GENERAL OSTEOPATHIC COUNCIL

PROFESSIONAL CONDUCT COMMITTEE

Cases: 744/5358 & 745/5358

Professional Conduct Committee Hearing

DECISION

Case of:	Jason Gaffney
Committee:	Andy Skelton (Chair) Nora Nanayakkara (Lay) Helena Greenwood (Osteopath)
Legal Assessor:	Peter Steel
Representation for Council:	Matthew Corrie
Representation for Osteopath:	Mark Kelly (16th – 20th November 2020) Stuart Sutton (23rd March 2021)
Clerk to the Committee:	Nyero Abboh
Date of Hearing:	16th – 20th November 2020, 23rd March 2021

Summary of Decision:

Patient A: allegation 1 admitted and found proved. Allegations 2b(i), 2c and 3 (in respect of 2c) found proved. Allegations 2a and 2b(ii) found not proved.
Patient B: Allegation 1 admitted and found proved. Allegation 2a found proved. Allegations 2b, 3 and 4 found not proved. UPC found proved in respect of the proven allegations. Sanction of Admonishment imposed.

Allegations (as amended) and Facts:

Patient A:

The allegation is that you, Mr Jason Gaffney, have been guilty of unacceptable professional conduct, contrary to section 20(1)(a) of the Osteopaths Act 1993, in that:

1. On or around 8 December 2006, Patient A attended an appointment with you at Rosegarth Clinic (the 2006 Appointment).

2. During the 2006 Appointment, you:

a. failed to communicate with Patient A in an appropriate and/or professional manner, using words to the effect set out in Appendix 1;

b. provided treatment to Patient A:

i) for which you failed to obtain valid consent; and/or

ii) which was inappropriate and/or not clinically justified as set out in Appendix 2;

c. failed to respect Patient A's dignity and/or modesty by your conduct set out in Appendix 3.

3. Your conduct as alleged at paragraphs 2a and/or 2b(ii) and/or 2c transgressed professional boundaries.

Appendix 1

i) "No wonder you have a bad back carrying those around." (referring to Patient A's breasts);

ii) "My Thai bride does anything for me, if you know what I mean?"

Appendix 2

i) You carried out High Velocity Thrust treatment whilst Patient A's arms were by her side.

Appendix 3

i) Remaining in the room and near to Patient A as she undressed and/or dressed;

ii) Unfastening Patient A's bra without her consent;

iii) Treating Patient A while her breasts were exposed;

iv) Failing to offer Patient A a cover-up.

Patient B

The allegation is that you, Mr Jason Gaffney, have been guilty of unacceptable professional conduct, contrary to section 20(1)(a) of the Osteopaths Act 1993, in that:

1. On or around 15 November 2015, Patient B attended an appointment with you at Rosegarth Clinic (the 2015 Appointment).

2. During the 2015 Appointment, you provided treatment to Patient B:

a. for which you failed to obtain valid consent; and/or

b. which was inappropriate and/or not clinically justified.

3. By your conduct as alleged at paragraph 2 (b), you transgressed professional boundaries.

4. Your conduct as alleged at paragraph 2 (b) was ~~sexually motivated~~ sexual in nature.

Preliminary issues

1. Mr Corrie, on behalf of the General Osteopathic Council (GOsC), applied to amend head 4 of the allegation concerning Patient B so as to substitute the words "*sexual in nature*" in place of the words "*sexually motivated*".

2. The reason for seeking this amendment came about as a result of a recent case, *General Medical Council v Haris* [2020] EWHC 2518 (Admin), in which the judge had said: "*..it does seem to me that pleading "sexual motivation" is unhelpful. Similarly, to look for "sexual gratification" may be misleading and overcomplicating. It is irrelevant to the actions which the GMC would wish to proscribe whether or not the perpetrator was sexually "gratified" at all - whether before, after or during the act in question. Gratification, as with "pursuit of a relationship" are, pace the analysis of Mostyn J in Basson , not helpful in my judgement in promoting the public interests at stake here. These criteria set the bar too high and I respectfully disagree that they represent the law."* Mr Corrie submitted that the same considerations applied in this case and that the conduct was more appropriately pleaded as being 'sexual in nature"".

3. The Registrant did not oppose this amendment. Having consulted the legal assessor, the Committee allowed the amendment in accordance with Rule 24 of the General Osteopathic Council Professional Conduct Committee (Procedure) Rules 2000 (the Rules).

Admissions

4. At the outset of the hearing, Mr Kelly, acting on behalf of the Registrant, indicated that allegation 1 in respect of both Patient A and Patient B were admitted and they were found proved on that basis.

5. However, it transpired during the course of the hearing that the admission in respect of Patient B was as per the Schedule of Agreed Facts presented to the Committee as part of the GOsC Bundle, which stated that, "*Patient B had one appointment with the Registrant which took place in November 2015*".

6. The Registrant's notes indicated that the appointment was on 25 November 2015, not 15 November 2015 as Patient B had asserted in her statement (indeed the new patient form she had completed at the appointment contained her signature next to the date 25 November 2015). Mr Kelly, on behalf of the Registrant, conceded that the date was not a material averment, in that there was no dispute that the Registrant had treated Patient B on one occasion. The Committee noted that it was likely that the actual date of the appointment was 25 November 2015, but given that the allegation had been pleaded as "*On or about 15 November 2015*" and nothing turned on this, it did not consider it necessary to amend this particular.

Background

7. Patient A and Patient B separately saw the Registrant on one occasion for osteopathic treatment, Patient A in 2006 and Patient B in 2015.

8. Neither Patient A nor Patient B made any complaint immediately following their appointments. Patient A and Patient B work together. They discussed their experiences of treatment by the Registrant at some point following on from Patient B's appointment.

9. Subsequently, in response to an advert she had seen on social media, Patient B wrote a review of the Rosegarth Clinic (the Clinic) on Google. This prompted a response from the owner of the Clinic who wrote to Patient B on 14 August 2019 seeking that the review be removed. Patient B then attempted to speak to the owner of the Clinic but was not able to do so. Later in 2019, Patients A and B reported their experiences to the police and then to the GOsC.

Application to admit hearsay evidence

10. Mr Kelly applied to admit the statement of Michele Godber (the Statement), the receptionist of the Clinic at the relevant times, into evidence. She had been due to attend the hearing but had indicated to the Registrant's solicitors shortly beforehand that she was unable to do so as a result of her participating in an online training course during the week of the hearing. Mr Kelly submitted that her evidence was relevant to the matters in issue before the Committee and that fairness to the Registrant weighed in favour of it being admitted, despite the witness's inability to attend. Any matter of the prejudice caused to the GOsC could be addressed by way of the weight the Committee afforded to the statement.

11. Mr Corrie objected to the application. Parts of Ms Godber's evidence were disputed and the GOsC would want the opportunity to cross examine her. There had been no proper explanation of Ms Godber's absence or of the attempts that had been made to allow her to participate in the hearing. Looking at the matters set out in the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin), the correct course was for the Committee to reject the application.

12. The Committee listened carefully to the submissions of Mr Kelly on behalf of the Registrant and of Mr Corrie on behalf of the GOsC. It accepted the advice of the legal assessor. The Committee took account of the criteria to be applied in considering whether to exercise its discretion to admit the Statement described in the case of *Thorneycroft v Nursing and Midwifery Council* .

13. Though the Statement was not the sole or decisive evidence in support of the Registrant's case, it was relevant to the issue of the reliability and credibility of all three witnesses from whom the Committee had heard, Patient A, Patient B and the Registrant himself. In the Committee's view, it was clear from the face of the Statement that Ms Godber was likely to be subject to cross-examination, given her role in the Clinic and the events surrounding the Google review. In that light, it accepted that the GOsC was prejudiced to some extent by not being able to question the live witness.

14. The Committee had no reason to believe that Ms Godber's evidence was fabricated and it took full account of the seriousness of the allegations against the Registrant. However, the Committee did not find that the reason supplied for Ms Godber's non-attendance (that she was engaged in an online training course between 7am and 5.30pm every day this week) to be satisfactory. Nor had there been any real attempt to explain to the Committee what steps had been undertaken to attempt to arrange Ms Godber's participation in the hearing. It was not clear whether, for instance, the Registrant's solicitors had canvassed her availability after receipt of the Notice of Hearing or had discussed the possibility of obtaining a witness summons to secure her attendance. It appeared that the

question of her inability to attend was only raised with the GOsC shortly prior to this hearing.

15. In the circumstances, the Committee was not persuaded that there was a good reason why Ms Godber could not attend by video conference at some point during the hearing to give her evidence, as the other witnesses had done. Taking into account the need for fairness to all parties, the Committee concluded that, on balance, it would not be in the interests of justice to admit her statement as evidence.

Determination

The witnesses

16. The Committee heard live evidence from the following witnesses on behalf of the GOsC:

- Patient A;

- Patient B; and

- Mr Tim McClune, an expert osteopath.

17. The Registrant gave evidence on his own behalf and provided (among other documents) written statements from the owner of the Clinic, Jennifer Dady and from Ms Godber, the receptionist at the Clinic, neither of whom attended to give evidence. The evidence of Ms Dady was agreed. As noted above, the Committee rejected the application to admit Ms Godber's statement as evidence and so took no account of it.

18. The Committee carefully considered all the papers with which it had been provided, in particular the written statements of the witnesses, the notes for Patient A and Patient B, the correspondence relating to the complaints and the two Schedules of Agreed Facts.

19. The Committee formed the following impressions of the witnesses.

20. Patient A was an honest witness and credible, in that she appeared to be saying what she genuinely believed happened. She gave her evidence in a calm and measured way. She conceded appropriately when she couldn't remember facts and the elements of vagueness in her evidence appeared consistent with someone doing their best to recall an appointment 14 years ago in an honest and sincere way. The Registrant corroborated some of the details she remembered – for instance the lack of a screen, the position of the treatment table and the presence

of sink and mirror in one of the treatment rooms. Overall, the Committee considered her evidence reliable, but at the same time found it entirely possible that elements of her account had merged somewhat with the account of Patient B, through retelling and discussion with Patient B, rather than any intention to mislead.

21. Patient B was also clear and straightforward in her evidence, indeed immoveable on the events that she said had occurred during the appointment with the Registrant. In other respects, her account did move during the course of her evidence, particularly as regards the transactions with the receptionist and Clinic owner after the appointment. She was also clearly mistaken on some issues, in particular the date of the appointment. The Committee considered that these matters somewhat undermined her reliability and credibility as a witness, as did the chronology of her complaint.

22. The evidence of Patient A and Patient B did support each other's account to some extent and was broadly consistent, though the Committee did not place any particular weight on this, given their friendship and the fact they had discussed each other's experiences extensively. As noted above, though this may have led to some blurring of their accounts, the Committee did not consider that it necessarily detracted from their independent experiences of treatment by the Registrant. The Committee had no reason to believe either patient had fabricated their accounts, nor was there any sense that they stood to benefit in any way from complaining.

23. As regards the Registrant, he had no independent recollection of either of the appointments. His evidence was confined to confirming the content of his notes and explaining his usual practice. The Committee found that he was credible and reliable to that extent. He remained consistent in his responses and was able to articulate his treatment rationale as set out in the notes clearly.

24. The GOsC had also instructed an expert, Mr McClune, to report on the clinical aspects of the case. While the Committee had no doubt about his expertise, the extent to which he could assist the Committee was limited, given the crucial issues of fact were, as his reports indicated, for this Committee to decide.

Findings of fact

25. The Committee carefully considered all the written and oral evidence which it had received, as well as the submissions of Mr Corrie and Mr Kelly. It accepted the advice of the legal assessor. Having done so, it found as follows.

Patient A

2. During the 2006 Appointment, you:

a. failed to communicate with Patient A in an appropriate and/or professional manner, using words to the effect set out in Appendix 1;

i) "No wonder you have a bad back carrying those around." (referring to Patient A's breasts);

Not proved. Patient A's evidence on this point was slightly uncertain. She said initially that the conversation had happened as she walked into the consultation room, but in cross examination, she said that this remark had been made as she and the Registrant walked down the corridor to the room. The Committee considered there was some strength to the submissions on behalf of the Registrant that the likelihood of his making such a comment to a new patient, where he did not know what the patient's presenting complaint was or what that patient's reaction would be to the remark, in close proximity to the receptionist and possibly others, was low. It took into account the Registrant's good character as to his propensity to act as alleged. The Committee therefore concluded that the Council had not proved this allegation to the requisite standard.

ii) "My Thai bride does anything for me, if you know what I mean?"

Not proved. Again, there was a clear conflict of accounts about whether the Registrant had made any such statement. The Registrant absolutely denied that this had happened and explained that although he had married a Cambodian woman in 2014, he had not met her in 2006, was at that point in time unmarried and had never visited either Thailand or Cambodia. Patient B gave evidence to the effect that she had looked on social media in about 2019 to find a photograph of the Registrant and had seen a photograph or photographs of his family, including a woman who appeared to be of South East Asian origin and may have shown this to Patient A. The Committee considered that this may have been an instance of the inadvertent conflation of accounts between Patient A and Patient B. It therefore did not find this allegation proved on the balance of probabilities.

b. provided treatment to Patient A:

i) for which you failed to obtain valid consent; and/or

Proved. Patient A's account of the appointment and her treatment in this regard was persuasive and clear. It was evident to the Committee that she did not understand the treatment offered to her whether then or now and had received no proper explanation of it. In contrast, the Registrant could only state what he

said was his usual practice. The Committee noted that Patient A had received massage a month prior to the appointment, so had some experience of having an intimate form of therapy. In that context, there was clearly something surprising or shocking about her treatment by the Registrant. In the Committee's view, this was entirely consistent with her expressed shock at the undoing of her bra strap.

ii) which was inappropriate and/or not clinically justified as set out in Appendix 2;

i. You carried out High Velocity Thrust treatment whilst Patient A's arms were by her side.

Not proved. There was a clear consensus between the expert and the Registrant that it was unlikely that Registrant could have accomplished an HVT if Patient A's arms had been by her side. The Registrant's notes indicate that he did however undertake an HVT and he was clear about how he would have achieved this. Further, Mr McClune's report specifically stated, "*Patient A's evidence does not suggest any inappropriate osteopathic treatment techniques were carried out by the Registrant*". On that basis, the Committee did not find this allegation proved.

c. failed to respect Patient A's dignity and/or modesty by your conduct set out in Appendix 3.

i) Remaining in the room and near to Patient A as she undressed and/or dressed;

Proved. The Committee preferred the evidence of Patient A on this point. As the Registrant conceded, she could have received treatment in room 4, which had a sink and mirror as she described and the Committee found her account of his washing his hands in the sink as she put her top back on convincing (and appeared consistent with the fact the Registrant had used oil to massage her). The Registrant, as indicated previously, had no independent recollection of the appointment at all.

ii) Unfastening Patient A's bra without her consent;

Proved. The Registrant said his usual practice would have been to undo bra straps, so the Committee considered it probable he would have done so on this occasion. Patient A had recently had massage treatment. In that context, the Committee considered that she would have had an expectation of undressing. She was clear in her recollection that the Registrant had undone her bra strap without asking her and she was shocked by this. The Committee believed her evidence on this point and on that basis found this allegation proved.

iii) Treating Patient A while her breasts were exposed;

Proved. Patient A provided a clear and compelling description of trying to hold her bra on during part of the treatment. The Committee therefore found it more likely than not that, having had her bra strap undone, at some point during the treatment cycle her breasts were exposed (and while she may not have had arms by her side during the HVT manoeuvre, her arms may have been by her side for some part of the treatment).

iv) Failing to offer Patient A a cover-up.

Proved. The Committee considered that if there had been a towel available to Patient A, none of the above would have been in issue. The Committee considered that her evidence on this point, which it accepted, and the overall sense of unease she had about the appointment was consistent with the fact that she was not offered a cover-up. It therefore found this allegation proved.

3. Your conduct as alleged at paragraphs 2a and/or 2b(ii) and/or 2c transgressed professional boundaries.

Proved. As it had not found allegation 2a and 2b(ii) proved, the Committee only considered this allegation in respect of allegation 2c. The Committee interpreted "*transgressed professional boundaries*" as meaning a breach of the relevant standards in the Code of Practice May 2005 (the Code of Practice) (in this instance clauses 45, 46 and 62). In light of its findings under 2c above, the Committee found that those provisions in the Code of Practice had indeed been breached and that therefore this allegation was found proved.

Patient B

2. During the 2015 Appointment, you provided treatment to Patient B:

a. for which you failed to obtain valid consent; and/or

Proved. Patient B's evidence was that the Registrant did not explain what he was about to do or how he was going to position her during the assessment and treatment sequence, but had just instructed her. She described feeling powerless and being manipulated by the Registrant in a mechanical fashion. She was clear that she had felt uncomfortable about the appointment throughout, which the Committee saw as consistent with a lack of explanation of the process. She accepted in cross examination that there had been some conversation about assessment and prognosis (she mentioned the Registrant suggesting that the course of treatment might take up to 6 weeks, though the Registrant denied that

this was his common practice) but was evidently still entirely unclear about the purpose and nature of the treatment she underwent .

The Registrant's notes for the appointment contained the acronym "DROP", meaning "Discussed Reaction Outcomes with Patient". He told the Committee that at that time he would routinely include this in his patient notes, so it was not in the Committee's view a reliable indicator that there had been a valid consent process. Given all the circumstances, the Committee considered it more likely than not that as Patient B asserted, she had not received a proper explanation of the treatment or given a valid consent to it.

b. which was inappropriate and/or not clinically justified.

Not proved The Committee understood this allegation to refer only to the part of the appointment where Patient B said that she was asked to sit on the treatment table in front of the Registrant, place her hands on his hips and place her head in the area of his stomach while he massaged her shoulders. Patient B was adamant that this had happened as she described and that it had occurred at the end of the treatment session. Again, though the Registrant had no recollection of the appointment at all, he was clear that such an incident had not happened nor would it ever happen. The Committee was in no doubt that there had been some problem at the appointment, as its finding on the lack of valid consent suggested.

However, a number of the surrounding features of Patient B's complaint inclined the Committee to have some doubts whether this specific incident had occurred in the way she described. Patient B said in her statement and in her evidence to the Committee that she had described the incident in full shortly after the appointment to her GP (though there was no record of this conversation to corroborate this); to her solicitor (who noted that she had had a "*bad experience*"); and to the physiotherapist she saw subsequently, as well as to Patient A and some other colleagues. The Committee found it implausible that none of the professionals, nor her colleagues, had advised her to pursue a complaint to the police if she had described to them an incident which, according to her statement, she had felt at the time was of a sexual nature.

Further, when she came to complain via the Google review in 2019, she referred to "*inappropriate behaviour from a member of staff throughout my consultation*", which seemed to the Committee to be a somewhat different complaint to the one her evidence subsequently suggested, namely an unambiguous sexual assault.

The trigger for her visit to the police and complaint to the GOsC had been the receipt of a letter from the Clinic threatening legal action were she not to remove the review. Patient A confirmed that when she and Patient B had gone to the police, it was more in the way of seeking advice than to report an offence. It

seemed to the Committee that Patient B's complaint had therefore evolved over time from a more general concern of inappropriateness to something that was described as obviously sexual in nature.

On that basis and bearing in mind the inherent probabilities of the competing scenarios before it, the Committee was not satisfied that this allegation was proved to the relevant standard.

3. By your conduct as alleged at paragraph 2 (b), you transgressed professional boundaries.

Not proved. Given the Committee's finding concerning allegation 2 (b), this allegation fell away.

4. Your conduct as alleged at paragraph 2 (b) was sexual in nature.

Not proved. As above.

Decision on Unacceptable Professional Conduct

26. The Committee went on to determine whether the facts found proved amounted to UPC at the resumed hearing on 23 March 2021, at which point the Registrant was represented by Mr Sutton. The Committee took account of its findings of fact, the written submissions received from the parties in advance of the resumed hearing and the further oral submissions of both counsel.

27. The Committee bore well in mind the overarching objective of these proceedings, namely the protection of the public. It reminded itself that the three limbs of that objective are: protecting and promoting the health, safety and wellbeing of the public; promoting and maintaining public confidence in the profession; and promoting and maintaining proper standards and conduct for members of the profession.

28. The Committee accepted the advice of the legal assessor and had regard to Section 20 of the Act and the well-known case of Spencer v GOsC [2012] EWHC 3147. From this it is clear that UPC is conduct which "*falls short of the standard required of a registered osteopath*" and it is of sufficient seriousness to attract a degree of "*moral blameworthiness*". The Committee also bore in mind that there was no standard of proof to be applied at this stage and that consideration as to whether the threshold for UPC had been reached was a matter for its own independent judgment. Although Mr Sutton had helpfully conceded on behalf of the Registrant that the facts found proved constituted UPC when viewed in the

round, the Committee considered the allegations on their merits to determine whether they amounted to UPC.

29. The facts that the Committee had found proved amounted to a failure to obtain valid consent from Patient A during treatment in December 2006 and similarly failing to obtain consent from Patient B during treatment in November 2015. The Registrant had also failed to respect Patient A's dignity and modesty during the treatment.

30. Mr Sutton had rightly conceded that any failure to obtain valid consent was a serious matter for an osteopath and amounted to UPC. Obtaining valid consent and respecting patients' dignity are fundamental parts of the examination and treatment process. Failing to do so raised issues of trust in the Registrant and in osteopathy generally.

31. The Committee considered the three limbs of public protection and was satisfied that the Registrant's conduct, as demonstrated by the facts found proved, engaged all three limbs. There was clearly a question of promoting the health, safety and well-being of patients and the behaviour in question equally had the potential to damage the reputation of the profession in the general sense as well as to damage the view that specific patients may have of the Registrant and other osteopaths. Lastly, there was a clear failure to meet the standards expected of osteopaths.

32. In coming to the above conclusions, the Committee considered (in respect of Patient A) the Code of Practice May 2005, in particular the following sections:

"As an Osteopath you must:

Make the care of the patient your first concern, by

- *Treating every patient politely and considerately;*
- *Respecting patients' dignity, individuality and privacy;*
- *Never abusing your professional position…*

Respect the rights of patients to be fully involved in decisions about their care, by:

- *Obtaining consent before you examine or treat a patient;"*

as well as the guidance offered in Clauses 23, 24, 45 and 46.

33. The Committee also considered (in respect of Patient B) the OPS 2012. It considered that the following are engaged in this case:

A1 – You must have well-developed interpersonal communication skills and the ability to adapt communication strategies to suit the specific needs of a patient.

A3 – Give Patients the Information they need in a way that they can understand

A4 – You must receive consent before Examination and Treatment

D17 – Uphold the reputation of the profession through your conduct.

34. The Committee found that the behaviour represented by the facts it had found proved was likely to damage public confidence in the profession and represents a serious departure from expected standards. It therefore amounts to UPC.

Decision on Sanction

Submissions

35. In his submissions on behalf of the Council, Mr Corrie referred to its overarching duty of protection of the public. He emphasised that the Committee should keep proportionality in mind and consider the least restrictive sanction first. Mr Corrie confirmed that the Registrant had no previous regulatory history.

36. Mr Corrie invited the Committee to scrutinise the evidence of insight and remediation which Mr Sutton had provided to the Committee on the Registrant's behalf. Turning to the question of sanction, he had no positive submission to make on the appropriate outcome, but observed that the patients in question had been caused real distress and these were not isolated incidents, though it was acknowledged that the last of them had been 5 years previously without any subsequent problems coming to light.

37. Mr Sutton submitted that as soon as the Committee had made its decision on the facts and conscious of the likely finding of UPC, the Registrant had contacted a senior expert osteopath, Mr Steven Vogel, of the University College of Osteopathy, for advice. Mr Vogel had developed a bespoke learning plan, containing a considerable amount of learning and reflective work concerning communication with patients, dignity and modesty, boundary maintenance and consent.

38. The learning plan had involved a lot of insightful work. This in turn touched on the Registrant's remorse. The submissions on UPC had contained his expression of apology to Patient A and Patient B. The Registrant was naturally very sorry that he had caused distress to patients or caused any harm to the profession he loved. Mr Sutton referred to the 21 testimonials previously supplied to the Committee,

including many from female patients, who were supportive and fully aware of the nature of the complaints against him.

39. In respect of sanction, Mr Sutton also referred to the principle of proportionality, which demanded starting with the least restrictive sanction and working upwards. However, were the Committee minded to impose a conditions of practice order, Mr Sutton queried what else was left for the Registrant to do in that respect. There was an action plan in place for his practice and the Registrant had undertaken relevant training and reflection. Imposing a conditions of practice order would simply ask the Registrant to repeat the work he had already done.

40. Taking this into account, Mr Sutton suggested that an Admonishment was the appropriate sanction. There was no evidence that the Registrant presented a danger to the public and he has demonstrated insight by his conduct since the findings on fact. The behaviour in question had not been deliberate and there was no finding of sexual motivation.

41. In answer to questions from the Committee, the Registrant confirmed that he had seen patients and had put the learning he had acquired into practice. Despite the COVID-19 related restrictions, he had continued to practice in a health centre treating patients with multiple sclerosis, as well as from home. The Registrant told the Committee that he was continuing his study of reflective practice, had begun a reflective journal, had booked himself onto a "motivational interviewing" course in June and was hoping to institute some form of peer review in his practice. The Registrant provided the Committee with some further evidence of his amended practice and continued reflection, including his reflective journal, a self-assessment and reflective questionnaire on patient dignity and modesty, and the standard note he sent to patients in advance of appointments, entitled "*Making the most out of your osteopathy appointment*", which he had revised in the light of his learning.

Decision

42. The Committee determined that the appropriate sanction is one of Admonishment.

Reasons

43. The Committee again took note of the overarching objective as set out above, it considered the Sanctions Guidance provided by the GOsC and the submissions of both advocates. It accepted the advice of the legal assessor.

44. In looking at the overall seriousness, and aggravating factors present in the Registrant's conduct, the Committee considered that a failure to obtain consent or respect a patient's dignity were innately serious matters.

45. As to the relevant mitigating factors, the Committee noted that the Registrant had no previous history, benefitted from a significant number of positive testimonials, including from a number of female patients. The Registrant had engaged expert help and begun remedial work, albeit prompted by this Committee's findings, and had demonstrated some commitment to revising his approach to this area of his practice.

46. In considering the sanctions in turn, the Committee was satisfied that the Registrant has shown some acceptance and insight into where he has gone wrong, despite the comment of Mr Vogel in February 2021 to the effect that he still had some difficulty accepting the veracity of the complaints against him. The Committee was satisfied that the Registrant has begun the process of recognising and remediating his unacceptable conduct and trusted that he would continue that process notwithstanding its decision today.

47. The Committee first considered whether an Admonishment was sufficient to meet the seriousness of this case. Although there was at least one factor that did not support such a sanction, given this was not an isolated incident, the Committee did accept that there was a lack of serious harm, some evidence of insight and remorse, and the Registrant had made some strides toward preventing any reoccurrence of the issues that had brought him before this Committee. Though the Committee considered long and hard whether a more restrictive sanction was necessary, it ultimately concluded that the public interest was in these circumstances protected by an Admonishment.

48. In reaching that view, the Committee considered whether it should impose a Conditions of Practice Order. The Committee accepted that there was some force in the submissions made on behalf of the Registrant that conditions would not achieve more than the Registrant had voluntarily undertaken himself, and that he had worked since these complaints came to light without any restriction on his practice. The Committee therefore concluded that a Conditions of Practice Order was not necessary to protect the public, nor would it be proportionate to the shortcomings demonstrated by the case. The Committee was quite clear however that had it not been for the remedial work the Registrant had undertaken since its findings on the facts, this would have been a much more difficult judgment.

49. The Committee also considered whether any more restrictive sanction, i.e. Suspension, was necessary in this case and concluded that it was not. It was not satisfied that the Registrant's conduct was serious enough to require any greater sanction than an Admonishment for the reasons set out above. Any harsher action would be disproportionate in the circumstances of this case.

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

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

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

Section 22(13) of the Osteopaths Act 1993 requires this Committee to publish a report that sets out the names of those osteopaths who have had Allegations found against them, the nature of the Allegations and the steps taken by the Committee in respect of the osteopaths so named.