GENERAL OSTEOPATHIC COUNCIL

PROFESSIONAL CONDUCT COMMITTEE

Case No: 900/5129

Professional Conduct Committee Hearing

DECISION

Case of:	**Martin Grundy**
Committee:	Lakshmi Ramakrishnan (Chair) Sarah Cant (Lay) Tom Bedford (Osteopath)
Legal Assessor:	Jon Whitfield KC
Representation for Council:	Sarah Przybylska
Representation for Osteopath:	Phillip Vollans
Clerk to the Committee:	Sajinee Padhiar
Date of Hearing:	18,19,20,21,22 November 2024 20 December 2024 27 March 2025

Summary of Decision:

Case Number

The Committee found proved
Allegation 1, 2a, 2b, 2c, 2e, 2f, 2g,
3a in relation to allegations 2b, 2c, 2e, 2f, 2g
3b in relation to allegations 2b, 2c, 2e, 2f, 2g
3c in relation to allegations 2b, 2c, 2e, 2f, 2g
3d (part 1, professional boundaries) in relation to allegations 2b, 2c, 2e, 2f, 2g

The Committee found not proved
Allegation 2d
3a in relation to allegations 2a, 2d
3b in relation to allegations 2a, 2d
3c in relation to allegations 2a, 2d
3d (part 2, sexual boundaries) in relation to allegations 2a – 2g

3e in relation to allegations 2a – 2g
3f in relation to allegations 2a – 2g
3g in relation to allegations 2a – 2g

UPC: Found proved

Sanction: The Committee determined that the appropriate level of sanction was one of admonishment.

Allegation 839/2855

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

1. **Patient A attended one appointment (the Appointment) with the Registrant on 9 September 2022 (the Appointment)**
   Admitted. Found proved

2. **At the Appointment, the Registrant:**
   a. told Patient A that he was going to check her pelvic floor; and/or
   Admitted. Found proved
   b. slid his hand under her underwear onto her pubic bone; and/or;
   Denied. Found proved
   c. told Patient A "I could do this through her clothes, but I prefer skin to skin", or words to that effect; and/or
   Denied. Found proved
   d. lifted the same hand to his nose and/or sniffed his fingers, after taking his hand away from Patient A's pubic bone; and/or
   Denied. Found not proved
   e. made audible grunting and/or sighing noises whilst touching Patient A;
   Admitted. Found proved
   f. failed to ask Patient A whether she wanted a chaperone present; and/or
   Admitted. Found proved
   g. failed to obtain valid consent from Patient A.
   Admitted. Found proved

3. **The Registrant's conduct at Particular 2:**
   a. was inappropriate;
   Denied
   Found proved in relation to allegations 2b, 2c, 2e, 2f, 2g
   Found not proved in relation to 2a, 2d
   b. was unprofessional;
   Denied
   Found proved in relation to allegations 2b, 2c, 2e, 2f, 2g
   Found not proved in relation to 2a, 2d
   c. was not in Patient A's best interests;
   Denied
   Found proved in relation to allegations 2b, 2c, 2e, 2f, 2g
   Found not proved in relation to 2a, 2d
   d. breached professional and/or sexual boundaries;
   Denied
   Found proved in relation to professional boundaries regarding allegations 2b, 2c, 2e, 2f, 2g
   Found not proved in relation to professional boundaries regarding allegations 2a and 2d

Found not proved in relation to sexual boundaries

e. amounted to sexual touching;
Denied
Found not proved

f. was sexually motivated.
Denied
Found not proved

Preliminary Matters:

1. The Committee was informed at the start of the hearing that the expert witness to be called by the GOsC was not available on Monday afternoon, Tuesday, or Wednesday morning. The matter was discussed between Counsel Ms Przybylska (for the GOsC) and Mr Vollans (for the Registrant) and the Legal Assessor and thereafter with the Committee. The parties agreed and the Committee determined that the case should proceed in the expectation that it was likely to be part heard, rather than adjourn the case entirely. Neither party sought an adjournment. The principal witness was in attendance to give evidence, and the Registrant was also understandably concerned by the prospect of delay. The Committee considered that adjourning the case would not meet the overarching objective of public protection and would be unfair to both Patient A, and the Registrant.

Summary & Opening

2. Ms Przybylska read the Allegation into the record. Mr Vollans advised that Allegations 1, 2a, 2e, 2f, 2g were admitted, Allegations 2b, 2c, 2d and 3a – 3f were all denied.

3. Ms Przybylska referred the Committee to the written documentation and outlined the case in brief. She said that the Registrant practised in Witley Bay. He saw Patient A who was complaining of pain in her back and hip. He saw her without a chaperone. He took a history and asked for consent prior to touching her body. During the period when the Registrant touched Patient A he made loud grunting noises. He touched her upper chest then moved to the solar plexus and then he moved his hand under her clothes and inside her knickers. As he did this he said he was checking Patient A's pelvic floor.

4. Ms Przybylska submitted that Patient A described the Registrant's bare hand as being on and covering her pubic mound. The Registrant said he 'preferred skin on skin' and asked if Patient A was OK. Patient A was not expecting this since the Registrant had not mentioned the pelvic floor. Thereafter the Registrant lifted his fingers to his nose in what Patient A described as a 'sneaky' action. Following discussion with a friend Patient A complained to the police.

5. Ms Przybylska further submitted that the Registrant said he could not remember Patient A but said that he used his own technique to balance the pelvic floor with one hand under the sacrum and the other on the front of the body. He told patients to tell him if they were uncomfortable [where he was putting his free hand] but in any event he would not go lower down the body than the pubic bone. He could not remember Patient A. It was a joke at the practice that he huffed and puffed a lot.

Evidence

Evidence for the GOsC

6. Patient A was shown her witness statements dated 30 October 2023 and 10 June 2024. She confirmed that the contents were true since she had taken time to ensure that what was said was correct. Mr Vollans then asked questions in cross-examination.

7. Patient A agreed that she attended an appointment at the Registrant's practice. She said she was greeted by a lady at the front desk. When the consultation concluded she went to reception to pay and spoke to someone but she was not sure if it was the same lady as she spoke to on arrival. Mr Vollans suggested that at this point Patient A had an opportunity to raise her concern about the Registrant. Patient A replied that the Registrant had gone quite heavily into things about consent but when one is lying on a bed in the hands of a professional you don't question their work. She said there were certain things that occurred about which she was not happy. It was suggested she had the opportunity to stop anything that concerned her and she said '*possibly yes but it all happened quickly'*. She continued to say '*when I came out I was confused a lot of things happened in the last couple of minutes'.* She then asked herself 'what is going on here?' and said if she had been thinking straight she would have complained but she did not like confrontation and did not raise her concerns at the time.

8. Patient A confirmed that Dylan, a long-time friend who she trusted, had recommended the Registrant to her. She again said she spoke to the receptionist following the consultation. Mr Vollans referred Patient A to a passage in her statement which jogged her memory that she had spoken to the receptionist about where she (Patient A) had lived and the receptionist had said the Registrant was nice. She said she may also have spoken to a member of the public since she was a chatty person but she had no clear recollection of this. Some time later she spoke to "J" (an employee at GOsC) and answered questions.

9. Mr Vollans then took Patient A through the sequence of events. She agreed that the Registrant met her by the waiting room and invited her into the consultation room. He sat at his desk, she sat on a chair next to the desk, it was much like seeing a doctor. She had not been to see an osteopath since about 1998 but was aware there would be an assessment and that the Registrant would be manipulating part(s) of her body. Patient A said the Registrant spoke of the matter of consent '*pretty much straight away'*. She described it as being raised '*repeatedly, excessively*', saying '*if I touch you here again and again'*. She said that the Registrant said it so many times she found it odd. She could not remember the exact words he used but it was along the lines '*you must consent or if there is something you must let me know'*. She said that the words '*you must consent'* were used repeatedly to the point where she thought '*in my head, yeah OK I get it you know'*. She said that the verbal

assessment of her complaint was a couple of minutes, most of the talking was about consent. She agreed the discussion may have been for about eight minutes and she said she was thinking '*come on I am here for treatment*'.

10. Patient A described herself as quite open and able to express what had been asked of her. She said she might inquire why an apparently irrelevant question was asked of her but she had no reason to inquire up to this point of the consultation. She said that consent was not a concern to her and she wondered if this was now how the UK health system operated (she later explained she had been abroad) but she had no concerns. Patient A agreed that they discussed her lifestyle and activities but she did not recall if the Registrant was assessing if osteopathy may help her or not. She had gone in for treatment. Up to this point there had been no physical contact.

11. Patient A confirmed that she and the Registrant both then stood up and she asked if she needed to remove her upper-body clothing but the Registrant said '*no I can work through clothing*. She could not recall him telling her to keep her clothes on, rather she said he had told her he could work through her clothes. She said that apart from the consent thing (ie the oddity of its repetition) she had no concerns. During the standing assessment Patient A said that the Registrant said something about her hips and something else. Whilst she was standing he had examined down her back asking her to bend over. She was not concerned since she had leggings and a long-sleeve t-shirt she had worn to ensure the Registrant could see her body. She arrived wearing a kimono but could not recall at what point she had taken this off but she was not wearing it when she lay on the bed (treatment couch).

12. When she lay on the treatment couch Patient A described Registrant putting his hands on her upper chest, between her neck and cleavage. He then asked if it was OK to touch her at this point. She said yes. He did not explain where he would touch her next but he moved his hands to below her breasts and again asked if it was OK. He next moved his hand under the waistband of her leggings and touched between her naval and her pubic area. She said this surprised her. Patient A confirmed that the Registrant did not ask for permission before he moved and/or placed his hands on her. Instead he placed them on her and then asked if it was OK to touch and she said yes. She said that once he was touching her '*the noises started*'. She said that she had experienced this abroad with other types of treatment such as shamanic energy work but she did not expect it here in North Tyneside. The Registrant did not explain it and she did not ask. She was not sure if it was grunting, sighing or a sound of relief/release. She said it was loud and she found it odd albeit not odd enough to say anything.

13. Patient A reiterated that the Registrant touched her upper chest then moved to the area of her solar-plexus and put his hands at these locations for about 90 seconds. Each time he asked if it was OK and she said yes. She said he '*then went further down and he slid his hand into my leggings below the naval in the area of the sacral chakra*'. She confirmed he put his hands into the band of her

legging and touched her below her naval. He did not touch her naval but '*he put his hand into the band of my leggings and touched not on my belly button but below that where the sacral chakra would be*'. She said her leggings were covering her belly button. She again said the Registrant's hand was '*between her waist and her pubic area'*.

14. Mr Vollans took Patient A to a point in her statement where she described the Registrant touching her belly button and she clarified this saying that the base of the Registrant's hand would have been on/touching her belly button but he was not using his fingers to purposely touch this, his fingers were lower. She agreed the Registrant's hand would have been in this position for about 90 seconds. Again she described the Registrant asking if it was OK to touch her there and she said yes albeit she found it odd and was shocked that he had gone into her leggings particularly since he had said he could work outside her clothing. His action was not explained and not expected. Patient A then said, '*he put his hand under my leggings and then put his hand into my underwear and at that point he said he was checking my pelvic floor'*. She confirmed he was moving his hand as he said this.

15. Patient A accepted that it was some time after these events that she made a complaint to the police. Mr Vollans took her to a part of the written record of that complaint. Patient A said that the document was not written by her but was written by a police-officer. She repeated that the Registrant's hand was already moving and '*down there'* and '*in the band of my underwear'* when he spoke of her pelvic floor. Mr Vollans suggested that the Registrant had spoken before moving his hand however Patient A rejected this and said, '*he did not move his hand afterward . . . his hand was actually moving under the band of my underwear as he said that*.' She said she recalled the Registrant touching her. She was not aware of the pubic symphysis so she looked up anatomy to ensure what she said was accurate. She confirmed she knew where her pelvic floor was and the female anatomy. She said she was lying down on a [treatment couch] with a professional and she did not want to question his expertise but she had attended with a back problem and, although she knew osteopathy was a holistic treatment, her pelvic floor had not been discussed.

16. When she was asked where the Registrant placed his hand Patient A said the Registrant was covering '*the full triangle*' (referring to her pubic area). She said, '*his hand did not go inside (ie inside her vaginal canal) but it was covering . . . his hands did not stop at the top (of her underwear), his hand went right in there*.' Patient A agreed she had said yes to the touching and said she had seen doctors for smears etc. she said it was not her best grammar but she was not expecting what he did. She agreed that the correct terminology of where the Registrant touched was 'mons pubis' and that she had told the police officer the Registrant had placed his whole hand over her vagina. However, when it came to making her own statement she had looked up the proper term. When speaking to the police officer she had referred to vagina not as the vaginal canal but the triangle between her thighs. She confirmed that his hand went to '*where it starts to bend*' [meaning where the body curves under, beneath the

pubis] she then said, '*his hand went to the gusset of my underwear. . .it went inside my underwear it went as far as it could go'*. Mr Vollans suggested that the Registrant did not put his hands into her underwear and she retorted that '*he did go into my underwear'*. She said that the Registrant did not explain what he was doing until his hand was fully into her underwear and it was then that he mentioned her pelvic floor.

17. Patient A confirmed the Registrant's hand had been in her underwear for about 60 seconds. Mr Vollans asked if Patient A thought this had been a 'sexual touching' and she replied '*I don't know. . .not for me it wasn't'*. She confirmed that when the Registrant's hand was inside her underwear he did not move his fingers – nor had he done so when he had touched her body elsewhere. It was put to Patient A that the Registrant had said her hips were locked. She said that she had since seen five other osteopaths and none had touched her as the Registrant had or said they needed to. She said the last time he touched her his hand was '*fully inside my underwear*.'

18. Following the Registrant removing his hand Patient A described the Registrant as turning away from her and lifting his hand to his nose. She described him rubbing his fingers along under his nose three times and said, '*that was a lightning bolt to me what the hell was that*'. It was at that point she was thinking what had just gone on. It was suggested that the Registrant had just scratched his nose. Patient A rejected this and said he had sniffed his fingers rubbing them along under his nose three times. Mr Vollans put to Patient A that in her police statement she had commented that the Registrant may have been scratching his nose. She said she had mentioned scratching as a hypothetical but '*you don't do it with two fingers rubbing under your nose'* and she did not believe he was scratching his nose.

19. Mr Vollans suggested that Patient A had confused matters but she rejected this and said the Registrant had abused his position. She said '*if I rubbed my hand under my nose what would you think. It did happen and he knows it happened*.' She said following the consultation she went into reception but had no recollection of booking another appointment and was puzzled by the rebooking because the Registrant had said he did not need to see her again.

20. There was then a short break during which an anatomically correct diagram was produced at the request of the Committee. The diagram was agreed and put to Patient A. She confirmed that the Registrant had put his ungloved hand into her underwear '*right into the gusset'*. She confirmed this by marking the diagram showing the tip of the Registrant's fingers at the base of her vulva. She said, '*his hand did not curve but it was right in'*. She rejected the suggestion that the Registrant's hand did not go below her pubic bone.

21. After she left the practice, Patient A described sitting in her car thinking '*woah what happened*'. She said she had a cigarette and tried to piece it together. Later she spoke to a friend of hers, 'D' a nurse in America because '*something did not sit right with me*'. She described where D had worked including in

maternity and confirmed she was a nurse based in America. She agreed nurses worked in healthcare and would have rules of conduct. Patient A confirmed that when she told D what had happened, D had described the Registrant as 'a dirty bastard' and had said that not providing a chaperone and not using gloves were also unethical for a medical professional. Patient A said her head was spinning since she thought what had happened was not right. She confirmed she had told D what had happened. She also told another friend 'J' who could see that something wasn't right. She said the thought of it all weighed heavily on her and she told the police. She had spoken to J at GOsC in around October to see if what the Registrant had done was normal. She was asked if she wished to complain but at the time she had too much going on in her personal life to do so. Patient A said she had told 'Dy' about what had occurred and he felt bad. However his girlfriend said nothing like that had happened to her when she had seen the Registrant. It was then that she phoned the GOsC but did not put in a complaint.

22. However, in around June 2024 a friend 'S' was due to see an osteopath and had sent a photograph of the Registrant to ask Patient A if this was the person she was concerned about. She said '*I recoiled'* at the photograph. S then went on to talk about hypnotism and neuro-linguistic programming (NLP) which Patient A understood to be the use of repeated suggestions as used in sales-pitches. She said it then made sense why he had repeatedly talked of consent and why she had not said anything at the time. It was then that she phoned the police. She agreed the consultation was 30 minutes long and said 8 minutes of talk seemed like a long time and confirmed the Registrant said *'you must consent . . . I touch you here you must consent*.' She said that NLP made sense to her regarding why she did not say anything when she was on the treatment couch. She said she did not know if the Registrant used NLP upon her but he used the term consent many times and this is how NLP works. They did not talk of NLP. She said he repeatedly mentioned consent in the discussion and asked once each time she was touched.

23. Patient A said that reporting the matter to the police was traumatic and she understood what they were investigating/considering. She was concerned that the chronology should not be minimised as to what went on. She agreed that the consultation was an unfamiliar process with an unfamiliar person but she said she had had many medical and holistic treatments. She reiterated that the Registrant had repeated the term consent; that his touching made her feel uncomfortable albeit she did not say so at the time; she was not offered a chaperone and the noises the Registrant were very odd. He did not explain them. She said the Registrant touching her was not sexual in the sense that he was coming on to me but '*it is often linked with different things if you look'*. She said that the Registrant violated her body and her trust and she believed he sniffed his fingers and did not scratch his nose. Her thoughts were validated when she discussed them with her friend D who was a nurse and midwife but not an osteopath. She said she told her friends exactly what happened as she had said in evidence and there was nothing different in her statement as told to the police.

24. In re-examination Patient A confirmed the Registrant did not mention her pelvic floor before he touched her rather he did so '*as he was doing it'*. She repeated that he had said he could work through clothes but he preferred skin on skin. She said this was a very vulnerable area to touch and skin on skin felt very odd. The Registrant did not explain why he was examining or treating her pelvic floor nor did he explain the risk or benefits of this.

25. In response to questions from the Committee, Patient A could not recall if the Registrant had asked her to lie on the couch to continue examining her or whether it was to treat her. She agreed she had described what the Registrant had done with one of his hands. She could not recall clearly what he had done with the other. She felt that when he had one hand on her solar plexus perhaps he had his other hand under her spine but she was not sure of this. She did not feel any movement of her body indeed his hand remained flat and did not move wherever he placed it. She said she did not focus on his other hand particularly when he had one hand near or on her pubis area. She said she did not feel physically different after the treatment just very confused. She said when the session concluded the energy in the room changed. She said the treatment did not help with her presenting problem and she had seen several chiropractors and osteopaths since.

26. Ms Przybylska called Mr Hearsey as an expert witness to assist the Committee. He confirmed his expertise and adopted his two reports dated 30 May 2024 and 10 November 2024. Ms Przybylska asked for his opinion concerning the Registrant's method to examine Patient A's pelvic floor namely that he used skin-on-skin contact between himself and a patient and advanced his hand down the body from solar plexus toward the pubis until the patient says stop, if she did not say stop he would stop at the pubic bone. Mr Hearsey said he would not expect a reasonably competent osteopath to make skin on skin contact for that approach. He described the Registrant's approach to assessing the pelvic floor as an indirect one and it did not require skin to skin contact. He could see no benefit in such contact and, given that the Registrant's technique took his hand close to the pubis, an intimate area, he would expect a reasonably competent osteopath to offer a chaperone. He described the Registrant's alleged use of his bare hand on Patient A's pubis as far below the competence required of a registered osteopath.

27. As to the Registrant's method of using skin to skin contact and advancing his hand toward the pubis whilst relying on a patient to say it was OK or stop, Mr Hearsey said that would require a clear consent process. It did not just involve use of the word 'consent' but would require a clear explanation so that a patient could understand what is to happen, where it would happen and whether to use a chaperone. He said that the Registrant's failure in this respect meant that both he and Patient A were at risk and again he said that the failing was far below the competence required of a registered osteopath.

28. Regarding the description of the Registrant placing his hands in various positions and asking if that was OK, Mr Hearsey confirmed his opinion that this did not comply with the modern standards of consent. He said that it sounded as if the Registrant was using contact on Patient A's sternum but that he should have checked before he did so. He said the check mechanism (ie checking after contact is made) is valid but it required consent before the touch. He said that a patient should be aware in advance of what was going to happen. He said it is good practice for a patient to be aware what is going to happen before it occurs, not in the minutiae of each exact touch but sufficient to know in advance. Based upon Patient A's account of skin on skin contact with no mention of the pelvic floor he said that an adequate consent process did not take place. As to her description of the Registrant's hand covering her pubic mound and him making contact with her pubic hair, Mr Hearsay said '*that is not a recognised osteopathic practice, no*.'

29. Mr Hearsey was then cross-examined. Mr Vollans reminded the witness that the Registrant accepted there was skin to skin contact, that he did not offer a chaperone and that valid consent was not obtained. Mr Hearsey said that the Registrant's techniques were recognisable from an osteopathic viewpoint but that the examination was incomplete in that the Registrant should have conducted a neurological examination of Patient A before treating her. Mr Hearsey conceded that osteopaths may in some instances combine assessment and treatment, but that was not a safe approach when a patient had a potential mechanical cause for their symptoms. He agreed that the Registrant had a plausible, coherent and safe method of treatment regarding Patient A. Regarding both the validity of consent and the safety of combining assessment and treatment, Mr Hearsey said that the approach must be explained to the patient. In addition, the necessity to examine the cause of symptoms trumped the method of treating and assessing at the same time. It was not appropriate to use the assess/treat method from the start. He regarded the Registrant's osteopathic examination as insufficient to assess the reason for Patient A's complaint. Any working assumptions should only follow examination and the assessment. Mr Hearsey remained of the view that the examination was incomplete without a neurological assessment.

30. Turning to the method the Registrant used, Mr Hearsey agreed that the Registrant palpated (ie touched) Patient A's muscles and this was not necessarily invasive. He said that 'with some exceptions' the Registrant was using recognised osteopathic approaches toward Patient A. He agreed there was no stretching of muscles albeit the tissues would move a little. He repeated that the approach was risky without a neurological examination and he rejected the suggestion that such an examination could take place during or after a cranial approach and manipulation. Mr Hearsey said it may have been safe to treat Patient A in the absence of the neurological examination but, that was the problem, he did not know. He agreed that cranial osteopathy was a non-invasive treatment involving no gross manipulation/movements.

31. Regarding the issue of skin on skin contact, Mr Hearsey said that this should make no difference to the Registrant. He said that gloves should make no difference and a reasonably competent osteopath would be expected to get used to them quickly. Mr Hearsay commented that thin clothing was like a further layer of skin. He observed that the Registrant said he could work through clothing so he did not understand why he should change to skin-contact when touching the lower abdomen.

32. When asked about Patient A's best interests, Mr Hearsey said he recognised what the Registrant was trying to do but he did not understand the need for skin-contact. As to a chaperone, Mr Hearsey said that the Registrant was working on an intimate area of Patient A namely her pubis and that a chaperone should have been offered. He said that the cranial approach to the pelvic floor meant that treatment could be conducted from the head or the sternum and there was no need to contact the pubis. He said that a chaperone protected both a registrant and a patient and its rejection by a patient should be recorded.

33. Dealing finally with consent, Mr Hearsey said that to be valid, consent must be voluntary, informed and given by a patient with capacity to make the decision. Consent could be sought during treatment but it should be obtained at the outset mapping out what was to occur revising this if need be as the assessment/treatment progressed. Finally, Mr Hearsey said that he had provided his opinions on the basis of what the Registrant accepted as likely, namely that he had touched Patient A's pubic bone. He was however aware of Patient A's evidence.

34. In re-examination, Mr Hearsey said that his comment regarding the propriety of using gloves or a patient wearing clothes were not the question, rather it was whether it was clinically necessary for the Registrant to touch Patient A under her clothes.

35. In response to questions from the Committee, Mr Hearsey explained his understanding and experience of cranial osteopathy and said that how and from which part of the body a cranial osteopath worked from was 'murky'. He said that cranial osteopathy lent itself to functional movement but treatment was done mainly from the scalp. There was no definitive answer as to what cranial osteopathy involved and a patient would experience light contact on their head and perhaps their sternum, pelvis or sacrum. It could also be the feet. He said it would feel very gentle, rather like 'laying on of hands' and the technique could be used over clothes.

36. Regarding the Registrant's technique of placing one hand under the sacrum, Mr Hearsey said this was an established osteopathic practice, with one hand active and one hand monitoring. He said it was very subjective with the monitoring hand listening or perceiving muscle tension or energy. He repeated that the treatment could be undertaken over clothing and that his issue was there was no reason to move under patient A's clothing. Mr Hearsey was shown Exhibit 1 and said that he would expect the Registrant to use the heel of his

hand to make initial contact with the pubis or pubic bone, that was the most appropriate way, with the fingers pointing towards the head. If thereafter the Registrant palpated the pubis it would be appropriate to use the heel of the hand. Whilst one could palpate the pubis with the fingers facing towards the feet one would have to be extremely careful. Mr Hearsay said that apart from one potential clinical reason that did not apply in this case there was no clinically justifiable reason for the Registrant to place his hands as far down patient A's body as she described.

37. In response to a further question from Mr Vollans, Mr Hearey said it was acceptable for a registrant to use the heel of their hand to locate the pubic bone and then turn his hand to use their fingers to palpate the bone but at no point should the fingers be used to locate the pubic bone.

Evidence for the Registrant

38. The Registrant took the oath and confirmed that his statement dated 22 February 2024 was correct as well as the information he gave to the police when he was interviewed. He also relied upon his clinical notes which he believed were accurate. He confirmed that he believed he had given a correct explanation for what had occurred.

39. In answer to questions from Mr Vollans, the Registrant said that he had identified a number of physical complaints by Patient A and that he touched various parts of her body as a consequence. He said he explained what he was doing. When Patient A was on the treatment couch, the Registrant described assessing Patient A's middle and upper thoracic spine palpating with his hands underneath her. Prior to this, he had placed one hand under her occiput and one hand under her thoracic spine. He checked her upper thoracic spine with one hand on top of her sternum and said the purpose of doing this was to check the response of the tissues around Patient A's upper ribs. He said the whole purpose of palpation was to assess tissue response. He said that palpation could be at different levels but his hands would essentially be passive feeling for a response.

40. The Registrant said that Patient A appeared to have a number of things going on albeit he now had no memory of her and was relying upon his notes. He had taken a history and included non-verbal clues in his assessment. He said there was a plausible mechanical explanation for her complaints but that was a trap and it required further assessment. In other words, he formulated a working hypothesis and then tried to disprove that hypothesis.

41. Mr Vollans asked the Registrant why he had touched Patient A’s chest and pelvis and why he had touched her under her clothes. The Registrant said there was a standard technique of palpating the pubic floor over clothing, one hand under the sacrum, one hand on the pubis. However, he said he had a number of patients who, for personal reasons, may be triggered or traumatised by touch. Such patients would not want his hand anywhere near the lower abdomen

possibly not even the upper abdomen. Nonetheless, he said he needed a way to assess the pelvic floor. He considered that if a patient was actively engaged he could get a better or closer understanding of it. He agreed that the pelvic floor could be palpated from the head or the feet but said this only gave an overview.

42. To get around what he perceived as a difficulty the Registrant said he developed the approach of providing a patient with a long explanation to get them engaged in the process and take control of what was going on. Regarding what he told Patient A, he said he was relying upon his usual practice. The aim of moving his hand was to engage the patient in deciding what was comfortable for them. He said that if he touched a patient over their clothing they were more likely to allow him to move his hand closer to a trigger point or intimate area and he did not want this. If he touched them on their skin he felt patients were more likely to stop him at a distance from such trigger points or intimate areas. He said the majority of his patients would ask him to stop his hand halfway between their navel and their pubis. He said that he would palpate the pubis using the heel of his hand he said that fingertips on or about the navel would mark the start of the examinations. He indicated on a diagram where he said that most patients would stop him, that being between the navel and the pubis. He said that some patients allowed him to go closer to the pubis but in any event he would stop as soon as he felt the top of the pubic bone.

43. The Registrant was shown the diagram (Exhibit 1) of where Patient A said she felt his fingers, he denied this. He said that the whole point of his technique was to stay away from intimate areas. When asked whether he placed his hand under Patient A's leggings and underwear he said it depended upon where the waistband was. He marked on a diagram (Exhibit 2) where he said he would touch patients. He indicated the lowest point he would reach and said he would touch with a light pressure avoiding pressing down on the pubis. His other hand would be under the sacrum.

44. The Registrant said that patients would feel a light touch, some may feel nothing others may feel slight changes but when assessing cranially one could not palpate and guarantee there would be no change. He said the idea of a cranial assessment and treatment was that most of the time when palpating he was observing what the tissues were doing and letting them do it. He called it treating by observation. The Registrant agreed that he did not conduct a neurological assessment but said he was concerned to explore whether there was anything that did not fit a mechanical explanation. He wanted to do things as quickly as possible since he thought that this informed the need for a neurological assessment or any further referral. He regarded a C8 nerve compression as being the most likely explanation for some of Patient A's symptoms and he was concerned to see if there was something else. He agreed that he did neurological examinations regularly but it was not his first priority in this case.

45. The Registrant said that the whole consultation was an assessment and if there was a response he would record this. Having examined Patient A's upper body the Registrant said that he wished to examine whether this had affected her pelvis or whether there had been changes. He said he was wary of doing a lot of treatment at a first meeting and said that if he observed changes he would not do further treatment. A second appointment would involve him assessing any response from the first appointment and anything in the intervening period. He agreed that this might involve a neurological examination and that this would in normal practise come first. He said that this was probably an odd case.

46. Regarding the noises that he accepted he made, the Registrant described these as exhaling when tissues released/relaxed or balanced themselves. He described these noises as a loud sigh or a grunt depending upon how much support he had provided to the tissues that were now releasing. The Registrant described them as involuntary noises caused by the release of air and not something he could produce on order. He said it was well known in his practice that he made this noise and he normally told patients but he could not guarantee he told everyone.

47. The Registrant then answered questions from Ms Przybylska. He first confirmed that he could work on the pelvic floor by contacting the scalp only. It was put to him that there was no clinical justification for putting his hands under Patient A's clothing, touching her bare skin. He replied that the clinical reason for doing this was to gain a better impression of the pelvic floor than he would get working through clothing or working from the cranium or the feet. He said that skin contact was not so much a clinical necessity but was to avoid being too close to areas around which a patient was uncomfortable.

48. Ms Przybylska asked the Registrant how skin contact achieved his aim. He explained that his rationale was to actively engage a patient in the process, trying to get them to take control of what is happening. To achieve this he would get the patient to determine where he should put his hand. He would move his hand towards the pelvic floor having instructed a patient at great length to stop him whenever they felt uncomfortable. He said he wanted to be behind that line. He said that if a patient wore clothes they would allow him to get closer into an area of ambiguity. He said his technique would give him the view of the pubic symphysis some distance away from areas of risk. He said he would work further away with his hand on skin and repeated that it was about staying as far away as possible while still getting a close view.

49. The Registrant said it was not a technique that he had used for some time. He felt that it enabled him to work at a distance while still getting a quality of information similar to that from closer to the pubis. It was suggested that he did not instruct Patient A at great length but he did not accept that.

50. The Registrant was asked about consent and said that he thought he was obtaining it but following his attendance at an Institute of Osteopathy roadshow he realised he was not doing this correctly. He said he had tried to incorporate

consent into a patient-led history, consultation and so on but he realised he could not do it that way. He now realised that for a patient to know the benefits and risks and to give valid consent he had to stop at a particular point, namely the end of his standing examination, and explain. He now said he explained things in a very structured way before he touched a patient. He said the practice thought they were doing it right but they were only getting functional consent not valid consent.

51. Regarding Patient A's account of there being no lengthy discussion of the pelvic floor and no understanding that he would slide his hand into her underwear, the Registrant said his explanation was an integral part of the whole process. The whole point was to get Patient A's active engagement and the preamble was critical to this. He agreed that Patient A was clearly not actively engaged and said this was a major reason why he had stopped using this technique. He thought Patient A was engaged but she was not, and he could not guarantee it would not happen again.

52. Ms Przybylska then put each of the allegations to the Registrant. Regarding allegation 2b, the Registrant accepted that he might have put his hand under Patient A's underwear depending upon how high her waistband was. He said he would only do so with consent. He also accepted that it was possible he touched Patient A's pubic bone but he did not accept that this necessarily happened. He did not accept that he had put his hand upon or over Patient A's pubic mound.

53. As to allegation 2c, the Registrant conceded that it was a correct statement of his opinion but he did not accept that he used those words. He said that he would have used a whole preamble/process. He accepted he wanted to convey the meaning in the words but not that he used the words. Rather he said he would have explained that he preferred to work skin on skin to be behind the line of ambiguity/comfort.

54. Turning to allegation 2d, the Registrant confirmed that he had no memory of the consultation but said that sniffing his fingers was not something he would have done. It was put to him that he made contact with Patient A's groin for sexual gratification and that sniffing his fingers was part of that. He denied this.

55. When asked about offering a chaperone the Registrant said when checking the pelvic floor in the way that he had described he never offered a chaperone. He was asked if it occurred to him to do so and replied that the whole purpose of the technique was to avoid getting toward an intimate area such as the pubis and avoid being too close to the pelvic floor. He said that at the time he was seeking to avoid these and other intimate areas so he thought he did not need to offer a chaperone.

56. The Registrant agreed that a chaperone was there to protect both a registrant and patients from potentially sexual contact however he was not sure whether or not a chaperone would be able to judge what was clinically necessary. He

said if a chaperone was present they would observe him constantly checking with a patient to see if they were comfortable. It was suggested to him that he did not offer a chaperone since their presence would prevent him from putting his hand into Patient A's underwear he replied, '*absolutely not*'.

57. Ms Przybylska turned to allegation 3 and suggested that the Registrant touching Patient A as he did was inappropriate but he rejected that suggestion. It was suggested a failure to offer a chaperone was also inappropriate. He replied that he was not sure he accepted this although with the benefit of hindsight it would have been better to offer a chaperone. When asked if he thought that a failure to obtain valid consent was inappropriate the Registrant said '*that it was a legal requirement so I guess it was inappropriate since we need to have a valid consent*.'

58. Regarding allegation 3b Ms Przybylska suggested it was unprofessional not to gain informed consent from Patient A. The Registrant replied it '*depends on how you define unprofessional*'. He made the same comment regarding a failure to offer a chaperone. He said looking back it would have been better to offer a chaperone but he did not think his failure to do so was unprofessional. Regarding the allegation of skin to skin contact and touching Patient A's pubic bone it was put to him that that too was unprofessional but he said '*no I do not accept it is necessarily unprofessional.'*

59. Ms Przybylska next dealt with allegation 3c and suggested it was not in Patient A's best interest for the Registrant to touch her pubic bone. The Registrant disagreed. Regarding the lack of a chaperone the Registrant said one could argue it was in a patient's best interests to offer a chaperone in all circumstances but he did not concede that his failure was not in Patient A's best interests. Regarding his failure to obtain valid consent it was put to him that this too was not in a patient's best interests he said, *'no I do not accept this*'. He said that it at every stage with every patient in general their best interests were at the forefront of his mind, that was what it was all about.

60. Ms Przybylska concluded her cross examination by putting to the Registrant that if he had really wanted to stay away from Patient A's pubis he would not have done as he did. She suggested that he acted for his own sexual gratification. The Registrant replied that that was '*simply untrue*'.

61. In response to questions from the committee, the Registrant agreed that he had recorded Patient A's presenting complaints and conducted a standing assessment. He said his cranial assessment was recorded in the box marked treatment. He said that he would have assessed Patient A by asking her to bend over placing his thumbs on various areas of her spine he would have conducted a similar assessment of the base of her neck. All this would be while she was standing. He said that the only cranial work he did was an assessment and he recorded this in the treatment box for his convenience. He recorded his palpation of the tissues and their response but denied giving any specific treatment. He said that there was a change in Patient A's response to his cranial

assessment that was expected. If he had observed or detected other changes he may have had to make other enquiries or possibly refer Patient A elsewhere. He said that his technique was not necessarily used to relieve symptoms it was designed to discover whether they had a mechanical cause.

62. The Registrant was asked if he would use his modified technique of placing his hand upon the abdomen of a male patient and he said that he would. Regarding the process of gaining consent from patients he said that both he and his colleagues had worked for quite some time concerning this. He said that his technique of getting consent was something he had developed. He had modified the standard technique of palpating the pelvic floor from the front and from behind, that is between the pubis and the sacrum. In order to get information equal to that which he would get if he was closer and used a more invasive technique, the Registrant said that he attempted to engage patients to get them to focus consciously and subconsciously on the pelvic floor. He did this due to the history of some patients, who would not find it acceptable to be touched in the way required. By using his technique of getting the patient to focus he said he could get a really good impression of the pelvic floor from just below the naval and the patient was in control of what happened.

63. The Registrant said that the standard technique was to place one hand under the sacrum and to palpate the pubis with the heel of the other hand. He said that his technique was not to go near the pubis but to stay further away and palpate from a distance. He had evolved this over years. He said that if a patient was 'zoned out' and not concentrating he would not get the same information compared to when they were engaged. He wanted to combine the benefit of an engaged patient with his process to get an impression of the pelvic floor without being near the pubis. Regarding a patient who was quiet and did not respond he said that he did not use the technique. He said he was explaining and engaging with patients all the time so that they could say when they were uncomfortable. He was receiving their oral feedback, if he did not then he did not proceed. He said that if he did not get a response he did not move. He said 'if they are fine then my fingers stop at the top of the pubic bone' he said he would not go further.

64. It was suggested that the Osteopathic Practise Standards (OPS) regard the pubic area as an intimate one. The Registrant said that since he was not going beyond the pubic bone he did not think he was going into an intimate area. He said the OPS definition was not clear. He conceded that moving on to the pelvic floor was an intimate area. He said that the OPS did not provide a dividing line and his attitude had changed. When asked about Patient A's evidence as to where he put his hand, he said he could not understand why she thought his hand would be there. He could speculate but could provide no direct explanation. He opined that patients sometimes feel contact in a place different to where that contact is actually made and he gave an example of someone having their knee treated.

65. The Registrant agreed that treating a patient with a hand over the clothing meant that he could see where his hand was. He conceded that by placing his hand under clothing he could not see his hand and could not assess any risk of misunderstanding. He said this was a justified criticism of his technique. He was asked to clarify his position regarding allegation 2b and said he did not necessarily agree that he placed his hand upon Patient A's pubic bone rather he said he did not know but felt he would have stopped at a point before that.

66. As to allegation 2c he said that he would not have used the particular combination of words alleged and it was not an accurate representation of what he said even the words 'to this effect' were considered. The Registrant was again asked why he felt it necessary to go close to or onto the pubic bone if he could get a really good impression using his technique just below the naval. He said it was the patient taking control and that is when he knew he could get a really close view of the pelvic floor because the patient has taken control.

67. In re-examination the Registrant confirmed that when transitioning from work over the clothing to work under the clothing he would not have made the comment alleged. He repeated that he would say 'if I go on top of the clothing you will let me go further and that is an area of ambiguity, being on the skin means I am further away'. He said that ordinarily he would talk about what he was intending to do and why he did not want to do anything that the patient was not happy about and he was relying upon his patients to say so.

Submissions of the Parties

68. Both Ms Przybylska and Mr Vollans provided written submissions regarding the facts.

69. Ms Przybylska adopted her written document in which she asserted that on the Registrant's own case he was deploying a novel technique of his own invention to balance the pelvic floor. This involved putting his bare hands under a female patient's clothing and advancing them downwards. He put the onus on the patient to stop him. The expert evidence was that there was no clinical justification for using bare hands under clothing on bare skin. He failed to offer a chaperone and failed to obtain valid consent. Ms Przybylska submitted that even on the basis of this admitted conduct, the Committee can find allegations 3a-d proved the latter being in respect of a breach of professional boundaries.

70. Ms Przybylska submitted in her written document that if the Committee accepted Patient A's account and particularly if they found allegation 2b proved then it was clear there was a breach of sexual boundaries. In the absence of a clinical reason or consent she submitted that the touching was sexual and that it was sexually motivated.

71. Ms Przybylska made further oral submissions. She said that the Registrant had used a technique that was inappropriate and unprofessional. It required a patient to direct him. She said the explanation for the technique was incoherent

since the Registrant said he could work adequately from the cranium to balance a patient's pelvic floor. He had said that contact well above the pubis was sufficient. She therefore submitted there was no justification to move to the pubis, even less so when using his bare hands under Patient A's clothing. She submitted that Patient A was to be believed and that Allegations 3a–c and 3d in relation to professional boundaries were proved.

72. Ms Przybylska then submitted that what lay behind the case was the sexual motivation of the Registrant. She observed that the Registrant claimed to want to remain distant from any intimate areas but 'why did he do the opposite to that and put his bare hands onto skin and then advance his hands toward an intimate area?' As soon as she left the practice and sat in her car Patient A had phoned a friend (D) and told her the Registrant had touched outside her vagina or pubis. Any comment by D did not affect what Patient A was saying rather D commented because of what Patient A told her. Ms Przybylska said that the immediate complaint and Patient A's immediate reaction was strong support for her account. The Registrant had said there was no cause for complaint and no scope for confusion or mistake, he did not have his fingers pointing toward Patent A's pubis and he did not inadvertently touch her. He said he did not go below the pubic bone. Patient A described the Registrant having his hand inside her pants over her pubic mound in contact with her pubic hair and that is what she told D. Ms Przybylska said there was no basis to conclude that Patient A was lying and that she had been accurate as to the nature of the touching.

73. Ms Przybylska submitted that likewise Patient A was accurate in her description of the Registrant touching his nose. She said that if Patient A was correct then there was a clear breach of sexual boundaries. She continued that if Allegation 2b was not proved there was no basis for a finding of sexual touching but, if it was proved and the Registrant put his bare hand on Patient A's pubic mound without consent and without a clinical reason then there was no other explanation but that it was a sexual touch. In addition she said that the Committee could also conclude that there was sexual motivation in the absence of any plausible reason, an absence of clinical indication and the Registrant putting his hand into Patient A's underwear and not having a chaperone present. She concluded by saying it all pointed to sexual gratification/motivation.

74. Mr Vollans also provided written submission to the Committee. In these he asserted that considerable weight should be given to the Registrant's good character and the testimonials. In summary, he submitted that the Registrant was motivated to clinically treat and improve the lives of patients such as Patient A rather than abuse his position or act with a sexual motive. He suggested that such conclusions were born from a misunderstanding of the circumstances.

75. Regarding allegation 2b Mr Vollans submitted that the Registrant had been clear and consistent in his explanations and that his fingers went no further than the top of the pubic bone which was to facilitate a recognised osteopathic

technique. He said that the Registrant was required to rely only upon his notes due to the delay in Patient A reporting her concerns. As to allegation 2c, he reminded the panel that the Registrant asserted this was not phraseology he would use and that this was not complained about when Patient A first spoke to D. Dealing next with allegation 2d, Mr Vollans pointed out that Patient A did not appear to have complained of this to D and the fact that a second appointment was booked was inconsistent with Patient A's concerns.

76. As to the matters admitted, Mr Vollans submitted that the Registrant had explained what the sighing/grunting noises were and why he made them and accepted it was an error of judgement not to offer a chaperone. Consent was of course always required.

77. Turning to Allegation 3, Mr Vollans submitted that each element of allegation 2 did not satisfy the elements of Allegation 3. He said that it was not inappropriate or unprofessional to have acted as admitted and/or as alleged nor did it adversely affect Patient A's best interests. He set out detailed written reasons for his arguments. Regarding the final important allegations of sexual touching and sexual motivation Mr Vollans submitted that although Patient A was clearly concerned about the Registrant's exhalations, they were properly explained and, his technique of placing a hand where he said he had was part of a recognised osteopathic technique. He submitted that neither allegation was made out.

78. In additional oral submissions Mr Vollans emphasised that the burden of proving the case was on the GOsC and was on the balance of probability. He said that before looking at the various allegations the Committee should consider that it was looking at a case involving a 69 year old man with no previous regulatory findings against him. He said it was more likely that the Committee had before it a man who sought to help others rather than take sexual advantage of them.

Advice

79. The Committee accepted the advice of the Legal Assessor. It recognised that the burden of proving the case was upon the GOsC and the standard of proof was on the balance of probability. It recognised that complaints such as this may be difficult to express and that delays in reporting matters to for example, the police or regulatory bodies were not matters to be held against Patient A. It understood the importance of consent, the meaning of and distinction between sexual touching and sexual motivation and it understood that it may draw inferences as to facts and/or states of mind from facts found proved.

Determination on the Facts

Allegation 1

Patient A attended one appointment (the Appointment) with the Registrant on 9 September 2022
Admitted and found proved

Allegation 2

At the Appointment, the Registrant:

a. told Patient A that he was going to check her pelvic floor; and/or
Admitted and found proved
b. slid his hand under her underwear onto her pubic bone; and/or
Denied. Found proved
c. told Patient A "I could do this through her clothes but I prefer skin to skin", or words to that effect; and/or
Denied. Found proved
d. lifted the same hand to his nose and/or sniffed his fingers, after taking his hand away from Patient A's pubic bone; and/or
Denied. Found not proved
e. made audible grunting and/or sighing noises whilst touching Patient A;
Admitted and found proved
f. failed to ask Patient A whether she wanted a chaperone present; and/or
Admitted and found proved
g. failed to obtain valid consent from Patient A.
Admitted and found proved

Allegation 3

The Registrant's conduct at Particular 2;

a. was inappropriate; and/or
Denied.
Found proved in relation to allegations 2b, 2c, 2e, 2f, 2g
Found not proved in relation to allegations 2a, 2d
b. was unprofessional; and/or
Denied
Found proved in relation to allegations 2b, 2c, 2e, 2f, 2g
Found not proved in relation to allegations 2a, 2d
c. was not in Patient A's best interests; and/or
Denied
Found proved in relation to allegations 2b, 2c, 2e, 2f, 2g
Found not proved in relation to allegations 2a, 2d
d. breached professional and/or sexual boundaries; and/or
Denied
Found proved regarding professional boundaries in relation to allegations 2b, 2c, 2e, 2f, 2g
Found not proved regarding professional boundaries in relation to allegations 2a and 2d
Found not proved regarding sexual boundaries in relation to allegations 2a – 2g
e. amounted to sexual touching; and/or

Denied
Found not proved in relation to allegations 2a – 2g

f. was sexually motivated.
Denied
Found not proved in relation to allegations 2a – 2g

Reasons

Allegation 2

At the Appointment, the Registrant:

a. told Patient A that he was going to check [Patient A's] pelvic floor
Found Proved
This was found proved by way of admission.

b. slid his hand under [Patient A's] underwear onto her pubic bone;
Found Proved.

80. The Committee considered Patient A's description of the Registrant moving his hand under her leggings and then under her underwear. She was consistent in this regard from her first complaint to her friend D through to her complaint to the police, the GOsC and in her evidence. However, whilst she consistently stated that the Registrant touched her under her underwear, she has provided different descriptions of how far his hand extended. She spoke of his hand covering her vagina when talking to D and the police; in evidence she said he covered her pubic mound and that his fingers reached the gusset of the knickers. Those terms all suggest his fingers extended deeply into her knickers. However, she also used the terms '*between her naval and her pubic area'* and '*in the area of the sacral chakra'*, which suggested his fingers extended into her underwear to a lesser extent. She was however clear that his fingers contacted her pubic hair. She was also clear that his hand was flat on her body and his fingers did not move.

81. In evidence the Registrant described placing his hands flat onto Patient A's body and said that he did not move his fingers which accorded with her description. He described moving his hand from Patient A's upper chest to her sternum and then moving further down toward her pubis. He said he would go no further than this. However, he accepted that with his hand was covered by clothing he could not see how far he was going but relied on the patient to tell him to stop. In his interview to the police the Registrant was asked if he would put his hand under a patient's trousers or knickers or whatever she was wearing. He responded, "*yes I will slide my hand down inside whatever the patient is wearing*". He said he would constantly check that the patient did not want him to stop. In that interview he said he would not put his hand below the top of the pubic symphysis and not below the top of the pubic bone. He said his hand would be "*right on top of the pubic bone*" but no further. He then

described what he said was the standard technique of palpating the pubic bone with the fingers.

82. The Committee concluded that Patient A was clear and consistent that she had been touched on an intimate area that at least included her pubic bone and, this had happened under her underwear. The Registrant described exactly this in his police interview. He also made it clear that he expected a patient such as Patient A to tell him to stop. Thus, his hand would only be prevented from reaching the area of the pubic bone if Patient A stopped him. Patient A described the Registrant moving his hand before or at the same time as he said he wanted to examine her pelvic floor. The Committee regarded this as providing no or insufficient time for Patient A to respond to validate his actions by way of consent. In any event she said that she did not stop him.

83. It was clear to the Committee that the Registrant conceded that he may well have placed his hand under Patient A's clothing and touched her pubic bone. Patient A's evidence was that this had occurred. For these reasons the Committee found the allegation proved.

c. told Patient A "I could do this through her clothes but I prefer skin to skin", or words to that effect;
Found proved

84. The Committee regarded Patient A's evidence as clear, consistent and emanating from a specific memory. She had described this phrase in her complaint to GOsC, her witness statement and her statement to the police. She confirmed it in evidence.

85. The Registrant denied the exact words stating that the information he imparted to any patient, and thus would have imparted to Patient A, was far more detailed. However, the Committee noted and the Registrant conceded that the two aspects of the comment namely (i) that he could work through a patient's clothes but (ii) he preferred to have direct contact with a patient's skin, accorded with the Registrant's assessment of his technique and his preference for direct contact. The Registrant had no recollection of Patient A or what he said. Conversely her evidence spoke to clear a recollection of the specific words or words to that effect.

86. Both Patient A and the Registrant described a conversation of several minutes duration. Even if there was further information provided by the Registrant during the initial discussion, this did not negate the clear memory described by Patient A in her evidence. The Committee found this allegation proved.

d. lifted the same hand to his nose and/or sniffed his fingers, after taking his hand away from Patient A's pubic bone;
Found not proved

87. Patient A described this alleged action by the Registrant as a 'lightning bolt'. Whilst she had been troubled by what the Registrant did in terms of the grunting/sighing and putting his hand into her underwear, it was this action which appeared to convince her that something was very wrong. However, it was notable that although she complained to her friend D very soon after the event, she did not mention this particular action. In her initial statement to the police she states that the Registrant put his hand up to his nose '*two fingers like he was sniffing them'*. In her complaint to GOsC she describes the Registrant using two fingers to '*rub against his nose'* and in her statement she said '*he may have been scratching his nose but it looked like he was sniffing his fingers'*. She later says she did not believe he was scratching and she considered the action to be '*sly and he pretended to rub his nose'*. Finally, in her evidence, Patient A firmly asserted that the Registrant did sniff his fingers and she believed he sniffed his fingers. She rejected the assertion that he had scratched his nose.

88. Having seen and heard Patient A's evidence the Committee concluded that she now firmly and sincerely believes that the Registrant sniffed his fingers. However, the Committee considered it notable that she also described him as rubbing his fingers on his nose and suggested at one point that he may have been scratching it. The Committee was of the view that Patient A was anxious and troubled by the Registrant's noises (which she described as possibly sexual noises) and the fact he placed his hand under her underwear. The Committee determined that the Registrant did indeed touch his nose but it could not exclude the likelihood of him scratching or brushing his nose rather than sniffing his fingers. The Committee considered it more likely than not that the Registrant scratched his nose and it is the context of the other inappropriate behaviour that led Patient A to believe that he was sniffing his fingers rather than scratching his nose.

e. made audible grunting and/or sighing noises whilst touching Patient A;
Found proved

89. Found proved by way of admission. The Committee noted that the Registrant and the practice seem to have treated him making these noises as something of a joke. Patient A said she had experienced similar noises in shamanic healing rituals abroad, she did not expect to hear such noises at a healthcare provider in Tyneside. It was notable that Patient A described the noises as sexual and she was clearly alarmed by this.

90. The Committee considered it likely to be one of the reasons why Patient A regarded the Registrant as having behaved in a sexualised way. The noises the Registrant made and his failure to explain them were not a joke rather they were a failing that contributed to Patient A's adverse experience and view of the Registrant.

f. failed to ask Patient A whether she wanted a chaperone present;

Found proved

91. Found proved by way of admission. The Committee noted that the Osteopathic Practise Standards state that all patients should be advised of the possibility of a chaperone being present. This is all the more important when a registrant is examining or treating an intimate area or is likely to do so. The Registrant said he had never offered a chaperone to patients when he examined their pelvic floor.

g. failed to obtain valid consent from Patient A
Found proved

92. Found proved by way of admission.

93. Having heard the evidence, the Committee regarded it as more likely that the Registrant failed to gain consent from Patient A from the outset. When he described how he explained matters to a patient the Committee found it to be dense, laboured and somewhat opaque. If the Registrant did explain matters as he asserted, it was clear from Patient A's evidence that she did not absorb or understand the content or importance of what he was saying, rather she was irritated by it.

94. Furthermore, as the Registrant touched various parts of Patient A's body, whilst he checked back with her regarding consent, this was her acquiescing after the event and not informed consent before he touched her. In reality the Registrant did not give Patient A time to properly consider, comment or consent. Rather she accepted what he had already done. When it came to placing his hands under her leggings and underwear onto her pubic bone, an area the Committee regarded as plainly intimate, it was clear to the Committee that the Registrant had not explained, or not sufficiently explained, what he was doing before he did it. Patient A was startled but did not complain, rather she trusted the Registrant relying upon him as a healthcare professional. Thus not only did the Registrant fail to get consent from the outset, that failure was exacerbated by repeated failure and the examination of an intimate area without proper warning, explanation or consent.

95. In coming to the above factual conclusions the Committee took account of Patient A and the Registrant in terms of their reliability bearing in mind always that the burden of proving each allegation rests only upon the GOsC. Overall it appeared that Patient A was doing her best to honestly and accurately describe what occurred or what she believed occurred. There were some inconsistencies in parts of her evidence as referred to in the individual decisions above but these were not such as to call her reliability or credibility into question. As to the Registrant, he conceded that he had no recollection of the events complained of. The Committee did not find that unusual given this was one consultation many months ago. However, it meant that the Registrant relied upon his usual practice to say what he believed he would have done regarding his assessment and treatment of Patient A. That said, he too was consistent

between his statements and his evidence and appeared to respond to questions in a measured way.

Allegation 3

The Registrant's conduct as set out in paragraph 2 was:

a. was inappropriate;
Denied

96. The Committee determined that the Registrant's conduct was inappropriate in a number of respects. It has set out its findings in respect of each such allegation below.

a. told Patient A that he was going to check her pelvic floor;
Found not Proved

97. Patient A attended for a consultation and, following an assessment the Registrant formulated a plan of further assessment and/or treatment, part of which included an assessment of Patient A's pelvic floor. It was not inappropriate for the Registrant to tell Patient A that he was going to check her pelvic floor indeed it would have been inappropriate for him not to do so.

b. slid his hand under her underwear onto her pubic bone;
Found Proved

98. The Committee regarded the expert evidence on how a competent registrant would locate a patient's pubic bone as clear and persuasive. This should be done with the heel of the hand such that the fingers point away from a patient's intimate area and they are clearly visible to a registrant. Whilst a registrant may thereafter turn their hand such that the fingers point toward a patient's intimate area, this would require very great care both in the movement itself and in the consent process.

99. The Registrant's method of advancing his hand 'fingers first' and waiting for Patient A to say stop or until his fingers were on her pubic bone was the opposite of the correct/competent approach outlined above. It was an ill-conceived modification of the correct technique. In this case it meant the Registrant placed his hand beneath Patient A's underwear so he could not see what he was doing and it resulted in his fingers being inappropriately close to and making contact with Patient A's pubis.

100. This technique also placed the onus upon Patient A to understand the lengthy pre-treatment explanation the Registrant said he would have given and act upon it by saying 'stop' if she felt uncomfortable. It was clear from Patient A's account that she did not appreciate his explanation nor did she have the opportunity to stop the Registrant before he touched her on an intimate area.

101. In all these aspects the Registrant's technique was inappropriate.

c. told Patient A "I could do this through her clothes but I prefer skin to skin", or words to that effect;
Found Proved

102. The expert evidence and the Registrant's evidence was that skin on skin contact was not necessary for the techniques that the Registrant was employing. The Committee has already found that the Registrant modified the technique inappropriately. Stating his preference in the way that he did was a further inappropriate aspect of this. It was a poorly judged phrase and it was open to misinterpretation and misunderstanding. In addition, stating what he preferred rather than asking her for her preference deprived Patient A of the unfettered opportunity to consent to his act. For these reasons the use of the phrase was inappropriate

d. lifted the same hand to his nose and/or sniffed his fingers, after taking his hand away from Patient A's pubic bone;
Found not proved

103. Whilst the Committee has, for the reasons set out above, found that the Registrant did touch his nose, such an action was not of itself inappropriate in the absence of an ulterior motive such as the sexual motivation alleged against him.

104. Patient A demonstrated an action that looked like someone scratching an itchy nose. In addition the Committee was not satisfied that the Registrant had sniffed his fingers. The Committee found it likely that the Registrant did indeed scratch his nose as demonstrated by Patient A and that she misinterpreted this action due to his other conduct.

105. It was Ms Przybylska's submission that the gravamen of this allegation was the clear sexual element in sniffing his fingers. The Committee has found this alleged sexual element was not present for reasons it has set out elsewhere. Without such a sexual element it was not satisfied that the Registrant scratching his nose was inappropriate.

e. made audible grunting and/or sighing noises whilst touching Patient A;
Found proved

106. Patient A described her consternation at the noises made by the Registrant. The Committee was satisfied that this was an unfortunate habit that the Registrant adopted. He and his colleagues appear to have regarded it as something of a joke.

107. What made these noises inappropriate was the Registrant's failure to explain them. This was compounded by the fact that they occurred in the midst

of the Registrant's other failings which reinforced Patient A's belief that the Registrant was behaving in an improper way.

f. failed to ask Patient A whether she wanted a chaperone present
Found Proved

108. The Committee found that the fact the Registrant did not offer a chaperone to Patient A could rightly be described as a failure. It has set out its reasons above.

109. In this case Patient A attended with a complaint of pain in and around her hip and lower back. Prior to the commencement of his physical assessment and/or treatment it would have been clear to the Registrant that he may be working in areas on or around Patient A's waist to hips. That may involve the removal of clothing and/or it may involve touching parts of Patient A's body close to her thighs, buttocks or more intimate areas. It ought to have been clear to the Registrant that he should offer a chaperone to Patient A at this early stage of the consultation.

110. As part of his assessment and/or treatment the Registrant considered that he should assess Patient A's pelvic floor. He chose not to make his assessment remotely as he said was possible but chose to deploy his own method of assessment which was itself inappropriate. Patient A described the Registrant touching her pubic hair which indicates that the Registrant was clearly making contact with an intimate area.

111. The Committee was of the view that the Registrant should have offered a chaperone to Patient A before he commenced this part of his assessment/treatment, all the more so when it must have been clear to him that he was touching an intimate area of Patient A's body.

112. The OPS makes it clear that a chaperone should be offered, particularly if a registrant is likely to be working close to any intimate area of a patient. The Registrant failed to abide by such guidelines indeed he said he had never done so when assessing the pelvic floor of his patients.

113. The Committee determined that the Registrant's failure to offer a chaperone was indeed inappropriate for the reasons stated.

g. failed to obtain valid consent from Patient A.
Found proved

114. The Committee was of the view that although the Registrant appeared to try and obtain consent, he did this in a way that resulted in him failing to do so. Furthermore, it was likely that the Registrant failed to obtain consent from the outset despite what he described as a fulsome and detailed explanation.

115. The language used by the Registrant to explain his actions was, in the Committee's view, dense and unclear. Patient A appeared to find it too detailed and confusing such that she was irritated by it rather than informed.

116. When it came to the Registrant placing his hands on her, Patient A expressed surprise which demonstrated that she was not expecting some of the Registrant's actions and further indicated a lack of consent. Indeed her lack of understanding and thus consent appeared to be a thread throughout the treatment. This included the placement of the Registrant's hands in various positions on Patient A's body and in particular putting his hands under clothing.

117. The Registrant's actions of 'checking back' with Patient A and asking if she was comfortable with where he had placed his hand presupposed that she understood what was about to happen, consented *beforehand* and was still comfortable once it had occurred. Instead, it was clear that Patient A had little foreknowledge regarding what would occur and, once the Registrant touched her it was equally clear that she acquiesced rather than consented.

118. The Registrant's rationale for working as he did, with his fingers close to Patient A's intimate area rather than the heel of his hand; placing his fingers under Patient A's underwear as opposed to working remotely; inviting Patient A to say if/when she felt uncomfortable; stating his preference of skin-on-skin contact rather than inviting her to state her preference, all of this was inappropriate and compounded the seriousness of his failure to obtain consent.

b. was unprofessional;
Denied

119. The Committee determined that the Registrant's conduct was unprofessional in a number of respects. It has set out its findings in respect of each such allegation below.

a. told Patient A that he was going to check her pelvic floor;
Found not proved

120. It was not unprofessional for the Registrant to tell Patient A that he was going to check her pelvic floor for the reasons set out at 3a(a) above.

b. slid his hand under her underwear onto her pubic bone;
Found Proved

121. The Committee adopts the reasoning set out at 3a(b) above. Not only was the Registrant's technique inappropriate it was sufficiently substandard and poorly executed to be regarded as unprofessional. It was unprofessional for the Registrant to use such an ill-considered and inappropriate modification to the correct technique on Patient A.

c. told Patient A "I could do this through her clothes but I prefer skin to skin", or words to that effect;
Found Proved

122. The Committee adopts the reasoning set out at 3a(c) above. Not only was the phrase inappropriate it was sufficiently problematic to be regarded as unprofessional.

d. lifted the same hand to his nose and/or sniffed his fingers, after taking his hand away from Patient A's pubic bone
Found not proved

123. In dismissing this allegation the Committee adopts the reasoning set out at 3a(d) above

e. made audible grunting and/or sighing noises whilst touching Patient A;
Found proved

124. The Committee adopted the reasoning set out at 3a(e) above. The Committee was of the view that the Registrant's actions were sufficiently serious to be described as unprofessional.

f. failed to ask Patient A whether she wanted a chaperone present;
Found proved

125. The Committee adopts the reasoning set out at 3a(f). The Committee was of the view that the Registrant's repeated failure during this consultation was sufficiently serious such that it could rightly be described as unprofessional.

g. failed to obtain valid consent from Patient A.
Found proved

126. The Committee adopts the reasoning set out at Allegation 3a(g) above. Consent is at the heart of professional osteopathic practice. It is the means by which an osteopath engages in the assessment and/or treatment of a patient that may otherwise involve an unlawful interference with their body. The Registrant's repeated failure to gain consent was sufficiently serious to be regarded as unprofessional.

c. was not in Patient A's best interests;
Denied

127. The Committee determined that in several respects the Registrant did not act in Patient A's best interests. It has set out its findings regarding each of the allegations below.

a. told Patient A that he was going to check her pelvic floor;

Found not proved

128. It was appropriate for the Registrant to tell Patient A that he was going to check her pelvic floor given his working hypothesis. It was in her best interests to test his hypothesis to clarify what treatment, if any, was required.

b. slid his hand under her underwear onto her pubic bone;
Found Proved

129. The Committee adopts the reasoning set out at 3a(a) and (b) above. The Registrant's modified technique was inappropriate and unprofessional. To use such a technique on Patient A was not in her best interests for the reasons set out above.

c. told Patient A "I could do this through her clothes but I prefer skin to skin", or words to that effect;
Found proved

130. The Committee adopts the reasoning set out at 3a(c) and 3b(c) above. The Committee has determined that the phrase was inappropriate and unprofessional. It was not in Patient A's best interests to use such a phrase for the same reasons.

d. lifted the same hand to his nose and/or sniffed his fingers, after taking his hand away from Patient A's pubic bone;
Found not proved

131. The Committee adopts the reasoning set out at 3a(d) and 3b(d) above

e. made audible grunting and/or sighing noises whilst touching Patient A;
Found proved

132. The Committee adopted the reasoning set out at 3a(e) and 3b(e) above. The Registrant was aware he may make such noises and he neither sought to control them nor did he explain them. The noises caused some considerable consternation in Patient A and were clearly not in her best interests.

f. failed to ask Patient A whether she wanted a chaperone present
Found proved

133. The Committee adopts the reasoning set out at 3a(f) and 3b(f). The Committee was of the view that the Registrant's failure meant that he did not act in Patient A's best interests. His failure meant that neither she nor he were protected from the misunderstandings and/or misconduct of the type alleged.

g. failed to obtain valid consent from Patient A.
Found proved

134. The Committee adopts the reasoning set out at Allegation 3a(g) and 3b(g) above. The Registrant's failure to obtain consent meant that at no stage was he working in Patient A's best interests albeit this was his stated intention.

d. (part 1) breached professional boundaries
Denied

135. The Committee noted that the GOsC did not state what boundaries were allegedly breached. It thus considered the professional boundaries to be those set by the standards of practice and/or behaviour established by the Osteopathic Practice Standards. It considered if/where these may have been breached.

a. told Patient A that he was going to check her pelvic floor; and/or
Found not proved

136. The Committee has determined that the Registrant had a hypothesis regarding Patient A's complaint and was working on that hypothesis by either assessing or treating her. It did not breach professional boundaries for him to explain what he was doing.

b. slid his hand under her underwear onto her pubic bone; and/or
Found proved

137. The Committee adopts the reasoning set out in respect of Allegations 3a(b) 3b(b) and 3c(c). The Registrant touched Patient A on an intimate area without her foreknowledge or consent. In doing so the Registrant failed to communicate effectively, failed to treat Patient A with dignity and failed to respect Patient A's dignity and modesty thereby breaching OPS Standard A1, in particular Clause 1 and 2, and OPS Standard A6. His inappropriate adaptation of a recognised technique represented a failure to maintain appropriate levels of skill and understanding contrary to OPS Standard B3

c. told Patient A "I could do this through her clothes but I prefer skin to skin", or words to that effect; and/or
Found proved

138. The Committee adopts the reasoning set out in respect of Allegations 3a(c) 3b(c) and 3c(c). This communication put the Registrant's needs before Patient A's and respected neither her dignity nor modesty breaching OPS Standard A5. It compounded the lack of consent since its use has the tendency to place pressure or influence upon a patient thereby breaching OPS Standard A4 and in particular Clause 4 thereof. The use of such phraseology was an example of poor communication thereby breaching OPS Standard A1 Clause 1.

d. lifted the same hand to his nose and/or sniffed his fingers, after taking his hand away from Patient A's pubic bone;

Found not proved

139. The Committee adopts the reasoning set out at Allegation 3a(d), 3b(d) and 3c(d) above.

e. made audible grunting and/or sighing noises whilst touching Patient A;
Found proved

140. The Committee adopts the reasoning set out in respect of Allegations 3a(e) 3b(e) and 3c(e). In treating the noises as somewhat of a joke the Registrant failed to properly reflect upon or critically appraise the propriety of this aspect of his practice thereby breaching OPS Standard B1 Clause 1.12. This was compounded by the lack of explanation which was a breach of OPS Standard A1 Clause 1.

f. failed to ask Patient A whether she wanted a chaperone present;
Found proved

141. The Committee adopts the reasoning set out in respect of Allegations 3a(f) 3b(f) and 3c(f). The Registrant's inappropriate techniques meant that he was not only working close to a specified intimate area (see paragraph 144 below) but that he was touching it directly. It was clear from the Registrant's evidence that during his assessment and treatment and before he touched Patient A's pubis that he would be working close to that area. His failure to offer Patient A a chaperone breached OPS Standard A6 Clause 5 and 5.1.

g. failed to obtain valid consent from Patient A.
Found proved

142. The Committee adopts the reasoning set out in respect of Allegations 3a(g) 3b(g) and 3c(g).

143. The Committee noted that OPS Standard A4 is mandatory in its language – a registrant "**must** receive valid consent for all aspects of examination and treatment". Clause 1 thereof reiterates that consent is a "*fundamental part of [a registrant's] practice and is both an ethical and legal requirement*." In failing to obtain valid consent the Registrant breached OPS Standard A4 and in particular Clause 1 thereof.

144. The Committee determined that in failing to ensure Patient A understood the nature and purpose of his actions and failing to explain the risk and benefits the Registrant breached Clause 6 of Standard A4. Similarly when simultaneously examining and treating Patient A and/or moving his hand down her body without full and understandable prior explanation the Registrant continued and compounded his failure contrary to OPS Standard A4 Clause 7.

145. The Committee noted that the OPS Standard A4 Clause 9 sets out the special importance of consent in relation to examination or treatment of intimate areas thus:
"It is particularly important to ensure that your patient understands and consents to the proposed examination or treatment of any intimate area before it is administered. Intimate areas include the groin, pubis, …."

146. The Committee determined that the Registrant's inappropriate techniques meant that he was not only working close to a specified intimate area but that he was touching it directly. His failure to pay particular heed to what he was doing and gaining consent breached this part of the OPS.

147. Each of the above findings and the associated breaches gives rise to a finding that the Registrant did not adapt his communication appropriately to meet Patient A's needs and he was not able to deliver competent and appropriate osteopathic care to Patient A thereby breaching OPS Standard C1. In so doing the Registrant failed to maintain clear professional boundaries contrary to OPS Standard D2 and he failed to uphold the reputation of the profession contrary to OPS Standard D7.

(part 2) breached sexual boundaries

148. The Committee determined that the Registrant's conduct did not breach sexual boundaries for the reasons set out below.

149. Taking account of the legal advice, the Committee understood that a registrant transgressed sexual boundaries when he/she acts for their own sexual gratification or to pursue a future sexual relationship. The latter was not suggested in this case.

150. The Committee determined that it should consider what inferences could be drawn from all the facts of the case including the circumstances and purpose of the acts found proved to determine why the Registrant acted as he did and, whether this was for the purpose of sexual gratification.

151. The Committee has set out its findings of fact above. In summary, the Registrant failed to communicate properly with Patient A and used inappropriate/unprofessional techniques to assess and/or treat her. He touched her on an intimate area without consent and made noises that clearly disconcerted her.

152. As set out above, the Committee found that the Registrant touched Patient A on her pubic bone whilst his hand was under her underwear. The Registrant described why he was examining Patient A and, how he believed he would have done this namely by advancing his hand down Patient A's body toward her pubis until she said stop or he reached her pubic bone.

153. The Committee noted that the expert evidence was twofold on this point. First, the Registrant may have had a clinical reason to examine Patient A's pelvic floor and he used recognised techniques to do so. The Committee found he did so in an inappropriate and unprofessional way. Second, there was no clinical justification for putting his hand under Patient A's clothing.

154. Patient A clearly stated that the Registrant did not say he was going to touch her under her clothing before he did so. He accepted and the Committee has already found that Patient A did not consent to this. However, the fact that the Registrant did not have consent does not negate the potential clinical purpose of his actions.

155. The description of placing a flat hand on Patient A's pubic bone is similar to an appropriate osteopathic technique. There was no suggestion that the Registrant sought to move his fingers or attempted to penetrate Patient A and there was no evidence that he was aroused in any way. Indeed Patient A's version of events was that the consultation ended quite quickly. The notes suggest that the Registrant moved to Patient A's feet and he treated/examined her from there. The Committee has already dismissed the allegation that the Registrant sniffed his fingers.

156. Finally the Committee noted the strength of the Registrant's denial of any sexual impropriety, his reason for the denial and, it noted his good character as being at least supportive of his position.

157. The Committee considered that it was unable to exclude the possibility that the Registrant had a legitimate purpose to what he was doing, namely examining Patient A's pelvic floor and that this is indeed what he was doing albeit in an inappropriate and unprofessional manner. The fact that he executed an appropriate technique in such a poor manner did not of itself preclude a legitimate purpose. Since the Committee was unable to exclude a legitimate purpose, the Committee was unable to construe the Registrant's actions as necessarily being for his own gratification. That being the case the Committee was not persuaded to the requisite standard that he breached sexual boundaries. It therefore found this allegation not proved.

e. amounted to sexual touching;

Denied
Found not proved

The Committee determined that the Registrant's conduct did not amount to sexual touching for reasons it has set out below.

158. Following the legal advice received, the Committee understood that a touch could of itself be sexual or, that a touch may be sexual and an examination of the circumstances and purpose of the touch would determine whether it was sexual or not. The term 'purpose' may include motivation but the higher courts have determined that it is not necessary to find motivation.

159. The Committee acknowledged the logic in the comment from the higher courts that if a touch may be sexual, and if accident, consent and/or clinical or other proper justification were all absent it would seem impossible to come to any conclusion other than the touch being sexual.

160. The Committee determined that it should consider what inferences could be drawn from all the facts of the case including the circumstances and purpose of the touch found proved.

161. The Committee adopted the reasoning set out above in respect of the alleged breach of sexual boundaries. Although the Registrant did not have consent to touch Patient A on an intimate area of her body, the Committee was not satisfied that this was more than the Registrant deploying a clumsy and ineptly modified version of an appropriate technique for an appropriate purpose.

162. Since the Committee was unable to exclude the Registrant acting for a legitimate purpose, namely examining Patient A's pelvic floor (albeit in an inappropriate and unprofessional manner), the Committee was unable to conclude that the Registrant's actions necessarily amounted to sexual touching. It therefore found this allegation not proved.

f. was sexually motivated.

Denied
Found not proved

The Committee determined that the Registrant's conduct was not sexually motivated for the reasons set out below.

163. The Committee adopted the reasoning in respect of Allegations 3d(part2) and 3e above. On the balance of probabilities the Committee concluded that the Registrant's actions were not motivated by sexual gratification, rather they were to treat Patient A. However, he did so in an inappropriate and unprofessional manner as described above.

164. Having made the above factual findings, the Committee adjourned the case to a later date to consider UPC and sanction.

Unprofessional Conduct (UPC) – 27 March 2025

Submissions

165. Ms Przybylska relied upon her written submissions in which she reminded the Committee that the Registrant's conduct included actions which breached a number of the professional standards expected of a registered osteopath (the OPS). Whilst she conceded that such breaches did not

automatically require a finding of UPC, she said that they were at least indicative of this. She submitted that the Registrant's conduct fell short of expected standards, the failings were serious and did amount to UPC despite the events being all part of one single consultation. She then reminded the Panel that there were multiple breaches of the OPS across all domains and referencing her written submissions these were Standard A (Communication and Patient Partnership), Standard B (Knowledge Skills and Performance) including the Registrant's inability to appraise his own practice, Standard C (Safety & Quality in Practice) and Standard D (Professionalism).

166. Mr Vollans also relied upon his written submissions. He further submitted that the findings of fact were not so serious as to amount to UPC. He reminded the Committee that there was no burden or standard of proof regarding UPC, it was a matter for the Committee's judgement. Furthermore he submitted that simply because the conduct was deemed inappropriate or unprofessional it did not always mean that a finding of UPC should be made. He submitted that there was a high threshold that needed to be met.

167. Mr Vollans reminded the Committee of the Registrant's good character and of the references which spoke of him as being a competent and caring practitioner acting with the legitimate aim of treating patients. There was nothing sexual in his touching or his actions and, he did not completely ignore the important issue of consent since it had been discussed at the start of the consultation and was repeated during treatment. Rather it was a case where there were issues that needed to be addressed. He again reminded the Committee that this was one consultation and not a series of events.

168. Mr Vollans submitted that the finding of a failure to inform Patient A about the exhalation noises that he made was an error of judgement and was not UPC. He made the same submission in respect of the lack of a chaperone. He repeated that this was a case of an improper approach to a proper technique and proper treatment and submitted that had the Registrant better explained his actions he may well have alleviated Patient A's concerns and put her at ease.

169. Mr Vollans submitted that the Registrant had reflected on his failings and addressed them with his colleagues. He had changed his approach in light of the complaint. Mr Vollans then invited the Committee to consider the reflective statement produced by the Registrant and the references in the bundle. In summary, Mr Vollans submitted that the case did not amount to UPC and that words of advice would meet the overarching objective of public protection.

Decision on UPC

170. The Committee accepted the advice of the legal assessor and then went on to consider the issue of UPC in light of its previous findings of fact and breaches of the OPS.

171. The Committee carefully considered the submissions made by both representatives and took note of the fact that the Registrant has no previous regulatory findings against him. It accepted the general proposition that the Registrant's actions were driven by an intention to provide treatment to Patient A rather than any other nefarious purpose. Nonetheless, the Committee regarded the Registrant's failings as sufficiently serious to be described as UPC. Whilst the matters complained of occurred in one consultation, the Registrant's failings were spread across a number of areas of his practice. In addition, the Registrant asserted that the inappropriate method he used when treating Patient A was the way that he treated patients normally. Thus, there was at the time, a serious systemic failure in his practice.

172. The Committee has already set out at Paragraphs 137 - 147 above where the individual matters found proved breached the OPS. However, they bear repetition to the extent that:

- The Registrant touched Patient A on an intimate area without her foreknowledge or consent. In doing so the Registrant failed to communicate effectively, failed to treat Patient A with dignity or respect her dignity and modesty thereby breaching OPS Standard A1 (Clause 1 and 2) and Standard A6.
- The inappropriate adaptation of a recognised technique represented a failure to maintain appropriate levels of skill and understanding contrary to OPS Standard B3.
- Poor communication breached OPS Standard A1 (Clause 1), Standard A4 (Clause 4) and Standard A5.
- There was a failure to reflect and critically appraise an aspect of his practice (the exhalations) thereby breaching OPS Standard B1 (Clause 1.12).
- The failure to offer Patient A a chaperone breached OPS Standard A6 (Clause 5 and 5.1)

173. Regarding consent, the Committee has already observed that the OPS Standard A4 is mandatory in its language – a registrant "**must** receive valid consent for all aspects of examination and treatment". Clause 1 thereof reiterates that consent is a "*fundamental part of [a registrant's] practice and is both an ethical and legal requirement*." There is in addition a special importance to consent in relation to examination or treatment of intimate areas as set out in OPS Standard A4 Clause 9 thus: *"It is particularly important to ensure that your patient understands and consents to the proposed examination or treatment of any intimate area before it is administered. Intimate areas include the groin, pubis, ….*" The breaches of the OPS relating to this issue of consent are set out in more detail earlier in this determination.

174. Each of the above findings and the associated breaches gives rise to a finding that the Registrant did not adapt his communication appropriately to meet Patient A's needs and he was not able to deliver competent and appropriate osteopathic care to Patient A thereby breaching OPS Standard C1. In so doing, the Registrant failed to maintain clear professional boundaries

contrary to OPS Standard D2 and he failed to uphold the reputation of the profession contrary to OPS Standard D7.

175. For the reasons set out above, the Committee concluded that the Registrant's conduct did amount to UPC.

176. Having made a finding of UPC, the Committee next considered the issue of sanction.

Sanction

177. Ms Przybylska adopted her written submissions and reminded the Committee that it should consider any aggravating and mitigating factors within the case. Regarding mitigating factors she said that the Registrant was of good character; the events complained of are now some time in the past and there have been no further complaints against him. She submitted that this was not a case where there was 'no harm' since it was clear that Patient A had been distressed by the Registrant touching her in an intimate area without her consent. As to aggravating features Ms Przybylska submitted that Patient A was vulnerable because no chaperone was present during the treatment session. Whilst this had not been a deliberate omission on the part of the Registrant, it left Patient A feeling vulnerable. Concerning the Registrant's stated intention to retire, Ms Przybylska accepted that this was genuine but said it was not a factor upon which the Committee could place any reliance since it was not unknown for registrants to consider retiring and then change their mind. She submitted that the Committee should work on the basis that the Registrant could continue to practise for some time to come.

178. Mr Vollans referred to his written submissions and amplified them in oral submissions. In the round he submitted that the sanction of Admonishment was most appropriate. He said that there was no evidence the Registrant posed a danger to the public and there were no previous or subsequent professional concerns regarding the Registrant. He referred to the time that has elapsed since these events; the fact that the Registrant had provided two reflective statements and that there had been discussion and changes within the practice as a whole. He said that the Registrant had addressed the areas of complaint as soon as the concerns had been raised and before any disciplinary action was taken against the Registrant. Mr Vollens stated that the Registrant now takes a much more rigorous and careful approach regarding the explanation of any treatment; what treatment is necessary; how this may change and how the Registrant ensure that a patient understands what he is saying rather than just simply acquiescing.

179. Mr Vollans drew attention to the reviews and changes that were instigated by the Registrant which started as early as 2022 and continued in 2023 and 2024. This he submitted, was indicative of ongoing reflection and change. He emphasised that the Registrant had been open and honest with his

colleagues and they had seen a change in him. He said that the Registrant was genuinely remorseful and that the risk of repetition was remote.

180. Regarding the lack of a chaperone, Mr Vollans said that in any case where a chaperone may now be required such patients were triaged and referred to one of the Registrant's female colleagues. As to the issue of vulnerability, he observed that all patients are vulnerable and that Patient A was no more vulnerable than others and the Committee should guard against 'double counting' on this issue.

181. Mr Vollans said that the Committee should only go on to consider a Conditions of Practice order if it remained of the view that further steps were required to protect the public beyond those set out within the Registrant's reflective statements.

182. In conclusion Mr Vollens stated that the practice will be closing in around 9 or 10 weeks' time, redundancy notices have been issued to employees and the Registrant really does intend to retire. He wanted these proceedings to close before doing so. With no continuing safeguarding issue or risk, a clear apology, remorse, good character and remedial action taken, Mr Vollans submitted that an Admonishment is appropriate.

Decision of the committee on sanction

183. The Committee determined that the appropriate level of sanction was one of Admonishment. In coming to this conclusion the Committee considered the Hearings and Sanctions Guidance (HSG) produced by the GOsC, the submissions by both advocates and it accepted the advice of the legal assessor.

184. Concerning aggravating and mitigating factors, the Committee was of the view that there were no particular aggravating features in this case and none of the factors listed within the HSG were present. Whilst Patient A was vulnerable, the Committee accepted the principle that all patients are vulnerable to some degree. As to mitigating factors, the Committee considered that several of the factors set out in the HSG were present. These included:

- evidence of the Registrant's good conduct since these events including the reflective statements and the remedial action taken
- the Registrant's good character before and since these events took place
- clear evidence of remorse
- the time elapsed since these events
- the steps taken by the Registrant to avoid repetition
- whilst there was no independent evidence of the training that the Registrant said he had undertaken, the Committee had no reason to disbelieve him.

185. Concerning the issue of insight, the Committee had observed the Registrant engaging with the regulatory process. It noted that he has amended his own practice and made changes to the practice as a whole. The Committee

considered that the remorse he felt and spoke of was genuine. In addition, the Committee found that he had reflected upon his errors and accepted them, he had changed his practise as a result and he had specifically acknowledged the impact his errors had upon Patient A. Taking all the above into account the Committee concluded that the Registrant had a good level of insight into his conduct.

186. The Committee was further reassured by the references contained in the hearing bundle from both professional and patient sources. These confirmed that the Registrant had engaged with colleagues to ensure the practice was run in an appropriate fashion and that he was otherwise well thought of.

187. In light of the above the Committee concluded that the risk of repetition was low.

188. Having come to the above conclusions the committee next considered the appropriate sanction in order of ascending gravity, taking account of the factors set out in the HSG. This guidance asserts that the sanction of Admonishment may be appropriate where a case may fairly be considered to be at the lower end of the spectrum of seriousness and where a number of factors are found to be present.

189. The above mentioned factors are:

a. There is no evidence to suggest that the osteopath poses any danger to the public.
b. The osteopath has shown insight into their failings.
c. The behaviour was an isolated incident.
d. There is no evidence to suggest that the osteopath poses any danger to the public.
e. The osteopath has shown insight into their failings.
f. The behaviour was an isolated incident.
g. The behaviour was not deliberate.
h. There has been no repetition of the behaviour since the incident
i. The osteopath acted under duress
j. The osteopath has genuinely expressed remorse.
k. There is evidence that the osteopath has taken rehabilitative/corrective steps.
l. The osteopath has previous good history.

190. Having carefully considered the above factors, the Committee concluded that, save for 'i' which was not applicable in this case, all other factors were present. Whilst it may have been that this incident was indicative of a wider systemic problem, the Committee was of the view that this had been addressed by the Registrant and the practice as set out above.

191. Concerning the question of seriousness, this case involved unintentional failings by the Registrant rather than deliberate actions. These failings did not involve any sexual element or dishonesty.

192. The Committee did consider whether a Conditions of Practice order was necessary however it determined that this would be disproportionate. In conclusion the Committee determined that the sanction of Admonishment was the most appropriate and proportionate sanction to meet the overarching objective on the facts of this case.