# GENERAL OSTEOPATHIC COUNCIL
## PROFESSIONAL CONDUCT COMMITTEE

## Case No: 1699/3712

## Professional Conduct Committee Hearing

### DECISION

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| **Case of:** | Martin Morris |
| **Committee:** | Alastair Cannon (Chair)<br>Nathalie Harvier (Lay)<br>David Propert (Osteopath) |
| **Legal Assessor:** | Tim Grey |
| **Representation for Council:** | Vivienne Tanchel |
| **Representation for Osteopath:** | The Registrant was not present and was not represented at the hearing |
| **Clerk to the Committee:** | Sajinee Padhiar |
| **Date of Hearing:** | 1 August 2024 |

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**Summary of Decision:**

The Registrant admitted all the Allegations and the facts were thereby found proved. The Committee determined that the facts as found proved did constitute unacceptable professional conduct in all the circumstances.

The Committee determined to suspend the Registrant's registration for a period of 3 months and concluded it was necessary to impose an immediate interim order of suspension.

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**Allegation and Facts**

The allegation is that Mr Martin Morris (the Registrant) has been guilty of unacceptable professional conduct, contrary to section 20(1)(a) of the Osteopaths Act 1993, in that:

1. Patient A attended one appointment with the Registrant on 6 April 2023 (the Appointment)

2. During the Appointment the Registrant delivered a high velocity thrust thoracic spine and/or rib joint manipulation to Patient A, which resulted in an audible 'crack sound'.

3. The Registrant failed to obtain valid consent from Patient A before carrying out the treatment set out in paragraph 2.

4. The Registrant's conduct as set out at paragraph 2 was:

   a. contraindicated;
   b. inappropriate.

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**Preliminary Issues:**

**Proceeding In Absence**

1. At the outset of proceedings Ms. Tanchel, on behalf of the Council, made an application for the hearing to proceed in the absence of the Registrant.

2. In so submitting, Ms. Tanchel took the Committee to the correspondence from the Registrant and his legal representatives, in which he explained he was not attending and nor were his lawyers, but providing some submissions in the form of a latterly served skeleton argument. Ms. Tanchel submitted that the service provisions set out in Rule 16(2) of the Health Committee (Procedure) Rules 2000 ("The Rules") had been satisfied.

3. Ms. Tanchel went on to address the Committee on the fairness of proceeding in absence. She submitted that the Registrant had made no application to adjourn the case, and in his most recent submission the Registrant's legal representatives explained that the Registrant was making admissions to the Allegation and neither he nor his lawyers were going to attend. In light of the Registrant's submission Ms. Tanchel submitted that it was clear the Registrant knew the hearing could go ahead in his absence and that he was content for it to do so.

4. The Committee accepted the advice of the Legal Assessor that the decision to proceed in the absence of the Registrant was a decision to be taken with the utmost care and caution. The Panel had regard to the relevant Practice Note,

the criteria set out in R v Jones [2002] UKHL 5 and the guidance in General Medical Council v Adeogba [2016] EWCA Civ 162.

5. The Committee reviewed all the relevant documentation. It noted that the Registrant had been informed by letter dated 14 May 2024 that the hearing would be taking place and the nature of the proceedings. The Committee concluded that the Registrant had been given sufficient notice had he wished to attend and take an active part in the hearing and that the notice had been provided in compliance with the Rules.

6. The Committee went on to consider whether it was fair in all the circumstances to proceed to hear the case in the absence of the Registrant. The Committee concluded that the Registrant had absented himself from the proceedings and had communicated with the Council to that effect. His lawyers had provided written submissions on his behalf and he had provided a reflective statement for the Committee's consideration.

7. The Committee carefully considered whether it was fair in the circumstances to proceed in the Registrant's absence. It concluded that balancing the interests of the Registrant with the interests of the public in conducting an expeditious hearing, meant it was both fair and reasonable to proceed in absence on this occasion. The Committee drew no adverse inference from the Registrant's absence.

## **Decision**:

## Facts

8. In April 2023 Patient A began experiencing discomfort in her back from gardening. She had never previously sought care from an osteopath. However, after a Google search she found the Registrant's details and spoke with him on the phone. In the course of the conversation, he told her that her discomfort was something that could be looked into and treated. An appointment was made for 6 April 2023.

9. On arrival at the Registrant's premises, Patient A waited in the waiting room where she was subsequently joined by him. They had a conversation about her discomfort and health during which she informed him that she suffered from osteoporosis.

10. Patient A explained to the Registrant that she had been diagnosed with osteoporosis about six years previously. She had undergone screening and

scans following an injury which confirmed her diagnosis. She informed him that she had been on medication for her osteoporosis but was not presently.

11. Patient A told the Registrant that she was taking aspirin and discussed with him the tightness she felt in her chest which he said could be linked to her back ache. She had no recollection of signing any forms whilst speaking with him in the waiting area.

12. Patient A and the Registrant then moved into the treatment room where she took off her coat and he checked her posture. He stated that her back wasn't aligned, and her right side was lower than her left side. They again discussed her osteoporosis.

13. The Registrant then asked Patient A to lie down on the treatment bed where he massaged her back and then asked her to turn to lie on her back and cross her arms over her chest. He did not describe to her what he was about to do apart from informing her that she would hear the sound of a crack.

14. Once Patient A was lying on her back, the Registrant performed a high velocity thrust ("HVT") manoeuvre involving the application of significant pressure to Patient A's chest with his elbow. She was then asked to turn onto her left side, and he massaged her back.

15. Following the treatment, Patient A suffered immediate pain to her chest but assumed that it would disappear. During the course of the following days the pain increased so Patient A cancelled her second appointment.

**The Investigation**

16. On 23 April 2023, Patient A made an online complaint to the Council, following which the Council undertook an investigation. As part of the facts disclosed within her evidence before this hearing, Patient A explained that she had told the Registrant the medication she had been taking for osteoporosis was risedronate sodium.

17. Thereafter, an expert report was commissioned by the Council from Mr. Tim McClune.

18. Mr. McClune concluded that Patient A's history of osteoporosis should have alerted the Registrant to the need to proceed with caution when providing thoracic spine treatment to Patient A and that HVT was contraindicated in her case. There was no evidence in the records that the Registrant had obtained valid informed consent. The treatment provided fell "considerably" below that which is expected of a reasonably competent osteopath.

19. In his initial response to the Allegation the Registrant explained that he always explained to patients how a technique would be performed before it

was undertaken, and he believed that he had obtained verbal consent. He further explained that he considered the treatment provided was not contraindicated.

20. In that response the Registrant gave his initial account of events. He went on to explain that Patient A was invited into the consultation room when she attended for her appointment on 6 April 2023 where she was asked whether he had ever seen an osteopath before, and a detailed explanation of the procedure was given to her, and her medical history was explored. She gave her consent for treatment. Patient A mentioned that she had osteoporosis. Patient A informed the Registrant that she had stopped taking medication for osteoporosis approximately 5-6 months earlier but was taking aspirin. According to the Registrant, Patient A did not mention that she had taken risedronate sodium. Patient A was invited to go into the treatment room to change. The Registrant followed her in about a minute later and he explained the procedure in detail. Her blood pressure was taken, and her reflexes and passive movement were checked. Before undertaking the high velocity thrust procedure, it was once again explained to Patient A, and she was advised that she would hear a crack. Mr. Morris did not use his elbow in executing the high velocity thrust. At no point after the treatment did Patient A complain of pain.

21. Mr. McClune provided an addendum report dated 26 February 2024 in which he concluded that on the Registrant's account of events, namely that Patient A had not informed him that she had been prescribed risedronate sodium, a high velocity thoracic thrust was nevertheless contraindicated.

22. The Registrant provided a reflective statement dated 15 June 2024 in which he set out that he has been a practising osteopath since 1998 and had no previous disciplinary history previously. Thereafter, he made what amounted to at least partial admissions that were later clarified as amounting to full admissions to the facts by his legal representative.

## The Committee's findings on the facts

23. In correspondence prior to the proceedings the Registrant, through his lawyers made unequivocal admissions to the factual Allegation.

24. In light of the admissions and pursuant to Rule 27(1) of the General Osteopathic Council (Professional Conduct Committee) (Procedure) Rules Order of Council 2000 ("The Rules") the Committee found the facts as alleged, proved.

## Submissions as to UPC

25. Having found the facts proved the Committee invited the Council to make submissions as to unacceptable professional conduct ("UPC"). In his written submissions the Registrant had not explicitly addressed the question of UPC. However, the Committee took full account of all the points raised in all the documents he had provided in coming to its assessment.

26. Ms. Tanchel, on behalf of GOsC, submitted that the identified and admitted failings concerned fundamental areas of the practice of Osteopathy and put Patient A at risk of injury.

27. She further submitted that there was no evidence that the Registrant explained to Patient A what she could realistically expect from her osteopathic treatment. There was no evidence that other care options were discussed, or that Patient A was encouraged to ask questions about the HVT. Mr. Morris had been practising as an Osteopath for almost 30 years and therefore should have been aware that undertaking a HVT on a patient who had been diagnosed with osteoporosis was inappropriate and not clinically indicated.

28. Ms. Tanchel noted the areas of factual disagreement outlined in the Registrant's skeleton argument. She submitted that the only one of any material relevance was whether the Registrant had been told the name of the medication Patient A had been prescribed for osteoporosis. Whilst she submitted that his conduct in employing HVT amounted to UPC regardless, had he been so informed it would have made his conduct all the more serious as he would have been on notice of the seriousness of her osteoporosis, thus making his conduct all the more objectionable. She therefore invited the Committee to resolve that sole factual dispute in its deliberations.

29. Ms. Tanchel further submitted that as the Registrant failed to consider adequately or at all her past clinical history, failed to explain adequately or at all the treatment and failed to obtain valid consent from her. These failures amounted to a failure to conform to fundamental elements of the standards expected of a registered osteopath.

30. The Registrant did not select and undertake appropriate clinical assessment of the patient, taking into account the nature of their presentation and their case history and did not adapt his treatment approach in response to findings from the clinical history provided by Patient A. The treatment provided was contraindicated and inappropriate, in that it was not in Patient A's best interests and potentially unsafe. In turn that compromised patient safety and therefore his conduct fell far below the standards expected of a registered osteopath.

31. She therefore submitted that the Registrant's conduct identified in each of the allegations, both individually and cumulatively, amounted to serious breaches

of his professional obligations, to Osteopathic Practice Standards A3, A4 and C1 and amounted to unacceptable professional conduct.

## The Committee's Findings on UPC

32. The Committee received and accepted the advice of the legal assessor. It was advised that the question of UPC was a matter for its own judgment and that there was, as distinct from the fact finding stage, no burden of proof. The Committee was advised that not every falling short of the standards amounts to UPC. For UPC to be found the act or omissions should be serious: Roylance v GMC [2000] 1 AC 311 & Nandi v GMC [2004] EWHC 2317. The Committee was further advised that in the terms of Spencer v GOsC [2012] EWHC 3147 the allegation should amount to conduct that can be considered deplorable and therefore worthy of the moral opprobrium and the publicity which flows from a finding of UPC.

33. The Committee was further advised of the case of Shaw v GOsC [2015] EWHC 2721 (Admin) in which the Court made it clear that the bar for a finding of UPC was not so high as to make the lowest form of sanction meaningless. For UPC to be found the conduct must be serious but not of such gravity that the lowest powers of sanction would be inappropriate.

34. The Committee noted that Particulars 1 and 2 of the Allegation were factual in character and had been admitted. Notwithstanding that position the Committee carefully considered whether any of the factual disputes identified by the Registrant in his skeleton argument, impacted on Particulars 1 and 2. It concluded that those disputes did not materially alter the position in relation to either Particular 1 or 2.

## Particular 3

35. The Committee noted that the Registrant had provided a limited and generalised account of how he tended to give information to patients. That account was at odds with the need for valid consent to be an organic and ongoing process, in which a patient could receive and question information. The Committee acknowledged that obtaining valid consent was a fundamental requirement for any healthcare professional and that a failure to do so was likely to be serious.

36. The level of information given to Patient A appeared to the Committee to have been extremely limited in circumstances where the treatment the Registrant was planning was highly invasive in character, such that it was extremely high risk, particularly in someone with osteoporosis. That made the consent process all the more important.

37. Whilst the Committee could conceive of occasions where a failure to obtain valid consent might not amount to UPC, in Patient A's case the profound lack of explanation of risks, benefits and alternative treatment options, coupled with the extreme nature of the treatment contemplated, meant that such a failure was of the most serious type.The Committee therefore concluded that the Registrant's conduct in this regard represented a breach of the OPS Standards A2, A3, and A4 and amounted to no less than UPC.

38. In so finding the Committee carefully considered whether any of the factual disputes raised by the Registrant in his skeleton argument impacted its assessment of UPC in Particular 3. The Committee concluded that none had any material impact on its assessment.

**Particular 4**

39. The Committee considered that treating Patient A in a contraindicated fashion with a highly invasive and inherently risky technique, which it considered the Registrant's application to be, was an extremely reckless course to take in a patient with diagnosed osteoporosis.

40. The Committee carefully considered whether that risk would have been amplified in any way had Patient A disclosed the name of the medication she had been prescribed previously for her osteoporosis. Whilst it noted Ms. Tanchel's submissions on the point, the Committee considered that it was of no material significance. The use of this HVT technique in a patient with any osteoporosis whether "mild" or "severe" was fundamentally wrong and could not be excused. The Registrant had known Patient A had received medication to treat her condition and the precise name of the medication (of which there are relatively few for osteoporosis) was of no real consequence. His decision to treat in that manner was dangerous to the patient and entirely ignored her best interests.

41. Such a decision showed a profound failure of the Registrant's understanding in the application and treatment of Patient A that the Committee found extremely concerning. Whilst the Committee considered there is nothing that can be described as "absolutely contraindicated," applying HVT in the manner the Registrant had to a patient with Patient A's medical history was as close to an absolute contraindication as the Committee could imagine. The identified factual disputes made no material difference to the Committee's view and therefore it concluded it was not necessary to resolve those disputes.

42. The Committee considered the Registrant's conduct in this regard amounted to a clear breach of OPS Standards B3 and C1 and amounted to no less than UPC.

43. The Committee therefore determined that both individually as reflected in Particulars 3 and 4 and cumulatively, the Registrant's admitted conduct amounted to UPC in all the circumstances.

**Sanction**

44. Having found the facts as admitted amounted to UPC, the Committee turned to consider the necessary and proportionate sanction and invited submissions from the Council.

45. Ms. Tanchel, made no positive submission as to the sanction that should be imposed. She took the Committee to the relevant parts of the Hearings and Sanctions Guidance. In so doing, she identified a number of mitigating factors, in particular the Registrant's prior good character, his good conduct since the facts giving rise to the allegation, including his remedial action, and his evidence of insight given his admissions. Ms. Tanchel submitted that none of the aggravating factors within the Guidance were present in this case, but that the list was not exhaustive. Thereafter she submitted that the question of sanction should be approached with the principle of proportionality in mind and that the ultimate sanction is a matter for the Committee's judgment.

46. The Committee received and accepted the advice of the legal assessor. It was advised that having found UPC it was required to impose a sanction. In considering the sanction there is no burden or standard of proof. The question of sanction is a matter for the Committee's judgment. It was advised that the purpose of sanctions is not to be punitive but to protect patients and the public interest in the wider sense, namely to maintain public confidence in the profession of osteopathy, and to declare and uphold standards. In considering what sanction to impose the Committee was advised that it should give effect to the principle of proportionality considering the least restrictive sanction available and moving from that only if it is necessary to protect the public or the wider public interest, namely to uphold confidence in the profession and declare and maintain standards.

47. The Committee began by considering the aggravating and mitigating factors present in the case. In terms of mitigating factors the Committee noted and took account of the following: the Registrant had no previous disciplinary or criminal history, his good conduct since the facts giving rise to the allegation and a measure of his insight to the extent exhibited by his admissions to the factual Particulars.

48. The Committee took careful account of the Registrant's reflective statement and his assessment of his CPD, albeit the Committee had been provided with limited information about the CPD he had undertaken. There was no evidence of the way in which that CPD had changed the Registrant's practise, no evidence identifying exactly what he had done as part of the CPD process.

The Committee were concerned by the lack of evidence that he had properly engaged with his failings to ensure that the risk of repetition is addressed.

49. Whilst the Registrant had shown some insight the Committee considered this was limited in scope and his insight had a significant way to go before it could be described as substantial and demonstrating a thorough understanding of the identified failings.

50. The Committee, whilst acknowledging the seriousness of the matters giving rise to UPC, did not identify any aggravating factors. Having identified the mitigating factors, the Committee then went on to consider what was the appropriate sanction, approaching the sanctions in ascending order of seriousness. It did so clear in its view that this case did involve a real element of risk to the public or patients, and that its main focus in this case was therefore in relation to the risk to the public as well as the wider public interest of upholding confidence in the profession and maintaining standards. In light of the limited evidence of insight and remediation that risk remained a significant one.

**Admonishment**

51. The Committee first considered whether an admonishment was the appropriate sanction in this case. The Committee concluded that the nature of the UPC identified, across two elements of the Registrant's practise as particularised in the Allegation, meant that an admonishment was wholly insufficient in protecting the public and in marking the seriousness of the Registrant's behaviour, and was therefore not sufficient to maintain public confidence in the profession of osteopathy and uphold professional standards in the profession.

**Conditions**

52. Having concluded that an admonishment was not sufficient to reflect the seriousness of the Registrant's conduct, the Committee went on to consider whether to impose conditions on the Registrant's practice. It concluded that conditions were not appropriate. The Registrant's behaviour underlying the finding of UPC was of sufficient seriousness and the Registrant's insight and remediation were still at the earliest stage, such that conditions alone would not be enough to protect the public and the wider public interest.

53. The Committee therefore concluded that conditions were not sufficient to meet the current level of risk in the Registrant's case, although with further work the Committee considered conditions might in the future be sufficient to protect the public and the wider public interest.

**Suspension**

54. In considering whether to suspend the Registrant's registration, the Committee carefully considered whether the conduct complained of was incompatible with continued membership of the profession. It concluded it was not. The breaches were serious and fundamental. However, the conduct was remediable, albeit the Registrant had yet to embark on a focussed attempt to remediate.

55. The Committee considered that insight and remediation could be addressed by the Registrant during a period of suspension of sufficient time to enable him to properly reflect on his identified failings, develop a real level of insight into the issues giving rise to that conduct and put in place mechanisms to ensure he did not treat patients in such a manner in the future and to provide assurance that he obtains valid, informed consent from patients.

56. The Committee concluded that in balancing the need to protect the public and the wider public interest with the Registrant's own interests in resuming practise, an order for suspension was both necessary and proportionate in all the circumstances.

57. The Committee determined that the appropriate length of the order was one of 3 months which it considered would enable to Registrant to develop real insight and start remediating his failings.

58. The Committee directs that there will be a review of the suspension approximately 1 month before its expiry.

On that occasion the PCC will be assisted by the following:

- A Personal Development Plan identifying how the Registrant will seek to address identified issues in:
    i. Consent and communication,
    ii. Appropriate selection of osteopathic techniques,
    iii. Clinical consideration of metabolic bone disease.

- Evidence of CPD undertaken or planned and targeted at the above areas of development.

- Evidence of reflective learning from CPD activities undertaken in the form of reflective learning statements.

- A further reflective piece from the Registrant identifying overall learning and development outcomes and next steps.

59. In light of the Committee's conclusion that there is an ongoing risk of repetition and therefore an ongoing risk to the public the Committee determined to impose an immediate interim order for suspension.

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Under Section 31 of the Osteopaths Act 1993 there is a right of appeal against the Committee's decision.

The Registrant will be notified of the Committee's decision in writing in due course.

All final decisions of the Professional Conduct Committee are considered by the Professional Standards Authority for Health and Social Care (PSA). Section 29 of the NHS Reform and Healthcare Professions Act 2002 (as amended) provides that the PSA may refer a decision of the Professional Conduct Committee to the High Court if it considers that the decision is not sufficient for the protection of the public.

Section 22(13) of the Osteopaths Act 1993 requires this Committee to publish a report that sets out the names of those osteopaths who have had Allegations found against them. The Registrant's name will be included in this report together with details of the allegations we have found proved and the sanction that that we have applied today.

# GENERAL OSTEOPATHIC COUNCIL
## PROFESSIONAL CONDUCT COMMITTEE

## Case No: 1699/3712

## Professional Conduct Committee Review Hearing

### DECISION

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|---|---|
| **Case of:** | Martin Morris |
| **Committee:** | Andrew Harvey (Chair)<br>Colin Childs (Lay Member)<br>Caroline Easter (Osteopathic Member) |
| **Legal Assessor:** | Tim Grey |
| **Representation for Council:** | Christopher Geering |
| **Representation for Osteopath:** | Kawsar Zaman |
| **Clerk to the Committee:** | Sajinee Padhiar |
| **Date of Hearing:** | 2 October 2024 |

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**Summary of Decision:**

Upon the expiry of the order of suspension, the Registrant will be subject to a Conditions of Practice order for 4 months.

Towards the end of that period the Committee directs a review hearing shall take place.

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**Allegation and Facts**

The allegation is that Mr Martin Morris (the Registrant) has been guilty of unacceptable professional conduct, contrary to section 20(1)(a) of the Osteopaths Act 1993, in that:

1. Patient A attended one appointment with the Registrant on 6 April 2023 (the Appointment)
   **Admitted and Found Proved**

2. During the Appointment the Registrant delivered a high velocity thrust thoracic spine and/or rib joint manipulation to Patient A, which resulted in an audible 'crack sound'.
   **Admitted and Found Proved**

3. The Registrant failed to obtain valid consent from Patient A before carrying out the treatment set out in paragraph 2.
   **Admitted and Found Proved**

4. The Registrant's conduct as set out at paragraph 2 was:

   a. contraindicated;
   b. inappropriate.

   **Admitted and Found Proved**

The Committee determined that the appropriate sanction was one of suspension of practice for a period of three months with a review before the end of that period. The Committee also made an immediate interim order of suspension.

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## Background:

1. In April 2023 Patient A began experiencing discomfort in her back from gardening. She had never previously sought care from an osteopath. However, after a Google search she found the Registrant's details and spoke with him on the phone. In the course of the conversation, he told her that her discomfort was something that could be looked into and treated. An appointment was made for 6 April 2023.

2. On arrival at the Registrant's premises, Patient A waited in the waiting room where she was subsequently joined by him. They had a conversation about her discomfort and health during which she informed him that she suffered from osteoporosis.

3. Patient A explained to the Registrant that she had been diagnosed with osteoporosis about six years previously. She had undergone screening and scans following an injury which confirmed her diagnosis. She informed him that she had been on medication for her osteoporosis but was not presently.

4. Patient A told the Registrant that she was taking aspirin and discussed with him the tightness she felt in her chest which he said could be linked to her back ache. She had no recollection of signing any forms whilst speaking with him in the waiting area.

5. Patient A and the Registrant then moved into the treatment room where she took off her coat and he checked her posture. He stated that her back wasn't

aligned, and her right side was lower than her left side. They again discussed her osteoporosis.

6. The Registrant then asked Patient A to lie down on the treatment bed where he massaged her back and then asked her to turn to lie on her back and cross her arms over her chest. He did not describe to her what he was about to do apart from informing her that she would hear the sound of a crack.

7. Once Patient A was lying on her back, the Registrant performed a high velocity thrust ("HVT") manoeuvre involving the application of significant pressure to Patient A's chest with his elbow. She was then asked to turn onto her left side, and he massaged her back.

8. Following the treatment, Patient A suffered immediate pain to her chest but assumed that it would disappear. During the course of the following days the pain increased so Patient A cancelled her second appointment.

**The Investigation**

9. On 23 April 2023, Patient A made an online complaint to the Council, following which the Council undertook an investigation. As part of the facts disclosed within her evidence before this hearing, Patient A explained that she had told the Registrant the medication she had been taking for osteoporosis was risedronate sodium.

10. Thereafter, an expert report was commissioned by the Council from Mr. Tim McClune.

11. Mr. McClune concluded that Patient A's history of osteoporosis should have alerted the Registrant to the need to proceed with caution when providing thoracic spine treatment to Patient A and that HVT was contraindicated in her case. There was no evidence in the records that the Registrant had obtained valid informed consent. The treatment provided fell "considerably" below that which is expected of a reasonably competent osteopath.

12. In his initial response to the Allegation the Registrant explained that he always explained to patients how a technique would be performed before it was undertaken, and he believed that he had obtained verbal consent. He further explained that he considered the treatment provided was not contraindicated.

13. In that response the Registrant gave his initial account of events. He went on to explain that Patient A was invited into the consultation room when she attended for her appointment on 6 April 2023 where she was asked whether she had ever seen an osteopath before, and a detailed explanation of the procedure was given to her, and her medical history was explored. She gave

her consent for treatment. Patient A mentioned that she had osteoporosis. Patient A informed the Registrant that she had stopped taking medication for osteoporosis approximately 5-6 months earlier but was taking aspirin. According to the Registrant, Patient A did not mention that she had taken risedronate sodium. Patient A was invited to go into the treatment room to change. The Registrant followed her in about a minute later and he explained the procedure in detail. Her blood pressure was taken, and her reflexes and passive movement were checked. Before undertaking the high velocity thrust procedure, it was once again explained to Patient A, and she was advised that she would hear a crack. Mr. Morris did not use his elbow in executing the high velocity thrust. At no point after the treatment did Patient A complain of pain.

14. Mr. McClune provided an addendum report dated 26 February 2024 in which he concluded that on the Registrant's account of events, namely that Patient A had not informed him that she had been prescribed risedronate sodium, a high velocity thoracic thrust was nevertheless contraindicated.

15. The Registrant provided a reflective statement dated 15 June 2024 in which he set out that he has been a practising osteopath since 1998 and had no previous disciplinary history previously. Thereafter, he made what amounted to at least partial admissions that were later clarified as amounting to full admissions to the facts by his legal representative.

16. The Committee found the Registrant's failure to obtain valid consent serious and all the more serious by reason of the nature of the treatment he planned to administer, which "was highly invasive in character, such that it was extremely high risk, particularly in someone with osteoporosis."

17. The Committee considered that in treating Patient A as he had the Registrant had treated her "in a contraindicated fashion with a highly invasive and inherently risky technique, which it considered the Registrant's application to be," and which "was an extremely reckless course to take in a patient with diagnosed osteoporosis."

18. The Committee concluded that such a decision showed a profound failure of the Registrant's understanding in the application and treatment of Patient A that the Committee found extremely concerning. Whilst the Committee considered there was nothing that can be described as "absolutely contraindicated," applying HVT in the manner the Registrant had to a patient with Patient A's medical history was as close to an absolute contraindication as the Committee could imagine.

19. The Committee concluded that the facts as found proved did amount to Unacceptable Professional conduct (UPC), and imposed an order of

suspension for a period of three months. An interim suspension order was also imposed.

**Decision:**

20. This is a first review of the substantive three month suspension order imposed on 1 August 2024, which came into effect immediately, by operation of the interim suspension order.

21. When imposing the order of suspension the Committee indicated that the PCC hearing the matter on review would be assisted by the following:

- A Personal Development Plan (PDP) identifying how the Registrant will seek to address identified issues in:
  i. Consent and communication,
  ii. Appropriate selection of osteopathic techniques,
  iii. Clinical consideration of metabolic bone disease.

- Evidence of CPD undertaken or planned and targeted at the above areas of development.

- Evidence of reflective learning from CPD activities undertaken in the form of reflective learning statements.

- A further reflective piece from the Registrant identifying overall learning and development outcomes and next steps.

## Evidence & Submissions of the Parties

22. On behalf of the Council, Mr. Geering made no positive submission as to the course the Committee should adopt. Rather, he identified the relevant law and submitted that the Committee should bear in mind the reasons for the imposition of the suspension in the first place, as well as assessing the extent to which the Registrant had complied with the invitation issued by the Committee on the previous occasion to provide information and reflection.

23. On behalf of the Registrant, Mr. Zaman provided the Committee with a document entitled 'Personal Development and Reflection.' In it the Registrant detailed his thoughts and CPD undertaken since the last occasion.

24. He also gave oral evidence before the Committee. He explained that he had focussed largely on consent and communication as the central issue in his remediation, as he felt that was the crux of his mistake. He had identified an element of complacency that had crept into his practice and that he needed

to ensure consent was an ongoing process. He had designed a new protocol for dealing with consent, although he had not chosen to provide a copy to the Committee.

25. The Registrant accepted that he had spent little time addressing issues around the appropriate selection of osteopathic techniques as he believed that was not the central issue. He had been in practice for 26 years without other incident and the incident with Patient A had been caused by miscommunication with the patient, rather than his poor treatment selection. He would now never use HVT for any patient with any metabolic bone disease.

26. The Registrant explained that in addressing the clinical consideration of metabolic bone disease he had attended a number of CPD courses and was now far better acquainted with the range of diagnostic tools for bone disease, as well as the treatment options for those suffering with such diseases.

27. The Registrant went on to explain that he had formed a mentoring/support group with around eight colleagues that meets roughly weekly to share learning and experience. That has helped him to identify issues in his own practice and to address those. He has also been meeting with another colleague and undertaking role play sessions to identify and address communication and consent issues, as well as general issues.

28. When explaining his consent process the Registrant told the Committee he did not use literature to explain any processes, and although thorough in some aspects there was no mention of any explanation of the risks and benefits of particular treatments, so that informed decisions could be made.

29. The Registrant accepted that regardless of Patient A no longer being prescribed medication to treat her osteoporosis, HVT was contraindicated and that he made a mistake in administering that treatment to a patient with osteoporosis. He explained that was a mistake that thanks to the Fitness to Practise experience, he would never repeat.

30. In his concluding submissions, Mr. Geering identified that the PDP the Registrant had been invited to provide had not been provided, some CPD had been undertaken, but with limited reflections as to the learning that had been achieved. There had been reference to a consent protocol document which had not been produced and although the clinical discussions with colleagues were a positive move, the Committee had been provided with no third party report or statement about those meetings. Mr. Geering submitted that the issue of appropriate treatment selection had been largely ignored, notwithstanding that the wrong treatment had been selected in this case, regardless of whether the patient had been on medication or not. Mr. Geering reiterated that the Council's position remained neutral as to whether a further order was necessary.

31. In his closing submissions, Mr. Zaman on behalf of the Registrant submitted that the Registrant was keen to resume practise as soon as possible, that he had addressed the areas of concern previously identified, albeit not only through CPD, but was not opposed to undertaking any further courses or other remedial action as necessary.

32. The Committee received and accepted the advice of the Legal Assessor. It was advised that it should exercise its independent judgment in relation to the action it should take, and should take the minimum action necessary to ensure protection of the public and the wider public interest. It should balance the interests of the Registrant in resuming unrestricted practice with those of the public interest as a whole.

**Determination**

33. The Committee first turned to consider the Registrant's reflective statement and oral evidence in the context of the recommendations made by the previous Committee. In doing so it noted that whilst the Registrant had addressed issues around consent and communication, there remained material omissions in his practice. In particular, he had not demonstrated any clear communication of risks and benefits of treatment to patients. That was of concern to the Committee, given that had he done so in Patient A's case it is at least possible that her osteoporosis would have raised a red flag in his mind at the time and he would have chosen a different treatment option. Equally, it would have enabled Patient A to better understand the risks of HVT in her case.

34. The Committee took careful account of the Registrant's oral evidence and was satisfied that he had made efforts to address the general issues around consent and communication as well as the clinical consideration of metabolic bone disease. However, as he had conceded, the Registrant had done very little to address the selection of appropriate osteopathic techniques. That raised considerable issues as to the Registrant's understanding of what led to the incident in question, it being a contraindicated technique for Patient A suffering with osteoporosis, regardless of her medicinal circumstances. The Committee respectfully agreed with Mr. Geering's analysis that the issue was one of selection of technique, every bit as much as it was an issue of communication and consent.

35. The Committee did not agree with the Registrant that because no incident of this sort had not happened before or since, it could be said there was no risk. The risk existed until the point the Registrant engaged fully with remediation and developed greater insight into what lead to the incident. A large part of that was his selection of HVT for treating an osteoporotic patient.

36. The Committee therefore concluded that whilst the Registrant had addressed a good deal of the underlying concerns identified by the Committee on the

previous occasion, he had not sufficiently addressed the selection of appropriate treatment techniques, such that it could be said there was no or very low risk to the public. The Committee therefore concluded that it was necessary to impose some further restriction on the Registrant's practice.

37. The Committee then considered the necessary steps needed to protect the public and the wider public interest. The Committee gave very careful consideration to the principle of proportionality and concluded that in light of the progress the Registrant had made over the course of his period of suspension, it was both necessary and proportionate to impose a period of conditional registration.

38. The Committee therefore orders that upon expiry of the order of suspension the Registrant's practise shall be made subject to a conditions of practice order in the following terms:

    1. You must must provide the GOsC with the full contact details of a professional colleague who is prepared to supervise your compliance with the conditions and provide a report to the GOsC towards the end of this period of conditional registration. The supervising colleague must be approved by the GOsC. Any fees due to the supervising colleague must be paid by you.

    2. You should meet with your supervisor at intervals of no more than 2 weeks.

    3. You must work with your supervisor to formulate a personal development plan (PDP), specifically designed to address deficiencies in the following area: identifying and selecting the appropriate osteopathic techniques.

    4. You must allow your supervisor to prepare a report on your progress over the period of your conditional registration, which should be sent to the GOsC one month before the expiry of your period of conditional registration. The report should have specific regard to your development of knowledge and skills in treatment selection.

    5. This Order will be reviewed at a hearing before it expires.

       At the Review Hearing the Committee will wish to see the following evidence:

       - The PDP developed with your supervisor;

       - Evidence of completion or work in progress measured against the PDP;

       - The report from your supervisor

- A reflective statement from you identifying how you have developed both your understanding and your skills over the period of your conditional registration, and how you have introduced that learning into your practice.

For the avoidance of doubt the Conditions **do not** require you to be closely or directly supervised in your day to day practice.

39. The Committee considered that in order for the Registrant to have sufficient time to put the conditions in place and develop real learning based upon the framework the conditions envisaged, the minimum period necessary was one of four months.

40. The Committee has therefore determined it is necessary to impose an order of conditional registration in the terms set out above for a period of 4 months from the date of expiry of the existing suspension order.

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Under Section 31 of the Osteopaths Act 1993 there is a right of appeal against the Committee's decision.

The Registrant will be notified of the Committee's decision in writing in due course.

All final decisions of the Professional Conduct Committee are considered by the Professional Standards Authority for Health and Social Care (PSA). Section 29 of the NHS Reform and Healthcare Professions Act 2002 (as amended) provides that the PSA may refer a decision of the Professional Conduct Committee to the High Court if it considers that the decision is not sufficient for the protection of the public.

Section 22(13) of the Osteopaths Act 1993 requires this Committee to publish a report that sets out the names of those osteopaths who have had Allegations found against them. The Registrant's name will be included in this report together with details of the allegations we have found proved and the sanction that that we have applied today.

# GENERAL OSTEOPATHIC COUNCIL
## PROFESSIONAL CONDUCT COMMITTEE

## Case No: 1699/3712

## Professional Conduct Committee Review Hearing

### DECISION

| | |
|---|---|
| **Case of:** | Martin Morris |
| **Committee:** | Pamela Ormerod (Chair)<br>Manjit Darby (Lay Member)<br>Kenneth McLean (Osteopathic Member) |
| **Legal Assessor:** | Tim Grey |
| **Representation for Council:** | Michael Bellis |
| **Representation for Osteopath:** | Kawsar Zaman |
| **Clerk to the Committee:** | Sajinee Padhiar |
| **Date of Hearing:** | 24 January 2025 |

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**Summary of Decision:**

No further order made. Conditions of practice order to lapse at the end of the period.

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**Allegation and Facts**

The allegation is that Mr Martin Morris (the Registrant) has been guilty of unacceptable professional conduct, contrary to section 20(1)(a) of the Osteopaths Act 1993, in that:

1. Patient A attended one appointment with the Registrant on 6 April 2023 (the Appointment)
   **Admitted and Found Proved**

2. During the Appointment the Registrant delivered a high velocity thrust thoracic spine and/or rib joint manipulation to Patient A, which resulted in an audible 'crack sound'.
   **Admitted and Found Proved**

3. The Registrant failed to obtain valid consent from Patient A before carrying out the treatment set out in paragraph 2.
   **Admitted and Found Proved**

4. The Registrant's conduct as set out at paragraph 2 was:

   a. contraindicated;
   b. inappropriate.

   **Admitted and Found Proved**

The Committee determined that the appropriate sanction was one of suspension of practice for a period of three months with a review before the end of that period. The Committee also made an immediate interim order of suspension.

The order of suspension was reviewed on 2 October 2024 and replaced with an order of conditions for 4 months.

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## **Background:**

1. In April 2023 Patient A began experiencing discomfort in her back from gardening. She had never previously sought care from an osteopath. However, after a Google search she found the Registrant's details and spoke with him on the phone. In the course of the conversation, he told her that her discomfort was something that could be looked into and treated. An appointment was made for 6 April 2023.

2. On arrival at the Registrant's premises, Patient A waited in the waiting room where she was subsequently joined by him. They had a conversation about her discomfort and health during which she informed him that she suffered from osteoporosis.

3. Patient A explained to the Registrant that she had been diagnosed with osteoporosis about six years previously. She had undergone screening and scans following an injury which confirmed her diagnosis. She informed him that she had been on medication for her osteoporosis but was not presently.

4. Patient A told the Registrant that she was taking aspirin and discussed with him the tightness she felt in her chest which he said could be linked to her back ache. She had no recollection of signing any forms whilst speaking with him in the waiting area.

5. Patient A and the Registrant then moved into the treatment room where she took off her coat and he checked her posture. He stated that her back wasn't aligned, and her right side was lower than her left side. They again discussed her osteoporosis.

6. The Registrant then asked Patient A to lie down on the treatment bed where he massaged her back and then asked her to turn to lie on her back and cross her arms over her chest. He did not describe to her what he was about to do apart from informing her that she would hear the sound of a crack.

7. Once Patient A was lying on her back, the Registrant performed a high velocity thrust ("HVT") manoeuvre involving the application of significant pressure to Patient A's chest with his elbow. She was then asked to turn onto her left side, and he massaged her back.

8. Following the treatment, Patient A suffered immediate pain to her chest but assumed that it would disappear. During the course of the following days the pain increased so Patient A cancelled her second appointment.

**The Investigation**

9. On 23 April 2023, Patient A made an online complaint to the Council, following which the Council undertook an investigation. As part of the facts disclosed within her evidence before this hearing, Patient A explained that she had told the Registrant the medication she had been taking for osteoporosis was risedronate sodium.

10. Thereafter, an expert report was commissioned by the Council from Mr. Tim McClune.

11. Mr. McClune concluded that Patient A's history of osteoporosis should have alerted the Registrant to the need to proceed with caution when providing thoracic spine treatment to Patient A and that HVT was contraindicated in her case. There was no evidence in the records that the Registrant had obtained valid informed consent. The treatment provided fell "considerably" below that which is expected of a reasonably competent osteopath.

12. In his initial response to the Allegation the Registrant explained that he always explained to patients how a technique would be performed before it was undertaken, and he believed that he had obtained verbal consent. He further explained that he considered the treatment provided was not contraindicated.

13. In that response the Registrant gave his initial account of events. He went on to explain that Patient A was invited into the consultation room when she

attended for her appointment on 6 April 2023 where she was asked whether she had ever seen an osteopath before, and a detailed explanation of the procedure was given to her, and her medical history was explored. She gave her consent for treatment. Patient A mentioned that she had osteoporosis. Patient A informed the Registrant that she had stopped taking medication for osteoporosis approximately 5-6 months earlier but was taking aspirin. According to the Registrant, Patient A did not mention that she had taken risedronate sodium. Patient A was invited to go into the treatment room to change. The Registrant followed her in about a minute later and he explained the procedure in detail. Her blood pressure was taken, and her reflexes and passive movement were checked. Before undertaking the high velocity thrust procedure, it was once again explained to Patient A, and she was advised that she would hear a crack. Mr. Morris did not use his elbow in executing the high velocity thrust. At no point after the treatment did Patient A complain of pain.

14. Mr. McClune provided an addendum report dated 26 February 2024 in which he concluded that on the Registrant's account of events, namely that Patient A had not informed him that she had been prescribed risedronate sodium, a high velocity thoracic thrust was nevertheless contraindicated.

15. The Registrant provided a reflective statement dated 15 June 2024 in which he set out that he has been a practising osteopath since 1998 and had no previous disciplinary history previously. Thereafter, he made what amounted to at least partial admissions that were later clarified as amounting to full admissions to the facts by his legal representative.

16. The Committee found the Registrant's failure to obtain valid consent serious and all the more serious by reason of the nature of the treatment he planned to administer, which "was highly invasive in character, such that it was extremely high risk, particularly in someone with osteoporosis."

17. The Committee considered that in treating Patient A as he had the Registrant had treated her "in a contraindicated fashion with a highly invasive and inherently risky technique, which it considered the Registrant's application to be," and which "was an extremely reckless course to take in a patient with diagnosed osteoporosis."

18. The Committee concluded that such a decision showed a profound failure of the Registrant's understanding in the application and treatment of Patient A that the Committee found extremely concerning. Whilst the Committee considered there was nothing that can be described as "absolutely contraindicated," applying HVT in the manner the Registrant had to a patient with Patient A's medical history was as close to an absolute contraindication as the Committee could imagine.

19. The Committee concluded that the facts as found proved did amount to Unacceptable Professional conduct (UPC), and imposed an order of suspension for a period of three months. An interim suspension order was also imposed.

20. On 2 October 2024 the Registrant's suspension was subject to a review by the Committee.

21. On that occasion, the Committee noted that whilst the Registrant had addressed issues around consent and communication, there remained material omissions in his practice. In particular, he had not demonstrated any clear communication of risks and benefits of treatment to patients. That was of concern to the Committee, given that had he done so in Patient A's case it is at least possible that her osteoporosis would have raised a red flag in his mind at the time and he would have chosen a different treatment option. Equally, it would have enabled Patient A to better understand the risks of HVT in her case.

22. The Committee was satisfied that the Registrant had made efforts to address the general issues around consent and communication as well as the clinical consideration of metabolic bone disease. However, as he had conceded, the Registrant had done very little to address the selection of appropriate osteopathic techniques. That raised considerable issues as to the Registrant's understanding of what led to the incident in question, it being a contraindicated technique for Patient A suffering with osteoporosis, regardless of her medicinal circumstances.

23. The Committee determined that there remained a risk of repetition up until the point the Registrant engaged fully with remediation and developed greater insight into what lead to the incident. A large part of that was his selection of HVT for treating an osteoporotic patient.

24. The Committee therefore concluded that whilst the Registrant had addressed a good deal of the underlying concerns identified by the Committee on the previous occasion, he had not sufficiently addressed the selection of appropriate treatment techniques, such that it could be said there was no or very low risk to the public. The Committee therefore concluded that it was necessary to impose some further restriction on the Registrant's practice. The Committee therefore made the Registrant's registration subject to a conditions of practice order in the following terms:

    1. You must must provide the GOsC with the full contact details of a professional colleague who is prepared to supervise your compliance with the conditions and provide a report to the GOsC towards the end of this period of conditional registration. The supervising colleague must be

approved by the GOsC. Any fees due to the supervising colleague must be paid by you.

2. You should meet with your supervisor at intervals of no more than 2 weeks.

3. You must work with your supervisor to formulate a personal development plan (PDP), specifically designed to address deficiencies in the following area: identifying and selecting the appropriate osteopathic techniques.

4. You must allow your supervisor to prepare a report on your progress over the period of your conditional registration, which should be sent to the GOsC one month before the expiry of your period of conditional registration. The report should have specific regard to your development of knowledge and skills in treatment selection.

5. This Order will be reviewed at a hearing before it expires.

   At the Review Hearing the Committee will wish to see the following evidence:

   - The PDP developed with your supervisor;
   - Evidence of completion or work in progress measured against the PDP;
   - The report from your supervisor
   - A reflective statement from you identifying how you have developed both your understanding and your skills over the period of your conditional registration, and how you have introduced that learning into your practice.

## **Decision:**

25. This is a review of the substantive four month order of conditions imposed on 2 October 2024 which came into effect upon the expiry of the previously imposed 3 month suspension order.

## Evidence & Submissions of the Parties

26. On behalf of the Council, Mr. Bellis made no positive submission as to the course the Committee should adopt. Rather, he identified the relevant law and submitted that the Committee should bear in mind the reasons for the imposition of the suspension in the first place, as well as assessing the extent to which the Registrant had complied with the conditions imposed by the Committee on the previous occasion.

27. On behalf of the Registrant, Mr. Zaman provided the Committee with two documents. The first was a witness statement to which was appended a PDP developed by the Registrant and his supervisor(s), evidence of completion or work in progress measured against PDP, a report from his supervisor and a reflective statement. Mr. Zaman provided an addendum to the reflective piece in a separate document. In those documents the Registrant and his supervisor detailed his progress since the last occasion.

28. The Registrant also gave oral evidence before the Committee in which he clarifies his learning and reflection since the last occasion the matter was before the Committee. He explained the methodology he now used in taking case histories from patients and in involving patients more in decisions about the appropriate treatment option. In relation to HVT he explained he would not use it for a patient with osteoporosis in the future, but would use soft tissue techniques or articulation techniques instead, depending upon what was most appropriate. He would also consider referring the patient elsewhere if he could not assist.

29. The Registrant explained the benefit he had received from working closely with a supervisor and with a wider group of colleagues, in sharing knowledge and skills. He explained it was his intention to continue to keep in touch with those colleagues in order to continue progressing and developing as an Osteopath.

30. In his concluding submissions, Mr. Bellis on behalf of the Council submitted that if the Committee considered the risks identified on previous occasions had now been addressed then it should make no order. If it did not, the Committee should make the necessary and proportionate order required to protect the public and the wider public interest.

31. In his closing submissions, Mr. Zaman on behalf of the Registrant submitted that the Registrant had gone to great lengths and made extensive efforts to address the concerns identified by the Committee in October. He had developed clear insight through working both with a supervisor and with an informal community of osteopaths to share ideas and knowledge, had shown insight and remediation in developing new processes within his practice, seeking to involve patients in their care throughout the process. Mr. Zaman therefore submitted that the Registrant no longer posed a risk such that he could be readmitted to unrestricted practice.

32. The Committee received and accepted the advice of the Legal Assessor. It was advised that it should exercise its independent judgment in relation to the action it should take, and should take the minimum action necessary to ensure protection of the public and the wider public interest. It should balance the interests of the Registrant in resuming unrestricted practice with those of the public interest as a whole.

## Determination

33. The Committee took careful note of all the written evidence provided to it, in particular the documents the Registrant had provided and those provided by his supervisor. It also paid close regard to his oral evidence.

34. The Committee considered the Registrant had systematically and diligently addressed the concerns raised by the reviewing Committee in October and had complied with the conditions imposed upon him by the previous reviewing Committee. He had demonstrated sufficient insight into his failures, undertaken the requisite education in the form of CPD and applied it in practice. He had adopted a new process for taking case histories which was far more complete and demonstrated an holistic approach to the management of patients, engaging them more in decisions about their own care.

35. The Registrant had developed a more questioning and cautious approach to treatment through peer discussions with colleagues, and had engaged fully with a wider osteopathic community that had offered support and learning opportunities. He had developed a greater understanding of the range of techniques available to him when treating patients and was now able to deploy the most appropriate technique from that range.

36. The Committee determined that the Registrant had provided examples of learning and change being embedded in his approach to his practice such that he had addressed all the concerns identified by the original Committee and the reviewing Committee.

37. The Committee therefore concluded that no further order is necessary to protect the public or the wider public interest.

38. The Committee has therefore determined to make no further direction and to allow the order of conditions to lapse at its conclusion.

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Under Section 31 of the Osteopaths Act 1993 there is a right of appeal against the Committee's decision.

The Registrant will be notified of the Committee's decision in writing in due course.

All final decisions of the Professional Conduct Committee are considered by the Professional Standards Authority for Health and Social Care (PSA). Section 29 of the NHS Reform and Healthcare Professions Act 2002 (as amended) provides that the PSA may refer a decision of the Professional Conduct Committee to the

High Court if it considers that the decision is not sufficient for the protection of the public.

Section 22(13) of the Osteopaths Act 1993 requires this Committee to publish a report that sets out the names of those osteopaths who have had Allegations found against them. The Registrant's name will be included in this report together with details of the allegations we have found proved and the sanction that that we have applied today.