, and he has not hitherto identified to the panel any witnesses whom he specifically intended to call.

Mr Smith objected to the panel receiving the reference and to any adjournment to allow witnesses to be called. He submitted that there has been ample opportunity for Mr Golden to call witnesses and to present his case in the normal way. Mr Smith submitted that Mr Golden had not communicated to the panel during this hearing that he had intended on calling any live witnesses. He submitted that in providing additional information at this very late stage of the hearing, Mr Golden appeared to be attempting to frustrate these proceedings.

The legal assessor advised the panel to admit the reference, as it would be fair to Mr Golden to do so and it would not prevent the case concluding during the time allowed.

In the interests of justice, the panel decided to allow the character reference to be admitted but to reject the remainder of Mr Golden's application, which was to allow time for him to call witnesses at this late stage. The panel concluded that this was a further attempt by Mr Golden to frustrate the process as he had been given ample opportunity to engage in the hearing and to call any witnesses at the appropriate time and he had chosen not to.

Second application made by Mr Golden on 20 April 2022 to adduce further evidence

After the panel had reached its decision on sanction and it was in a position to hand down its written reasons on 20 April 2022, it was informed that the NMC had received a further email from Mr Golden. In this email Mr Golden attached a document titled *'Regarding NMC Expert Witness Report by [Ms 1] Midwife (Somek Assoc)'*.

Mr Smith submitted that as this document includes submissions made by Mr Golden, the panel should read the document. He submitted that it had been provided far too late and as it is not relevant to the sanction stage, it should be disregarded. Mr Smith submitted that this document would have been relevant at the facts stage, and he added that Mr Golden's detailed references to the report of Ms 1 undermine Mr Golden's previous assertions that he was unable to access the electronic documents sent to him by the NMC.

The panel accepted the advice of the legal assessor, who advised that the arguments made by Mr Golden would have been relevant at earlier stages of the proceedings, but that it was now too late for him to adduce this evidence.

Having had sight of the document, the panel considered that Mr Golden's submissions in respect of the expert evidence of Ms 1 would have been relevant at the facts stage when she could have been cross examined as she attended and gave live evidence at this hearing. The panel concluded that Mr Golden had been provided with ample opportunities to attend this hearing and to provide submissions or documentation for the panel to consider.

The panel had regard to the case of *TZ* and determined that this document was not relevant or admissible at this stage of the proceedings.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Mr Golden's name off the NMC Register (the Register). The effect of this order is that the Register will show that he has been struck off the Register.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Submissions on sanction

Mr Smith informed the panel that the NMC sanction bid in this case is that of a striking-off order. In his submissions he drew the panel's attention to the SG and what the NMC

considered to be the aggravating features of this case and commented that there were no mitigating features.

Decision and reasons on sanction

Having found Mr Golden's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Mr Golden abused his position of trust. Patient A, having decided to have minimal clinical intervention, placed her trust in Mr Golden as her sole healthcare professional.
- Mr Golden's misconduct, whilst relating to one patient, was wide-ranging and occurred over a significant period of time.
- Mr Golden discharged Patient A at a late stage in her pregnancy and without any clinical justification.
- Despite Patient A asking for help, Mr Golden ignored her concerns.
- Mr Golden's actions and omissions caused emotional distress to Patient A.
- Mr Golden's actions and omissions had the potential to cause harm to Patient A and her baby.
- Mr Golden did not inform Patient A at the outset of their agreement that he could not sign the required birth certificate documents.
- Mr Golden practised as a midwife in France in contravention of the laws of that country.
- Lack of insight and remorse.

The panel had regard to Mr Golden's submissions that he has had a previously long and unblemished career and that he was of good character. The panel also took into account the three references which Mr Golden provided, which praise his character and his work as a midwife. The panel was not satisfied that, given the seriousness of the charges found proved, and having identified a lack of integrity and serious deep-seated attitudinal concerns, Mr Golden's previous long and unblemished career could be considered as mitigating features in this case. The panel found there were no mitigating features in this case.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection and attitudinal issues identified, an order that does not restrict Mr Golden's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mr Golden's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mr Golden's registration would be a sufficient and appropriate response. Having found that there are serious attitudinal concerns about Mr Golden, taken together with the seriousness of the misconduct and his lack of insight, the panel is of the view that there are no practical or workable conditions that could be formulated. The panel was of the view that whilst an interim order panel determined that an interim conditions of practice order was proportionate and workable, the interim order panel's role was to carry out a risk

assessment pending this substantive panel's determination on all of the evidence. The panel determined that Mr Golden's deep seated attitudinal concerns, including his lack of integrity and insight, cannot be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Mr Golden's registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *…*
- *…*

Whilst the charges arose whilst Mr Golden was providing care to one patient, the concerns were wide ranging and occurred over a significant period of time. The charges found proved identified concerns in Mr Golden's clinical practice, namely that his lack of record keeping and failure to carry our proper risk assessments placed Patient A at a risk of developing sepsis, which could have led to her death. Furthermore, the panel determined that Mr Golden's actions and omissions also placed the baby at risk of harm or being still born. The panel concluded that Mr Golden's lack of empathy and engagement with Patient A caused her emotional distress which did have had a negative impact on her and could have impacted negatively on the pregnancy. In addition to this, the panel found that Mr Golden practised without the requisite insurance and registration and demonstrated a lack of integrity. The panel therefore determined that this case did not involve a single instance of misconduct. Further, the panel concluded that Mr Golden tended to blame Patient A for

his failure to provide the necessary maternity care which she had contracted him to provide.

The panel considered that Mr Golden demonstrated deep-seated personality and attitudinal problems, he acted without integrity and empathy and he has demonstrated a lack of insight into his actions and omissions. Whilst the panel noted that there is no evidence that Mr Golden has repeated the behaviour, as set out in its earlier decision, the panel determined that the risk of repetition is high in this case.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

The panel also had regard to the NMC guidance on 'Serious concerns which could result in harm to patients if not put right', in particular:

> *'We wouldn't usually need to take regulatory action for isolated incidents of these failings unless the incident suggests that there may be an attitudinal issue such as displaying discriminatory views and behaviours. This may indicate a deep-seated problem even if there is only one reported incident. A pattern of incidents is usually more likely to show risk to patients or service users, requiring us to act.'*

The panel found that whilst the charges relate to one patient, Mr Golden's misconduct persisted in different forms and over a significant period of time. The panel has found that Mr Golden has demonstrated no insight into his misconduct and that it is likely that his behaviour would be repeated and, as a consequence, he poses a risk to patients and their babies.

The panel determined that the conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered midwife. The panel concluded that the serious breaches of the fundamental tenets of the profession evidenced by Mr Golden's actions are fundamentally incompatible with him remaining on the Register.

Mr Golden's actions were significant departures from the standards expected of a registered midwife, and are fundamentally incompatible with him remaining on the Register. The panel found that Mr Golden's misconduct could have had a potentially catastrophic outcome for Patient A and her baby and that he continues to pose a risk of harm to the public. The panel was of the view that the findings in this particular case demonstrate that Mr Golden's actions and omissions were very serious and he has demonstrated a flagrant disregard for the laws of the country he practised in. The panel determined that to allow Mr Golden to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to public protection concerns identified, the effect of Mr Golden's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered midwife should conduct himself, the panel has concluded that nothing short of this sanction would be sufficient in this case.

The panel considered that this order was necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear

message about the standard of behaviour required of a registered midwife or nurse. Accordingly, Mr Golden's name will be struck off the Register and he will no longer be permitted to practise as a midwife or nurse.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Mr Golden's own interests until the striking-off order takes effect.

Submissions on interim order

The panel took account of the submissions made by Mr Smith. He submitted an interim order is necessary on the grounds of public protection and it is otherwise in the public interest. Mr Smith invited the panel to impose an interim suspension order on public protection and public interest grounds for a period of 18 months. He submitted that if no appeal is made then the interim order will lapse and the striking-off order take effect.

The panel accepted the advice of the legal assessor, who advised that for an order to be necessary for the protection of the public, the panel must be satisfied that there is a real risk of significant harm to patients or others. It is not enough that the order should be desirable. If an order is decided on, interim conditions of practice must be considered first and only if inadequate, should an interim suspension order be imposed. He pointed out that Mr Golden had originally been made subject to an interim suspension order, but that order had been changed to an interim conditions of practice order.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive striking-off order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive striking-off order. The panel therefore imposed an interim suspension order for a period of 18 months to cover the appeal period.

If no appeal is made, then the interim suspension order will be replaced by the substantive striking-off order 28 days after Mr Golden is sent the decision of this hearing in writing.

That concludes this determination.

This will be confirmed to Mr Golden in writing.