GENERAL OSTEOPATHIC COUNCIL

PROFESSIONAL CONDUCT COMMITTEE

Case No: 676/3413

Professional Conduct Committee Hearing

DECISION

Case of:	Mr Garry Hares
Committee:	Mr Alastair Cannon (Chair) Mr Colin Childs (Lay) Mr Kenneth McLean (Osteopath)
Legal Assessor:	Mr Gary Leong
Representation for Council:	Ms Rachel Birks
Representation for Osteopath:	Mr Paul Grant
Clerk to the Committee:	Miss Jemima Francis (13 – 17 January 2020) Ms Nyero Abboh (July 2020)
Date of Hearing:	13, 14, 16 & 17 January 2020 July 2020

When the hearing commenced in January 2020, it was held in the hearing room on the premises of the General Osteopathic Council and was adjourned part-heard. However, due to the Covid-19 pandemic crisis, when the hearing resumed in July 2020, it was conducted remotely using video and audio conferencing software (GoToMeeting). This ensured that all the participants were both visible and could be heard.

Summary of Decision:

The Professional Conduct Committee found particulars 1(a), 1(b), 1(c), 2(a) and 2(b) proved.

The Professional Conduct Committee found particulars 3(a), 3(b), 4, 5(a), 5(b), 6(a), 6(b)(i) and 6(b)(ii) not proved.

The Committee's full decision is set out below.

Allegation as amended at the hearing

The allegation is that Mr Garry Hares (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 three appointments with the Registrant on the following dates:*
    a. *23 September 2013 (Treatment 1)*
    b. *28 April 2015 (Treatment 2)*
    c. *11 May 2015 (Treatment 3)*

2. *At Treatment 1 and/or Treatment 2, the Registrant:*
    a. *massaged Patient A's groin;*
    b. *massaged Patient A's buttocks.*

3. *Before commencing the massages detailed at 2(a) and/or 2(b) the Registrant failed to:*
    a. *offer a chaperone; and/or*
    b. *obtain valid consent.*

4. *At Treatment 3, the Registrant prematurely ended the treatment session with no apparent reason for doing so.*

5. *The Registrant's conduct as set out at paragraphs 2(a) and/or 2(b) and/or 3(a) and/or 3(b) and/or 4 was:*

a. inappropriate; and/or

b. not in Patient A's best interests.

6. The Registrant's conduct as set out at paragraphs 2(a) and/or 2(b) and/or 3(a) and/or 3(b):

a. was sexually motivated; and/or

b. transgressed

i. professional boundaries; and/or

ii. sexual boundaries.

Background:

1. Patient A attended to be treated by the Registrant on three occasions in September 2013, April 2015 and May 2015. She described herself as a [redacted]. She attended the appointment with the Registrant in September 2013 for a sports massage, which she had booked through Groupon.

2. On the first treatment session, the Registrant treated patient A in her groin area and her buttocks. At the second appointment in April 2015, the Registrant treated Patient A's groin and her buttocks in the same way. On the third appointment in May 2015, Patient A asked the Registrant to concentrate on her legs, which the Registrant did.

3. Several years later, when Patient A was discussing the #MeToo phenomenon with several of her girlfriends, she came to the conclusion that the Registrant's treatment on the first two treatment sessions was so different from the treatment she received subsequently from various Sports Massage therapists, in that they had not treated her groin area or buttocks, that she concluded that the groin or buttock area are never massaged during a sports massage[redacted]. As a result she concluded that the treatment by the Registrant on the first two occasions must have been sexually motivated. Patient A concluded that the reason the third treatment

she received was shorter must have been because the Registrant "*had lost interest"* when she told him to concentrate on her legs alone.

Preliminary Matters:

4. In accordance with Rule 6 of the General Osteopathic (Professional Conduct Committee) (Procedure) Rules Order of Council 2000 ("the Rules"), the Committee considered whether there was any reason why any member of this panel of the Committee would not be eligible to hear this case. The Committee determined that there was no such reason.

Special Measures Application

5. Ms Birks, on behalf of GOsC, made an application for Patient A to give her evidence from behind a screen. She told the Committee that Patient A had indicated when she arrived today that she was more anxious about giving evidence than she had anticipated she would be.

6. Mr Grant on behalf of the Registrant did not object to the application for screens, although he did not accept that Patient A was a vulnerable witness.

7. The Committee accepted the Legal Assessor's advice. He advised that special measures are intended to enable vulnerable witnesses to give their best evidence. He further advised that just because a witness is eligible for special measures it did not mean that special measures should automatically be put in place. The use of special measures was always at the discretion of the Committee, striking a balance between the competing interests.

8. The Committee took into account the Council's Practice Note of 2014/04 on Evidence. The Committee was satisfied that Patient A, as the complainant in a case involving sexual misconduct, should be treated as a vulnerable witness.

9. The Committee went on to consider the application for screens. The Committee determined that the use of screens would be the least restrictive way to enable Patient A to give her best evidence. It took into account that Mr Grant would be able to see Patient A when she gave her evidence, and the Registrant would be able to see where Patient A indicates on the

mannequin (provided by the Council to assist the parties) where she says he treated her, and *vice versa.*

10. In those circumstances, the Committee determined that any disadvantage to the Registrant if screens were used could be kept to a minimum.

11. Accordingly, the Committee granted the application for screens.

Amendment of Allegation

12. Ms Birks, on behalf of the Council, applied to amend the Allegation. She submitted that the amendments sought were consistent with the evidence before the Investigating Committee, and that they served to clarify the allegation by giving better particulars.

13. Mr Grant, on behalf of the Registrant, did not object to the amendment.

14. The Panel accepted the advice of the Legal Assessor, who advised that under Rule 24 of the GOsC (Professional Conduct Committee) (Procedure) Rules 2000, it was open to the Panel to amend the Allegation and its particulars, provided no injustice would be caused by the amendments. The Panel considered that the amendments sought served to clarify the Allegation and the basis upon which the Council was now bringing its case and would not cause injustice. The Panel therefore allowed the amendments to be made. The amended Allegation is as set out above.

15. The Committee has carefully considered all the evidence in this case. It has noted the submissions of Ms Birks on behalf of the GOsC and Mr Grant on behalf of the Registrant. It has accepted the advice of the Legal Assessor.

16. The Registrant admitted Particular 1 but denied the remaining Particulars of the Allegation. Accordingly, the Committee found Particular 1 proved in accordance with Rule 27.

17. The Committee reminded itself that the burden of proving the facts is on the Council alone and that the standard of proof is the ordinary civil standard, namely the balance of probabilities.

18. On behalf of the Council, the Committee heard oral evidence from Patient A, and Dr De Coninck, an expert witness in Sports Massage and soft tissue

techniques. On behalf of the Registrant, the Committee heard oral evidence from the Registrant, and Mr Butler, an expert witness in Osteopathy. The Committee also received bundles of documents from each party.

19. Generally, both Patient A and the Registrant were hampered by the passage of time such that neither could recall events clearly. The Registrant was assisted by the patient notes that he had made at the time.

The Witnesses

Patient A

20. The Committee's assessment of Patient A was that this was not someone who was fabricating evidence nor actively seeking to mislead the Committee. Patient A freely admitted when she could not recall events.

21. In relation to Patient A, the Committee had concerns about the reliability of her evidence. It was only during a conversation with her friends about the #MeToo movement several years after the treatment, that Patient A began to wonder whether or not she too was a victim. There were parts of her oral evidence that were incongruous, for example the Committee did not find it credible when she said that if she had not been happy about the treatment at the time she would not have said something about it. Patient A presented as a confident and assertive person who would more than likely have voiced any concerns she had at the time with regard to any treatment she was receiving. The Committee determined that it was more likely that nothing was said because she was not sufficiently concerned at the time.

22. Patient A had formed a retrospective and settled opinion that the Registrant was not carrying out sports massage that was appropriate for [redacted] based upon conversations she had with other people about sport massage and her later experience of receiving sports massage on several occasions. Having formed that settled opinion, it appeared to the Committee she then presumed that the treatment provided by the Registrant could not be the treatment that she had sought and then further extrapolated that she must therefore have been the subject of a sexual assault by the Registrant.

Expert witness Dr De Coninck

23. The Committee found Dr De Coninck's evidence to be helpful in that she was doing her best to help in an impartial way. She was an open and honest witness. However, she was not an Osteopath and she was clear that her instructions were for her to give evidence based upon her expertise in sports massage. She acknowledged that she did not know anything about the Osteopathic Practice Standards. She trained in holistic massage and later specialised in sports and remedial massage.

24. Dr De Coninck told the Committee that trigger point techniques were included in sports massage curricula. However, not everyone who is a sports massage therapist ("SMT") would be trained in trigger point techniques. Only those who have trained to Level 4 and above would have been taught trigger point techniques.

The Registrant

25. The Committee found the Registrant to be an honest witness, albeit guarded and evasive at times under cross-examination. He answered the questions put to him to the best of his abilities and if he could not remember whether something had occurred, he was open and honest about it and did not attempt to speculate to fill in gaps in his memory. In assessing the credibility of the Registrant's evidence, the Committee also took into account his good character. The Legal Assessor had advised that character evidence of itself did not amount to a defence of any allegation and that is merely a matter to be taken into account when assessing the Registrant's evidence.

26. However, his recall of events was at best patchy due to the passage of time. He was assisted to a degree by contemporaneous notes made at the time and there was no reason to doubt their reliability. There was some overlap in his use of the words "massage" and "trigger point therapy". It was clear, from the overall evidence given by him and his notes, that his practice centred around trigger point therapy, which he stated was his default technique.

Expert witness 2, Mr Butler

27. The Committee found Mr Butler's evidence also to be helpful. He was an open and honest witness. He is an Osteopath and is familiar with the Osteopathic Practice Standards. He told the Committee that he was aware of what trigger point therapy was but that he had not trained in it. However, he has read about it extensively and recognised that some components of trigger point therapy overlapped with some of the treatment that he provides his clients as an Osteopath.

Determination on facts

Particular 1

1. Patient A attended three appointments with the Registrant on the following dates:

a. 23 September 2013 (Treatment 1)

b. 28 April 2015 (Treatment 2)

c. 11 May 2015 (Treatment 3)

28. The Committee finds Particular 1 proved based on the Registrant's admission.

Particular 2

2. At Treatment 1 and/or Treatment 2, the Registrant:

a. massaged Patient A's groin;

b. massaged Patient A's buttocks.

29. All the witnesses gave evidence with regard to this particular and made use of a mannequin to demonstrate the parts of the body that they were talking about. Both expert witnesses were present when Patient A and the Registrant gave evidence and were able to closely observe the parts of the mannequin to which the witnesses pointed.

30. The Registrant initially denied this factual particular on two grounds. Firstly, he did not accepted that he had treated Patient A's groin where she had

indicated and secondly, he had not massaged Patient A using the techniques she described. However, after hearing both expert witnesses define what the groin area encompassed, the Registrant accepted that where he says he treated Patient A was part of the groin. Both experts gave evidence that the points where the Registrant says he treated Patient A were at the outer edges of the region that they would consider to be the groin. Having heard the Council's expert, the Registrant now accepted that his trigger point technique was a massage technique.

31. Patient A told the Committee that she was a [redacted]. Several other [redacted] had told her that it was a good idea to have sports massage. Patient A told the Committee that she found a discount offered by the Registrant on Groupon for sport massage. She said she telephoned and booked an appointment for 23 September 2013. She said that she arrived and went into the treatment room where the Registrant asked her general preliminary questions such as whether she was on any medication. She told the Committee that at the time she was not aware that the Registrant was an Osteopath. When it was pointed out to her that the Groupon coupon also offered other services, including osteopathy, she said that she did not pay any attention to that as it was not relevant to her as she was only interested in sports massage.

32. Patient A said that she arranged and attended the second appointment with the Registrant because she had a [redacted]approaching and wanted to try another treatment to see if it would help and also because it seemed commonplace for [redacted] to have sports massage.

33. Patient A booked a third session with the Registrant specifically for her legs because that was where she thought she needed a massage as her quads and calves were apt to get sore. She confirmed that at that treatment she was only treated on her legs. She could not remember how long that session lasted, but she remembered thinking at the time, it was significantly shorter then the previous two sessions.

<u>Massage and Trigger Point Therapy</u>

34. There was initial dispute about whether the techniques used by the Registrant could be described as massage. When Patient A was asked what she meant by massage, she replied "pressing, kneading, pushing."

The Registrant said he did not use those massage techniques but rather used Trigger Point Therapy.

35. Dr De Coninck told the Council that sports massage is a specialisation that includes Swedish massage techniques and other soft tissue techniques. She said that sports massage was an umbrella term for a number of techniques and that one of those sets of techniques included Swedish massage, which features “pressing”, “kneading”. and “pushing”. She said that that would be the public's understanding of massage, whereas a SMT trained to Level 4 would understand that the term "sport massage" could include trigger point techniques. She said that Patient A's description of massage was that of Swedish massage.

36. Dr De Coninck explained that trigger point therapy is the treatment of trigger points, which are specific hyper-irritable nodules within muscle tissue, or tendon tissue, or connective tissue. It can be treated by a number of different techniques, which involve ischaemic pressure, which can be described as prodding or applying a static pressure. She said that this is different from massage, which is more of a dynamic treatment. She said that if a patient were expecting a massage (which included Swedish massage techniques) and a practitioner applied trigger point therapy, that patient might think that was a massage.

37. The Committee took into account the evidence of Dr De Coninck that whilst trigger point therapy was unique, sports massage is an umbrella phrase that can include that therapy. Furthermore Dr De Coninck’s evidence about trigger point therapy was that it can involve the application of pressure on a *trigger point* whilst moving the muscle.

38. In that sense, the Committee was satisfied that Trigger Point Therapy can fall within the definition of massage for the purpose of Particular 2. Patient A was clear that she was there for sports massage, and the Registrant was also clear that she was there for sports massage. The Committee was also satisfied that Patient A could reasonably have thought that the treatment being applied was a massage as she understood it, which included pressing, pushing and kneading.

<u>Placement of treatment during sessions 1 and 2</u>

39. Patient A said she was instructed to take off her tracksuit bottoms and lay down on the table, which she did and she was wearing a pair of shorts that were close-fitting. She told the Committee that the treatment started with

her lying on her back. She said that the Registrant then proceeded to massage her groin area and demonstrated on the mannequin the part that she meant. She acknowledged that she could not see his hands at the time that the treatment was applied. She said she was then told to turn and lie on her front and then the Registrant massaged both her buttocks. She said that only her groin and buttock areas were treated during the first session and she could not remember how long the treatment session went on for, as it had been several years ago. She said that she did not know that the Registrant was going to massage her groin area or her buttocks.

40. She said that after the treatment she felt surprise that the Registrant did not include her legs, which was what she had expected. However, she accepted that she had no experience of sports massage at that time. When she was asked questions by Mr Grant, she stated that she was not asserting that the Registrant did not treat her legs at all but rather she was concentrating on what she thought was the "*inappropriate bit".* She said that she was expecting a leg massage but that she could not remember if he did treat her legs or not.

41. She described the area that the Registrant massaged as being the ridges between the front of her genital area and each inner thigh - the crease that forms the top of the leg when the leg is bent upwards towards the body, on both sides. This was demonstrated, and marked, on the mannequin before the Committee and both experts. The area indicated by Patient A was the inner upper part of the thigh, which included the external genital area. As part of her documentary evidence produced by the Council, Patient A used an anatomical diagram of the thigh and pelvis to mark, with a cross, where she said the Registrant touched her. This mark is right on the *Adductor Longus* where it meets the *Obturator Externus.*

42. The Registrant said he did not treat Patient A where she indicated he had. The Registrant produced the notes that he made contemporaneously during the three sessions in question. He said that on each occasion he carried out trigger point therapy on Patient A. Although it is not recorded in his notes, he said that he recalled being told by Patient A that she was having problems with her [redacted] because it was such a unique phrase.

43. By reference to his notes, the Registrant described the treatment he provided Patient A on each of the appointments, and demonstrated the areas treated on the mannequin before the Committee and the expert

witnesses. He pointed to the medial muscles located on the outside of the hip. He also produced pictures using a model, served on the Council before this hearing, to show those areas.

44. He said that on the first session his notes indicated that he recorded the reduced strength of hip flexors, tensor fasciae latae, iliotibial band, hamstrings, gluteals and legs of Patient A. He said he was familiar with underperforming hip flexor mechanisms as he had dealt with that issue in the past and also from his own experience as a [redacted] himself.

45. He told the Committee that it was his normal practice to give a running commentary about what was happening and what was about to happen as he provided treatment to his patients. He said that this not only alerted them what was next as he treated them but also gave them a better understanding and an ability to start to take charge of their problems.

46. He told the Committee that after having heard Dr De Coninck's definition of the groin area he accepted that the medial muscles located on the outside of the hip were within the groin area. His previous understanding of the groin area was one that encompasses a smaller area and closer to the midline than where he treated Patient A. He told the Committee that there were muscles closer to the midline but he did not consider that they needed treatment as in the past (with other patients) he only needed to treat the outer region in order to effect an improvement in that group of muscles.

47. The Registrant told the Committee that on the second appointment the treatment he provided to Patient A was different because she presented complaining of bilateral buttock / upper hamstrings ache. According to his notes, on this occasion he used trigger point therapy to treat Patient A's buttocks and hip flexors. He said he found there was a weakness in the hip flexors that allowed him to skip the lumbar spine and focus on the hip extensors and leg muscles. He denied that he had touched or treated the inner thigh area that Patient A had marked on the diagram she produced.

48. Dr De Coninck told the Committee that if someone had a problem with [redacted], then it was clinically indicated that the practitioner would look at the hip flexors as the Registrant described. She agreed that the *bony landmark* indicated in the pictures produced by the Registrant is where a trigger point is located and where a therapist would apply trigger point therapy in order for that therapist to orientate themselves. She also confirmed that there were trigger points in the gluteals and that depending on what type of training an athlete is involved in, there could be trigger points

in the gluteus minimus. She said that there could also be trigger points in the actual gluteus maximus, which forms the bulk of the buttock muscle.

49. Dr De Coninck said that it would not be inappropriate to be examining or treating the buttock if she were examining the hamstrings in response to someone presenting, as Patient A did, with an issue to do with [redacted].

50. Dr De Coninck told the Committee that from her experience as both an educator and a therapist, terminology such as "hip" and "groin" mean different anatomical areas when they are used by general members of the public compared to when they are used by health practitioners. She said that the pictures produced by the Registrant showing finger placement, and the place he indicated on the mannequin, were within the area she considered to be the groin area.

51. Based upon the admission made by the Registrant and evidence before the Committee, it determined that the Registrant did massage Patient A's groin on Treatment 1 and Treatment 2. The Committee also accepted the Registrant's evidence that the area of Patient A's groin that he treated was where he had indicated – at the limit of the groin area. The Committee preferred the Registrant's evidence over that of Patient A because his evidence was more internally consistent and logical and was corroborated by his notes, whereas Patient A's evidence was an attempt to recall where he had treated her several years after the treatment.

52. The Committee therefore finds Particular 2(a) proved on the balance of probabilities.

53. Based upon the admissions made by the Registrant and the evidence before it, the Committee determined that the Registrant did massage Patient A's buttocks.

54. Therefore, the Committee finds Particular 2(b) proved on the balance of probabilities.

Particular 3(a)

3. Before commencing the massages detailed at 2(a) and/or 2(b) the Registrant failed to:

a. offer a chaperone;

55. It was not disputed that the Registrant did not offer a chaperone to Patient A during Treatment 1 or during Treatment 2.

56. The issue is whether he was under a duty to offer a chaperone. Ms Birks made it clear that when the particular alleges that the Registrant "failed" to make such an offer, it is alleging that there was a duty upon the Registrant to do so.

57. The Committee took into account that it had found that the Registrant did not touch Patient A's inner thigh but had treated the part where the hip bone was located.

58. The Committee also had regard to the Osteopathic Practice Standards 2012 ("OPS"). It noted that where guidance was given to Osteopaths as to actions to be taken, the Standards use the words "must, "may" and "should". The Committee determined that where the word "must" is used in relation to any action, that tells an Osteopath that it is mandatory, and where the word "may" is used, then it was at the Osteopath's discretion as to whether she/he decided to carry out the action. The Committee determined that the word "should" when used by the OPS was ambiguous but its intent lay somewhere between mandatory and absolute discretion and that it was a matter of degree. Based upon the evidence of the experts, the Committee determined that, depending upon the circumstances, a duty could be imposed upon a Registrant to offer a chaperone. The OPS standard C6.5 in relation to chaperone states:

5. You should ask a patient if they would like a chaperone when:

5.1. You examine or treat an intimate area.

5.2 You are treating a patient under 16 years of age.

5.3 You are treating an adult who lacks capacity.

5.4 You are treating a patient at their home.

59. The Committee also took into account that the OPS describes the groin area as an intimate area in paragraphs A2.5 and A4.8, but does not provide any anatomical definition.

60. Patient A told the Committee that the Registrant did not mention that she was entitled to a chaperone and she did not ask for a chaperone as she was not expecting to need one.

61. The Registrant said that he did not think a chaperone was required as he felt he was working far enough away from the midline of the body for that to be necessary. He said that this was a very frequent treatment that he would give to his patients. He said that until he heard the experts' evidence today, he did not think the area he treated was part of the groin area and therefore he did not think it was an intimate area at the time. He said that when he explained to Patient A what the treatment entailed she had not expressed any concerns or appear in anyway to have reservations about the proposed treatment and that if she had, he would have told her that she had the option of having a chaperone present. He said that if a patient wanted a chaperone he would arrange for a chaperone. However, he accepted that a patient can only decide if they need to have a chaperone if they know that is an option and that he did not tell Patient A of that option.

62. Dr De Coninck told the Committee that in her opinion any palpation or any touching around what the general public considers to be the groin may well be considered to be an intimate area. She said that the area that the Registrant indicated that he had treated Patient A was on the *lateral boundary* of what the general public would conceive to consist of the groin, and that the groin was not medically defined.

63. Mr Butler did not disagree with Dr De Coninck. He agreed that for therapists, the groin area starts laterally at the anterior superior iliac spine extending right across the junction of the thigh and abdomen to the medial part of the body, near the midline. He said that in many people's minds the groin area would most commonly refer to the genital area and also include the upper thigh and the upper inner thigh. He said that a reasonable body of Osteopaths would not consider the area of the groin where the Registrant treated Patient A to be an intimate area. He said that patients might, as individuals, nevertheless consider that area to be intimate. In his opinion, in the absence of any such indication by the patient, a large part of the osteopathic profession would not consider the area of the groin that the Registrant treated on Patient A to be an intimate area.

64. Mr Butler told the Committee that if there was to be any internal examination or any contact with the external genitalia or with the anal area, then it was a must that there should be a chaperone present, have written consent and

take particular care even though the word “must” is not used by the OPS in relation to the offer of a chaperone. In relation to the groin area that was treated by the Registrant (the anterior superior iliac spine), he said that the majority of osteopaths in practice, who were reasonable and respectable, would not offer a chaperone in the absence of any concern by the patient.

65. The Committee accepted the experts’ evidence that the area where the Registrant treated Patient A was on the boundary of what would be considered to be the groin area and as such it could not automatically be assumed to be an intimate area. It accepted the Registrant’s evidence that he did not touch Patient A’s genital area.

66. The Committee determined that in the circumstances, the Registrant was not under a duty to offer a chaperone to Patient A. Accordingly the Committee found Particular 3(a) not proved.

Particular 3(b)

3. Before commencing the massages detailed at 2(a) and/or 2(b) the Registrant failed to:

b. obtain valid consent.

67. Patient A told the Committee that she did not consent to the Registrant massaging her groin as part of the treatment. She said that if he had told her that he would massage the area she said that he had massaged, she would have said that she was there for a leg massage. She could not recall any specifics about the conversation prior to her treatment during the first two sessions but she did recall the Registrant asking her some questions in relation to her “*medical history, general history, age, etc*”. Initially she was clear that the Registrant did not explain what he intended to do during the treatment.

68. However, when Mr Grant provided more details of the conversation that the Registrant said had taken place and had recorded in his contemporaneous notes, Patient A recalled those details, for example a discussion about a [redacted], about a time that she had acted as a ‘guinea pig’ for a friend who was training to be a sport masseur and telling him that she was having difficulties in [redacted]. She also recalled that there was a diagram on the wall at the time. Initially she said she could

not recall if the Registrant had pointed it out. She then said she was sure he did not point it out to her or use it to explain his proposed treatment.

69. With regard to the second treatment session, Patient A told the Committee that she could not recall if the Registrant had reviewed how she felt about how the previous treatment had progressed but she was "*pretty sure*" he did not.

70. The Registrant told the Committee he always obtained informed consent before treating a patient. He said that his normal practice is to take a case history and then use anatomical trigger point charts in order to explain and highlight to his patients what is proposed. Whilst he has no independent recollection of doing so with Patient A, he said that his contemporaneous notes, whilst sparse, contained information that indicated that he had done so. He said that he believed he received informed verbal consent from Patient A otherwise he would not have proceeded with her treatment. He referred to the numerous testimonials from his other patients that he produced in evidence to demonstrate what his usual practice was before commencing treatment on his patients.

71. The Committee took into account all the evidence before it and reminded itself that the burden of proof lies upon the Council. Particular 3(b) depended upon the reliability of Patient A's evidence. The Committee did not find Patient A's evidence reliable. She initially said that she could not recall the conversation she had with the Registrant but she was sure that he did not explain the procedure to her. However, as details of the conversation were provided to her, she gradually accepted that those details were discussed but she remained adamant that he did not explain the treatment to her or she would have recalled it. The Committee determined that Patient A's recollection of events was unreliable and that the Council had not proved Particular 3(b).

72. On the other hand, the Registrant's Patient Notes record that he did take some form of history and that is consistent with what the Registrant says is his normal practice when obtaining consent from his patients. The Committee also took into account the testimonials provided to the Registrant by his patients that indicate what his normal practice is in relation to obtaining informed consent. The Committee reminded itself of the Legal Assessor's advice that it could take into account the Registrant's good character and testimonials insofar as they demonstrate what his normal practice was. The Legal Assessor had also reminded the Committee that

how the Registrant acted in the past is not necessarily determinative of how he acted on this occasion.

73. The Committee determined, on the balance of probabilities, that the Registrant had not failed to obtain Patient A's consent on both occasions.

74. Therefore the Committee finds Particular 3(b) not proved.

Particular 4

4. At Treatment 3, the Registrant prematurely ended the treatment session with no apparent reason for doing so.

75. Patient A's evidence initially was that after the Registrant massaged her legs she remembered putting her tracksuit bottoms back on and there was no further discussion between her and the Registrant about the massage. She said that there were just pleasantries and she left the clinic. However, when questioned by Mr Grant, she accepted that after the Registrant had massaged her legs there was a conversation about a form of breathing (Buteyko breathing) that the Registrant felt might improve her performance [redacted] She said that it was not something she took on board because it was not something she was interested in.

76. The Registrant told the Committee that on the third session, Patient A presented requesting that her legs be massaged specifically and therefore he applied Trigger Point Therapy to her legs only. He said after he had finished treating her legs, he had a discussion with Patient A about Buteyko Breathing, which he said would assist her [redacted] performance.

77. Ms Birks submitted that because the treatment was shorter than the previous two treatment sessions, the Committee can find that the Registrant had prematurely ended the treatment session. She initially invited the Committee to interpret the word "prematurely" as meaning earlier than Patient A expected. When it was pointed out that Patient A did not say she thought the treatment ended prematurely, merely that it was shorter than she expected, Ms Birks submitted that the interpretation of what is meant by "prematurely" was a matter for the Committee.

78. Mr Grant reminded the Committee of the evidence of the Osteopathic expert witness, Mr Butler. Mr Butler told the Committee that in relation to treatment provided by an Osteopath, there is no set time for each session and that "*it is hugely variable"*. He pointed out that there is no requirement in the OPS for an Osteopath to provide treatment sessions of any particular length of time.

79. Mr Grant submitted that the expert's evidence was that there is no timing for a treatment – it can be five minutes or it can be half an hour – but all Patient A says about the matter is that the third appointment was much shorter than the previous two.

80. The Committee determined that in order for the Council to prove this Particular, it must show that the Registrant ended the treatment of Patient A before completing it, or put another way, there was some part of the treatment left undone when it should have been done during that session.

81. The Council has not provided any evidence as to how the Registrant had failed to complete his treatment on that session, nor have they asserted what that treatment should have been, as opposed to the treatment provided by the Registrant.

82. Patient A's evidence about when the treatment ended is when the Registrant stopped massaging her legs. However, she does recall that after that treatment there was a discussion about Buteyko breathing.

83. The Committee determined that whilst there was evidence that the third session was shorter than the previous two sessions, there was no evidence that the Registrant's treatment session on the third occasion was ended prematurely and therefore the Committee finds Particular 4 not proved.

Particular 5

5. The Registrant's conduct as set out at paragraphs 2(a) and/or 2(b) and/or 3(a) and/or 3(b) and/or 4 was:

a. inappropriate; and/or

b. not in Patient A's best interests.

84. The Registrant's evidence is that the treatment he provided to Patient A was appropriate and in her best interest. He provided his justification for treating Patient A's groin area and her buttock during the first two treatment sessions.

85. Ms Birks submitted that these were matters of judgement for the Committee and that it should consider there had been a falling short of the OPS and how that impacted upon Patient A's experience. Ms Birks based her submission on the basis that the actions of the Registrant were carried out without Patient A's consent and that there was a duty to offer a chaperone. Ms Birks made it clear that the Council was not suggesting that the massage of the groin and buttocks would not be clinically indicated in a case like this. She further submitted that it was appropriate for the Committee to take into account that Patient A had an expectation that the treatment would involved a massage to her legs when considering the appropriateness of the treatment the Registrant provided her. She said that the context for the Committee's consideration of this Particular will depend on its findings in relation to the other particulars cross-referenced therein.

86. The Committee has found Particular 3(a), 3(b) and 4 not proved. Therefore it needed only consider Particular 5 in relation to Particular 2(a) and 2(b). In the context where the Committee has found that the Registrant had obtained valid consent and did not have to offer a chaperone, it determined that the only remaining issue was whether the treatment was clinically justifiable.

87. The Committee was of the view that it could consider this Particular as a whole because if the conduct of the Registrant as set out at Paragraph 2 was inappropriate, it would necessarily also not be in Patient A's best interest and vice versa.

88. The Committee considered the evidence of the experts to be the important factor in relation to this particular. Both experts, one a SMT and the other an Osteopath, say that the Registrant's treatment on both occasions was clinically justified from the perspective of their respective professions.

89. In that context, the Committee finds Particular 5 not proved.

Particular 6(a)

6. The Registrant's conduct as set out at paragraphs 2(a) and/or 2(b) and/or 3(a) and/or 3(b):

a. was sexually motivated; and/or

b. transgressed

i. professional boundaries; and/or

ii. sexual boundaries.

90. Again, as the Committee has found Particular 3(a), and 3(b) not proved, it need only consider Particular 6 in relation to Particular 2(a) and 2(b).

91. Ms Birks submitted that the Committee should adopt the two stage test set out in the case of *R v H [2005] EWCA Crim 732 and* firstly consider whether the reasonable person could consider the Registrant's conduct could be sexual in nature and then, consider whether in all the circumstances the reasonable person would consider the touching to be sexual. She submitted that if the Committee preferred the evidence of Patient A in relation to where the groin was touched, then the relevant circumstances would be that the Registrant was under a duty to offer a chaperone and had not offered one, and whether he had obtained valid consent for his treatment.

92. Ms Birks also submitted that in order to find sexual motivation on the part of the Registrant, the Committee would need to identify acts or behaviour designed or intended to arouse or gratify sexual impulses or desires.

93. The only reference that the Registrant's conduct might be sexually motivated is the speculation by Patient A as to why the Registrant left the room at one point during the first session. Such speculation is not evidence and the Committee could not, and would not, place any weight on it. It was clear that such speculation had no basis whatsoever in the light of the fact that Patient A said "*I did not notice anything unusual about Mr Hares in his appearance or speech, nor did I observe any change to his body language."*

94. The Committee reminded itself of the advice of the Legal Assessor in regard to sexual motivation. He also referred to the case of *R v H* and the two-stage test. He advised the Committee to bear in mind that sexually motivated conduct was one of specific intent and cannot be committed recklessly nor negligently. He also advised the Committee that it was a very serious allegation to be made against any person and that the more serious the allegation, the less likely it is that the event occurred and the stronger

should be the evidence before the Committee concludes that the allegation is proved on the balance of probabilities.

95. The Committee adopted the two-stage test referred to by Ms Birks. The Committee was aware that the reasonable person alluded to by Ms Birks would have knowledge of all the evidence before the Committee, the findings of the Committee in relation to the facts and also that this reasonable person would not be unduly suspicious. This reasonable person would also take into account the Registrant's good character.

96. The Committee determined that if the reasonable person took into account the context where the treatment provided by the Registrant was confirmed by two experts from two different but relevant professions as being clinically indicated and appropriate and that there was no sign, nor evidence of sexualised behaviour on the part of the Registrant, that reasonable person could not consider that the touching could be sexual in nature.

97. Therefore, the Committee determined that Particular 6(a) is not proved.

Particular 6(b)

> *6. The Registrant's conduct as set out at paragraphs 2(a) and/or 2(b) and/or 3(a) and/or 3(b):*
>
> *b. transgressed*
>
> *i. professional boundaries; and/or*
>
> *ii. sexual boundaries.*

98. As indicated above, the Committee need only consider Particular 6 in relation to Particular 2(a) and 2(b).

99. There was limited evidence provided by the Council as to what it meant by the phrases *"professional boundaries*" and *"sexual boundaries"*.

100. Mr Grant submitted that in professional relationships, individuals use their expert knowledge to meet the needs of their clients. Therefore "professional boundaries" are the limits within professional relationships that allow for safe connections based on the needs of individuals. He submitted that there was no evidence that the Registrant was doing anything other then using his expertise to try and help Patient A.

101. In relation to professional boundaries, the Legal Assessor advised the Committee that when considering whether there has been a breach of professional boundaries the Committee should take into account that professional boundaries exist to protect client interests. He also advised that breaches of professional boundaries usually involve actions or conduct that benefit the practitioner and are generally to the detriment of the client, in the light of a relationship where there is an imbalance of power.

102. In relation to sexual boundaries transgressions, the Legal Assessor advised that even the Council for Healthcare Regulatory Excellence (now known as the Professional Standards Authority for Health and Social Care) found that there are difficulties around definitions of sexual boundary violations. He advised that it is not easy to define what is meant by the phrase “sexual boundaries” as used in the allegation. He suggested that in the context, a breach of sexual boundaries involve a breach of professional boundaries where sexual actions and feelings have entered into the relationship. However, he made it clear that it was a matter for the Committee whether it accepted that definition, and that it was proffered merely as one possible interpretation.

103. The Committee took as its starting point that it had already determined that there had not been a failure by the Registrant to obtain consent, that his treatment had not been applied with sexual motivation and that his treatment of Patient A was clinically justified.

104. The Committee also took into account paragraph D16 of the OPS. Whilst it deals with professional and sexual boundaries without defining either, it is clear that Paragraph D16 is about the need for Osteopaths not to abuse their position of trust, particularly in the context of an Osteopath/patient relationship where an imbalance of power exists.

105. The Committee determined that the Registrant had not abused his position of trust in relation to Patient A and that there was no transgression of professional or sexual boundaries by him.

106. Therefore, the Committee determined Particular 6(b)(i) and 6(b)(ii) are not proved.

Determination on Unacceptable Professional Conduct

107. The Committee next considered whether the facts it had found proved amounted to conduct falling short of the standard required of a registered osteopath – namely, whether they amount to unacceptable professional conduct ("UPC").

108. In the light of the Committee's finding above, the Council determined that it did not wish the case to proceed any further and made no submissions as to whether the matters found proved amount to Unacceptable Professional Conduct.

109. Mr Grant did not make any submissions in the light of the Council's position.

110. The Committee bore in mind that there is no standard of proof to be applied at this stage and that the consideration as to whether the threshold for unacceptable professional conduct has been reached is a matter of judgment. The Committee took into account the guidance of Mr Justice Irwin in *Spencer v The General Osteopathic GOsC [2012] EWHC 3147 Admin)* in which it was stated that a finding of UPC implies "*moral blameworthiness and a degree of opprobrium*.

111. The Committee considered that the facts found proved occurred within a normal professional clinical setting. The Committee determined that the facts found proved did not breach any of the Osteopathic Practice Standards and nor was there anything untoward in the Registrant's treatment of Patient A. Therefore the Committee determined that the Particulars 1 and 2 did not amount to Unacceptable Professional Conduct.

112. Therefore the Allegation is unfounded.

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 nature of the Allegations and the steps taken by the Committee in respect of the osteopaths so named.