GENERAL OSTEOPATHIC COUNCIL

PROFESSIONAL CONDUCT COMMITTEE

Case No: 857/10254

Professional Conduct Committee Hearing

DECISION

Case of:	Romilly Jarrett
Committee:	Andrew Harvey (Chair) Nathalie Harvier (Lay) Kenneth McLean (Osteopath)
Legal Assessor:	Peter Steel
Representation for Council:	Rachel Birks
Representation for Osteopath:	Paul Grant
Clerk to the Committee:	Sajinee Padhiar
Date of Hearing:	1 – 3 July 2024

Summary of Decision:

At the outset of the hearing, the Registrant admitted particulars 1, 2 and 4 b. and the Committee therefore found those Particulars proved.

Committee determined Particular 3 proved in part and 4 a. proved.

UPC found proved.

Sanction of admonishment.

Allegation (amendments shown in red) and Facts

The allegation is that Ms Romilly Jarrett (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 ~~seven~~ appointments with the Registrant as follows:
   30 November 2021 ("Appointment 1")
   7 December 2021 ("Appointment 2")
   8 January 2022 ("Appointment 3")
   22 January 2022 ("Appointment 4")
   29 January 2022 ("Appointment 5")
   12 February 2022 (Appointment 6")
   12 March 2022 ("Appointment 7") ~~at the Halos Clinic between 30 November 2021 and 12 March 2022.~~

   (together "the Appointments").

2. During Appointment 5 and/or Appointment 6 and/or Appointment 7, the Registrant:
   a. applied dry needling treatment to Patient A ("Treatment"); and
   b. failed to obtain valid consent from Patient A for the Treatment.

   ~~The Registrant provided Patient A with acupuncture/dry needling treatment without the appropriate training to do so~~.

   3. During Appointment 7, the Registrant failed to deliver safe, competent and/or appropriate osteopathic care to Patient A, in that she

   ~~The Registrant did not obtain valid consent for the acupuncture/dry needling treatment provided to Patient A~~

~~4. The Registrant failed to inform Patient A of any material or significant risks associated with the acupuncture/dry needling treatment~~

~~5. The Registrant provided further acupuncture/dry needling treatment at the final appointment on 12 March 2022 and:~~
   ~~a.~~ inserted the needles too deeply into Patient A's upper thorax during the Treatment.
   ~~b. this led to Patient A having collapsed lungs on both sides~~

~~6.~~ 4. Following ~~the a~~Appointment 7, ~~on 12 March 2022~~ Patient A reported ~~the~~ signs and symptoms to the Registrant and the Registrant did not
   a. recognise the signs and symptoms as pneumothorax
   b. immediately refer Patient A to hospital for emergency treatment.

~~7. The Registrant's actions as described at 2 to 4 above were inappropriate.~~

~~8. The Registrant's actions as described at 5 and 6 above were not clinically justified.~~

Preliminary Matters:

Application to Amend the Allegation

1. At the outset of the hearing, Ms. Birks, on behalf of the Council, made an application, pursuant to Rule 24 of the Rules, to amend the Allegation in the terms set out above. She submitted that the amendment was both necessary and desirable in order to ensure clarity in the Allegation. The proposed amendments more adequately and fully reflected the nature of the evidence, without materially altering the nature and scope of the case.

2. On behalf of the Registrant Mr. Grant did not object to the application to amend.

3. The Committee received and accepted the advice of the Legal Assessor. It was advised that its power to make such an amendment was governed by Rule 24 of the Rules. The Committee thereby had a discretion to amend the Allegation at any time if, having heard submissions and received legal advice, it considered that an amendment could be made without injustice.

4. The Committee carefully considered whether the proposed amendments might lead to any unfairness to the Registrant. Having done so, it concluded that the amendments as sought by the Council could be made without injustice and were both necessary and desirable to properly reflect the nature of the case and in order for the Committee in exercising its case management functions to effectively and expeditiously consider all matters referred to it by the Investigating Committee.

Admissions:

5. At the outset of the hearing, Mr Grant indicated that the Registrant admitted particulars 1, 2 and 4 b. as amended. The Committee therefore found those particulars proved.

Decision:

Background

6. The Registrant is a Registered osteopath, having qualified in September 2019 from the European School of Osteopathy. These matter arose from her practice at a clinic in Oxted, Surrey.

7. On 17 March 2022 Patient A's husband submitted a complaint to the Council regarding the treatment Patient A had received from the Registrant.

8. Patient A attended her GP in about September 2021 complaining of bad headaches and migraines. Her GP suggested she might seek other treatment, including from an osteopath.

9. Patient A had a number of osteopathy treatments with the Registrant between 30 November 2021 and 12 March 2022. At Patient A's fifth appointment, on 29 January 2022, the Registrant first employed dry needling as an adjunctive treatment technique. Further dry needling was undertaken at Patient A's appointments on 13 February 2022 and 12 March 2022.

10. Patient A stated that the Registrant did not really explain what the treatment involved or why it was required. She said that the Registrant had answered some questions about what the dry needling involved after the treatment had commenced on 12 March 2022.

11. At no time did the Registrant inform Patient A as to the risk of a pneumothorax occurring as a result of the dry needling in the upper thorax. At that appointment needles were placed around the left side of the neck and shoulder blade and then repeated on the right-hand side. Patient A experienced pain and slight pressure on the right side of her chest when one of the needles was inserted. Some bleeding also occurred.

12. Patient A reported feeling okay initially after the treatment but when driving home, she felt pain in the top of her chest. She realised when she got home that she was also out of breath even with minimal exertion. She was experiencing rib pain. She decided to telephone the osteopathy clinic for advice but obtained no response.

13. Patient A therefore emailed the clinic explaining her symptoms. She received a reply to the effect that the Registrant would call when she had the chance (it was a Saturday). The Registrant duly telephoned at around 18:00 and Patient A described her symptoms. The Registrant told Patient A that it was probably nothing to worry about and to call the out of hours doctor if the problem continued the next day.

14. The next morning Patient A telephoned NHS 111 and was told to attend A&E. She did so and was told that both lungs had collapsed. She was told this was as a result of trauma rather than a spontaneous collapse. The bilateral pneumothorax was treated in hospital as being '*secondary* to' the dry needling procedure, the onset of symptoms having begun within an hour of the treatment.

Evidence

15. The Committee was provided with witness statements from Patient A, dated 20 July 2022, from Patient A's husband dated 2 July 2022, and from the Registrant dated 6 June 2024. It also received a number of other documents, including: two reports from an expert witness, an osteopath with experience in dry needling, Mr Devan Rajendran, dated 27 July 2023 and 20 February 2024 respectively, together with notes of clarification from the expert dated 19 and 21 June 2024; Patient A's clinical records; a copy of a certificate confirming the Registrant's attendance on a dry needling course; a copy of the Registrant's certificate of attendance at a course on Shared Decision Making, a copy of the Registrant's confirmation of booking at a course on consent, a number of emails and other correspondence containing representations from the Registrant's solicitors and a number of testimonials for the Registrant. The Committee heard oral evidence from Patient A and the Registrant, both of whom affirmed.

Patient A

16. Patient A confirmed the content of her witness statement dated 20 July 2022 and the exhibits to it (the front sheets of which were dated 21 July 2022, as Patient A said there was a delay in receiving the exhibits and she had therefore signed them the day after signing the statement).

17. Patient A was then asked some supplementary questions. She stated that she had been getting tension headaches prior to her appointments with the Registrant. Patient A therefore went to see a GP, who undertook a number of tests to rule out anything sinister and prescribed some strong painkillers, which she had not wanted to take. Patient A had then gone to see another GP who suggested physiotherapy or osteopathic treatment, as well as a mouthguard.

18. Patent A said that she then arranged to see the Registrant, and in the last few appointments had undergone dry needling. Patient A said that she was not told much about dry needling by the Registrant, but she understood it was intended to reduce spasm in muscles.

19. Patient A said that on 12 March 2022 (at which point the Registrant had previously performed dry needling on her) she underwent a normal manipulation and the Registrant then suggested that they try dry needling again. Patient A stated that the Registrant inserted needles at the top of her back around her neck and shoulders. Patient A said that she did not know there were any risks associated with the treatment at the time.

20. Patient A said that one of the needles was put near the top of her left shoulder. She said that this felt a bit painful, which was a different feeling to her experience of the other needles and it "*pressed*" her chest a little. Patient A thought she had told the Registrant that it hurt, or that the Registrant had asked her if it hurt, and she had replied yes.

21. Patient A said that the appointment had lasted, she thought, about 45 minutes or an hour. The needling had taken place towards the end of the appointment. Patient A said that immediately after the treatment she felt fine. However, as she drove away she began to notice a strange sensation in the upper part of her chest, like she could not breathe, together with some pain, and it felt like there was a lump in the upper part of her chest. She said that it did occur to her that this could be associated with the treatment she had just had.

22. Patient A stated that when she got home, she had to walk her dog. She found this experience frightening, as there was a short hill she had to walk up and she felt really breathless doing so. Patient A said that although she was not experiencing pain anywhere else, she was still quite concerned. It was at that point she decided to ring the clinic to get some reassurance.

23. Patient A thought she had rung the clinic and had then sent an email, setting out her concerns. She did not speak to anyone at the clinic until the Registrant rang her back. Patient A said that at that point she was still feeling the same. She recalled saying to the Registrant that she had chest pain and that she was having difficulty breathing.

24. Patient A said that she remembered the Registrant asking her if she was having palpitations, like a fast heartbeat. At that time, she was not sure that she was having palpitations, so she said no. Patient A said that the Registrant told her to go to a walk-in centre the following day if she was still concerned, because it was a weekend.

25. Patient A said that the following day she still was not feeling great and had not slept very well, as she could feel "*something funny happening*" in her lung and was quite frightened. Patient A said she had some breakfast and still

was not feeling great. She rang NHS 111, who advised her to go straight to A&E and made an appointment for her as well as telling her not to drive herself there.

26. At the hospital Patient A said that she was diagnosed as having a pneumothorax. She was told that her lung on one side had fully collapsed, and the other had partly collapsed. Patient A stated that she told the hospital doctors about the dry needling treatment she had received. She said she was told this was highly likely to be the cause of the lung collapse. Patient A said her husband had sent a complaint to the GOsC while she was in hospital, as he was concerned about what had happened. Patient A said that making a complaint might prevent something similar happening in the future.

27. In answer to questions in cross examination from Mr Grant, Patient A confirmed that she had seen the Registrant for 7 appointments in total and at the last few appointments, the Registrant did dry needling. Patient A said that she had been satisfied with the osteopathic treatment the Registrant had provided. Patient A said that the Registrant had explained what she was doing as regards manipulations.

28. Patient A agreed that her first appointment with the Registrant had been about an hour because she had to provide a case history to the Registrant and that the subsequent appointments had been 30 minutes in length, sometimes extending to about 45 minutes. Her last appointment on 12 March 2022 had lasted about 45 minutes.

29. Patient A said that what was said about needling at the last appointment had been along the lines of the Registrant asking whether Patient wanted to try using needles. There had previously been some conversation about the dry needling reducing spasm in muscles, to help with the upper back pain and headaches Patient A was getting. Patient A thought this was something to do with reducing tension.

30. Patient A said that she was not told anything about the risks of dry needling. She could not remember the Registrant saying anything about the possibility of bruising and bleeding from dry needling. The Registrant had told her about the bleeding from the needle that had caused her pain, because obviously she would not have seen that on her back.

31. When asked to explain what she had meant by "*lower rib pain*" as per the Registrant's note of the telephone conversation on 12 March 2024, Patient A said that she could feel something moving about, and that she had pain on moving about even gently. Patient A said she did not recall saying that she was not experiencing sharp pain or saying that that she was not overly

concerned, but accepted that she might have done because she did not want to make a fuss.

The Registrant

32. The Registrant confirmed the content of her statement dated 6 June 2024. The Registrant said that having subsequently attended a number of courses, including on e.g. shared decision making, and having reflected, she had realised she should have referred Patient A to A&E immediately and therefore now admitted this.

33. The Registrant said that she denied particular 3 as she did not purposefully insert the needles too deeply to cause Patient A harm. The Registrant accepted that in all probability she had caused the pneumothorax, but she had not deliberately inserted the needles too deeply.

34. In answer to questions in cross examination from Ms Birks, the Registrant said that she had taken a dry needling course in 2017. However, she did not start dry needling until she had qualified as an osteopath in 2019. The Registrant was not able to say exactly how many patients she had dry needled between 2019 and March 2022 when she stopped offering it as a treatment, but she thought she performed dry needling on about 10% of her patients. The Registrant said that she would generally see between 25 and 30 patients a week.

35. The Registrant said that she had experienced one other patient contacting her urgently following dry needling. One of her private patients had complained of a rash after dry needling. She had referred them to a walk-in centre and it transpired they had an allergy to the alcohol swab that had been used.

36. As regards Patient A's report of pain during the last appointment. The Registrant said that some patients she had dry needled had reported experiencing pain, but it is common for needling to cause a muscle spasm, which can be described by the patient as painful, or uncomfortable.

37. The Registrant accepted that she was aware from Patient A's email on 12 March 2022 that Patient A was reporting chest pain, rib pain, and that it was more difficult to breathe than when the Registrant had seen her earlier. The Registrant also accepted that Patient A reported that she had a blockage in chest, and her breathing problems were worse when walking, doing mild exercise or lying down.

38. The Registrant also accepted that she knew from her telephone conversation with Patient A on 12 March 2022 that the latter's complaints included chest and rib pain, a feeling of a blockage on her chest and that her symptoms were not getting any better or worse. The Registrant agreed that there had been no change in Patient A's symptoms from the point when earlier that day she had been concerned enough to email the clinic.

39. The Registrant said that apart from the patient with the rash, this urgent report of symptoms was not something she had encountered before. The Registrant said that she linked some of the symptoms to Patient A's anxiety, namely the shortness of breath and the heavy feeling on her chest, but not the report of rib or chest pain, or of breathlessness that was worse on exertion.

40. The Registrant said that she and Patent A had spoken quite a lot about Patient A's anxiety. The Registrant had recommended a local mental health charity to her. She could not recall discussing the symptoms of Patient A's anxiety with the Registrant but accepted that she would not previously have been aware of Patient A's shortness of breath or the heavy feeling on her chest being associated with anxiety. The Registrant said she could not remember if those were typical ways in which Patient A manifested her anxiety.

41. The Registrant agreed that the telephone conversation on 12 March 2022 was an unusual phone call, as there had only ever been one patient previously who had contacted her to ask about symptoms following dry needling.

42. The Registrant maintained that she had recognised pneumothorax as one of the differential diagnoses. She accepted that she had not recorded this in her telephone note of the conversation nor had she told Patient A that this was one of her differential diagnoses. Ms Birks referred the Registrant to her representative's email of 4 April 2023, in which it was said on the Registrant's behalf that she "*did not recognise there and then a pneumothorax*"

43. The Registrant said that at the time she had not reached a final diagnosis that Patient A had suffered a pneumothorax. The Registrant accepted that she had not taken the steps that would have been expected in the circumstances, namely urgently referring Patient A to A&E. The Registrant said that she did not recognise at the time that the definitive diagnosis was a pneumothorax, but that had been one of her differential diagnoses which is why the Registrant had told her to seek urgent care if she deteriorated.

44. The Registrant said that she thought that Patient A had been describing classic symptoms of a pneumothorax. Referring to her representative's email of 4 April 2023, the Registrant said that she thought she had inserted needles too deeply, and accepted that it was highly likely she caused the pneumothorax. The Registrant asserted that she had used the proper length of needles and inserted them in the right way. The Registrant stated that she had stopped dry needling but if the patient were in front of her she would do the same thing again.

Submission of the Parties

45. Ms. Birks, on behalf of the Council, referred to the skeleton argument she had submitted on behalf of the Council. Ms Birks observed that there were two remaining particulars for the Committee to decide upon.

46. As regards particular 3 of the Allegation, Ms Birks submitted that the Council did not allege causation, i.e. that but for the dry needling the pneumothorax would not have occurred, and did not need to for these purposes.

47. Ms Birks said that the first point for the Committee to consider was that pneumothorax was a known risk of dry needling, as confirmed by the expert report of Mr Rajendran. Patient A had experienced pain and shortness of breath when driving home, i.e. within a short period of the treatment on 12 March 2022. Patient A went on to experience further significant symptoms within a short period after the treatment, including shortness of breath on even mild exertion and a feeling of a blockage in the chest.

48. In addition, there was Patient A's hospital treatment record which suggested that that the pneumothorax was secondary to the dry needling. Patient A's discharge summary indicated the diagnosis of those treating Patient A, including her treating consultant, was that the pneumothorax was iatrogenic and associated with the dry needling.

49. Ms Birks submitted that in the light of: the diagnosis of the consultant treating Patient A; the frank admissions by the Registrant in her evidence that it was highly likely that she caused the pneumothorax, and that she inserted the needles too deeply; and Mr Rajendran's opinion that if the Registrant had (as she apparently accepted was highly likely) caused the pneumothorax that this was as a result of incorrect needling technique, the Committee could conclude that on the balance of probabilities, the Registrant had inserted the needle too deeply into Patient A's upper thorax.

50. Ms Birks reminded the Committee that the dry needling was a non-essential treatment. The Registrant could have chosen not to dry needle the area at

all, as Mr Rajendran had indicated in his opinion. Ms Birks said that Mr Rajendran had also confirmed that in his opinion that the angle or depth chosen in the dry needling fell far below the standard expected of a competent osteopath, and so she invited the Committee to conclude that the treatment the Registrant had provided was not safe, competent or appropriate.

51. As regards particular 4 a., Ms Birks observed that that the Registrant had agreed that all the symptoms displayed by Patient A were typical symptoms of pneumothorax. Ms Birks suggested that the diagnosis should have been of a suspected pneumothorax, instead the Registrant had concluded that Patient A's symptoms were due to anxiety. Ms Birks submitted this was not a reasonable conclusion for the Registrant to reach.

52. Ms Birks suggested that all the indicators were that the Registrant did not have pneumothorax in mind as a potential diagnosis on 12 March 2022. The Registrant had not told Patient A that diagnosis, had not made a note of that diagnosis and had not taken the actions one would expect an osteopath to take if she had suspected a possible pneumothorax.

53. On behalf of the Registrant, Mr. Grant said that he would take the outstanding unadmitted particulars back to front. He said that as regards 4 a., Ms Birks had in effect submitted that the Registrant had lied to the Committee. Mr Grant said that the Committee had in consequence a very serious decision to make. Mr Grant said that the Registrant had shown insight, made appropriate admissions and yet on the Council's case had not told the truth.

54. Mr. Grant said that whether Patient A's pneumothorax was iatrogenic was not entirely certain, and that was the reason why the Registrant had not noted this. He reminded the Committee of the Registrant's statement that she had a lot on her mind at the time but submitted that to say she lied was just not acceptable and the allegation should be dismissed.

55. As regards particular 3 and the allegation of overly deep needling, Mr Grant said that the Committee were not dealing with a crime scene and could not do a forensic examination of a body. Mr Grant said that the expert instructed by the GOsC could not confirm that the pneumothorax was caused by too deep needling.

56. Mr Grant said that in truth he could not understand the GOsC' s case . He suggested that the GOsC were saying they did not allege causation, but that had nonetheless sought to do so. Mr Grant said there was no absolute proof the dry needling caused the pneumothorax. Mr Grant accepted that the likely

cause was indeed the dry needling, but he submitted that it was impossible to say for certain.

57. Mr Grant said the Committee should ask itself whether this was osteopathic care at all. He asserted that dry needling was something separate to osteopathic care. Mr Grant submitted that the Committee needed to consider this question in considering whether this was safe, competent or appropriate osteopathic treatment. He suggested the Committee was left with a question about whether the Registrant did drive the needles in too deep. Although Mr Grant accepted that the standard of proof was the balance of probabilities, he suggested there was not enough evidence for the Committee to find this particular proved.

Determination on the Facts

58. The Committee received and accepted the advice of the Legal Assessor. The Committee was advised that the Council bears the burden of proof throughout and the standard of proof is the civil standard, namely the balance of probabilities. The Committee was further advised that in assessing the evidence it was entitled to draw inferences, that is it was entitled to come to common sense conclusions based upon the evidence, but that it should not speculate on the evidence.

Particular 3: "During Appointment 7, the Registrant failed to deliver safe, competent and/or appropriate osteopathic care to Patient A, in that she inserted the needles too deeply into Patient A's upper thorax during the Treatment."

59. The Committee noted that in the original email of representations provided by her solicitor to the GOsC dated 4 April 2023, it had been accepted on her behalf that the Registrant "*admitted to putting in the needles too deep and the pneumothorax*". In her oral evidence to the Committee, the Registrant accepted it was "*highly likely*" that she had inserted the needles too deeply.

60. The Committee considered that this evidence, combined with the evidence that those who treated Patient A for the pneumothorax had assessed that it was a traumatic, iatrogenic injury, was sufficient to allow it to find on the balance of probabilities that the Registrant had indeed inserted the needles too deeply into Patient A's upper thorax as alleged.

61. The undisputed evidence of the expert, Mr Rajendran, as set in his first report dated 27 July 2023 from paragraph 6.6.4 onwards, was to the effect that dry needling treatment of the kind received by Patient A carried a risk of pneumothorax:

"*These areas are known to warrant caution when proceeding with needle insertion due to potentially close proximity of lung tissue. Inserting needles into these area requires care and if deemed necessary, to use both a superficial needle insertion and/or a shallow angle of insertion (White, Cummings and Filshie, 2008 - page 157), or, in my opinion, if the practitioner is in any doubts, they may choose to avoid needling these areas all together*." (paragraph 6.6.7) [N.B. the Committee noted in passing that Mr Rajendran referred in his report to treatment to the upper fibres of trapezius, levator scapulae and supraspinatus, and the Committee understood that was what was represented in this particular by the term "*upper thorax*"]

62. Accordingly, the Committee concluded that in inserting needles too deeply in an area where to do so ran the risk of pneumothorax, on the balance of probabilities, the Registrant had failed to deliver safe osteopathic care to Patient A.

63. By contrast, Mr Rajendran's unchallenged opinion as set out in paragraphs 6.4 and 6.5 of his first report was that the Registrant's use of dry needling on Patient A was both clinically justified and appropriate. Accordingly, the Committee did not find proved that the Registrant had failed to deliver "*appropriate osteopathic care*".

64. Similarly the Committee could not identify any or any sufficient evidence supporting the allegation that the Registrant had failed to deliver "*competent…osteopathic care*" other than the implication that Patient A's bilateral pneumothoraces were indeed caused by overly deep dry needling (a link the GOsC had indicated it was not seeking to make). Mr Rajendran had no criticism of the Registrant's qualification to undertake dry needling as a therapy and she was qualified to do so. The only other evidence the Committee had heard on the point was from the Registrant, who asserted she had employed the right needle lengths and application techniques.

65. The Committee therefore found Particular 3 proved as:

"*During Appointment 7, the Registrant failed to deliver safe osteopathic care to Patient A, in that she inserted the needles too deeply into Patient A's upper thorax during the Treatment***."**

Particular 4 a.: "Following Appointment 7, Patient A reported signs and symptoms to the Registrant and the Registrant did not:
a. recognise the signs and symptoms as pneumothorax"

66. The Committee noted that in the submissions sent to the GOsC by the Registrant's solicitors on 4 April 2023, it was said on her behalf: "*The symptomology was such as described that the registrant thought that she was in a situation of nervous strain and did not recognise there and then a pneumothorax and did tell Patient A that if it got worse to refer herself for urgent help*."

67. However, in her evidence to the Committee, the Registrant said that she had recognised *the classic signs of pneumothorax*" from what she had been told by Patient A ". She said that she made differential diagnoses of pneumothorax and anxiety. The Registrant accepted that she had not told Patient A of this nor she had not made any note of those diagnoses.

68. Mr Rajendran had stated as follows in his first report dated 27 July 2023:

"*6.8.4. It is my opinion that an acupuncture induced pneumothorax may develop up to 2 days to manifest itself so it is important that practitioners who dry needle recognise this (White, Cummings and Filshie, 2008 - page 158). I teach that if a patient reports onset of chest pain, shortness of breath, coughing within three days of receiving needling to the chest wall, in particular to the upper regions of the thoracic region (i.e. the upper fibres of trapezius, levator scapula or supraspinatus areas), the patient should be advised to present urgently to hospital and obtain a chest X-Ray for a suspected pneumothorax.*"

69. The Registrant was clearly aware of Patient A's complaint of pain when she had inserted a needle in the supraspinatus and that the needling caused some bleeding. Patient A in her email of 12 March 2022 had reported further symptoms to the Registrant suggesting a deterioration in her condition, which ought to have prompted consideration of a pneumothorax (as the Registrant had originally conceded) and should have led to an immediate referral to hospital for emergency treatment (which the Registrant did now admit).

70. The Committee therefore concluded that: (a) in the absence of any contemporaneous record that the Registrant had made a diagnosis of pneumothorax, and (b) recognising, as the Registrant had apparently accepted in cross examination, that she had failed to take the steps that would have been expected in the light of such a diagnosis, it was more likely than not that the Registrant had not recognised the signs and symptoms reported by Patient A in her email and in the telephone conversation as signs and symptoms of a pneumothorax.

71. The Committee therefore found this particular proved.

Decision on Unacceptable Professional Conduct

72. On behalf of the Council, Ms Birks referred the Committee to the submissions on Unacceptable Professional Conduct ("UPC") contained in her skeleton argument and summarised the relevant law.

73. Ms Birks reminded the Committee of the reports of Mr Rajendran, the expert, and his subsequent notes of clarification, which set out his opinion that: (a) in employing the needling technique (whether in terms of needle angle and/or depth) she did into a region that was well-known to have an increased risk of serious adverse events, the Registrant fell far below the standard expected of a reasonably competent acupuncturist/dry needle therapist and/or osteopath; (b) the Registrant's failure to recognise the signs and symptoms presented by Patient A as pneumothorax fell far below the standard expected of a reasonably competent osteopath; (c) the Registrant's failure to immediately refer Patient A to hospital for emergency treatment fell far below the standard expected of a reasonably competent osteopath; and (d) that the Registrant's failure to obtain valid consent from Patient A fell below the standard expected of a reasonably competent osteopath (though Mr Rajendran considered the extent that it fell below the standard was for the PCC to decide).

74. Ms Birks drew the Committee's attention to the following Standards in the Osteopathic Practice Standards 2019 ("the OPS") which she submitted were relevant to the decision on UPC:

- A3 (*You must give patients the information they want or need to know in a way they can understand*)
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- A4 (*You must receive valid consent for all aspects of examination and treatment and record this as appropriate*);

- B1 (*You must have and be able to apply sufficient and appropriate knowledge and skills to support your work as an osteopath*), in particular paragraphs B1.3 (*These should include:…a knowledge of pathophysiological processes sufficient to inform clinical judgement and to identify where patients may require additional or alternative investigation or treatment from another healthcare professional*); and B1.10 (*These should include:…problem-solving and thinking skills in order to inform and guide the interpretation of clinical and other data and to justify clinical reasoning and decision-making*); and

- C1 (*You must be able to conduct an osteopathic patient evaluation and deliver safe, competent and appropriate osteopathic care to your patients*) in particular paragraphs C1.8 (*monitor the effects of your care, and keep this under review; you should cease care if requested to do so by the patient or if you judge that care is likely to be ineffective or not in the patient's best interests*); C1.9 (*recognise when errors have been made, and take appropriate action to remedy these, taking account of the patient's best interests under your duty of candour (see standard D3)*); and C1.10 (*where appropriate, refer the patient to another healthcare professional, following appropriate referral procedures*).

75. In his submissions, Mr Grant reminded the Committee that just because there may have been a breach of the OPS, this did not necessarily constitute UPC. He drew the Committee's attention to the case of *R (Calhaem) v General Medical Council* [2007] EWHC 2606 (Admin) and the principle that in professional regulatory cases, mere negligence did not constitute misconduct. Mr Grant said that the essence of this case was negligence in respect of one patient.

76. Looking at the elements of the allegation that the Committee had found proved, Mr Grant said that as regards the question of Patient A's consent, the Registrant had accepted that she had failed to advise Patient A of the risk of pneumothorax, which was nonetheless a very remote risk. Mr Grant submitted that the question of the deep needling was mere negligence.

77. Lastly, considering the conversation between Patient A and the Registrant on 12 March 2022, Mr Grant said that the Committee's decision had been to the effect that the Registrant had made the wrong differential diagnosis.

78. Mr Grant reminded the Committee of the Registrant's extenuating circumstances. He said that the Registrant had suffered a great trauma herself at the time and many things were playing on her mind. It was important for the Committee to note what the Registrant had nonetheless told Patient A as recorded in the telephone note, namely: "*advised urgent care walk in or NHS 111 if symptoms maintained or worsened, and would follow up*", which was what, in Mr Grant's submission, effectively happened.

79. Mr Grant submitted that the case law suggested a very high standard of seriousness was required in decisions about UPC, and taken together the findings were not serious enough to constitute UPC.

80. The Committee accepted the advice of the Legal Assessor, including about the principles set out by Jackson J. in the case of *Calhaem*. The Committee bore in mind that there is no standard of proof and that a determination as to

whether the threshold for Unacceptable Professional Conduct has been reached is a matter of judgment. The Committee had regard to Section 20 of the Osteopathic Act 1993, which defines Unacceptable Professional Conduct as conduct which "*falls short of the standard required of a registered osteopath*". It considered guidance from the Council and the matters set out in *Spencer* that Unacceptable Professional Conduct is conduct which implies some degree of "moral blameworthiness". It bore in mind the case of *Shaw v General Osteopathic Council* [2015] EWHC 2721 (Admin), which indicated that although conduct had to be serious to reach the required threshold, it did not need to be so serious that imposing an admonishment would be too lenient.

81. The Committee had found that the Registrant had failed to obtain valid consent from Patient A, had failed to deliver safe osteopathic care to Patient A, in that she inserted the needles too deeply into Patient A's upper thorax, had not recognised the signs and symptoms reported to her by Patient A as signs and symptoms of pneumothorax and had not immediately referred Patient A to hospital for emergency treatment.

82. The Committee considered that these were serious matters and could not be viewed as a single act of negligence. The Registrant's actions or omissions had breached the OPS in a number of respects, namely Standards A3, A4, B1, C1 and also C2 (*You must ensure that your patient records are comprehensive, accurate, legible and completed promptly*). The Committee observed that osteopathy is generally considered a low-risk treatment, and thus it is all the more important that where osteopaths employ an adjunctive treatment, this is carefully explained to patients so that they can appropriately weigh and understand the risks and benefits of the treatment, and in order that they may participate in meaningful shared decision-making.

83. Taken together, the Committee had little doubt that the facts it had found proved would convey a sufficient degree of opprobrium and moral blameworthiness to the ordinary, intelligent citizen. It therefore found UPC proved.

Decision on Sanction

84. Ms Birks, on behalf of the Council confirmed that the Registrant had no previous regulatory history. She submitted that the appropriate sanction was a matter of judgment for the Committee, based on what it had heard in this case and informed by the guidance contained in the Council's Hearing and Sanctions Guidance 2019 ("HSG").

85. Ms Birks referred the Committee to paragraph 11 of the HSG, which reminded the Committee that having found UPC, it was obliged to impose one of the four sanctions set out at section 22 of the Osteopaths Act 1993.

86. In arriving at its determination, Ms Birks said that the Committee should also have regard to paragraph 26 of the HSG and the Council's overriding objective, namely the protection of the public, which in turn involves protecting, promoting and maintaining the health, safety and well-being of the public; promoting and maintaining public confidence in the profession of osteopathy; and promoting and maintaining proper professional standards and conduct for members of the profession.

87. Ms Birks said that the Committee was also required to act proportionately in imposing a sanction, and that this should be done by assessing each available sanction in ascending order of gravity, evaluating the mitigating features as well as the aggravating features and balancing them against each other before arriving at a proportionate sanction.

88. Ms Birks indicated that the Council was not seeking a particular sanction but suggested that the Committee ought to consider whether the mitigating evidence the Registrant had supplied addressed adequately all the concerns raised by this case. If the Committee were minded to impose conditions on the Registrant, Ms Birks reminded the Committee of the need to have regard to provisions of the HSG and the GOsC guidance on formulating conditions of practice orders.

89. Ms Birks said that the Council did not seek to suggest that this case was so serious that it required consideration of suspension or removal from the Register as a sanction.

90. On behalf of the Registrant, Mr Grant asked the Committee to bear in mind the following points. First, this was a one-off case. Second, the Committee should remember the personal circumstances the Registrant found herself in at the time the events occurred. Mr Grant said that the public might rightly have some sympathy with the Registrant in the circumstances. Further, the Registrant had not just brushed off Patient A's inquiry but had provided advice to her.

91. Mr Grant invited the Committee to take into account Patient A's statement, in which she said that the Registrant was an excellent osteopath, with whom she would have been entirely happy but for the incident in question.

92. Mr Grant also asked the Committee to take into account the testimonials from patients in the bundle, which spoke to the Registrant's abilities as an osteopath and the trust they placed in her.

93. In Mr Grant's submission it was significant that the Registrant's employer was happy to carry on employing her, so she would continue to practise in a supportive environment. The Clinic Director had also provided two testimonials for the Registrant which were contained in the bundle before the Committee, and which expressed the high regard in which he held the Registrant as a "*thoughtful, conscientious and considerate colleague*".

94. Mr Grant said that the Registrant had demonstrated some insight in the partial admissions she had made.

95. Mr Grant said that the Committee should bear in mind the case of *Cohen v GMC* [2008] EWHC 581 (Admin) and ask itself whether the breaches in this case were remediable, or whether they had already been remedied, and whether the chance of such breaches being repeated was so remote that it did not affect the practitioner's fitness to practise.

96. Mr Grant said that the Registrant had remedied the problem in this case by stopping doing dry needling altogether. She had (as indicated in her statement) been shocked by these events and had expressed her clear intention not to offer dry needling ever again. Mr Grant therefore suggested that a conditions of practice order would be unnecessary and unhelpful in such circumstances.

97. Mr Grant submitted that the Registrant was a competent and reflective osteopath who was safe to return to practise. She was also currently the sole breadwinner in her family, with dependent children, The effect of any restriction of her practice would be little short of disastrous for her and her family, as she only got paid when she worked as an osteopath.

98. Mr Grant suggested that the appropriate sanction would be an admonishment. Having regard to the factors set out in the HSG relevant to admonishment, Mr Grant said there was no evidence that the Registrant posed any danger to the public. In addition: she had shown insight; her behaviour in the case was not deliberate as she was not seeking to hurt Patient A; there had been no repetition of the behaviour since the incident; the Registrant had genuinely expressed remorse to Patient A; she had taken rehabilitative steps in her practice and finally, the Registrant had a previous good history.

Legal Advice

99. The Committee heard and accepted the advice of the Legal Assessor. He reminded the Committee that, having found that the Registrant's actions amounted to unacceptable professional conduct, it was required to impose a sanction. The available sanctions are set out in Section 22 of the Osteopaths Act 1993.

100. The Legal Assessor reminded the Committee that it should take into account the guidance in the Council's Hearing and Sanctions Guidance 2019. The Legal Assessor reminded the Committee of the guidance contained in the well-known case of *Bolton v Law Society* 1994 1 WLR 512 which underlined that the purpose of imposing a sanction was not to punish a registrant, but to protect the public, maintain confidence in the profession and promote proper standards of conduct and behaviour. The collective reputation of a profession is more important than the fortunes of an individual member.

Determination on Sanction

101. The Committee took into account the submissions of the parties. The Committee considered the available sanctions from the bottom upwards on the scale of seriousness. It bore in mind that the sanction imposed must be proportionate, weighing the Registrant's interests with the public interest.

102. The Committee did not identify any particular aggravating features of the case. As regards mitigation, the Committee noted that:

- The Registrant was of previous good character;

- There was evidence of remedial activity following the incident. The Registrant has undertaken training in shared decision making and consent. Further, as set out in the letter from her Clinic Director, she had precipitated a number of positive changes at the clinic where she worked. This included proactively updating case histories for clarity of recording of consent, and updating of all the patient consent forms, as well as taking steps to improve the safety of dry needling within the clinic in which she worked, based on her own review of best practice, despite the fact she was no longer providing such treatment herself;

- The Registrant had appropriately expressed remorse and apologised to Patient A during her evidence;

- The Committee had heard evidence of the Registrant's personal circumstances at the time of the incident that had caused her a degree of stress, but which were now resolved;

- The Registrant had taken steps to avoid a repetition by ceasing dry needling;

- The testimonials received from patients attesting to her professionalism and the standard of her osteopathic care; and

- There have been no other concerns raised since the complaint came to light.

103. The Committee first considered whether to admonish the Registrant. The Committee took full account of the factors listed in the HSG at paragraph 64, which suggested the circumstances in which an admonishment may be appropriate. It also noted the submissions on behalf of the Council to the effect that this case was at the lower end of the spectrum of seriousness

104. In addition to the points in mitigation outlined above, the Committee considered that although the Registrant's dealings with Patient A involved a number of failings, it was an isolated incident in the context of her overall practice.

105. Further, it had not involved deliberate misconduct, and particularly with regard to her decision to amend and remediate her own practice (and seek to improve practice within her own clinic), the Registrant had demonstrated a degree of insight.

106. Concerning the question of danger to the public, the Committee found reassurance in the letter from the Clinic Director of her current employer, which stated: "[*The Registrant*] *ceased to use any dry needling in clinic from March 2022 and has explored with colleagues other modalities to employ within her treatment*", his assessment of the Registrant as bringing "*a professional, conscientious and compassionate approach to patient management*", the absence of any issues since this case arose, and the patient testimonials referred to above. It concluded that there was no current evidence that the Registrant posed any danger to the public.

107. The Committee considered that, viewed in the round, the Registrant's conduct had been at the lower end of the spectrum. Given the factors outlined above, the Committee concluded that an admonishment was an appropriate sanction in the particular circumstances of this case, and by marking the profession's disapproval, was sufficient to satisfy the public interest in promoting and maintaining proper professional standards and conduct for members of the osteopathic profession.

108. The Committee carefully considered whether a Conditions of Practice Order might be necessary to meet the justice of this case. Given the factors outlined above, the Committee concluded that a Conditions of Practice Order would be neither workable nor proportionate to the shortcomings identified in the case.

109. The Committee therefore determined that the Registrant should be admonished.

110. That concludes this case.