GENERAL OSTEOPATHIC COUNCIL

PROFESSIONAL CONDUCT COMMITTEE

Case No: 1754/5554

Professional Conduct Committee Hearing

DECISION

Case of:	Vanessa Hayward
Committee:	Andrew Harvey (Chair) Catherine Hamilton-Plant (Osteopath) Andrew Howard (Lay)
Legal Assessor:	Tim Grey
Representation for Council:	Jessica Bass
Representation for Osteopath:	Philip Dayle
Clerk to the Committee:	Sajinee Padhiar
Date of Hearing:	15 January - 20 January 2026 The Hearing was conducted remotely

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Summary of Decision:

Paragraph 1 of the Allegation was admitted and found proved
Paragraphs 2, 3, 4 and 5 were found not proved.

The Allegation

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

1. Patient A attended one appointment with the Registrant on 8 July 2024 (the Appointment).

2. During the Appointment, the Registrant failed to conduct an adequate clinical examination of Patient A, in that she:

    a. did not assess Patient A's hip joint mobility;
    b. did not assess Patient A's cervical spine area.

3. During the Appointment, the Registrant performed one or more cervical spine manipulation techniques to Patient A, which:
    a. were not recorded in Patient A's osteopathic notes;
    b. were not clinically justified.

4. The Registrant failed to obtain valid consent from Patient A for the treatment provided to Patient A during the Appointment.

5. The Registrant's conduct as set out at paragraphs 2 and/or 3 and/or 4 was inappropriate.

Decision:

Preliminary Issues:

Special Measures

1. At the outset of the hearing Ms Bass on behalf of the Council, made an application for the Registrant to switch off her camera during Patient A's evidence, so that Patient A did not see the Registrant whilst giving her evidence. In support of the application Ms Bass relied upon the terms of the Council's Practice Note 2014/04, and in particular the provision therein for special measures to be granted at the Committee's discretion, where it concluded it would assist the witness in providing their best evidence. The Committee was provided with a telephone attendance note concerning a call from Patient A in which she identified the following:

> *"I think for me to speak without getting anxious or getting upset I'd like to not see her. I think I will be calmer and not get upset or anxious if I am clearly able to speak to the people I need to, knowing she has her camera off. I don't mind her being present I just don't want to see her. I would be able to focus on giving my evidence solely. I am having difficulty thinking about this at night and it is affecting my sleep."*

2. Ms Bass therefore submitted that Patient A would be able to give her best evidence if, when doing so, she was unable to see the Registrant.

3. On behalf of the Registrant, Mr Dayle did not object to the application.

4. The Committee received and accepted the advice of the Legal Assessor. It was advised that in applying the test for special measures it should consider the definition of vulnerable witnesses identified in criminal proceedings. Whilst that strict test was a starting point, the Committee should note that in its proceedings it had a general discretion, once it had identified a witness's vulnerability, to make such reasonable adjustments as it thought necessary to achieve the witness's best evidence, conscious that in doing so it needed to ensure fairness to all parties, including the Registrant. The Committee was advised that because an application had been made, it should not in any way affect their assessment of the witnesses, the Registrant or the evidence of any party.

5. The Committee determined that in light of the identified discomfort and upset seeing the Registrant was likely to cause Patient A, it was fair in all the circumstances to accede to the application for special measures, such that during the course of Patient A's evidence the Registrant's camera would remain switched off. That would not affect the Registrant's ability to see and hear the proceedings, nor would it affect her ability to give instructions to her advocate, either during or after Patient A's evidence had been adduced.

6. The Committee therefore granted the Council's application for special measures to the extent sought.

Background

7. Patient A was at all material times a personal trainer and had experience as a pilates instructor. She had a history of back issues including a diagnosis of suspected cauda equina syndrome in 2017, and had received treatment from a chiropractor in 2023, the year before she saw the Registrant, that had caused her discomfort and some pain. She attended one appointment with the Registrant on 8 July 2024, complaining of symptoms including tightness in her left hip, which she perceived to be either in the hip flexor, piriformis and/or gluteal muscles.

8. During the course of the treatment and afterwards, Patient A asserted that the Registrant had undertaken manipulation of her back that she had not consented to, and had actively asked the Registrant not to undertake, in particular clicking her back. Patient A further asserted that the treatment had

caused her considerable pain and had led to her having to seek further treatment from other healthcare professionals including her GP.

9. In consequence on 5 August 2024 Patient A made a complaint to the Council.

Evidence

10. The Committee received documentary evidence, comprising a witness statement and exhibits from Patient A, an expert report from Tim McClune, instructed by the Council, an expert report from Devan Rajendaran, instructed by the Registrant, a joint expert report prepared by both experts, and two witness statements and exhibits from the Registrant.

11. In her oral evidence, Patient A told the Committee that she had chosen to see an Osteopath as they would be able to identify the cause of her pain as well as providing symptomatic relief. She had attended the Registrant following word of mouth recommendations.

12. During the appointment Patient A had told the Registrant about her suspected cauda equina diagnosis which had led to her being hospitalised for three to four days, as well as the loss of bladder control and numbness in her right leg. She did not tell the Registrant about her historic whiplash injury dating back 15 years or so, since she did not consider it was relevant given the problem she was experiencing was in her hip.

13. Patient A explained that she had informed the Registrant that she didn't want her to click or pop her back. She did not recall being asked to sign anything or fill in any forms, with the whole appointment feeling rushed, in comparison to Patient A's own practice when meeting a new personal training client. Patient A explained she was not asked to complete a medical history form and there was very limited discussion about her condition.

14. Patient A then went on to explain that the Registrant had begun "poking around her hip area" as she was lying static, all the while conducting general "chit chat" conversation, unrelated to the treatment process. This first phase of massaging lasted, in Patient A's estimation, for about ten minutes, after which the Registrant said she would ease off the tight areas she had found asking Patient A to sit up on the treatment table.

15. Patient A described the Registrant undertaking a technique in which Patient A was seated with her legs forming a triangle, knees raised and feet flat on the table, with a bolster in front of her knees. She explained that the Registrant had drawn Patient A's knees into her chest and with one hand on her back and another in front of her she threw her forward and "sandwiched together." This

"popped" Patient A's thoracic spine, taking her by surprise. Having been returned to a seated posture, the Registrant repeated the movement, this time with her hand on the back of Patient A's head just below her hairline.

16. This manipulation caused Patient A "excruciating pain" in her neck, which she communicated to the Registrant. As a result, the Registrant asked Patient A to lie down, without any explanation.

17. Patient A told the Committee that the Registrant then put her finger tips along her spine whilst taking the weight of her head. She then threw Patient A's head quickly to one side which caused another crack in her neck.

18. At that point Patient A formed the view the Registrant was rushing through things in order to be ready for her next appointment, but notwithstanding that feeling, the Registrant did not end the appointment at that stage. Instead the Registrant asked Patient A to sit up and offered and administered treatment with an ultrasound device to her shoulders and neck. She then took payment for the treatment and Patient A left, unable to move her head.

19. Patient A sent a text message to the Registrant later that day in which she explained her neck remained very painful. The next day Patient A went to see her GP and was sent to A&E.

20. In cross-examination Patient A confirmed that she had not received a final diagnosis of cauda equina syndrome, it was only suspected and had since been ruled out as a diagnosis, following surgery to her back in October 2024.

21. Patient A confirmed she had a routine MRI scan of her lower back the year before she saw the Registrant, not prompted by any particular issue but just a general investigation around the suspected cauda equina diagnosis and some lower back ache and muscle spasms. When she saw the Registrant she had no issues in her back, only the hip joint soreness.

22. Patient A explained that the issue with her left hip had started about six to eight weeks before she saw the Registrant.

23. In relation to the whiplash injury Patient A explained that she did not disclose that to the Registrant as she did not think it was relevant. Had she been taken through a detailed medical history questionnaire she would have declared it, but that did not happen.

24. Patient A could not recall having straight leg raises administered, although she did recall the Registrant moving her hip and leg when she undertook the

massage. Patient A did not accept the Registrant told her the problem was in her lower back.

25. When asked about the conversation during the appointment, Patient A told the Committee that there was no conversation about what was happening, it was general conversation about her children and the [redacted]. However, the Registrant had told Patient A it was probably the piriformis muscle causing the issue as that is where the pain was when she massaged across it.

26. Patient A accepted that at the outset of the appointment there had been some discussion about the reason for her attendance and what Patient A was seeking to accomplish by attending the appointment.

27. In answer to questions from the Committee Patient A confirmed that she did not ask questions of the Registrant during the massage phase of the appointment, nor did the Registrant say anything about what she was doing.

28. Following the onset of pain during the appointment Patient A explained that going into the horizontal position and thereby bearing the weight of her head on her neck, was extremely painful. When it happened, it was "like a gun had gone off with intense heat and pain." The Registrant had her hands supporting patient A's neck and lifted it off the treatment table. Patient A told the Committee she had asked the Registrant not to click her neck.

29. The Committee then heard from Tim McClune, an expert witness called by the Council. Mr. McClune was asked to account for the difference between the opinion he provided in his initial report that there was no hip mobility test performed and his later opinion in the joint report that there was an adequate assessment undertaken. He explained that his original report had been written with the benefit of only Patient A's evidence. That account, taken together with the records, which contained no detail of any test for hip joint mobility, meant there was no evidence to support the assertion that hip joint mobility had been assessed. Having seen the Registrant's account and the full evidence and exploring the description of treatment Mr. McClune explained that his opinion had changed and that there was now sufficient evidence to suggest there had been some assessment of hip joint mobility. When pressed, he explained that it was not the sort of testing that would cause an osteopath "to pass an exam" but was likely to be adequate in the circumstances. In particular he noted the straight leg raises recorded in the records, Patient A's account of the Registrant moving her hip and the Registrant's account of undertaking a hip mobility test.

30. Mr McClune went on to confirm that the Registrant placing her hands on Patient A's neck was reasonable and did not amount to a cervical spine manipulation

(CSM). Such a check would not have required an assessment of Patient A's neck.

31. Thereafter, Mr McClune was asked about the manipulation administered to Patient A's thoracic spine. He explained that part of what is described by Patient A accords with the DOG technique which is a kind of High Velocity Thrust technique (HVT) applied to the thoracic spine. The technique is supposed to create a force but it can only be done with the patient supine. Sometimes it will produce a click. If a patient had asked that their back not be clicked undertaking that technique should be avoided. The technique can stretch things around the joint and a muscular response or contraction can result and may be very painful. In Mr McClune's opinion that was the most likely cause of Patient A's pain, as the pain being in the neck does not necessarily mean the technique was being undertaken in the neck. The neck muscles could react afterwards even with an appropriately delivered technique to any part of the upper thoracic spine.

32. Asked about verbal consent Mr McClune opined that the most simplistic consent is to explain what might have happened what techniques the Osteopath wishes to undertake, and the risks and benefits of those techniques, including the possibility of soreness after administration. The patient should then be asked if they wish to proceed. Whilst that is not the only method of obtaining informed consent it was, in Mr McClune's opinion, the basic structure of a valid consent process. That process should also include an explanation of the various techniques being used. Notwithstanding his formulation, Mr McClune accepted that obtaining consent is a dynamic process and often done orally and during treatment.

33. When asked about cauda equina syndrome Mr McClune confirmed it was a condition osteopaths should be familiar with as a serious problem in the lower back and spine. It refers to nerve endings at the end of the spine and so affects lumbar spine. It is a potentially serious problem and if a patient may be suffering with it the osteopath should not manipulate or seek to crack the lumbar spine. However, a history of cauda equina syndrome would not mean manipulation of the thoracic spine was necessarily wrong and it could be helpful.

34. When asked about the affect of the thoracic spine manipulation to the neck, Mr McClune was of the opinion that it would have been quite possible to have neck muscle reactions from thoracic manipulation. Cervical spine manipulation could also cause neck muscle reactions.

35. The Committee then heard oral evidence from the Registrant. She explained that at the time of the appointment with Patient A she was working in private

practice and had been since 2004, and was also working in the NHS as a first instance practitioner. She had previously worked as a tutor at the British School of Osteopathic Medicine.

36. The Registrant was asked about the appointment with Patient A. She explained that when Patient A first arrived she welcomed her into the treatment room. She invited her to sit on a chair in the corner and the Registrant sat on a chair and put her laptop on the treatment table to make notes.

37. The Registrant asked what had brought Patient A to see her and when and how her symptoms first started and progressed, and how she could help Patient A. Patient A had explained she was quite nervous having had a chiropractic treatment involving lumbar spine manipulation leaving her immobile, the previous year. Given she was worried about that and had had two pregnancies, one of them being traumatic which therefore might have involved pelvic and lumbar spine issues, the Registrant had decided she would not manipulate the lumbar spine.

38. The Registrant explained the provenance of her records and the time stamps shown on them, which confirmed she had made all the records during the appointment (between 12.28pm and 13.06pm). The records were therefore typed up as she was speaking to Patient A. By reference to her notes the Registrant explained that she had asked about aggravating symptoms, but Patient A identified none and explained the pain was constant. The Registrant then asked about Patient A's work and work history. She explained she had worked in a desk based occupation until sixteen years before. then became a personal trainer and pilates teacher. Patient A had been a keen runner prior to becoming a personal trainer, running up to 50 miles per week.

39. The Registrant explained she had asked about her two children and the fact Patient A had a caesarean section. She recalled Patient A saying she did not want popping or clicking in relation to the lumbar spine only.

40. The Registrant explained that she had not noted this in the records because given the red flag of suspected cauda equina, the caesarean birth, and the report of lower lumbar pain generally, it was out of the question that she would manipulate the lumbar spine in any event.

41. In relation to the assessment she undertook, the Registrant told the Committee that she performed an assessment of Patient A whilst she was standing, checking forward flexion. With Patient A supine the Registrant undertook straight leg raises to assess the hip mobility and lumbar spine. She then asked Patient A to lie on her side and took the leg and flexed the hip. She put her hand on Patient A's hip and with her hip and knee bent in flexion moved it into

extension, into external and internal rotation. This enabled her to assess hip movement into the lumbar spine and into thoracic spine.

42. The Registrant went on to explain that she could feel a restriction in the lumbar spine and up into the thoracic spine which was confirmed her findings in the assessment. She therefore formed a working diagnosis that the pain was coming from the lower back

43. The Registrant told the Committee that during the examination she was giving Patient A a clear description of what she was finding. This was particularly detailed given Patient A had an understanding of anatomy through her own work.

44. The Registrant recalled Patient A being unimpressed at the idea this was down to a lower back issue, but that she was otherwise content. The Registrant then explained thoracic spine manipulation, asked Patient A to flex her knees and hips whilst she was on her back which formed a triangle with her feet flat on the treatment table. The Registrant used a bolster to act as soft cushioning to place over Patient A's elbows to protect her own abdomen The Registrant did not accept throwing Patient A forwards, or crunching her together towards her knees.

45. The Registrant then reassessed and decided to do a mid-thoracic spine manipulation, which required the patient to co-operate with certain key movements and positions. The Registrant explained this to Patient A who consented. She undertook the manoeuvre twice, the first occasion having not released the restriction. Following the second occasion the Registrant became aware Patient A was in pain. She asked Patient A to lie back down placing her hands around her upper thoracic spine. The Registrant administered gentle traction to the Cervical Thoracic Joint at C7 (CTJ) but did not undertake any cervical spine manipulation. The Registrant finished the appointment by administering ultrasound for four or five minutes.

46. Patient A then got up and got dressed, before rebooking for the following week.

47. Later that day, the Registrant phoned Patient A back after Patient A had phoned her and sent her a text message. The Registrant spoke to Patient A for 3 minutes to see how she was feeling. The Registrant thereafter gave an account of the contact between the two, leading up to Patient A's complaint to the Council.

48. In answer to questions in cross-examination the Registrant confirmed that she was seeing on average between eight and ten patients a day. Her normal

working pattern was to see around three or four patients then have a gap before seeing further patients.

49. The Registrant accepted her records were not 100% perfect and explained they were made during the appointment. She accepted she had not recorded that she had obtained valid consent in the records but explained that she always obtained verbal consent.

50. In relation to her various responses to the complaint the Registrant told the Committee her initial response had been prepared after 27 August 2024, when she was first informed of the complaint made to the Council. She had prepared that response by looking at her records and Patient A's complaint and witness statement.

51. The Registrant explained she had demonstrated the thoracic spinal manipulation technique prior to using it as part of the consenting process. The Registrant denied taking the weight of Patient A's her neck in her hands nor did she crack or pop her neck. The Registrant was emphatic that at no point did she treat Patient A's neck. In treating her upper thoracic spine and CTJ she had her hands under Patient A's neck but this was not an attempt to administer a cervical spine manipulation technique.

52. In answer to the Committee's questions the Registrant explained that she had not performed full traction to the cervical spine, even though the recorded acronym appeared in the records. Rather, she had performed very minimal and gentle traction to the CTJ.

53. In further cross-examination it was suggested to the Registrant that she had altered her position from the position in the records and in her original response. The Registrant did not accept there was an alteration, and that where she had referred to cervical spine in relation to traction she had intended to convey the CTJ region.

54. The Committee thereafter heard from Mr Rajendran the expert witness called on behalf of the Registrant. Mr Rajendran provided limited oral evidence, largely adopting his report and the joint report. He expanded on the definition of cervical spine manipulation explaining that "traction" is a form of treatment but would not amount to cervical spine manipulation, albeit he accepted he was not present in the appointment and could not definitively say that the Registrant had not administered cervical spine manipulation.

Submissions of the Parties

55. Ms Bass on behalf of the Council submitted that in order to come to its determination the questions the Committee would need to ask were:
    - Did the Registrant assess Patient A's hip mobility and neck?
    - If not, did that render the assessment inadequate?
    - If the Registrant did manipulate Patient A's neck, did she record it properly in the records?
    - Did the Registrant obtain valid consent?

56. In order to answer those questions Ms Bass invited the Committee to consider first, whether it found the Registrant had manipulated Patient A's neck or not. That decision, she submitted, would inform the Committee's position in relation to other parts of the Allegation.

57. Ms Bass accepted that the fact that Patient A told her GP she had neck pain was no longer in itself supportive of an allegation that the Registrant must have treated Patient A's neck given Mr. McClune's opinion that pain in the neck can occur as a result of thoracic spine manipulation.

58. Notwithstanding that, Ms Bass submitted that Patient A had given a detailed and reliable account of neck manipulations and had no reason to fabricate her account. In her witness statement she had described two incidents of neck manipulation, the second resulting in a pop.

59. Conversely, the Registrant described a first manipulation delivered to the thoracic spine on two occasions. Thereafter she administered traction to the CTJ. It was, Ms Bass submitted, entirely plausible that both Patient A and the Registrant remember the same events differently, and that was accounted for as a result of the malleable nature of memory even in an honest witness.

60. Ms Bass therefore submitted that contemporary accounts and comments are generally a better route to the truth. In circumstances where the Registrant saw numerous patients every day, had spent only 30 minutes with Patient A, including taking payment from her and booking another appointment, her recollection was likely to be less reliable than the contemporaneous accounts given by Patient A to her GP and to the hospital, shortly after the appointment.

61. The contemporaneous records prepared by the Registrant were completed under time pressure and were acknowledged by all to be incomplete. It was clear, Ms Bass submitted that the Registrant's recollection was hampered by a lack of detail in the records.

62. Ms Bass then addressed each Paragraph of the Allegation in turn. In relation to Allegation 2(b) she submitted that if the Committee found there was a manipulation of the neck as set out in Paragraph 3, then an assessment ought to have been done. Both the Registrant and the experts agreed no such assessment was done. Whether an assessment should have been done could only be answered by reference to the Committee's determination of Paragraph 3. Ms Bass therefore invited the Committee to consider Paragraph 3 of the Allegation prior to considering Paragraph 2.

63. In relation to Paragraph 2(a) Ms Bass submitted that notwithstanding Mr McClune's opinion that there was evidence of a hip mobility test, it was not a test that would pass an exam, it was not a clear assessment and was therefore inadequate.

64. In relation to Paragraph 3 Ms Bass submitted that if the Committee concluded a neck manipulation had been carried out the entirety of Paragraph 3 would be found proved. If it did not, the entirety of the Paragraph would fail.

65. In relation to Allegation 4, Ms Bass submitted that it encapsulated two distinct evidential elements. First, whether there was consent for the high velocity thrust manipulations on either description (whether cervical or thoracic) and second, whether there was consent for the neck manipulation/traction. Patient A's evidence was that she had asked the Registrant not to click her back. The Registrant had said she would not. Yet she then administered manipulations that resulted in clicking or popping. The Registrant's account of Patient A restricting the clicking or popping to the lumbar or lower back appeared nowhere in the records and was therefore less reliable than Patient A's account of the comment.

66. Patient A's position was supported Ms Bass submitted, by Mr. McClune's evidence of the need for careful consenting in circumstances where thoracic manipulation will involve a click or pop if the patient had specifically asked not to be clicked or popped in the lower back. Moreover, the Registrant had made an assumption that there was consent because Patient A had moved into position for the manipulation. That was insufficient for valid consent. Paragraph 4 should therefore be found proved.

67. Ms Bass further submitted that whilst the Registrant denied a second manipulation involving the neck, if that had taken place she did not obtain consent and on that basis Paragraph 4 should be found proved.

68. In so far as Paragraph 5 of the Allegation was concerned, Ms Bass submitted that stood or fell on the Committee's findings in relation to Paragraphs 2, 3 and 4.

69. On behalf of the Registrant, Mr Dayle submitted that in relation to Paragraph 2(a) of the Allegation, the Council had pursued the matter in spite of its own expert being unsupportive of the position in the joint report. The evidence from both was clear, the Registrant had done an adequate assessment in the circumstances. He therefore submitted that Paragraph 2(a) should be found not proved.

70. In relation to Paragraph 2(b) Mr Dayle submitted that the Registrant's first response to the Council made it clear she had undertaken some exploratory investigation of the cervical spine and neck, but had not treated there. It was confined to gentle traction in the region of the CTJ, which was consistent with her other responses and with her records. The Registrant had therefore undertaken some assessment of the cervical spine even though she did not treat it and was therefore under no obligation to conduct such an assessment. Paragraph 2(b) should therefore be found not proved.

71. Mr Dayle submitted that the evidence for cervical manipulation was limited and there was no support from the medical consequences of the treatment, given both experts agreed that thoracic manipulation could cause neck pain. In addition, Patient A's medical history prior the appointment with the Registrant could account for the neck pain she suffered. The MRI conducted shortly after the appointment recorded no bony or muscular injury to the neck, indicating that injury to the neck was not caused by manipulation of the cervical spine.

72. There was, Mr Dayle submitted, no independent evidence of cervical spine manipulation and the Registrant's account on the point had been consistent throughout and should be accepted. Paragraph 3 should therefore be found not proved.

73. In relation to the issue of consent Mr Dayle submitted that there was agreement between the experts that obtaining consent was a dynamic exercise and that it may mean obtaining written consent is not feasible prior to treating. Given the Registrant's long-standing and unblemished career, Mr Dayle submitted that it was inherently unlikely that she had not sought and obtained consent for involved and difficult manipulations, requiring the co-operation of the patient.

74. Notwithstanding the lack of consent recorded in the records, Mr Dayle submitted the records were, in general terms, more consistent with a practitioner who had discussed her process with Patient A and had arrived at an agreed and consented treatment plan.

75. Mr Dayle therefore invited the Committee to find Paragraph 4 not proved.

76. In relation to Paragraph 5 Mr Dayle agreed with Ms Bass that it was parasitic on the Committee's findings in relation to Paragraphs 2, 3 and 4 and that therefore it should be found not proved for the reasons he submitted applied to each of the other Paragraphs.

The Committee's Findings on the Facts

77. The Committee received and accepted the advice of the Legal Assessor. The Committee was advised that the Council bears the burden of proof throughout and the standard of proof is the civil standard namely the balance of probabilities. The Committee was further advised that in assessing the evidence it was entitled to draw inferences, that is it was entitled to come to common sense conclusions based upon the evidence, but that it should not speculate on the evidence. The Committee had heard and read evidence form experts. It was not bound to accept that evidence and should treat it with the same careful analysis as any witness evidence, whilst bearing in mind that experts bring to bear their knowledge and expertise in a particular field.

78. The Committee was directed to the case of Montgomery v Lanarkshire [2015] UKSC 11 as to the definition of consent.

79. The Committee was further advised as to the Registrant's good character. It was advised that good character of itself provided no defence but should be taken into account in the Registrant's favour in relation both to an assessment of credibility and propensity.

80. Where the Council alleged that the Registrant had "failed," that connoted a culpable failing. The Council would therefore have to prove that there was a duty upon the Registrant to do or to not do something and that he had failed in that duty.

Paragraph 1 - Admitted and Found Proved

81. The Registrant admitted Paragraph 1 of the Allegation at the outset of proceedings. Pursuant to Rule 27(1) of the General Osteopathic Council (Professional Conduct Committee) (Procedure) Rules Order of Council 2000 ('the Rules') the Committee found that Paragraph proved.

Paragraph 2(a) - Not Proved

82. The Committee first considered the accounts of both Patient A and the Registrant. It considered that whilst there were differences in those accounts, both gave an account involving movement of the hip and joint flexion, such

that both Mr McClune and Mr Rajendran were satisfied that the Registrant had undertaken a sufficient hip mobility assessment in the circumstances. Whilst the Committee recognised that Mr McClune did not consider it to be of the sort that would "pass an exam" that was not the issue before the Committee. The Committee was required to consider if such a test had been undertaken and whether it was adequate. The evidence demonstrated that such an assessment had been carried out and in the opinion of both experts was adequate. The Committee therefore found Paragraph 2(a) not proved.

Paragraph 2(b) - Not Proved

83. The Committee noted that Patient A had recalled the Registrant touching and treating her neck. The Registrant herself accepted touching Patient A's neck, but denied administering any manipulation to it. There was therefore some evidence to support an assertion that the Registrant had undertaken a cervical spine assessment of some sort, on both Patient A's account and that of the Registrant, albeit Patient A may not have perceived it as such.

84. The Committee was therefore not satisfied there was sufficient evidence to show that it was more likely than not that no assessment had been carried out of the cervical spine. The adequacy of that assessment was of concern to the Committee, but was necessarily informed by the Committee's determination of the treatment administered to the cervical spine. The greater the level of treatment to the cervical spine the more important was a thorough assessment. In light of its determination at Paragraph 3 below the Committee found there was no requirement for the Registrant to undertake a cervical spine assessment of any sort, since it had not been her intention to treat Patient A's cervical spine, nor had she undertaken a cervical spine manipulation technique.

85. The Committee therefore found Paragraph 2(b) not proved.

Paragraph 3 - Not Proved

86. The oral evidence before the Committee from the Registrant was that she had undertaken no treatment to Patient A's neck. That appeared to be at odds with her records which described traction being applied to the cervical spine. The Committee was therefore concerned that the Registrant had overstated the position to some degree. The Committee noted that Patient A was clear that she recalled treatment being administered to her neck as well as the thoracic treatment, and relied upon the pain in her neck as evidence of the neck treatment.

87. The Committee agreed with Ms Bass that in light of the agreed position of the experts, there was no real scope for asserting that the neck pain Patient A

suffered was more likely than not attributable to treatment of the cervical spine. To the contrary, it appeared on the evidence to be as consistent if not more consistent, with a properly applied thoracic spine manipulation. Given the diametrically opposed accounts of Patient A and the Registrant on the point, the Committee considered the patient records to be of considerable importance. Those made no mention of cervical spine manipulation and it was, in the Committee's judgment, highly unlikely that had such a treatment been administered it would have been wholly unrecorded.

88. Patient A had attributed the popping or clicking to a cervical manipulation, but the Committee considered the Registrants' account of the thoracic manipulation to be an account of a recognised and standard manipulation, that often caused a clicking or popping, and was a more likely cause.

89. Whilst the Committee was in no doubt that Patient A's account was an honestly held perception of what had occurred, and that as a result she suffered considerable pain, it was not able to conclude that her account of the treatment to her cervical spine was an account that was more likely than not to have been correct. The fact the Registrant had touched Patient A's neck at other points and had conducted traction at C7, with her hand positioned under Patient A's head, might well have caused Patient A to perceive the Registrant to be treating her cervical spine with a manipulation technique, which when coupled with pain in her neck led Patient A to the conclusion a manipulation technique had been applied to her cervical spine.

90. The more likely reality in the Committee's judgment, was that the Registrant had acted as she recalled and as was clinically indicated, had administered minimal treatment to Patient A's cervical spine at C7 but had not gone as far as to undertake a cervical manipulation technique. To that extent the Committee accepted Mr Rajendran's distinction between traction and a manipulation technique.

91. Whilst the Committee concluded that Patient A had an honestly held belief that treatment had proceeded as she had explained, it preferred the Registrant's account on the point, save that it considered the records supported the finding that some minor treatment had been administered in terms of traction at C7.

92. The Committee therefore determined that on the balance of probabilities there was insufficient cogent evidence before it to show that a cervical spine manipulation had been performed by the Registrant and there was some evidence it had not been performed.

93. The Committee therefore found Paragraph 3 of the Allegation not proved.

Paragraph 4 - Not Proved

94. The Committee carefully considered the accounts given by Patient A and the Registrant of the discussions and conversations that took place in the appointment. The Committee considered Patient A's initial evidence of the Registrant saying nothing about diagnosis or treatment and just engaging in general "chit chat" about personal matters, to be more condemnatory of the Registrant's overall demeanor than her later evidence, in which she accepted the Registrant had asked her what her reason was for attending, what she sought to gain from treatment and how long the symptoms had persisted.

95. Those elements of Patient A's account were reflected in the records as were other aspects of discussion that must have occurred between Patient A and the Registrant in order for them to appear in the contemporaneous record. Whilst the Committee accepted the record was limited both in its content and in its evidential significance, it nonetheless alluded to a version of the appointment more in line with the Registrant's recollection than that of Patient A. The Registrant had recorded numerous details of Patient A's medical history, her treatment plan and proposed techniques, so that the records were in the Committee's judgment, broadly supportive of the Registrant's account.

96. The Committee noted that the Registrant gave a cogent and clear account of demonstrating the thoracic manipulation technique to Patient A as part of the consent process, and that the technique itself was an involved and complicated one that required patient acquiescence and cooperation, at the very least.

97. The Committee had the advantage of being able to evaluate Patient A first-hand and formed the view that Patient A was both articulate and knowledgeable enough to object to a course of treatment if she had not consented to it. In circumstances where she had a clear view of what might be the cause of her pain, the Committee considered it less likely than not that she would acquiesce to treatment without understanding the risks and benefits.

98. The Committee accepted the evidence of the experts that obtaining consent is a dynamic process and is ongoing throughout treatment. Whilst the Committee could not be sure exactly what was discussed, it was satisfied that the lack of a written record of consent was not, in the circumstances, sufficient evidence to show that on the balance of probabilities no valid consent was given.

99. There was in the Committee's judgment, a lot of conversation and discussion taking place in the appointment. It could not find sufficient cogent evidence to show that, on the balance of probabilities, the Registrant had failed to obtain valid consent.

100. The Committee therefore found Paragraph 4 not proved.

Paragraph 5 - Not Proved

101. The Committee was unable to identify anything that Paragraph 5 helpfully added to the Allegation. It was wholly parasitic on paragraphs 2 – 4. In light of the Committee's findings in relation to those Paragraphs, the Committee determined that Paragraph 5 was not proved.

Findings on Unacceptable Professional Conduct ("UPC")

102. On behalf of the Council, Ms Bass submitted that the proven Particulars did not disclose any breaches sufficient to amount to UPC.

103. Mr Dayle, on behalf of the Registrant agreed with the Council's submission.

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

105. Upon the Registrant's admission the Committee found 1 of the Paragraphs of the Allegation proved. In considering the Paragraph admitted, it determined that it was nothing other than discursive and disclosed no breach of the Osteopathic Practise Standards 2018 ("OPS").

106. It therefore determined that none of the Particulars found proved amounted to UPC.

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

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

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

that the PSA may refer a decision of the Professional Conduct Committee to the High Court if it considers that the decision is not sufficient for the protection of the public.