In the matter of Section 22 of the Chiropractors Act 1994 ("the Act")

and

The General Chiropractic Council (Professional Conduct Committee) Rules 2000 ("the Rules")

and

The consideration of an allegation by the Professional Conduct Committee

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NOTICE OF FINDING BY THE PROFESSIONAL CONDUCT COMMITTEE OF THE GENERAL CHIROPRACTIC COUNCIL

Name of Respondent:	**Mr Vesa Tapani Heikkinen**
Address of Respondent:	**City Chiropractic** **BSS House** **Cheney Manor** **SWINDON** **WILTSHIRE** **SN2 2PJ**
Registration Number of Respondent:	**01571**

On 14-16 December 2020 the Professional Conduct Committee ("the Committee") of the General Chiropractic Council met to consider the following allegation against you, referred to it by the Investigating Committee in accordance with Section 20(12)(b)(ii) of the Chiropractors Act 1994 ("the Act"):

THE ALLEGATION:

That being a registered chiropractor you are guilty of unacceptable professional conduct.

PARTICULARS OF THE ALLEGATION:

That, being a registered chiropractor, you are guilty of unacceptable professional conduct in that:

1. At all material times you were a registered chiropractor providing chiropractic treatment to patients at City Chiropractic, Lion House, 41 York Place, Leeds, West Yorkshire LS1 2ED ("the Clinic").

2. Between approximately 4 June and 23 July 2019 you provided chiropractic assessment and/or care and/or treatment to Patient A at the Clinic, including an initial assessment appointment on or around 4 June 2019 and approximately six treatment appointments commencing on or around 3 July 2019.

3. Patient A's clinical presentation, as related to you, included a number of "red flag" signs and/or symptoms, including the following:

    a. At the time of the initial assessment appointment:
        i. A recent history of pelvic carcinoma in 2018;
        ii. A primary complaint of mid-thoracic pain in the absence of trauma;
        iii. Marked sleep disturbance and/or pain at night;
        iv. Constant, unremitting pain.

    b. At the time of the first treatment appointment and/or subsequent treatment appointments:
        i. Emerging radicular symptoms in the upper extremity, including numbness/loss of sensation in the thumb and forefinger.

4. In light of the clinical presentation set out at 3(a) and/or 3(b) above, you failed to:

    a. Obtain and/or document adequate detail to inform your understanding of Patient A's health status;

    b. Make and/or document adequate enquiry about the current status of Patient A's management, including when she had last been checked and where treatment had been carried out;

    c. Carry out any or any adequate further enquiry in relation to the symptoms Patient A described;

    d. Recognise adequately or at all the potential that there was serious underlying pathology, including a metastatic spread from a primary tumour, in this case;

    e. Refer Patient A for assessment and/or review by a medical practitioner;

    f. Refer Patient A for diagnostic imaging prior to recommending and/or commencing treatment;

    g. Conduct a further neurological examination of the upper extremities in response to the symptoms referred to at 3(b).

5. In light of the failures referred to at 4 above, you:

    a. Reached a diagnosis and/or differential diagnosis which was seriously flawed;

    b. Recommended a course of chiropractic treatment which was inappropriate and/or contraindicated in the circumstances;

    c. Implemented that course of treatment by providing chiropractic treatment, on approximately six occasions in July 2019, which included manual manipulation of the pelvis, thoracic and cervical spine, when it was inappropriate to do so.

AMENDED ALLEGATION

APPLICATION TO AMEND

At the start of the proceedings, Mr Collins on behalf of the GCC applied to amend various of the Particulars of Allegation. Mr Fortune on behalf of the Registrant accepted that the proposed amendment would not cause the Registrant any injustice and raised no objection. After receiving and accepting legal advice, the Panel allowed the proposed amendments.

That, being a registered chiropractor, you are guilty of unacceptable professional conduct in that:

1. At all material times you were a registered chiropractor providing chiropractic treatment to patients at City Chiropractic, Lion House, 41 York Place, Leeds, West Yorkshire LS1 2ED ("the Clinic").

2. Between approximately 4 June and 23 July 2019 you provided chiropractic assessment and/or care to Patient A at the Clinic.

3. On 4 June 2019 Patient A's clinical presentation included "red flag" signs and/or symptoms:

   i) history of pelvic carcinoma in 2018;
   ii) primary thoracic spine pain in the absence of trauma;
   iii) pain at night giving rise to disturbed sleep;
   iv) constant and/or severe pain, whilst taking analgesic medication;

4. In light of the clinical presentation set out at 3 above, you failed at that appointment and/or subsequent appointments to:

   a) conduct and/or record any or adequate enquiries of Patient A's cancer:
      i) the current status Patient A's cancer;
      ii) the date of Patient A's most recent cancer treatment and or/ review;
      iii) where Patient A had cancer treatment and/or who carried out the treatment;
      iv) the date of Patient A's last diagnostic imaging

   b) recognise adequately or at all the potential that there was serious underlying pathology;

   c) refer Patient A for assessment and/or review by a medical practitioner;

   d) refer Patient A for diagnostic imaging prior to recommending and/or commencing care;

5. In light of the failures referred to at 4 above, you:

   a) arrived at a working diagnosis and/or rationale for care which was flawed;

   b) recommended a course of chiropractic treatment which was inappropriate and/or contraindicated;

c) implemented a course of treatment which was inappropriate and/or contraindicated

DECISION

BACKGROUND

On 1st September 2019, Patient 'A' made a complaint to the General Chiropractic Council (GCC) in relation to the Registrant. She made a Witness Statement on 10th January 2020 and exhibited thereto her Complaint (GS/01) and a copy of her MRI Report of Findings (GS/02).

Patient 'A' died in July 2020.

It is accepted by the GCC that the alleged failings of the Registrant did not in any way cause or contribute to the death of Patient 'A'

APPLICATION TO ADDUCE EVIDENCE

As Patient 'A' died in July 2020, the GCC applied for her Statement and Exhibits together to stand as her evidence in chief. The Registrant did not object to this application and accepted that such a course would not cause him any injustice. The Panel, having received and accepted legal advice, allowed the GCC's application.

DECISION ON FACTS

It was agreed that the Allegations could be taken as read and Mr Fortune on behalf of the Registrant informed the Panel that the Registrant admitted the factual Particulars of Allegation (PoA) but, in relation to PoA 4a)i) and 4a)iv), it was on the basis that he failed to conduct and record adequate enquiries and that in relation to PoA 4b) it was on the basis that he failed to recognise adequately the potential for serious underlying pathology.

Mr Collins on behalf of the GCC told the Panel that, whilst any factual basis on which an allegation is proved remained a matter for the Panel, the GCC accepted the basis of the Registrant's admission.

The Panel heard and accepted the advice of the legal assessor and found the facts contained within PoA 1 to 5 proved through admission. They indicated that they would consider the proposed basis upon which the admission had been made, in due course.

THE GCC EVIDENCE

Patient 'A'

In her Statement, Patient 'A' described how she had suffered severe thoracic spinal pain since March 2019 along with muscle spasms and knotted shoulders. She stated that despite numerous visits to her GP as well as a number of physiotherapy sessions, nothing was easing her symptoms. She was aware that 'Spinal Work' was a specialism of Chiropractic and so, as she thought that her problems were with her spine, she decided in June 2019 to consult a Chiropractor. She chose the Registrant because his name 'popped up' on her Facebook page, he was offering a reduced initial consultation rate and his Leeds City Chiropractic Clinic was local to her.

Patient 'A' found the initial consultation to be thorough with the Registrant conducting a series of examinations that included assessing the range of motion in her neck. She stated that during the consultation she informed the Registrant that she had suffered with pelvic cancer the previous year but had been informed that since January 2019 this had been in remission.

The Registrant proposed a treatment plan that consisted of six sessions of manipulation of her pelvis as well as her thoracic and cervical spine, spread over a three week period plus a daily exercise regime.

Patient 'A's first treatment did not take place until 3rd or 4th July 2019 when she returned from holiday. Thereafter the remaining 5 appointments each lasted between 10 and 15 minutes and consisted of manipulations and a regime of daily exercises for her to perform at home.

On the final appointment, the Registrant recommended that Patient 'A' return in two weeks time for further treatment but, as she felt there had been no improvement in her levels of pain and of limited improvement in her range of motion, she decided not to book any further appointments.

Patient 'A' decided in early June 2019 to visit a physiotherapist who did some gentle massage on her neck/thoracic spine before advising her, on her second session, to arrange to have a private MRI Scan. This was arranged and took place on 9th August 2019.

The MRI Scan revealed that Patient 'A' had high grade vertebral collapse in the C6 and T3 vertebrae and early collapse of the C7 vertebra due to tumours on her spine.

Patient 'A' attended her GP before being admitted to hospital for emergency major surgery on her spine, which took place on 15th August 2019.

Patient 'A' then re-commenced treatment for her cancer on 30th October 2019.

Patient 'A' emailed the Registrant to highlight her concerns that vital signs had been missed, she could have ended up paralysed and that the Registrant should never have manipulated her spine.

Patient 'A' says that she never received a response to her email.

Richard BROWN

The Panel agreed that his three Reports could stand as his Evidence in Chief and, once he had affirmed, confirmed that they represented his expert opinion on the case.

Mr Brown was taken to Para 136 of his Report (Bundle C1 Pg 108) and explained that when he stated that the potential consequences of the application of spinal manipulation to Patient 'A' could have been catastrophic, he was referring to the possibility of paraplegia including paralysis which, he said, would be a profound neurological compromise.

Mr Brown emphasised that part of the undergraduate training that the Registrant would have received, would have included recognising contraindications to spinal manipulation. He said that, specifically in relation to this case, the recent history of cancer in the face of the described symptoms, would be one such contraindication in the absence of adequate enquiry.

He also emphasised the importance not only of recognising Red Flags but also of acting upon them.

He said in relation to Red Flags that, in the case of Patient 'A' the constellation of symptoms taken together would have raised concern in any competent Chiropractor and should have persuaded the Registrant to 'work to remove any possibility of underlying pathology.'

In relation to the Remediation Documents submitted by the Registrant, he said that his view was that the remediation undertaken was relevant to the matters in hand and it seemed to him that the Registrant had made all necessary and due improvements to his clinical practice.

When cross-examined, Mr Brown agreed that the Registrant had taken a careful case history from Patient 'A' when he first met her, but said that there were times when the Registrant could have made further enquiries. He also agreed that, having elicited her history in an appropriate fashion, the Registrant had then carried out an examination that was appropriate and consistent with the standard he would expect. He also agreed that the history and examination had been recorded appropriately and to a standard that he would expect.

He agreed with Mr Fortune that he would not expect a Chiropractor to have found Patient 'A's tumours from palpation during his examination of her.

Whilst he agreed that a Chiropractor should take into account a patient's appearance and what they say about their lifestyle and working practice, where, as here, Red Flags appear during the taking of the case history, extreme caution should be taken in taking the appearance of the patient at face value.

Mr Brown also pointed out that Chiropractors are trained and obliged to undertake independent and full evaluations of patients. He said therefore that previous x-rays and interactions with other health-care professionals should not lead to an assumption that serious underlying pathologies could be excluded.

Mr Brown expressed the view that the Registrant in the courses he had undertaken, had addressed the matters he would consider most important. He went on to agree with Mr Fortune that in his expert opinion, there was nothing more that the Registrant cold have done to assist in his remediation.

THE REGISTRANT'S EVIDENCE

The Registrant

The Registrant confirmed that his statement and reflective piece were true to the best of his knowledge and belief and confirmed that he had never had a complaint of any sort made against him and had never before been referred to the PCC during his 19 years of practice.

The Registrant confirmed that when he had examined Patient 'A' he had found a number of Red Flags which he listed as Pain at Night; History of Thoracic Pain; History of Cancer; and Pain not being relieved by anything.

He confirmed that he had learned about Red Flags and their significance when he was an undergraduate and accepted that these meant that he should have referred Patient 'A' back to her GP.

He confirmed that although he had recognised the Red Flags, he had failed to act upon them. He explained the reason for this was a combination of things including her appearing to be very healthy and strong and active; her X-Rays showing no abnormality; her receiving the all clear in relation to the cancer and the fact that she was continuing with the scans. He also said that all of this, plus the fact that she worked on a laptop all day and thought maybe she had caused her problems at the gym, all contributed to taking his focus away from the Red

Flags and into believing that it was a musculo-skeletal problem. He stated that he took responsibility for not acting on them.

The Registrant confirmed that, although Patient 'A' did not apparently receive it, he had responded to the email she had sent him after she had decided not to continue with treatment.

He said that, looking back on his management of Patient 'A', he wished he had acted on the Red Flags when they were first presented rather than let his focus shift away from the facts.

He explained to the Panel that it had taken him 3 weeks to put together his Reflective Statement and, although it had not been easy, he felt it was necessary as otherwise the whole situation would have been a waste of an opportunity for him to learn from his failing.

When cross-examined by Mr Collins, he confirmed that he was aware of the underlying Red Flags at Patient 'A's first appointment and continued to be aware of them throughout the course of treatment.

He agreed that the treatment he provided had been contra-indicated could have resulted in catastrophic injuries. He said that although he was aware of the potential for injury, he was not concentrating on that.

He agreed he had a suspicion of underlying pathology but had not acted on it at the time.

UNACCEPTABLE PROFESSIONAL CONDUCT

UNACCEPTABLE PROFESSIONAL CONDUCT

The Panel heard closing submissions from the parties in relation to UPC and heard and accepted the advice of the legal assessor.

The Panel firstly considered the totality of the evidence presented and decided that the basis upon which the Registrant's admission had been made was a proper one.

In considering whether the Registrant's conduct constituted UPC, the Panel bore in mind that there was no standard or burden of proof involved and that it was for them to make an independent, professional judgement.

The Panel carefully examined the evidence of Mr Brown, the Chiropractic expert called by the GCC.

The Panel noted that Mr Brown had made it very clear that in his opinion, firstly there had been a number of breaches of the Standards of Conduct, Performance and Ethics for Chiropractors (the Code) and secondly that the combination of those breaches if not the individual breaches themselves, amounted to UPC

The Panel was aware that, although the opinion of such an expert was powerful evidence, the Panel was not bound by it and should therefore examine it critically when coming to its own conclusions.

In considering whether the conduct of the Registrant amounted to UPC, the Panel had the following evidence very much in mind:

a. That in cross-examination the Registrant conceded that he was aware of the underlying pathology but had not concentrated on it or acted on it
b. That the Registrant accepted that he had been aware of the Red Flags from the outset
c. That although the Registrant had thought he was doing the right thing for Patient 'A', he had, as he admitted, from the outset failed to act on the Red Flags
d. That although the Registrant considered that he was putting Patient 'A' first, and doing what he thought was best, he had in fact, as he admitted, got it wrong
e. That the Registrant accepted, with hindsight, that there had been potentially catastrophic implications from the course of treatment he provided to Patient 'A'

The Panel concluded that the evidence demonstrated that there had been a number of breaches of the Code:

1. Code A3 had been breached as the Registrant had failed to take appropriate action despite having concerns about the safety of Patient 'A'
2. Codes A5 and F3 had been breached as the Registrant, on his own admission, failed to refer Patient 'A' to her GP when it was appropriate to have done so
3. Code C5 had been breached as the care that the Registrant provided to Patient 'A" was not appropriate given the existence of the Red Flags and his awareness of them

The Panel considered the submission by the GCC that the conduct complained of constituted multiple acts or omissions spread over a three week period; it also considered the submission on behalf of the Registrant that although the conduct was spread over a three week period, it was in fact a single act or omission that was made on the first treatment and then perpetrated throughout the three week period.

The Panel concluded that whether the conduct constituted a single failure or multiple failures was of little importance as the combination of the breaches of the Code as set out above, coupled with the potentially catastrophic implications of the Registrant's conduct was so serious that either way, it constituted UPC.

The Panel therefore concluded that the conduct of the Registrant did constitute Unacceptable Professional Conduct.

SANCTION

The Panel heard submissions on Sanction from Mr Collins on behalf of the GCC and Mr Fortune on behalf of the Registrant. The Panel also read and took into account the written submissions on Sanction provided by Mr Fortune as well as the Testimonials and References supplied on behalf of the Registrant.

The Panel heard and accepted the advice of the legal assessor.

In determining the appropriate Sanction, the Panel had regard to the GCC's Guidance on Sanctions and kept well in mind the principle of proportionality.

The Panel first considered whether there were any aggravating factors in the Registrant's conduct.

Although the Panel did not find the Registrant's conduct to have constituted a pattern of UPC over a period of time, it did find that his conduct could foreseeably have caused either direct or indirect harm to Patient 'A.' The Panel therefore concluded that this was an aggravating factor.

The Panel did not find any other aggravating factors.

The Panel then went on to consider, against the background of the GCC's over-arching objective to protect the public, whether there were any mitigating factors.

The Panel found and took into account the following mitigating factors:

1. The fact that the Registrant's conduct related to a single patient and constituted a single failure that was perpetrated throughout the 3 week period that he had treated Patient 'A.' The Panel found that the Registrant's focus had been diverted at the beginning of the course of treatment and had remained diverted throughout.
2. There was firm evidence of the Registrant's understanding of and good insight into his failures. The Panel took the view that the Registrant's admissions were also some evidence of this insight
3. The Panel accepted that the Registrant's remorse and regret were genuine and sincerely held

4. The Panel accepted that the Registrant had made every attempt to address and remediate his conduct by undertaking relevant courses that were also designed to assist in ensuring that nothing like this would ever happen again
5. The Panel accepted and agreed with the assessment of Mr Brown, the expert witness called by the GCC, that the Registrant had done everything that he could possibly do both to remediate his conduct and to prevent anything like this from ever happening again, including making changes to his practice paperwork as illustrated on Bundle D1 at Pg 183
6. That the Registrant had practised for some 19 years without any complaint being levelled at him and that he had demonstrated and abided by the principles of good practice throughout his career before the conduct complained of

Having considered the mitigating factors as well as the single aggravating factor, the Panel proceeded to consider what sanction would be most appropriate in the circumstances of this particular case.
In accordance with the requirement for the Panel to consider sanctions in ascending order, it first considered whether Admonishment would be appropriate.

The Panel considered the 8 factors set out in Paragraph 81 of the Guidance on Sanctions, which comprised factors that indicated consideration of Admonishment would be appropriate and concluded as follows:

a. Although there was no evidence that the Registrant's behaviour caused either direct or indirect harm to Patient 'A', the Panel concluded that the behaviour 'could' have had such an effect so that this paragraph was not applicable to this Registrant
b. In the light of the evidence of the Registrant which it accepted, the testimonials provided on his behalf, the numerous courses he had undertaken and the evidence of Mr Brown that there was nothing else that he could have done to remediate his conduct, the Panel concluded that he had good insight into the matters found proved
c. As the Panel had already found that the Registrant's conduct constituted a single failure perpetrated throughout the 3 week period that he had treated Patient 'A.' it concluded that the Registrant's behaviour in reality constituted an isolated incident which had definitely not been deliberate
d. For the reasons already set out, the Panel were satisfied that the Registrant's expressions of regret were genuine
e. This paragraph was not applicable as there was no suggestion that the Registrant had been acting under duress
f. The Panel were satisfied that the Registrant had a previous good history as demonstrated by the fact that no complaint had ever been levelled against him in his 19 years in practice, the evidence that he gave before the Panel and the testimonials provided on his behalf
g. There was no suggestion that there had been any repetition of the behaviour since the incident
h. For the reasons already set out, the Panel were satisfied that the Registrant has taken effective rehabilitative and corrective steps

The Panel kept firmly in mind the over-arching objective of the GCC to protect the public as well as the fact that the purpose of imposing a sanction was not to punish, although it accepted that a Sanction may have a punitive effect.

In all the circumstances, the Panel concluded that it would be sufficient to conclude this case with an Admonishment and that any Sanction that was more restrictive would be disproportionate.

The Panel therefore decided to impose on the Registrant the Sanction of Admonishment.

You should be in no doubt that any finding of unacceptable professional conduct by your regulatory body is a serious matter and you should not take this admonishment lightly.

In accordance with Section 31 of the Chiropractors Act 1994, this decision will not have effect until the expiry of 28 days from the date on which notification is served on you or, where an appeal is made, until the appeal is withdrawn or otherwise disposed of.

That concludes this case.

Chair of the Professional Conduct Committee

In accordance with provision of Rule 18(1)(a) of the General Chiropractic Council (Professional Conduct Committee) Rules 2000, we must remind you of your right of appeal under Section 31 of the Chiropractors Act 1994, as amended by Section 34 of the National Health Service Reform and Health Care Provisions Act 2002, to the High Court of Justice in England and Wales against this decision of the Committee. Any such appeal must be made before the end of the period of 28 days, beginning with the date upon which this notice is served upon you.

Please note that the decision of this Committee is a relevant decision for the purposes of Section 29 of the National Health Service Reform and Health Care Professions Act 2002.

The Professional Standards Authority has a period of 40 days, in addition to any appeal period provided to the chiropractor, in which to lodge an appeal.

Signed: Dated: 16 December 2020

Satpal Singh Bansal
On behalf of the Professional Conduct Committee

Explanatory Notes:

Notices of Finding are normally divided into three sections, which reflect different stages of the hearing process:

1. The Allegation: This section contains the full allegations as drafted by the Investigating Committee and as considered by the Professional Conduct Committee.
2. The Decision: This section contains the findings of fact reached by the Professional Conduct Committee on the allegation and the reasons therefore. In particularly complex cases the reasons may be given separately from the findings of fact for purposes of clarity.

3. The Sanction: This section contains details of the sanction applied by the Professional Conduct Committee. In certain cases the section may be sub-divided for the purposes of clarity.