

**GENERAL OSTEOPATHIC COUNCIL**  
**PROFESSIONAL CONDUCT COMMITTEE**

**Case No: 1788/1030**

**Professional Conduct Committee Hearing**

**DECISION**

**Case of:** Ian Pitt

**Committee:** Andrew Harvey (Chair)  
Tamsyn Webb (Osteopath)  
Nathalie Harvier (Lay)

**Legal Assessor:** Tim Grey

**Representation for Council:** Andrew Faux

**Representation for Osteopath:** Philip Dayle

**Clerk to the Committee:** Sajinee Padhiar

**Date of Hearing:** 6 - 9 & 12 October 2026  
The Hearing was conducted remotely

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**Summary of Decision:**

Paragraphs 1, 3(a) and 3(b) of the Allegation were admitted and found proved.  
Paragraphs 4(a) Schedule 1 (i), 4(b), and 5(b) in relation to 4(a)(i) were found proved.  
Paragraphs 2(a) and (b), 4(a) Schedule 1 (ii) - (iv), 5(a), 5(b) in relation to Schedule 1 (ii) - (iv), 6 and 7 were found not proved.

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**Allegation (as amended)**

The allegation is that you, Ian Pitt, have 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 you on 6 February 2025 (the Appointment).
2. During the Appointment, you:
  - a. touched and/or stroked Patient A's left buttock cheek;
  - b. whilst touching Patient A in the matter set out at 2a, asked Patient A if her tattoos "come down to here", or words to that effect, referring to where your fingers were touching her buttock cheek.
3. During the Appointment, you:
  - a. asked Patient A to remove her sports bra; and
  - b. did not offer Patient A a cover-up.
4. During the Appointment, you:
  - a. made comments to Patient A as set out in Schedule 1, or words to that effect;
  - b. failed to obtain valid consent from Patient A for all aspects of treatment provided.
5. Your conduct as set out in paragraph 2, 3 and/or 4a, was:
  - a. a transgression of professional boundaries;
  - b. not clinically justified.
6. Your conduct as set out in paragraphs 2 and/or 3 was a transgression of sexual boundaries.
7. Your conduct as set out in paragraph 2a and/or 2b constitutes sexual touching.

**Schedule 1**

- i. "woah! That is a lot of tats"
  - ii. Asked Patient A if her tattoo "goes all the way down", referring to a tattoo on her back
  - iii. Asked Patient A how long her back tattoo took
  - iv. Asked Patient A if the back tattoo hurt her
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**Decision:**

**Preliminary Issue:**

## Allegation Amendment

1. On behalf of the Council, Mr. Faux made an application, pursuant to Rule 24 of the Rules, to amend the Allegation in the terms set out above. He submitted that the amendment was both necessary and desirable in order to ensure clarity in the Allegation, and that such amendments as were proposed reflected the totality of the matters referred by the Investigation Committee. The proposed amendments more adequately and fully reflected the nature of the referred matters, without materially altering the nature and scope of the case.
2. On behalf of the Registrant Mr. Dayle did not object to the application to amend.
3. The Committee received and accepted the advice of the Legal Assessor. It was advised that its power to make such an amendment was governed by Rule 24 of the Rules. The Committee thereby had a discretion to amend the Allegation at any time if, having heard submissions and received legal advice, it considered that an amendment could be made without injustice.
4. The Committee carefully considered whether the proposed amendments might lead to any unfairness to the Registrant. Having done so, it concluded that the amendments as sought by the Council could be made without injustice and were both necessary and desirable to properly reflect the nature of the case and in order for the Committee in exercising its case management functions to effectively and expeditiously consider all matters referred to it by the Investigating Committee.

## Background

5. Patient A was at all material times a personal trainer, rugby player and had experience of treatment by numerous healthcare professionals, although prior to the events in question she had not seen an Osteopath. She attended one appointment with the Registrant on 6 February 2025, complaining of a shoulder issue, concerning her right rotator cuff, although she may also have had issues concerning her ribs and upper back.
6. During the course of the treatment and afterwards, Patient A asserted that the Registrant had commented on her tattoos in a manner that was unprofessional, had touched her left buttock and stroked it and had undertaken treatment she had not consented to.

7. In consequence on 20 March 2025 Patient A made contact with the Council and on 30 March 2025 completed a complaint form.

## **Evidence**

8. The Committee received documentary evidence, comprising a witness statement and exhibits from Patient A, an expert report from Jonathan Hearsey, instructed by the Council, an initial response form and a further three witness statements and exhibits from the Registrant.
9. In her oral evidence, Patient A told the Committee that she had chosen to see an Osteopath as she was suffering with a shoulder injury caused by playing rugby. The Committee heard that she had a GP referral qualification alongside her personal training qualifications and had a degree in Health Sciences. She had been a personal trainer for 10 years. The appointment with the Registrant was the first occasion on which she had seen an Osteopath. Patient A was asked about being invited to remove her bra and explained that at the time she was lying prone on the treatment table with her head to the side, her forehead resting on the bed but with her arms under her upper body.
10. Patient A went on to confirm that in this position she could not see what the Registrant was doing, but heard him moving to the foot of the treatment table and fetching something. As he returned to the head end of the table she felt him touch her left buttock and perceived his fingers stroking her, although she could not see this.
11. When asked about her presenting complaint Patient A said that she had attended in relation to back neck and shoulder pain predominantly centred on her right rotator cuff. All of this work was in her view on her upper right back and did not require any treatment to her lower back or elsewhere. Patient A did not accept that the Registrant had provided treatment to her whole back and said that there was no need for him to have done so given the location of the presenting complaint.
12. When asked about the use of a percussion massager Patient A explained that the Registrant had fetched a massage gun from the foot of the bed and that it was used solely on her upper right rotator cuff area. Prior to this, treatment had begun with the Registrant providing massage, during which time he had asked her to remove her sports bra.
13. Patient A explained that when she was first examined by the Registrant he commented on her tattoo which was extensive. He said "whoa there are a lot of tats there." Later when touching her left buttock Patient A told the committee

that the Registrant had asked how far down the tattoos came referencing her lower back and buttock.

14. The following day Patient A spoke to colleagues, to BUPA who had referred her to the Registrant, and her husband. Following those conversations in which she reported feeling uncomfortable about the appointment with the Registrant, she formed a view that the Registrant's touching and stroking of her buttock was sexual because it was a private part of her anatomy and no part of any treatment.
15. Patient A accepted the conversation about her tattoos was triggering to her due to traumatic past experiences. She considered the comments were unprofessional and inappropriate.
16. When asked by the Committee about the order of events Patient A explained that the first comment concerning her tattoo was made when she was standing during the initial examination. There was then further discussion as she lay on the treatment table after the Registrant had taken her medical history. She explained that she had felt uncomfortable about the removal of her bra because the Registrant did not leave the treatment room or provide a cover-up and this caused her to be worried that she might expose herself.
17. Patient A could not remember the precise nature of the conversation thereafter but it did concern rugby and tattoos. She explained her primary reason for attending an appointment with the Registrant was for treatment for the rotator cuff injury and that therefore he had no reason to treat any other part of her body.
18. When asked by the Committee whether the Registrant said "do they come down to here?" in reference to her tattoos, Patient A explained that she knew where he was referring to by reason of the touch and the stroke to her buttock.
19. The Committee then heard from Jonathan Hearsey, an expert witness called by the Council. Mr. Hearsey confirmed that in his opinion the clinical treatment provided by the Registrant was to an acceptable standard and was clinically justified. When asked about the question of consent Mr. Hearsey opined that a failure to obtain valid consent is likely to be far below the standards of a reasonably competent Osteopath because without consent there is a real risk of the patient not understanding the risks of having treatment the benefits of having treatment and the risks and benefits of alternative treatments including the option of no treatment.
20. Mr. Hearsey went on to explain that for valid consent to be gained an Osteopath needed to have a comprehensive discussion with a patient. In this case Mr.

Hearsey could see no evidence of such a discussion whether documented in writing in the treatment notes or in the accounts given by Patient A or the Registrant.

21. Mr. Hearsey explained that in his view there was an inconsistency in Patient A's account given that her witness statement referred to her attending with rotator cuff pain, problematic ribs and SI joint. That complaint was a broader one than the later account she gave. In any event, the treatment provided by the Registrant was consistent with those complaints.
22. When asked about the concept of keeping hands on a patient Mr. Hearsey explained that it was a technique taught to osteopaths in order to ensure therapeutic flow and that patients were not surprised by sudden touches when they were unable to see what was happening, by reason of body position. Mr. Hearsey later clarified that it would not be acceptable to touch a patient's buttock as part of that process without consent unless there was a specific clinical justification. When asked about treatment of the rotator cuff and right shoulder pain, Mr. Hearsey explained that it would be acceptable for an osteopath to examine and treat the lower thoracic and lumbar spine so long as consent had been obtained.
23. The Committee then heard oral evidence from the Registrant. He explained that he had been in Osteopathic practice since 1984 and worked as a single-handed Osteopath although his wife also worked in the practice, providing health and beauty therapy.
24. He first encountered Patient A when she rang him to book an appointment. When she attended for the appointment she explained her history of shoulder issues, her issues with her ribs and with her SI joints. She explained that she had seen numerous healthcare professionals over the years. This in turn made the Registrant nervous and he felt out of his depth.
25. The Registrant conducted the history taking which proceeded without any incident. He formulated a plan following examination and decided to treat the patient in the prone position so that he could access her shoulder and the other areas he needed to treat. She was wearing leggings which came up to her L2/L3 vertebrae on her back and a sports bra which covered a wide area of her upper back. The Registrant explained that he asked Patient A to remove her bra because it was going to be easier to treat if she did so. He looked away when she did but accepted that he had not offered her a cover-up or drape although he would do so now and indeed would likely now leave the room too.
26. He proceeded to treat by massage and palpation of soft tissues in the lumbar and mid-thoracic area of her back and by gently mobilising the subluxed ribs.

He also lightly palpated her SI joints and given her history of subluxation he examined her pelvic bones and sacrum rotation.

27. Thereafter, the Registrant explained that he used the percussion massager on Patient A's thoracic spine. He estimated that the appointment as a whole took an hour with the treatment element taking about half an hour of that time.
28. The Registrant explained that he first saw patient A's tattoo on the initial examination when she turned round with her back to him. His reaction was to say "wow that's a tattoo!" The Registrant did not accept that he said "whoa that's a lot of tats" or words to that effect. In hindsight, the Registrant concluded that mentioning the tattoo had triggered Patient A and had clearly upset her although he was unaware of it at the time, given she did not indicate any upset during the appointment.
29. The Registrant accepted he did not speak to Patient A about the risks and benefits of treatment. He had understood her to have a lot of knowledge about anatomy and physiology from her work and previous experience with other healthcare professionals, and that he therefore presumed she would understand what he was doing and why he was doing it. He explained that he is now more assiduous in writing down and recording consent but that his treatment is so safe that the risks are minimal.
30. The Registrant explained that when Patient A removed her bra he had turned his back. He hadn't realised that the bra was an overhead removal. He accepted he had not provided Patient A a drape and that he had changed his practise since.
31. The Registrant said that during the appointment there was general conversation about Patient A's work as a prison officer, her rugby career and refereeing, and that he considered they had built something of a rapport as a result.
32. When asked about whether he touched or stroked Patient A's buttock the Registrant denied doing so either deliberately or at all. He accepted it might have been possible that he inadvertently touched her buttock with his elbow or another part of his arm or that in moving the percussion massager he might have inadvertently dragged the cable over Patient A, causing her to perceive a touch and a stroke. At no point did he act in a manner that was sexual in nature.
33. In cross examination the Registrant denied touching Patient A's buttock at all whether out of curiosity or for any sexual motivation. He explained that he had assessed her SI joints through her leggings feeling the posterior and superior

iliac spines to check movement. That would have happened as part of the palpation and massaging process. Whilst the Registrant accepted he might not have talked through everything, he would have explained something of what he was doing and went on to explain that his process now is to do a running commentary of all that he is doing for a patient. The Registrant did not accept saying at any point "does it come all the way down to here?" in relation to the tattoos. The Registrant accepted that the topic of Patient A's tattoo came up again at the end of the appointment but it was a brief mention and not something that at the time seemed significant. Whilst the Registrant accepted that conversation had dropped off towards the end of the appointment he did not accept that this signified anything abnormal to him at the time, rather it appeared to him that they had simply run out of things to talk about.

### **Submissions of the Parties**

34. Mr. Faux on behalf of the Council submitted that in relation to Paragraph 3 of the Allegation which was admitted, this amounted to a transgression of professional boundaries because there was an expectation as to the agreed behaviours of a professional and that the Registrant had failed in this regard. So far as sexual boundaries were concerned, Mr. Faux did not invite the Committee to conclude that Paragraph 3 could lead to the conclusion that the Registrant had transgressed sexual boundaries in behaving as he had.
35. In relation to Paragraph 4(a) of the Allegation Mr. Faux submitted that there was, in reality, no material difference between the Registrant's assertion that he said "that's a lot of tattoos" or words to that effect and the Council's assertion that he said "whoa that's loads of tatts" or words to that effect. In any event, he submitted that the account given by Patient A was to be preferred in this regard. In particular, Mr. Faux submitted that her recollection of the conversation concerning tattoos was likely to be more reliable given the impact it had upon her.
36. In relation to paragraph 4(b) Mr. Faux submitted that in reality this was admitted. The Registrant had accepted not providing information about the risks and benefits of treatment and that he had therefore not done what was necessary in order to obtain valid consent from Patient A.
37. In relation to Paragraph 2 Mr. Faux submitted that there was in fact little between the two accounts given by the Registrant and Patient A. The Registrant fetched the percussion massager, walking around the treatment table to do so. The touch and stroke were, Mr. Faux submitted, matters that Patient A had been consistent about throughout and were consistent with someone being curious about her tattoo and perhaps in an unthinking way

asking where it came down to, touching and stroking her in the process. Taking those words and the touching together Mr. Faux further submitted that the Committee could conclude that Patient A's account was correct. As to the sexual nature of the touching Mr. Faux submitted that touching Patient A on her buttock was sexual by its very nature, unless it was clinically indicated and undertaken with consent. That was not the case here. He therefore invited the committee to find paragraph 2 proved.

38. In relation to the transgression of professional boundaries, Mr. Faux indicated that he did not invite the Committee to find this proved insofar as it related to Paragraph 3 of the Allegation.
39. On behalf of the Registrant, Mr. Dayle submitted that the Council bears the burden and standard of proof and had not proved its case to that standard. He submitted that the sexual touching came down to a decision as to who was right Patient A or the Registrant. He accepted that the Registrant could be overly verbose and may have been in the appointment. He further submitted that Patient A had attended for treatment to her back rib and shoulder and that the inconsistency in her accounts was evidence of her unreliability.
40. Patient A had recounted the touch to her buttock and the stroke but accepted that she could not see either and that this rendered her account unreliable given that she had accepted being in a heightened state of hyper alertness by this point.
41. Mr. Dayle further submitted that it was only after speaking to colleagues, BUPA, another osteopath and her husband that Patient A had formed the view that what had happened was sexual in nature. It was clear, Mr. Dayle submitted, that Patient A was deeply troubled and triggered by discussion of tattoos given past trauma and that this had influenced her perception of events.
42. It had been the Registrant's intent to keep an engagement with Patient A that had led him to the conversations and this was in no way a transgression of professional or sexual boundaries. Mr. Dayle submitted that there was no touching or stroking of patient A's buttock and no conversation about the tattoo at that point.
43. Mr. Dayle further submitted that whilst there was no written consent in evidence, the nature of the patient the Registrant was treating and her prior knowledge meant that consent was implied.
44. Mr Dayle therefore invited the committee to find the outstanding paragraphs of the allegation not proved.

## **The Committee's Findings on the Facts**

45. 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 from 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.
46. The Committee was directed to the case of *Montgomery v Lanarkshire* [2015] UKSC 11 as to the definition of consent.
47. 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.
48. 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**

49. The Registrant admitted Paragraphs 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**

50. The Committee considered the accounts of both Patient A and the Registrant as well as the evidence of Mr. Hearsey. The Committee concluded that there was no clinical justification for the Registrant to have touched Patient A's buttock, as alleged. The Committee noted that Patient A had not been able to see the touch or stroke but had felt both. The Committee noted the Registrant's evidence that he did not touch Patient A's buttock or stroke it. The Committee considered both accounts to be credible but that in both versions there were weaknesses. The Committee could not discount the possibility the Patient A

had felt something but that the touch and stroke had been caused by the lead of the percussion massager or by an inadvertent touch from the Registrant's elbow as he was moving past her with the percussion manager. In the circumstances the Committee did not consider there was sufficient evidence to satisfy the standard of proof borne by the Council. The Committee therefore found Paragraph 2(a) not proved.

### **Paragraph 2(b) - Not Proved**

51. The Committee noted that this paragraph was contingent upon a finding that paragraph 2(a) was proved. In light of its finding above, the Committee therefore found Paragraph 2(b) not proved.

### **Paragraph 3 – Admitted and Found Proved**

52. The Registrant admitted Paragraph 3 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 4(a) – Proved in relation to Schedule 1 (i) only**

53. 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 that the distinction the Registrant drew between the words alleged in Schedule 1 and those he accepted saying, was illusory. They were, in the Committee's judgment, materially the same, such that they could amount to "...words to that effect" as charged. The Committee therefore concluded that insofar as schedule 1(i) was concerned, Paragraph 4(a) was proved.
54. The Committee noted the accounts given by both Patient A and the Registrant of the other conversations that took place in the appointment. In the Committee's judgment neither account was clear as to what was discussed and when. A general discussion took place about a number of different matters throughout the appointment and it was clear to the Committee that one topic of discussion was Patient A's tattoo. However, there was insufficient evidence to demonstrate that the Registrant had in each case prompted the conversation by asking the specific questions charge at Schedule 1 (ii) – (iv) concerning the tattoo. Patient A's evidence on the point did not demonstrate clearly that the conversation had taken place in that manner. The committee therefore found the remainder of paragraph 4(a) Schedule 1 not proved.

### **Paragraph 4(b) - Proved**

55. The Committee noted the language in paragraph 4(b) and use of the word "all." This raised the unhappy possibility of misunderstanding as to what the charge was referring to. Notwithstanding that ambiguity the Committee was content that there was no unfairness to the Registrant in proceeding on the basis that it referred to each and every clinical intervention. The Committee came to that conclusion because no issue had been raised by the Registrant during the hearing or before on the point and the Registrant's case had proceeded on the basis of such an interpretation.
56. The Committee carefully considered the evidence it had heard from the Registrant on the issue of consent. It was common ground between the Registrant and Patient A that she had not been told about the risks and benefits of treatment and had not been told of all treatment that was to be provided, but had been informed of some of the treatment and its intention. The Committee was not persuaded that the state of a patient's prior knowledge and relative sophistication about healthcare issues, abrogated the responsibility of a healthcare professional to ensure that a patient understood the nature of the treatment proposed, the risks and benefits of that treatment, the right of the patient to refuse treatment, and the other treatment options that might be available, including the option not to treat. The absence of any attempt to discuss such matters amounted to no less than an absence of valid consent.
57. The Committee was not assisted by the notional debate about a recording of consent or otherwise. Consent needed to be obtained on an ongoing basis and it needed to be documented. Neither of these things was done. The Committee therefore found Paragraph 4(b) proved.

### **Paragraph 5(a) - Not Proved**

58. Having found Paragraph 2 not proved the Committee confined its deliberations to Paragraph 3 and that part of Paragraph 4(a) that had been proved.
59. In relation to Paragraph 3, the Committee could see no sensible basis upon which asking Patient A to remove her bra and not offering a cover-up could amount to a transgression of professional boundaries. It therefore found Paragraph 5(a) not proved in relation to Paragraph 3.
60. In relation to Paragraph 4(a) Schedule 1 (i) the Committee could likewise see no basis at all for an assertion that remarking upon a patient's tattoo in the manner alleged, amounted to a transgression of professional boundaries. The Committee agreed with Mr. Faux that there was no proper basis for inviting the Committee to so conclude and it therefore found Paragraph 5(a) not proved in relation to Paragraph 4(a).

### **Paragraph 5(b) – Proved in relation to 4(a) Schedule 1(i) only**

61. In relation to Paragraph 3 the Committee could make little sense of the complaint herein. It was quite clearly clinically justified to invite a patient to remove a piece of clothing to enable treatment and indeed Patient A accepted as much.
62. The tortuous language of the double negative in not offering a cover-up and that not being clinically justified made for an unintelligible pleading, and in any event reflected no mischief on the part of the Registrant. The Committee noted that Mr. Faux had not invited the Committee to conclude that Paragraph 5(b) was proved in relation to Paragraph 3. The Committee agreed and therefore found 5(b) not proved in relation to Paragraph 3.
63. In relation to Paragraph 4(a)(i) the Committee concluded that there was no clinical justification for the comment made about Patient A's tattoo. Whilst that necessarily meant that this part of the Allegation was proved, the Committee could find no basis at all for asserting that every utterance in an appointment needed to be clinically justified. Being courteous, building rapport and general communication with patients necessitated conversation outside the strict confines of clinical justification. Notwithstanding that analysis, the Committee found that as a matter of fact there was no clinical basis for the comment and therefore no clinical justification. On that sole basis it therefore found Paragraph 5(b) proved.

### **Paragraph 6 – Not Proved**

64. Having found Paragraph 2 not proved the Committee confined its deliberations to Paragraph 3.
65. The Committee could see no basis at all on the evidence before it to assert that the invitation to Patient A to remove her bra and not providing a cover-up was a transgression of sexual boundaries. As a matter of fact, the Committee concluded that there was no sexual element at all to either issue.
66. The Committee noted that in any event Mr. Faux had not invited the Committee to conclude that there was any sexual element outside the alleged touching, subject of Paragraph 2 and not proved. The Committee agreed and therefore found Paragraph 6 not proved.

### **Paragraph 7 – Not Proved**

67. In light of its findings in relation to Paragraph 2 above, the Committee found Paragraph 7 not proved.

### **Submissions on Unacceptable Professional Conduct ("UPC")**

68. On behalf of the Council, Mr. Faux conceded that on the basis of the facts found proved, the sole basis upon which a finding of UPC could be made concerned Paragraph 4(b) and the Registrant's failure to obtain valid consent to treatment.

69. Mr. Faux submitted that Mr. Hearsey had been clear that the failure to obtain consent was a serious falling short of the standards. He conceded that the Committee was not bound to accept Mr. Hearsey's opinion, but that it was at least persuasive. Mr. Faux accepted that Mr. Pitt had made changes to his practice, but submitted that in the Council's statutory regime questions of insight and remediation were not matters for consideration when assessing the issue of UPC.

70. Mr. Faux submitted that the Committee could properly conclude that the Registrant's conduct was serious and worthy of the moral opprobrium attaching to a finding of UPC.

71. On behalf of the Registrant, Mr. Dayle submitted that the conduct found proved was not so serious as to amount to attracting moral blameworthiness or opprobrium when viewed in the context of the factual framework.

72. Mr. Dayle agreed with Mr. Faux's concession that the only basis upon which the Committee could consider a finding of UPC was in relation to the issue of consent. In the circumstances of the case, whilst acknowledging that the lack of consent was a shortfall, it was, Mr. Dayle submitted, not a serious falling short, worthy of moral opprobrium. In so saying, Mr. Dayle reminded the Committee that Patient A was trained in matters concerning personal training and healthcare and that the Registrant had shown insight and remediated his practice since.

73. Mr. Dayle submitted that a finding of UPC was not necessary and that the Committee should instead consider giving advice to the Registrant as to his future conduct.

### **Decision on UPC**

74. The Committee received 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 or standard 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: *Roylance v GMC* [2000] 1 AC 311 & *Nandi v GMC* [2004] EWHC 2317. The Committee was further advised that 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.
75. The Committee was further advised of the case of *Shaw v GOsC* [2015] EWHC 2721 (Admin) in which the Court made it clear that the bar for a finding of UPC was not so high as to make the lowest form of sanction meaningless. For UPC to be found the conduct must be serious but not of such gravity that the lowest powers of sanction would be inappropriate.
76. The Committee was reminded that its sole consideration at this stage was whether the facts found proved amounted to UPC or not. It was not concerned with issues of remediation or insight at this stage, nor the issuing of advice.
77. The Committee took full account of all the evidence and submissions it had read and heard and carefully considered the conduct it had found proved.
78. The Committee agreed with both parties that the only facts found proved giving rise to a potential finding of UPC were those concerned with consent.
79. The Committee was concerned by the Registrant's failure to recognise that Patient A needed to be informed and be made aware of the risks and benefits of treatment in order to provide an informed and educated decision about whether to consent to treatment. She also needed to be made aware of the various treatment options and the nature of treatment that would be provided and her explicit agreement obtained.
80. The Registrant's presumption that Patient A would know what was going to happen given her previous experience, was fundamentally at odds with his duties as a registered Osteopath. Obtaining valid consent was, the Committee determined, a cornerstone of the treatment process, was central to issues concerning protection of the public and maintaining public confidence in the profession. It ensures patients are aware of what is going to happen and that patients are made active partners in the treatment process. The consenting process also facilitated better communication and left far less room for misunderstanding, and miscommunication between Osteopath and patient.

81. The Registrant's approach to the principle on this occasion did, in the Committee's judgment, amount to a serious falling short of the Standards, and in particular Standard A4 of the Osteopathic Practice Standards (2019).
82. The Committee therefore concluded that the conduct it had found proved did amount to UPC.

## **Sanction**

### **Submissions on Sanction**

83. Having determined that the conduct found proved did amount to UPC, the Committee next considered what sanction to impose.
84. On behalf of the Council, Mr. Faux made no positive submission as to the appropriate sanction, but rather invited the Committee to carefully evaluate all the evidence and approach the matter assisted by the Hearings and Sanctions guidance (effective from May 2025), with the principle of proportionality high in mind.
85. Mr. Faux accepted that part of the purpose of Professional Regulation was to retain good professionals who have remediated any concerns about their fitness to practise and that in this case the Registrant had shown a degree of remediation and insight. That factor needed to be balanced with the overarching duty to protect the public and the wider public interest.
86. On behalf of the Registrant, Mr. Dayle submitted that there was clear evidence of remediation and insight both in the written evidence given by the Registrant and in his oral evidence before the Committee. The Registrant had expressed his regret for the failings. Mr. Dayle further submitted that the Registrant had made changes to his practise as a consequence, and the new consent form he now employs in all patient consultations acts as a guide to his new way of working. Consequently Mr. Dayle submitted there was no risk of repetition.
87. Mr. Dayle invited the Committee to carefully consider what sanction was necessary to protect the public, uphold public confidence in the profession and maintain and declare standards and to do so in a proportionate manner beginning with the least serious sanction and considering the sanctions in ascending order. In doing so, Mr. Dayle submitted that the Committee could properly conclude that a sanction of admonishment was the proportionate outcome in the Registrant's case.

## **Determination on Sanction**

88. The Committee received and accepted the advice of the legal assessor. The Committee was advised that in considering sanction there is no burden or standard of proof. The question of sanction is a matter for the Committee's judgment. The Committee was advised that having found UPC proved, it was required to impose a sanction. It was advised that the purpose of sanctions is not to be punitive but to protect patients and the public interest in the wider sense, namely to maintain public confidence in the profession of osteopathy, and to declare and uphold standards.
89. The Committee was reminded that in deciding upon sanction it should have regard to The Hearings and Sanctions Guidance published by the Council, and apply the principle of proportionality, weighing the interests of the public with those of the practitioner and taking the minimum action necessary to protect the public and the wider public interest.
90. The Committee began by identifying the aggravating and mitigating factors present. It considered that the conduct was aggravated by the fact it was widespread across the entirety of the course of treatment provided and not confined to a single narrow failure to, for example, set out fully the risks and benefits of a particular treatment or technique.
91. The Committee considered that the conduct was mitigated by the Registrant's previous good character and noted that there had been no previous complaints about him to the Council in a career spanning 42 years. The Committee accepted that the Registrant had shown genuine remorse for his failings, had taken time to develop real insight which was now, in the Committee's view, well developed, and had taken steps to remediate and ensure there would be no repetition of his conduct. In particular, the Committee noted his new consent form and the targeted and relevant CPD he had undertaken since the events in question.
92. The Committee bore in mind that the appointment with Patient A was now some 18 months ago and that there had been no repetition of the conduct complained of. It noted that this was, in so far as the evidence before it, an isolated incident and whilst doubtless upsetting to her, it had caused no actual harm to Patient A.
93. For the reasons set out above the Committee considered that the Registrant had shown real and genuine insight and had made significant attempts to remediate. In the circumstances, whilst the Committee could not entirely rule

out a repeat of the identified failings, it considered the risk of repetition to be low. The Committee therefore concluded that there was no ongoing risk to patients or to the public.

94. The Committee next considered the appropriate sanction to impose. In doing so it paid careful attention to the Hearings and Sanctions Guidance and approached the question of sanction in ascending order of seriousness.
95. The Committee first considered whether a sanction of admonishment would be sufficient to protect the public and the wider public interest. It determined that admonishment would send out a signal to the profession that a failure to obtain valid, informed consent was serious, and would thereby serve to uphold public confidence in the profession and maintain and declare standards.
96. In the absence of any risk to the public beyond that wider public interest, the Committee therefore concluded that admonishment was the necessary and proportionate sanction in this case. In so doing it considered that a sanction of any greater gravity would be disproportionate.
97. The Committee therefore determined to admonish the Registrant.

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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.