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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ALLEGATION REFERRED TO THE PROFESSIONAL CONDUCT COMMITTEE OF THE GENERAL CHIROPRACTIC COUNCIL PRELIMINARY MEETING

Name of Respondent:	Mrs Arleen Scholten
Address of Respondent:	Chiropractic 1st 68 The Mount, York, North Yorkshire YO24 1AR
Registration Number:	02405

On 19-30 April 2021 & 1-2 September 2021 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. Between 31 July 2017 and 11 August 2017, you provided chiropractic care and treatment to Patient A at Chiropractic 1st, 68 The Mount, North Yorkshire, YO24 1AR, ('the Clinic').

2. On 11 August 2017 you provided treatment to Patient A which included:
   a. a drop technique applied to the thoracic spine;
   b. the use of an Activator applied to the thoracic spine;
   c. the use of an Activator applied to the cervical spine.

3. Following the drop technique, Patient A indicated he was in discomfort and had lost sensation in his arms and you inappropriately continued treatment.

4. During the course of a subsequent 999 telephone call:
   a. you told the call handler that Patient A had laid on the adjusting table and you had used the Activator on his midback;
   b. you told the call handler that when you were using the Activator on Patient A's midback he had said his hands had gone numb;
   c. you told the call handler that as Patient A was elderly you had never used any manual adjustment on Patient A;
   d. you omitted to tell the call handler that you had used a drop technique on Patient A;
   e. you omitted to tell the call handler that Patient A had first expressed discomfort following the drop technique;
   f. you omitted to tell the call handler that you had treated Patient A's cervical spine.

5. When paramedics arrived at the Clinic:
   a. you told them words to the effect that you had manipulated Patient A's midback with the use of an Activator;
   b. you told them words to the effect that Patient A had first complained of discomfort when you had been using the Activator on his midback;
   c. you omitted to tell the paramedics you had used a drop technique on Patient A;
   d. you omitted to tell the paramedics that Patient A had first expressed discomfort following the drop technique;
   e. you omitted to tell the paramedics that you had treated Patient A's cervical spine;

f. you demonstrated the force applied by an Activator on one of the paramedic's arms.

6. In Patient A's records for 11 August 2017:
    a. you recorded that you had used the Activator on Patient A's thoracic spine at T2/3 level;
    b. you recorded that Patient A had directly said his arms felt numb;
    c. you omitted to record that you had used a drop technique on Patient A;
    d. you omitted to record that you had treated Patient A's cervical spine.

7. Your comments and omissions as set out above at 4 and/or 5, and/or as recorded at 6 above, were;
    a. inaccurate;
    b. misleading;
    c. dishonest in that you intended to mislead as to the precise details of the treatment you had provided Patient A.

DECISION

1. The Committee convened to consider an Allegation of Unacceptable Professional Conduct ("UPC") against Mrs Arleen SCHOLTEN. Miss Lydia Barnfather appeared on behalf of the General Chiropractic Council ("GCC"). Mrs Scholten attended and was represented by Mr Jonathan Goldring. The hearing was conducted remotely using Microsoft Teams due to the restrictions caused by the COVID-19 pandemic.

Application for part of the hearing to be in private

2. In order to preserve the anonymity of Patient A, both he and his wife were not referred to by name during the proceedings. However, it became apparent just before playing the 999 tapes in this case that Patient A was named. Accordingly the Committee agreed, after hearing submissions and legal advice, that the 999 tapes should be heard in private. It was made clear that in the event that any member of the public observing wished to have access to a redacted transcript, that could be arranged. The same applied to the video recordings of Mrs Scholten's police interviews and references to specific individuals (and details about them) within the psychiatric reports.

Admissions

3. Mr Goldring, on behalf of Mrs Scholten, indicated that the following facts were admitted: Particulars 1, 2(a), 4(a), 4(b), 4(c), 4(d), 5(a), 5(b), 5(c), 5(f), 6(a), 6(b), 6(c) and 7(a) and (b), insofar as they related to the aforementioned admitted facts. The Chair therefore announced that those matters were found proved. Later in the proceedings Mr Goldring indicated that 7(a) and 7(b) were not in fact admitted in respect of 4(c) and 6(b), since it was Mrs Scholten's case that she had not used any manual adjustment on Patient A, (Particular 4(c)) and the record that Patient A had directly said his arms felt numb was accurate, (Particular 6(b)). Accordingly, the Chair formally announced that position.

4. In relation to Particular 3 and the linked matters in 4(e) and 5(d), Mr Goldring said that those matters were admitted if the term "discomfort" related solely to a groan. However, if it related to Patient A saying he was being hurt, then it was denied. On that basis the Committee treated these matters as not admitted, but in the event that a finding were subsequently made on the basis admitted, the Committee would be cognisant of the fact that Mrs Scholten had made admissions on that basis.

Background

5. Mrs Scholten qualified as a Doctor of Chiropractic from the North Western College of Chiropractic, Minneapolis, USA in 2001. She came to England in 2004 and in 2006 she purchased Chiropractic 1st ('the Clinic') in North Yorkshire. She was practising from those premises when Patient A first attended the Clinic on 31 July 2017.

6. The allegations in this case concern the treatment provided by Mrs Scholten to Patient A at his fifth appointment on 11 August 2017 and her conduct thereafter following Patient A's collapse. It was not disputed that a Thompson Drop Technique was applied by Mrs Scholten to Patient A's thoracic spine that, it was alleged, caused Patient A to express discomfort. Patient A went on to indicate he had a sensation of numbness in his arms. It is alleged that Mrs Scholten did not stop at that stage and continued treatment, including with the use of an activator before asking Patient A to turn over onto his back. Patient A was unable to do so and became unresponsive and collapsed. He was taken by ambulance to hospital and passed away the next day. A post-mortem examination revealed that Patient A had suffered a fracture of his cervical spine (a broken neck) and catastrophic damage to his spinal cord. The cause of death was given as respiratory depression secondary to traumatic spinal cord injury.

7. A police investigation took place resulting in no criminal prosecution. An inquest was held in November 2019 at which Mrs Scholten gave evidence. It was found that Patient A suffered a fractured neck and spinal cord damage whilst undergoing chiropractic spinal adjustment and subsequent mobilization.

8. In the proceedings before the GCC Mrs Scholten did not face any allegations in connection with the cause of death. The allegations primarily focused on her alleged failures, during the important period after the patient's collapse, to provide true and accurate information to the emergency services or to make an accurate record of the treatment she had provided to Patient A. In particular the allegations focused on her alleged failures to mention the provision of a drop technique to Patient A when speaking with the call handler and subsequently the paramedics who attended. She faced additional allegations in connection with continuing treatment, including with the use of an activator after Patient A first expressed discomfort and a loss of sensation.

9. Patient A first attended the Clinic on 31 July 2017. At the time of first attending, Patient A was a 79-year-old man primarily seeking assistance in connection with aches and pains in

his legs. He provided a medical history that included a history of previous surgery for lumbar stenosis in 2009, which had involved the insertion of rods into his lumbar spine. It was recorded that he was active and walked regularly and he self-reported his level of health as 8-9 out of 10.

10. The initial consultation and examination with Mrs Scholten took place in the private treatment area upstairs at the clinic. Mrs Scholten recorded, amongst other things, that Patient A displayed anterior carriage of the head, muscular stiffness in the right side of the neck and in the lumbar spine. Marked stiffness of the ankles was also recorded as well as reduced spinal movement in the cervical and thoracolumbar spine. Following Mrs Scholten's assessment on 31 July 2017, arrangements were made for Patient A to re-attend for a report and treatment on 4 August 2017. Mrs Scholten transcribed her handwritten records as indicating that treatment was provided on 31 July 2017 to C7 and C1 using an activator (a spring-loaded, instrument assisted, reproducible force applied to a specific joint), albeit an activator (normally indicted by Mrs Scholten by an encircled letter A) was not recorded in the original notes themselves.

11. According to Patient A's wife ('Mrs A'), who accompanied him at each visit, on 4 August 2017 Mrs Scholten took Patient A through her findings and her proposed treatment plan and confirmation was obtained that his private health insurance was willing to cover 12 sessions. A written Treatment Plan was not provided, but it was Mrs A's understanding that Mrs Scholten intended to get Patient A's neck and shoulders back in line and, according to Mrs A, Mrs Scholten proposed providing him with 'alignment treatment'. Patient A then lay face down on a treatment table and Mrs Scholten provided treatment, which was transcribed as consisting of the use of an activator at C4 and C7, T2 and 3, and L1 as well as traction of the right leg. Mrs A said that thereafter Mrs Scholten told them to book in as many appointments as possible before she went on holiday the following week.

12. A third appointment was booked for 7 August 2017 and, again, the patient lay face down on the table upstairs and waited for Mrs Scholten. The treatment provided, according to Mrs Scholten's transcript, included the use of the activator at C1 and C7. In addition, a drop technique (known as a Thompson Drop technique) was utilized on the right sacroiliac joint, according to Mrs Scholten. The Thompson Drop technique utilizes a segmented treatment table, which is designed to lessen the force created by manually applied, high speed manipulative thrusts, while at the same time making them gentler and less fatiguing for the practitioner. The table has drop pieces for adjusting the thoracic, lumbar and pelvic regions of the spine. The drop technique system takes particular account of the anatomical

alignment of vertebral joints and uses directional thrusts with the aim of enhancing segmental joint movement of the spine. The direction of thrust is usually applied from posterior to anterior (back to front). Patients are therefore positioned prone (lying face down) for manipulative techniques using Thompson Drop technique. The application of the manipulative thrust / spinal adjustment can take place using what is referred to as a toggle recoil. The toggle recoil is a high velocity, low amplitude thrust delivered by positioning the hands in contact with the spine. Alternatively, the Chiropractor may use both hands, one on top of the other to push down and then follow through, guiding the joint (as demonstrated by Mrs Scholten).

13. A fourth appointment took place on 10 August 2017 and, in the same way, Patient A waited to be told by the receptionist when to go upstairs whereupon he lay down prone on the table and waited for Mrs Scholten. Mrs Scholten's transcribed records indicated that she used an activator to treat the cervical spine at C7, albeit there is no record of the activator itself in the handwritten notes. She also recorded performing a drop technique at T2-T4, which, she said, she would possibly have been repeated on two or three occasions. She transcribed that she also performed a drop on the right sacroiliac joint and mobilisation of the hips and a hip flexor stretch.

14. Mrs A was adamant that the drop technique was only performed twice, once on 10 August 2017 and once on 11 August 2017. Her evidence was that after the first time on 10 August 2017 her husband indicated he had not been happy with the drop technique and questioned whether to return to the chiropractor. Mrs A said that she persuaded him to continue.

15. On 11 August 2017, Patient A and his wife attended the clinic for an appointment at 12.15pm. Patient A was once more shown upstairs to the treatment area and lay prone with his head to one side whilst, according to Mrs A, they were chatting whilst awaiting for Mrs Scholten to complete treatment on a patient (Patient B) on an adjacent table concealed by a partition. Mrs A recalled that when Mrs Scholten arrived her manner was *'brusque' and 'rushed'*. She proceeded to work around Patient A's body, starting at the right side of his neck using the activator along his spine and down his body, in the way she had previously, including up his shoulders and neck. Mrs A said that when Mrs Scholten got about halfway up Patient A's left-hand side she said something along the lines of he would *'find this unusual'*, before pulling a lever and undertaking a drop technique.

16. In Mrs A's police statement, dated 19 August 2017, she described the use of the activator (at that stage she did not know the correct term for the instrument used) and that Mrs

Scholten was at the side of the bed in the middle and said something before making the central section of the bed drop down again whereupon her husband moaned and said *"You're hurting me."* She then described how Mrs Scholten continued with her treatment, using the *"hammer"* (as she described the activator) along both sides of his neck and only stopping when Patient A said he could not feel his arms.

17. In her evidence to the Coroner on 11 November 2019, Mrs A repeated her evidence stating that when the table went down again Patient A: *"…shouted, "You're hurting me, you're hurting me" and he started to moan and he said, "I can't feel my arms, I can't feel my arms" and things still seemed to, his treatment was still being carried out, there was no stop or anything, and then she said, "Turn over [Patient A]" but he couldn't and she said to me, "Will you help me…"*

18. In the statement prepared for these proceedings, dated 10 October 2020, Mrs A repeated her account that Mrs Scholten had carried on using the activator after the bed drop, up to and including his neck.

19. During the time Mrs Scholten was treating Patient A, Patient B was lying prone on the adjacent bed waiting for Mrs Scholten. Patient B was unable to see the treatment being provided to Patient A as there was a chest high partition between the treatment tables, but she recalled hearing Mrs Scholten greet Patient A. In a statement provided to the police, dated 21 August 2017, Patient B explained how she heard the thud made by the bed and a groaning noise, which she assumed to be the patient. She then heard the clicking noise of the *"syringe-shaped implement"* (her description of the activator) and later heard Mrs Scholten ask the patient to turn over.

20. In Patient B's evidence before the Coroner on 11 November 2019 she repeated that she heard the use of the activator after the thud of the bed, but indicated she was totally reliant in her recollection on her police statement.

21. In her statement prepared for the purpose of these proceedings, dated 19 February 2021, Patient B stated:

> "*I heard Mrs Scholten move the treatment bed next to me and then a bang. Then I heard Mrs Scholten say, "Was that a shock?". Then I heard Mrs Scholten continue treatment with a tool which I think looks like a syringe. I think she was using that for a*

couple of seconds and then she asked the patient to turn over. I think Mrs Scholten then said, "What? You can't turn over?" Then I think I heard the patient's wife giggling and saying "What is the matter with you? My recollection is that I heard the patient groan or mumble but did not hear him speak."

22. Following Patient A's lack of responsiveness, an ambulance was called. In the transcript of the subsequent 999 call, made at 12.24, Mrs Scholten informed the call-handler:

"*So, he laid on the adjusting table and I used an activator on his mid-back and he just said his hands went numb, but he is an elderly gentleman so I never used any manual adjustments on him, but he said he can't feel his hands so I think he may be having a stroke*. *His speech is gone so I…"*

23. In her police interview Mrs Scholten admitted to having performed a Thompson Drop Technique on Patient A on 11 August 2017. However, she failed to mention that in the 999 call, and in her subsequent conversations with the emergency services, and, it is alleged, sought to minimise the treatment she had provided to Patient A to the use of an activator. Mrs Scholten maintained that in setting out to the 999 call-handler what she had *not* done, she was not being defensive and asserted she was not denying the provision of a drop technique. She said she did not consider a Thompson Drop Technique to be a *'manual adjustment'*.

24. Mrs Scholten subsequently explained to the police that whilst she had performed a Thompson Drop technique she had not performed a diversified manual adjustment, which she explained is where she uses her hands to create a cavitation (producing a "cracking" or "popping" sound) in a joint. By saying she had not carried out any manual adjustments she intended to convey she had not used a manual diversified adjustment on Patient A. In her evidence before the Coroner, she elaborated and said that when she uses her hands to press down on a patient's back during a drop technique she would not call that a manual adjustment; however, where the table is locked and the force creates a cavitation she would call it a manual adjustment and, specifically, a manual diversified adjustment.

25. The GCC instructed Richard Brown, a chiropractor, as an expert witness. In his report he said that the application of a drop technique utilises features of a dedicated table but, "*the force that is applied during the toggle recoil thrust is generated manually and relies upon human factors to deliver the therapeutic content. Thompson Drop technique is frequently*

described as 'drop-assisted spinal manipulation'. In my opinion, to suggest that it is not a form of manual manipulation is incorrect."

26. The expert instructed on behalf of Mrs Scholten, Martin Young, a chiropractor, disagreed with Mr Brown and it was Mr Young's opinion that a body of reasonable chiropractors would classify the Thompson Drop as a form of mechanically assisted joint mobilisation and not manual spinal manipulation, albeit he did not deny the drop requires a manual thrust. Mr Young did concede there is some ambiguity within the profession as to the nomenclature. Mr Young further opined that the nature of the forces involved in the application of a drop technique and an activator are of similar magnitude. Mr Brown disagreed and remained of the view that there is a fundamental difference between the techniques involved in the use of an activator and a Thompson Drop, with the latter relying on variable human factors in the sense that it is a manually applied, high-velocity, low amplitude thrust whereas the activator is a spring-loaded, instrument assisted reproducible force applied to a specific joint.

27. When the paramedics arrived Mrs Scholten told them that she had only used an activator on Patient A's mid-back. A paramedic, Ms Davies, and an emergency technician, Ms Snowden, from Yorkshire Ambulance Service NHS Trust ('YAS') attended. In light of the information provided by Mrs Scholten the call out was passed on to them as being a possible stroke as opposed to a trauma incident. On arrival Patient A was assessed as having a Glasgow Coma Scale score of 3, the lowest level of consciousness.

28. Ms Davies made a note of the information provided: *"Pt was having chiropractor treatment lying flat on front; chiropractor used tool to put pressure onto T2/T3. Pt stated couldn't feel his arms, unable to sit up. Pt helped to seated position and became unconscious*".

29. In her reflection note made the same day, and her subsequent police statement, dated 12 September 2017, Ms Davies stated that Mrs Scholten informed them that Patient A had been lying prone and she had been manipulating his mid-back using a very small hammer-like tool, which Mrs Scholten had held up to show them. She stated in her reflection note that Mrs Scholten reported, "*He became aware that he couldn't feel his arms or push himself up from the bed and his speech was slurred and confused*". In her police statement Ms Davies repeated that she was told by Mrs Scholten that the patient had started to complain of weakness in his arms when she had been manipulating his mid-back using the tool.

30. In her testimony to the inquest on 11 November 2019, Ms Davies repeated her evidence and stated that, "*I think in the back of my mind there was bit of an idea, that obviously we were in a chiropractor so I had a little feel down his back, but there was no real suspicion of major trauma at that time from what the chiropractor had told me. She showed [Ms Snowden] the pressure [of the activator] on [Ms Snowden's] arm, which was quite a minor pressure*". At no stage did Mrs Scholten mention the use of the table.

31. Ms Davies set out the significance of the information supplied in terms of the management of the patient. The importance of providing accurate information to the emergency services was highlighted to the Coroner. Whilst ultimately not relevant to the outcome, the paramedic stated, "*If I had been told that the patient had had a traumatic incident… where he cried out in pain after an event had occurred where his body had been dropped then I would have immobilised him before moving him… I think I would have assessed the patient as a trauma patient rather than a medical patient".*

32. In her statement for these proceedings, dated 4 November 2020, Ms Davies set out that Mrs Scholten "*was reasonably calm, she handed over her concerns of possible stroke symptoms and explained that she had been doing light manipulation of the mid/thoracic spine with a small tool [an activator] …when the patient became unwell. Mrs Scholten did not mention handling the cervical spine of the patient at any point*".

33. The emergency technician, Ms Snowden, provided a police statement, dated 11 October 2017, in which she recalled that Mrs Scholten said she had been using the activator on the lowest setting and that Mrs Scholten had demonstrated its use on her arm to show the limited pressure. She stated that Mrs Scholten was quite adamant that she had not done anything which could have caused injury to the patient.

34. In her testimony before the Coroner, on 11 November 2019, Ms Snowden repeated her evidence of Mrs Scholten's handover and the failure to mention any treatment other than the activator to the mid-spine.

35. In her statement for the purpose of these proceedings, Ms Snowden recalled that Mrs Scholten, "*handed over the patient and what she had found in a calm manner. She took the time and had the demeanour to demonstrate the activator tool. Mrs Scholten did not mention the use of the drop table or manual handling of the cervical spine at any point. She stated she was manipulating the mid spine with the small tool…*".

36. Mrs Scholten told the police and Coroner that she completed her clinical records for 11 August 2017 after Patient A had been taken to hospital by ambulance. She recorded the use of the activator at T2/3. She did not document the drop technique, nor any treatment to the cervical spine. She recorded: "*T2/3 A [activator]– directly arms went numb – sat him in chair, responsive but no sensation to arms & called ambulance. Started mouth to mouth as he went pale. Breathing laboured*".

37. Mrs Scholten's account originally was that she had not seen any further patients after Patient A's departure. It was subsequently accepted by Mrs Scholten that, following Patient A's departure to hospital, she saw a number of patients whose appointments could not be cancelled. She thereafter attended the hospital and seeing Patient A in a cervical collar said she spoke to the consultant, "*and I just made them aware that I hadn't touched his neck that visit. I was a bit shocked because I hadn't touched that area of his spine*".

38. On the evening of 11 August 2017 Mrs Scholten left for a pre-arranged holiday. When she returned on 20 August 2017 she was arrested. In the presence of her legal representative, she was interviewed under caution by the police and, amongst other things, told them she had performed a drop technique on Patient A. She said she informed Patient A from the outset that she would be using only very gentle 'adjustments'. She said that she always felt a patient's spine at the outset of an appointment in order to get them to relax. She confirmed that prior to undertaking any spinal manipulation or adjustment she palpated Patient A's whole spine, starting at the neck, and working her way down to his pelvis. She described her treatment table as having four drop piece sections. She said the drop is 2-3cm and she used a lever to release the drop piece from its lock. She explained the drop technique as being on the gentlest setting and having activated it, "*Just with the pressure of my hands… On his back*".

39. The chiropractic experts, Mr Brown and Mr Young, agreed that if the drop piece is calibrated to the lightest setting then only minimal force is needed to apply the drop technique. They further agreed that if the drop piece is incorrectly set, then greater force may be required to trigger the drop mechanism.

40. Mrs Scholten highlighted to the police that she was working from memory and in the absence of sight of her records, which had not been found at that time. She said, during the police interview on 20 August 2017, that she remembered she had also used a drop technique on the cervical spine at the patient's treatment session immediately prior, on 10

August 2017. She had in fact recorded, for 10 August 2017, treatment at C7 but she subsequently transcribed this as being treatment by way of the application of an activator.

41. Of the drop technique performed at T2/3 on 11 August 2017 she told the police:

> "*so, he kind of made a groan a few seconds later. I said "[Patient A] are you all right?" and he just said, "My arms don't feel right" so I didn't do any more treatment. Just waited a few seconds. Sometimes I just, sometimes I just, because I've been in practice for 16 years, never experienced anything like this so I thought it was just a bit of muscle, muscle tension… but he just kept saying his arms don't feel right and so I said to his wife "It's best if we sit him up" … to be honest I didn't know what was going on…*"

42. She was asked about waiting a few seconds after he said, *"My arms don't feel right"* and she replied:

> "Yes…*I was waiting for him to I guess describe it a little bit more to me. Everyone describes symptoms in a different manner…so obviously because you are adjusting an area of spine you're obviously affecting the nerves down to the hand so I thought, you know, maybe he's just had a big flush of stimuli to the hands*".

43. She explained that people have groaned before because you are putting pressure on someone's back, but she was confused as "*the adjustment was so, so gentle*".

44. Mrs Scholten prepared two statements for the purposes of the inquest, dated 25 October 2018 and 4 November 2019. She stated that Patient A wanted to proceed with more frequent sessions because he had a holiday booked. The purpose of the drop was to create movement in the joint where the force was applied and following the drop, Patient A *"immediately made a groaning noise. I stopped treatment and asked him if he was okay. He replied, "My arms don't feel right" so I did not carry out any further treatment*".

45. Mrs Scholten set out in her statement that the paramedics had asked about the treatment she had provided and, "*I explained that following the use of the drop table [Patient A] had reported loss of sensation in his arms and I confirmed the sequence of events*." The evidence of both of the ambulance crew was that Mrs Scholten made no mention of the use

of a drop table. It was subsequently no longer Mrs Scholten's case that she informed the paramedics of the use of the drop technique.

46. Mrs Scholten went on to state that her notes with regard to using the activator were incorrect and she did not use the activator at T2/3 and did not treat the cervical spine on 11 August 2017.

47. Mrs Scholten gave evidence before the Coroner's Court on 12 and 14 November 2019. She stated that she performed a drop at T2/3 and Patient A let out a groan and said, *"My arms don't feel right"*. She went on to say, *"I think I waited a couple of seconds and I said, [Patient A] are you okay?" and he just said again "My arms don't feel right". I asked him if he could sit up*". She said she did not recollect him saying that she was hurting him.

48. She told the Coroner she did not remember why she told the paramedics she had used an activator and it may have been the result of shock "…*my recollection is that only the drop was used at that visit at T2/3 but from [Mrs A] and [Patient B's] statements it appears that the activator may have been used on that visit*". She went on to say she may have told them the activator had been used as, "*I had used it in the past, I guess maybe just, I don't know, you are in a state of shock, you knew you had used the activator on him previously, maybe I used it that day, maybe it had been in my pocket, I don't know*". She was asked if she agreed with Patient B's evidence to the effect that the activator was used and she replied, "*I believe so*".

49. In her subsequent written observations to the GCC Mrs Scholten repeated that she did not classify a Thompson Drop technique as a manual adjustment, which to her means a diversified manual adjustment where the joint is taken beyond its natural range of motion, which she did not perform. She said she did not, "*therefore accept that I misled the paramedics by stating that I did not carry out any manual adjustments*". She went on to say that she thought she had told the paramedics about the Thompson Drop but accepted that she had told them she used an activator. She said she was in shock, "*as events unfolded and the full scale of the seriousness of [Patient A's] condition became clearer… the medical emergency impacted on my state of mind, I cannot explain why I told them that I used the activator at T2/3*." She added, "*I am adamant that I ceased treatment after I understood clearly from [Patient A] that his arms were not right*".

The evidence of Ms Hudson and Patient C

50. On Tuesday 27 April 2021, following the oral evidence of Mrs Scholten, Mr Goldring indicated that the Defence would no longer be calling the clinic receptionist, Clare Hudson, or Patient C, a patient at the clinic on 11 August 2017. He invited the Committee to remove their statements and exhibits from the Registrant's bundle and to put their evidence out of its mind. Ms Barnfather, on behalf of the GCC, asked to be given time to take instructions. The case resumed on Wednesday 28 April 2021. Ms Barnfather indicated that the GCC would not object to the statements and exhibits remaining in the bundle and that it would be a question of weight to be attached to that evidence in light of the fact that neither witness would have given evidence on oath or been cross-examined. She made it clear that their evidence was not agreed.

51. This was not a straightforward matter. Ms Hudson had provided a detailed statement about the events of 11 August 2017 and in particular had made reference to Mrs Scholten's demeanour at the relevant time. This was, in the Committee's view, very much a live issue in this case. She also exhibited her statement, provided to the police on 16 September 2017, and a transcript of her evidence at the inquest on 11 November 2019. The Committee had read all this material in detail. Furthermore, her statement had been provided to Dr Seneviratne, the psychiatrist instructed on behalf of Mrs Scholten, who opined on whether Mrs Scholten suffered an Acute Stress Reaction in the aftermath of events on 11 August 2017 that may have impacted upon her memory. The Committee therefore indicated to the parties that it was considering using its powers under Rule 7(5) of the General Chiropractic Council (Professional Conduct Committee) Rules, Order of Council 2000, to call Ms Hudson as a witness. Rule 7(5) states:

> *"The Committee may of its own motion or on the application of a party require a witness to appear before it and give evidence, and may require a person to attend to produce documents …"*

52. The Committee indicated that it was content for Patient C to be dealt with in the way suggested by Ms Barnfather, with his statement and exhibit remaining in the bundle. When considering the facts in due course, the Committee would attach such weight as it considered appropriate to Patient C's evidence in light of the fact that it would be untested hearsay evidence.

53. Having been told by the Committee that the areas of Ms Hudson's evidence of particular note were her references to Mrs Scholten's demeanour on 11 August 2017, Mr Goldring indicated that he would be content to assist by facilitating Ms Hudson's attendance at the hearing that afternoon.

54. Having received legal advice from the Legal Assessor the Committee decided that it was prepared to exercise its powers under Rule 7(5) and require Ms Hudson to attend, but that if Mr Goldring was able to facilitate her attendance then it would prefer that course of action since it would save considerable time. In reaching that decision the Committee took into account the evidence of Dr Seneviratne who, at paragraph 49 of his report, dated 26 February 2021, stated:

> *"My opinion is based on the Registrant's description of her mental state but also that of the other patient in a different cubicle, as well as the receptionist, who describes her emotional state before and after the ambulance had taken away* [Patient A]*. I have also considered the paramedic's view of the Registrant's mental state, and that of Mrs.* [A]. *Neither of whom describe her as anxious. If the Committee accepts the account of the Registrant, the other patient* [Patient B] *and Clare Hudson, then this would be consistent with the Registrant having an acute stress reaction. If the Committee accepts the account of the paramedics and Mrs* [A] *then this would be inconsistent with an Acute Stress Reaction, as one would expect there would be physiological symptoms, such as agitation, shallow breathing and tremor."*

55. At paragraph 62, he said:

> *"An acute stress reaction is associated with poor concentration. It is well known to cause dissociative amnesia with an inability to recall critical aspects of the traumatic event. If the Committee find that the Registrant had no previous experience of a medical emergency, and that they agree that it was extremely stressful, and unforeseeable, then I humbly ask them to consider that this was an exceptional event. I ask the Committee to consider that, on the balance of probabilities, this led to an acute stress reaction which started at the time of the incident. It is a matter for the Committee to decide whether the eye witness accounts add weight to or detract from the diagnosis."*

56. In the Joint Expert Report produced by Dr Seneviratne and Dr Garvey, dated 12 April 2021, it was stated, *inter alia,* :

3. That the Registrant may have had impaired memory of the treatment she had offered, as a result of an Acute Stress Reaction, during the hours after the incident but equally she may not have and there could be other reasons for the discrepancies in her accounts.

11. That it is for the PCC to decide on the basis of all the evidence whether a possible Acute Stress Reaction led her to not report her treatment accurately or whether an alternative explanation is more likely.

57. It was apparent, therefore, that an important issue for the Committee to decide at the fact finding stage would be whether Mrs Scholten suffered an Acute Stress Reaction and if so whether it impacted upon her subsequent acts and omissions. Since Dr Seneviratne made specific reference to the evidence of Ms Hudson and highlighted that it was a matter for the Committee to decide whether the eye-witness accounts added weight to, or detracted from, the diagnosis of Acute Stress Reaction, the Committee considered it most important that it actually hear from Ms Hudson and thereby be in a position to clarify any matters within her evidence that required clarification on this key issue.

58. The Committee informed the parties of its decision and Mr Goldring confirmed the Defence would facilitate matters by ensuring Ms Hudson was available to give evidence at 2pm. Discussion then turned to the mechanics of how she would give her evidence in light of the fact that it was the Committee who wanted Ms Hudson to attend, not the Defence. Various suggestions were made, but Mr Goldring took exception to the assertion that the GCC would not be prohibited from cross-examining Ms Hudson on the entirety of her evidence, rather than on the discrete issue of her demeanour. Whilst it would be fair to say no consensus was reached on the correct approach, Mr Goldring, having taken instructions from Mrs Scholten and his instructing solicitor, indicated that the Defence would in fact call her as a witness in the usual way, as originally envisaged. In answer to a question from the Chair, Mr Goldring indicated that Mrs Scholten wished to assist and that whilst he might have taken a different view he had not made the decision under pressure and was acting on instructions.

59. Accordingly, Ms Hudson was called to give evidence on behalf of Mrs Scholten, rather than by the Committee having to exercise its powers under Rule 7(5).

Decision on facts

60. The Committee considered with care all the evidence, both oral and written, together with the submissions made by the parties. The Committee accepted the advice of the Legal Assessor and bore in mind that it was for the GCC to prove its case and to do so on the balance of probabilities.

61. The Committee first considered each witness's credibility and reliability. The Committee heard from the following witnesses on behalf of the GCC:

- Mrs A - wife of Patient A
- Patient B - patient on adjacent treatment table
- Eleanor Davies - paramedic
- Lauren Snowden - emergency technician
- Richard Brown - Chiropractor and expert witness

62. The report of each of the expert psychiatric witnesses, Dr Garvey and Dr Seneviratne, were read, together with their Joint Report.

63. The Committee heard from the following witnesses on behalf of Mrs Scholten:

- Mrs Scholten - Registrant
- Martin Young - Chiropractor and expert witness
- Clare Hudson - Receptionist at the Clinic

64. Mrs Scholten also relied on 97 written character references from professional colleagues, patients and friends, who spoke highly of her clinical abilities, professionalism and integrity. In addition there was the hearsay statement of Patient C.

65. The Committee considered Mrs A to be an articulate, clear, straight-forward and helpful witness. The Committee recognised what an extremely harrowing and traumatic event this must have been for her and how difficult it was for her to have to repeatedly re-live the events of that day. Like all the witnesses in this case she had provided a statement to the police in 2017, participated in the inquest in 2019 and then provided a statement for these proceedings in 2020, before appearing in 2021 to give evidence. She gave her evidence with conviction and a clear belief in her memory of events. Some of her evidence was not supported by other independent evidence, for example references to her husband shouting

or saying loudly that Mrs Scholten was hurting him, but overall the Committee found Mrs A to be a credible witness who was clearly doing her best to assist the Committee.

66. In relation to all the non-expert witnesses in this case and Mrs Scholten herself, the Committee was cognisant of the fact that they were all recalling events from August 2017 and the inherent difficulties involved in such a task. Nevertheless, they were all assisted somewhat by having provided police witness statements and, in Mrs Scholten's case a police interview, within days of the events when matters would have been much clearer in their memories. They also had the added benefit of having attended the inquest in 2019 and answered questions for the Coroner. They all had then provided witness statements in 2020 in preparation for this hearing. Finally, they gave oral evidence to this Committee. As one of the paramedic witnesses candidly put it, after so much time and with so many versions it was not always possible to separate out what knowledge of events one had learned and when. The Committee therefore took into account the inevitable possibility of events becoming confused and/or mixed up in the repeated re-telling. Accordingly, it was particularly guided by the earliest recollections as provided to the police in 2017. Indeed, all the witnesses accepted that the accounts they gave in 2017 were the most reliable and for some, for example Patient B, the only recollection of events this far on.

67. The Committee found Patient B to be a helpful and credible witness who provided clear, straightforward, objective and impartial evidence. She was entirely independent of the parties and relied solely on what she heard from the adjacent bed. She was able to recall hearing papers being shuffled at the start of Patient A's appointment, which she inferred was Mrs Scholten looking at the patient's records. She was able to hear the use of the drop bed which she was accustomed to, it being a technique Mrs Scholten had used on her. The same applied to the use of the activator. She was frank in saying she had very little recollection of the events now, over three and a half years later, and relied almost entirely on the content of her police statement made a few days after the event.

68. The Committee considered the paramedics to be helpful, credible and reliable witnesses. Their evidence was even-handed, measured, professional and essentially unchallenged. They too relied on the statements they provided to the police together with the notes they made at the time and, in Ms Davies' case, a reflective piece she wrote on the day.

69. The Committee noted that both Mr Brown and Mr Young were very experienced and knowledgeable chiropractors who had given evidence in many fitness to practise hearings. Their evidence was comprehensive, thorough and balanced. However, the Committee was

of the view that this was not a case that in fact relied heavily on expert chiropractic evidence, but rather on disputed factual issues as between Mrs A and Mrs Scholten, together with questions of dishonesty that were not within the experts' remit. As such the evidence of the chiropractic experts was of marginal assistance to the Committee in deciding the disputed factual particulars. Nevertheless, where their evidence did have a role to play, for example in understanding the operation of the drop table and activator and the use of the "toggle recoil" technique, the Committee found it helpful.

70. In relation to Dr Garvey the Committee noted from the joint psychiatric report that there was agreement between him and Dr Seneviratne and consequently neither were called to give evidence. The Committee considered their evidence to be most helpful and influential in deciding the issue of dishonesty.

71. When considering Mrs Scholten's credibility and reliability as a witness the Committee took into account her good character and the many references and testimonials attesting to her skill as a chiropractor and her honest character. Indeed, the Committee had never before encountered such an impressive collection of character evidence, which it considered particularly noteworthy. Their authors spoke of Mrs Scholten's high values and ideals, of her professionalism, of the gentle way in which she treats patients and about how kind and caring she is. They spoke of her integrity both as a chiropractor and as an individual. When giving evidence Mrs Scholten, like other witnesses, relied heavily on what she had told the police when interviewed. She accepted that her memory of events was poor and described it as a patchwork, with some things remembered and other matters completely blank. She had no explanation for the accounts she had provided to the 999 call handler, the paramedics and then as recorded in her notes, which did not in fact accord with the treatment she had provided to Patient A that day. The overall impression the Committee gained from having seen and heard at length from Mrs Scholten was that she was a decent hard-working, committed and dedicated chiropractor who was at a complete loss to understand what had happened that fateful day in August 2017. Insofar as she was able to remember events her evidence was credible.

72. The Committee considered Mrs Hudson to be a helpful, honest, straightforward and credible witness. She was clear in her evidence and particularly assisted the Committee in her description of Mrs Scholten's demeanour at the relevant time.

1. **Between 31 July 2017 and 11 August 2017, you provided chiropractic care and treatment to Patient A at Chiropractic 1st, 68 The Mount, North Yorkshire, YO24 1AR, ('the Clinic'). - <u>proved</u>**

73. Admitted and found proved.

2. **On 11 August 2017 you provided treatment to Patient A which included:**
   a. **a drop technique applied to the thoracic spine; - <u>proved</u>**
   b. **the use of an Activator applied to the thoracic spine; - <u>not proved</u>**
   c. **the use of an Activator applied to the cervical spine. - <u>not proved</u>**

74. 2(a) admitted and found proved.

75. With reference to 2(b) and 2(c), it was Mrs Scholten's case that she did not use the activator when treating Patient A on the 11 August 2017. She accepted that: she had told the call handler on the 999 call that she had used the activator on Patient A's mid back; she had told the paramedics who attended at the Clinic that she had manipulated Patient A's mid back with the use of an activator; that she had told the paramedics that Patient A first complained of discomfort when she had been using the activator on his mid back; that she demonstrated the force applied by the activator on one of the paramedic's arms; and that she recorded in her notes that she had used the activator on Patient B's thoracic spine at T2/3 level. She could not explain these anomalies other than to say it must have been the result of being in shock. She continued to deny ever having treated the cervical spine on 11 August 2017, whether with an activator or otherwise.

76. In her statement made to the police eight days after the event, Mrs A said that:

> *"[Patient A] moaned and said, "You're hurting me". Dr Scholten didn't say anything and moved up to [Patient A's] neck area. I thought she was being rough with him as she used her hands on either side of his neck and went up behind his ears. She used 'the hammer' along both sides of his neck and I could just hear the dum dum on his neck. At this point I heard [Patient A] say in a stressed tone "I can't feel my arms". [Patient A] didn't move and Dr Scholten continued with the 'hammer' and hands on his neck but I can't say for how long for… Dr Scholten said, "Turn over onto your back [Patient A]" but he couldn't. He again said, "I can't feel my arms". He didn't sound in pain, he sounded stressed. I asked [Patient A] if he could push himself up using his arms*

saying, "Just push up [Patient A] push" but he couldn't. At this point Dr Scholten turned to me and asked me to help her get [Patient A] up…"

77. In her evidence to the Coroner on 11 November 2019 Mrs A repeated her evidence stating that when the table went down Patient A:

> *"…shouted, "You're hurting me, you're hurting me" and he started to moan and he said, "I can't feel my arms, I can't feel my arms" and things still seemed to, his treatment was still being carried out, there was no stop or anything, and then she said, "Turn over [Patient A]" but he couldn't and she said to me, "Will you help me…""*

78. At the inquest when asked about the use of the activator Mrs A said, *"I think she used it on his neck and his shoulders and his feet, that's the memory I have about the activator."* And later, *"I think the activator was still being used at the side of his neck, because she didn't stop then, she carried on up the side of his neck …"*

79. In the statement prepared for these proceedings, dated 10 October 2020, Mrs A repeated that whilst half-way up Patient A's torso, Mrs Scholten:

> *"… made the central section of the bed drop down again with a lever and it immediately bounced back up. [Patient A] moaned and said, "You're hurting me" twice. Mrs Scholten then carried on up [Patient A's] spine using the activator. When Mrs Scholten got to about halfway between [Patient A's] waist and his shoulder blades I heard [him] say in a stressed tone, "I can't feel my arms".[Patient A] did not move and Mrs Scholten did not respond; she continued using the activator up [his] spine towards his neck.*
>
> *When Mrs Scholten got to [his] neck, she used the activator along the side of his neck up to behind his ears: I think she finished opposite where she had started on the other side. Then she stopped and said, "Turn over onto your back [Patient A]". [Patient A] did not move but said again, "I can't feel my arms". I urged [Patient A] to push with his arms but he said, stressed, that he couldn't feel his arms. [He] then became unresponsive…*
>
> *I asked Mrs Scholten if he had had a stroke; she lifted his chin up so that his head was against the back of the chair and said, "oh no, his features are symmetrical" or words to that effect before letting his head drop."*

80. In her oral evidence to the Committee Mrs A said that Mrs Scholten *"… went up to his neck and used her hands on his neck and behind his ears." "I could hear the dum dum dum on his neck" and she "… continued with the activator and hands on his neck, I can't say for how long."*

81. Patient B, who was waiting to be treated on the adjacent bed, gave oral evidence to the Committee and conceded at the outset that her memory of events relied almost entirely on what she had written in her police statement, provided 11 days after the event. In that statement she said:

> *"I heard a clicking noise next to me and assume Arleen was using the same metal syringe shaped implement… Before I heard the clicking noise I head a thud which I assumed was Arleen completing adjustments… When the bed next to me made the thud, I heard what I assumed to be the patient beside me make a groaning noise as if the air had been knocked out of his chest. Arleen said straight away, "It can be a bit of a shock when I first do it" or words to that effect…. I have then heard the clicking noises from Arleen using the syringe-shaped implement I believe and the patient beside me exhaled air loudly and made a groaning noise…. Within a minute or so I heard Arleen asking the patient beside me to turn over and there was a pause and I could not hear the patient moving in the bed. The patient next to me appeared to mumble something like, "I can't move my arm" or words to that effect. At that point I could hear Arleen and the elderly female say, "Can't you turn over?" or words to that effect…"*

82. In Patient B's evidence before the Coroner on 11 November 2019, more than two years after the event, she repeated that she heard the use of the activator after the thud of the bed, but indicated she was totally reliant in her recollection on her police statement.

83. In her statement prepared for the purpose of these proceedings dated 19 February 2021 she stated:

> "*I heard Mrs Scholten move the treatment bed next to me and then a bang. Then I heard Mrs Scholten say, "Was that a shock?". Then I heard Mrs Scholten continue treatment with a tool which I think looks like a syringe. I think she was using that for a couple of seconds and then she asked the patient to turn over. I think Mrs Scholten then said, "What? You can't turn over?" Then I think I heard the patient's wife giggling*

and saying "What is the matter with you? My recollection is that I heard the patient groan or mumble but did not hear him speak."

84. In her oral evidence Patient B said she relied on her police statement, but conceded under cross-examination that it was a possibility that she had mixed up the order of things. The Committee, however, considered her account given within days of the event to be far more reliable that anything she could remember now, some three and half years later.

85. The Committee noted that although Mrs A was adamant that Mrs Scholten had continued to use the activator after the drop technique had been performed, she also said in her statement prepared for these proceedings, *"I do not remember how many times Mrs Scholten used the activator during this appointment, or on which parts of* [Patient A's] *body, it was a sound I had heard before, so it was not unexpected."* In her oral evidence she said she had not been making a note at the time of where and when the activator had been used. Patient B was clear in her police statement that she heard the clicking sound of the activator after the thud of the drop, both being techniques she was accustomed to. Of course she could not see where the activator was being used, only that she could hear it being used. In a case where the two main witnesses, Mrs A and Mrs Scholten, were at odds with each other, the Committee found the impartial evidence of Patient B to be particularly helpful, not least because she was focussed on what she could hear and not distracted by anything she could see.

86. The Committee was thus satisfied that Mrs Scholten had used the activator on Patient A and furthermore had done so after the drop. However, it was not possible for the Committee to know on what part of Patient A the activator had actually been used. It could have been part of the thoracic spine or the cervical spine. The Committee noted that Mrs Scholten was adamant she had not used the activator after the drop, but did not consider her memory of events to be reliable in light of its conclusions (referred to below) in relation to the shock she was experiencing.

87. The Committee's decisions on the matters alleged in Particular 2, and indeed many of the particulars, depended in large extent on its assessment of Mrs Scholten and the evidence of whether or not she was in a state of shock at the time and, if so, to what extent the Committee was satisfied that being in a state of shock explained her actions and omissions. In making this assessment, the Committee bore in mind that it was not for Mrs Scholten to

disprove the matters alleged, but rather for the GCC to prove them, on the balance of probabilities.

88. The starting point was to consider the evidence of the expert psychiatric witnesses instructed by the GCC and that of Mrs Scholten.

89. In summary, Dr Seneviratne, instructed on behalf of Mrs Scholten, opined:

"It is my view, based on the description that Mrs Scholten gave me, that she suffered from an Acute Stress Reaction. An Acute Stress Reaction shows a typically mixed and changing picture of symptoms. Some people present with psychosis. The Registrant had no experience of resuscitation and had never attended a medical emergency before. She had no experience of an adverse reaction to chiropractic treatment. My opinion is based on the Registrant's description of her mental state but also that of the patient in the cubicle as well as the receptionist.
The Registrant reported a constriction of field of view, narrowing of attention and dissociation phenomena namely, partial amnesia for some events of the day, as well as depersonalisation that was self-limiting and disappeared after 72 hours. Memory impairment is not uncommon in acute stress. This has subsequently led to the development of Post-Traumatic Stress Disorder. The Acute Stress Reaction is associated with poor concentration. It is well known to cause dissociative amnesia with an inability to recall critical aspects of the traumatic event. I ask the Committee to consider that, on the balance of probabilities, this led to an Acute Stress Reaction which started at the time of the incident. It is a matter for the Committee to decide whether the eyewitness accounts add weight to, or detract from, the diagnosis. It is my view that the Registrant's mental state was impaired due to an Acute Stress Reaction, this in turn led to an impairment in laying down accurate memories and deficits in recall."

90. Mr Garvey, instructed on behalf of the GCC, opined:

"An Acute Stress Reaction is defined in the ICD-10 as a transient disorder that develops in an individual without any other apparent mental disorder in response to exceptional, physical and mental stress and which usually subsides within hours or days. Individual vulnerability and coping capacity play a part in the accounts and severity of Acute Stress Reactions. The symptoms show a typically mixed and changing picture and include an initial state of daze with some constriction of the field

of consciousness and narrowing of attention, inability to comprehend stimuli and disorientation. This state may be followed either by further withdrawal, to the extent of a dissociative stupor, or by agitation and over-activity. Autonomic signs of anxiety, tachycardia, sweating and flushing are commonly present. Symptoms usually appear within a few minutes of the impact of the stressful event and disappear within two to three days, often within hours. Partial or complete amnesia for the episode may be present. With regard to Mrs Scholten, I would wish to highlight that she appears to be a woman of at least normal psychological resilience with no past psychiatric history.

The events of 11 August 2017 would, in my view, have undoubtedly been highly stressful for Mrs Scholten. She was responsible for the care of the patient who became very seriously unwell. Her own account (which I have accepted) is that she had never been in such a position before within her professional practice and felt ill-equipped to cope. Although, as Dr Seneviratne points out in his report, there are mixed descriptions about Mrs Scholten's appearance and presentation at the time of the acute events, in my view it is likely that she was having some form of Acute Stress Reaction in any event.

With regard then to the possible effect of the Acute Stress Reaction upon Ms Scholten's accounts to the 999-call handler and to the paramedics, and with regard to her writing of the notes, and the differences between these accounts and her subsequent account to the police, I would wish to say as follows; Mrs Scholten was stressed at the time of the initial event and a diagnosis of an Acute Stress Reaction would be reasonable. A person suffering an Acute Stress Reaction can have difficulties with accurate recall."

91. In their joint report the Psychiatrists agreed:

1. That an Acute Stress Reaction can impair memory.

2. That the Registrant likely had an Acute Stress Reaction in the aftermath of the events of 11 August 2017 based on the evidence available to us, but it is for the PCC to decide whether they accept that an Acute Stress Reaction occurred.

3. That the Registrant may have had impaired memory of the treatment she had offered, as a result of an Acute Stress Reaction, during the hours after the incident but

equally she may not have and there could be other reasons for the discrepancies in her accounts.

4. That objective physical signs and symptoms do not reflect on the severity of intra-psychic phenomena.

5. That individual vulnerability and coping capacity play a role in the occurrence and severity of acute stress reactions.

6. That PTSD and its duration is not related to the severity of the initial acute stress reaction.

7. That the severity of an extraordinary event is not an indicator of whether memory would be impaired.

8. That there is no evidence that the Acute Stress Reaction presented with a psychotic disorder, where delusions and hallucinations are seen.

9. That the Registrant did not require psychiatric input after (sic) *during, and after the Acute Stress Reaction.*

10. That the Registrant does not have pre-existing psychiatric conditions, or a past history of trauma or witnessing trauma. Therefore, the Registrant does not have predisposing factors which would make an unusually severe Acute Stress Reaction more likely, i.e. the Registrant has a level of resilience.

11. That it is for the PCC to decide on the basis of all the evidence whether a possible Acute Stress Reaction led her to not report her treatment accurately or whether an alternative explanation is more likely.

Dr Garvey states in his report that Furthermore, the situation in which she found herself is one which is not extremely rare. We agreed that what Dr Garvey meant by this, was that PCC should be able to come to conclusions as to how the Registrant might feel and behave in such a situation without the need for expert advice and we both agree that this is the case. There were no significant areas of disagreement.

92. Given the presenting situation and the speed with which Patient A's condition deteriorated, resulting in Mrs Scholten resorting to administering mouth to mouth resuscitation before the paramedics arrived, the Committee considered it highly likely that she would have been in some form of shock as a result. Such a response would be entirely natural in the circumstances.

93. In her evidence at the Inquest, Mrs Scholten, in response to questions from Counsel representing Patient A's family, stated:

> *I play this over in my head hundreds and hundreds of times and I… I… guess maybe because the activator had been used so many times before it was something I was – it was part of my plan, it was something I was using and I can t explain that to you. I don t know."*

94. Mrs Scholten told the Coroner she did not remember why she told the paramedics she had used an activator and it may have been the result of shock "…*my recollection is that only the drop was used at that visit at T2/3 but from [Mrs A] and [Patient B's] statements it appears that the activator may have been used on that visit*". She went on to say she may have told them the activator had been used as, "*I had used it in the past, I guess maybe just, I don't know, you are in a state of shock, you knew you had used the activator on him previously, maybe I used it that day, maybe it had been in my pocket, I don't know*". She was asked if she agreed with Patient B's evidence to the effect that the activator was used and she replied, "*I believe so*".

95. In her written observations to the GCC Mrs Scholten said she was in shock, "*as events unfolded and the full scale of the seriousness of [Patient A's] condition became clearer… the medical emergency impacted on my state of mind, I cannot explain why I told them that I used the activator at T2/3*." She added, "*I am adamant that I ceased treatment after I understood clearly from [Patient A] that his arms were not right*".

96. She also said:

> *"Immediately following treatment on 11.8.2017 I believed [Patient A] had experienced a stroke as I did not consider the treatment I had provided (which had been safely provided to him previously) could have cause trauma of this nature. I was in a state of shock and confusion because something like this had never previously happened to*

me in 16 years of practice. I maintain that I did not carry out any further treatment after [Patient A] said his arms did not feel right."

97. In her oral evidence to the Committee Mrs Scholten said she was aware the experts thought she had suffered from an Acute Stress Reaction, but she had never heard of that before. She thought, however, that it made sense. She said, *"Anyone in that situation would have been under a huge amount of stress. I have no idea how I felt, there was an evolving medical emergency, I was very stressed … some memories are like pictures, the resuscitation for example. I sort of remember Ms Davies, she was in green, but it was all very short and quick. To be honest the way the brain works is it does not want to take you there."* She told the Committee that she had treated four more patients that afternoon but had absolutely no recollection of that, and only discovered she had done so a few months ago when Ms Hudson had been able to retrieve the archived records from the software company Chiropractic 1st used. Mrs Scholten said that her recollection of much of that day was a blur.

98. In her statement dated 4 February 2021, and confirmed in her oral evidence, the Clinic receptionist Ms Hudson said:

"Immediately after the ambulance left, I went upstairs to see Mrs Scholten. She was sitting on the treatment bed in the back office. Mrs Scholten was crying and shaking, she was in a state of shock. Mrs Scholten told me she had no idea what happened. I recall sitting down beside her on the treatment bed. I recall that I put my arm around Mrs Scholten and held her hand to comfort her.

Being quite pragmatic and in 'work mode' with my business head on, I asked Mrs Scholten if she wanted to see a couple of patients who had arrived. After about five or six minutes she went to see them. I said to Mrs Scholten it was a good idea to see them and then we could ring the hospital and see what's happened."

99. In his statement dated 30 March 2021, Patient C said he was present when Mrs Scholten and Mrs A were trying to get Patient A to sit up. He had not seen what preceded this and left because he could see it was a serious situation and he was concerned his children, who had accompanied him, would be distressed if they remained. He said:

"I have been asked if I can recollect Arleen's demeanour when I left and whether she appeared calm, worried or shocked. I would say by the tone of her voice she appeared

very concerned for the man's well-being as he was not answering, but in control of the situation in instructing Clare to call 999."

100. Whilst this was hearsay evidence and not tested under cross-examination, it was supported by the evidence of the paramedics and Ms Hudson, all of whom thought Mrs Scholten appeared calm at the time of handing over Patient A to the paramedics.

101. In her statement for these proceedings, dated 4 November 2020, and her subsequent oral evidence, the paramedic Ms Davies set out that Mrs Scholten:

"*was reasonably calm, she handed over her concerns of possible stroke symptoms and explained that she had been doing light manipulation of the mid/thoracic spine with a small tool [an activator] …when the patient became unwell. Mrs Scholten did not mention handling the cervical spine of the patient at any point*".

102. In her statement for the purpose of these proceedings, dated 2 November 2020, and her subsequent oral evidence, the emergency technician, Ms Snowden, recalled that Mrs Scholten,

"*handed over the patient and what she had found in a calm manner. She took the time and had the demeanour to demonstrate the activator tool. Mrs Scholten did not mention the use of the drop table or manual handling of the cervical spine at any point. She stated she was manipulating the mid spine with the small tool…*".

103. In their joint report both Dr Garvey and Dr Seneviratne consider it more likely than not that Mrs Scholten was suffering an Acute Stress Reaction on the day in question. The Committee agreed. On any account it was a fast moving, traumatic, unique set of events and the Committee considered it was inevitable that Mrs Scholten would have been suffering from shock as a result of Patient A's rapidly deteriorating condition, the need to give mouth to mouth resuscitation and to call for an ambulance. The Committee was of the view that it was the impact of that combination of factors and the effects of the shock that influenced Mrs Scholten's subsequent acts and omissions.

104. Returning then to Particulars 2(b) and 2(c), the Committee was satisfied on the balance of probabilities that the activator was used by Mrs Scholten on Patient A on the 11 August 2017 and indeed she conceded it was possible she had used it before the drop was carried out. What the Committee could not be satisfied about was which area of Patient A's spine

had been treated with the activator, namely whether it was the thoracic or cervical spine. Accordingly, in light of the way in which this Particular was alleged, the Committee could not be satisfied that the activator had been applied to his thoracic spine *or* his cervical spine and accordingly it found 2(b) and 2(c) not proved.

3. Following the drop technique, Patient A indicated he was in discomfort and had lost sensation in his arms and you inappropriately continued treatment - not proved

105. The evidence relied on by the GCC for Particular 3 came from Mrs A and Patient B. Mrs A was consistent in saying she was adamant treatment continued after the drop technique had been carried out and after her husband had indicated he was being hurt. This had been her evidence in the statement provided to the police within a matter of days of the event. She had repeated it at the Coroner's inquest in 2019. It was in her statement prepared for these proceedings and she repeated it in her oral evidence. It is fair to say that under cross-examination she conceded she could not be sure precisely where the activator was used on her husband after the drop or how many times. She was not, as she said, making a written note of all that went on. However, she was clear that treatment did not stop after the drop. She was also adamant that her husband said straight after the drop *"you're hurting me, you're hurting me".* This was referred to by Mrs A in her various accounts as *"a moan"*, as *"a shout"* and, at this hearing, *"said loudly".* The Registrant said she did not hear that. This was not, in the Committee's view decisive. Mrs Scholten may not have heard because she was concentrating on her treatment, she may have been distracted and there was evidence, given by Mrs A, that Mrs Scholten appeared particularly rushed that day. Mrs Scholten may have heard but chose to ignore it at the time, thinking it was not unusual for some treatment to have that effect. She may have decided not to admit to hearing it after the event in order to cover up her subsequent actions.

106. However, it is of particular note that it was not heard by Patient B either. Patient B was in the adjacent bed, albeit hidden behind a partition, and was able to hear much of what took place in the bed next door, including hearing papers been rustled at the start of the treatment. Accordingly, on the balance of probabilities, the Committee was unable to be satisfied that Patient A had said *"You're hurting me"* loudly enough for Mrs Scholten or Patient B to hear. However, the Registrant did admit to hearing a groan and Patient B heard a *"groaning noise as if the air had been knocked out of their chest."*

107. At the inquest Patient B told the Coroner that she had little independent memory of the events and relied on her police statement. She said the same at this hearing. When cross-examined she conceded that it was possible she had got the sequence of events mixed up. However, that concession had to be considered in light of her evidence that she had little or no recollection of events now, over three and a half years after the event. Accordingly, as mentioned above, the Committee considered her evidence, as provided to the police within days of the events occurring, to be the most reliable account. In that evidence she was clear that she heard the clicking of the activator after the thud of the drop table.

108. The Committee considered the sequence of events to be significant when considering Particular 3, which alleged that Mrs Scholten had continued treatment after Patient A had expressed discomfort and after he had lost sensation in his arms. Once again, Mrs A's evidence and Mrs Scholten's evidence were at odds with each other. The Committee has already indicated it could not be satisfied, on the balance of probabilities, that Mrs Scholten heard Patient A saying she was hurting him. It was satisfied, however, that she heard the groan because she admitted as much and Patient B agreed. That could be considered to be an indication of discomfort. However Particular 3 alleged discomfort and loss of sensation in his arms. Mrs A said that Mrs Scholten continued to treat her husband after he had groaned and after he has said he could not feel his arms. Mrs Scholten said she stopped treating as soon as Patient A said he could not feel his arms. According to Patient B, the time that she heard Patient A saying *"I can't move my arms"* or words to that effect, was when Mrs Scholten asked him to turn over. Patient B did not hear any more treatment after that point.

109. In light of Patient B's impartial, seemingly objective evidence, the Committee could not be satisfied that Mrs Scholten had continued treatment after she first heard Patient A express concern about his arms. On that basis, the Committee found Particular 3 not proved.

4. During the course of a subsequent 999 telephone call:

- **a. you told the call handler that Patient A had laid on the adjusting table and you had used the Activator on his midback; - proved**
- **b. you told the call handler that when you were using the Activator on Patient A's midback he had said his hands had gone numb; - proved**
- **c. you told the call handler that as Patient A was elderly you had never used any manual adjustment on Patient A; - proved**

d. **you omitted to tell the call handler that you had used a drop technique on Patient A; - <u>proved</u>**

e. **you omitted to tell the call handler that Patient A had first expressed discomfort following the drop technique; - <u>proved</u>**

f. **you omitted to tell the call handler that you had treated Patient A's cervical spine. - <u>not proved</u>**

110. Particulars 4(a), 4(b), 4(c) and 4(d) were admitted and found proved.

111. Particular 4(e) was admitted if the reference to discomfort was to the groan emitted by Patient A, but not if it included the words *"You're hurting me."* In accordance with its findings above and the Committee not being satisfied, on the balance of probabilities, that Mrs Scholten heard Patient A say *"You're hurting me"*, the Committee therefore found this Particular proved on the basis of Mrs Scholten's admission, that she omitted to tell the call handler that Patient A groaned following the drop technique.

112. Particular 4(f) was denied by Mrs Scholten on the basis that she did not treat Patient A's cervical spine on 11 August 2017. As already indicated in its findings in relation to Particular 2(c), the Committee was satisfied, on the evidence of Mrs A and Patient B, that Mrs Scholten continued to treat Patient A after the drop technique was performed, by using the activator, but could not be clear about what part of the spine had been treated. It followed that if the use of the activator on the cervical spine was not proved then Particular 4(f) must also be found not proved, since there was insufficient evidence to show Mrs Scholten had treated Patient A's cervical spine on 11 August 2017.

5. When paramedics arrived at the Clinic:

a. **you told them words to the effect that you had manipulated Patient A's midback with the use of an Activator; - <u>proved</u>**

b. **you told them words to the effect that Patient A had first complained of discomfort when you had been using the Activator on his midback; - <u>proved</u>**

c. **you omitted to tell the paramedics you had used a drop technique on Patient A; - <u>proved</u>**

d. **you omitted to tell the paramedics that Patient A had first expressed discomfort following the drop technique; - <u>proved</u>**

e. **you omitted to tell the paramedics that you had treated Patient A's cervical spine; - <u>not proved</u>**

f. **you demonstrated the force applied by an Activator on one of the paramedic's arms. - <u>proved</u>**

113. Particulars 5(a), 5(b), 5(c) and 5(f) were admitted and found proved.

114. Particular 5(d) was admitted on the same basis as 4(e) and, given its findings in relation to 4(e) the same applied to 5(d), which the Committee therefore found proved on the same basis.

115. Particular 5(e) was denied by Mrs Scholten on the basis that she did not treat Patient A's cervical spine. The Committee had already found in relation to Particulars 2(c) and 4(f), that there was insufficient evidence to prove that Mrs Scholten did treat Patient A's cervical spine. For the same reasons, therefore, the Committee found Particular 5(e) not proved.

6. In Patient A's records for 11 August 2017:

a. **you recorded that you had used the Activator on Patient A's thoracic spine at T2/3 level; - <u>proved</u>**

b. **you recorded that Patient A had directly said his arms felt numb; - <u>proved</u>**

c. **you omitted to record that you had used a drop technique on Patient A; - <u>proved</u>**

d. **you omitted to record that you had treated Patient A's cervical spine. - <u>not proved</u>**

116. Particulars 6(a), 6(b) and 6(c) were admitted by Mrs Scholten and found proved.

117. Particular 6(d) was denied on the basis that there had been no treatment to the cervical spine. The Committee had already determined in its findings above that there was insufficient evidence to prove that Mrs Scholten did treat the cervical spine. For the same reasons as above, the Committee therefore found Particular 6(d) not proved.

7. Your comments and omissions as set out above at 4 and/or 5, and/or as recorded at 6 above, were;

a. **inaccurate;**

b. **misleading;**

c. **dishonest in that you intended to mislead as to the precise details of the treatment you had provided Patient A.**

118. Mrs Scholten admitted that, in relation to the facts that she had admitted, her actions and omissions were inaccurate and misleading. Accordingly, the Committee found Particulars 7(a) and 7(b) proved in relation to 4(a), 4(b), 4(d), 5(a), 5(b), 5(c), 5(f), 6(a) and 6(c).

119. However, in relation to Particular 4(c), it was later clarified by Mr Goldring that Mrs Scholten's admission did not relate to 4(c) because her case was that she had never used any manual adjustment on Patient A. It followed, therefore, that what she had said was neither inaccurate nor misleading. The Committee heard a great deal of evidence from the two expert chiropractic witnesses on this subject and what amounted to a manual adjustment, with opposing views being taken. In short, Mr Brown maintained that the provision of the drop technique amounted to a manual adjustment because it involved some manual force by Mrs Scholten. Mr Young's opinion was that the drop technique does not require the application of force, but merely the lightest of toggle recoil actions to activate the drop. The Committee noted, however, that when Mrs Scholten demonstrated the drop table she did not use the toggle recoil action, but rather used one hand on top of the other to push down. On a straightforward understanding of the words "manual adjustment" the Committee considered the call handler would have concluded that Mrs Scholten had not touched Patient A with her hands; however, on her own account she had done so when carrying out the Thompson Drop Technique, using two hands and following through in the way she described and demonstrated to the Committee. Furthermore, the Committee was directed to the World Health Organisation Guidelines which describe an adjustment as *"Any chiropractic therapeutic procedure that ultimately uses controlled force, leverage, direction, amplitude and velocity, which is applied to specific joints and adjacent tissues."*

120. Accordingly, the Committee considered it was inaccurate of Mrs Scholten to have said to the call handler that she had never used any manual adjustment on Patient A and misleading since the call handler would have been misled into thinking no manual adjustment had been carried out in the sense that Mrs Scholten had not touched Patient A with her hands. The Committee therefore found Particulars 7(a) and (b) proved in relation to 4(c).

121. In relation to Particulars 4(e) and 5(d), the Committee had already determined that these facts were found proved and that Mrs Scholten omitted to tell the call handler, and subsequently the paramedics, that Patient A had first expressed discomfort following the drop technique. These omissions meant her accounts were inaccurate and misleading, since it was important information that should have been passed on. The Committee therefore found Particulars 7(a) and (b) proved in relation to Particulars 4(e) and 5(d).

122. In relation to Particulars 6(a), 6(b) and 6(c), Mrs Scholten had admitted these and that they were inaccurate and misleading. However, as with Particular 4(c), Mr Goldring was later to point out that 6(b) was not in fact inaccurate or misleading since it was what had actually happened. He therefore withdrew those admissions. In light of Mrs Scholten's unaltered admissions in relation to Particulars 6(a) and 6(c), the Committee found Particulars 7(a) and 7(b) proved in relation to those Particulars.

123. In relation to Particular 6(b), namely that Mrs Scholten recorded in Patient A's records that his arms felt numb, the Committee noted that this was essentially an agreed fact, it was something which occurred and it was recorded. However, it was the use of the word *"directly"* which the Committee considered to be both inaccurate and misleading. *"Directly"* means *"immediately"* and would not allow for any gap between the drop and when Mrs Scholten stopped treatment. The Committee has already indicated that, on the evidence, it was satisfied that Mrs Scholten had continued to treat Patient A after the drop, in accordance with the evidence of Patient B, who heard the clicking of the activator after the thud of the drop table. On that basis the Committee considered this record was inaccurate and misleading and found 7(a) and (b) proved in relation to 6(b).

124. The Committee next had to determine whether Mrs Scholten's acts and omissions as reflected in the matters found proved in Particulars 4, 5 and 6, amounted to dishonesty. The Legal Assessor reminded the Committee of the test laid down in the case of Ivey v Genting Casinos (UK) Ltd t/a Crockfords [2017] UKSC 67:

> *"When dishonesty is in question the fact-finding tribunal must first ascertain, subjectively, the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence, often in practice determinative, going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact*

finder by applying the objective standards of ordinary decent people. There is no requirement that the registrant must appreciate that what he has done is, by those standards, dishonest."

125. This was clearly the most important aspect of the whole case. In reaching its decision the Committee took into account Mrs Scholten's good character and the years of treatment she had provided to patients, many of whom had taken the trouble to provide testimonies about her character, attesting to her honesty, interiority, high values and ideals, as did her friends and professional colleagues.

126. Ms Hudson said:

"Mrs Scholten explained to me the the reason the GCC is having a hearing is because she is accused of acting dishonestly. I have worked with Mrs Scholten for over five years, for four days a week, with just us two at the Practice. We are very business-like in our working relationship. We have always kept our business and home life separate. It is a proper business relationship. I have never had any doubts about Mrs Scholten's professionalism, integrity or morality. She is a lady I admire enormously and I am shocked that the GCC considers Mrs Scholten was dishonest. I have never doubted Mrs Scholten's integrity in the five years I have known her. I have never known Mrs Scholten to be dishonest the whole time I have known her."

127. With reference to her character, Patient C said he and other family members had been going to Mrs Scholten for chiropractic treatment for some 16 years and added:

"I would say I trust Arleen to provide chiropractic care for myself and my family and have done so for many years as outlined above and continue to do so. I would not entrust this care to someone who I believe to be dishonest."

128. There follows some further comments from the many positive testimonials:

- Dr JS, a Consultant in Acute and General Medicine and a patient of Mrs Scholten who has had routine care from her 2-4 times a month over a number of years states Mrs Scholten *"is honest and truthful and very committed to her profession as a Chiropractor and to the care of her patients … she has never been dishonest in the information she has provided professionally."*

- Ms CH, a patient of Mrs Scholten since 2009, states: *"I consider her to be totally honest and truthful in all aspects. She is committed to her profession as a chiropractic doctor and is passionate about the care and well-being of all her patients."*

- Ms WO, a patient of Mrs Scholten for over 5 years, states: *"I believe Mrs Scholten to be a person who is honest, truthful and extremely committed to chiropractic and the care of her patients. She is a very caring person as well as being committed to clinical excellence. She is very professional, and I have never witnessed or heard second hand of any dishonesty on her part."*

- Dr SC, Chairman of a Clinical Ethics Committee for Covid-19 and Medical Ethicist, states: *"I have known Mrs Scholten since 2012 when I first consulted her professionally for chiropractic treatment. For the last few years, I have attended on a regular basis for chiropractic adjustments. During this time, I have been impressed by Mrs Scholten's commitment to chiropractic, and her holistic approach to treatment. I believe her to be an honest and truthful person who is committed to the overall well-being of her patients."*

- Ms ML, a professional colleague who has known Mrs Scholten for 11 years, states: *"Over the years* (prior to the incident with Patient A) *I have observed her in practice, have read her patient visit notes, have spoken to her patients over many years, engaged with her chiropractic assistant, spoken to persons involved with her business, spoken to the seminar providers to whom she has paid for seminars attended, contracted to her via my own business, having discussed her care and office practices with other colleagues who know her personally and have worked for her. No patient, friend, employee or colleague has ever notified me of dishonest behaviour on her part and I have never observed any dishonest behaviour in her notes, communications and financial interactions with myself or any other person."*

129. Against that backdrop, the Committee considered it inherently unlikely that Mrs Scholten would, in ordinary times, act dishonestly. It had no doubt that she was not inherently a dishonest person, indeed quite the opposite. She was clearly held in very high regard by professional colleagues, patients and friends alike. However, these were not ordinary times and the Committee had to factor in the exceptional circumstances that Mrs Scholten found herself in with the inevitable shock caused by Patient A's rapidly deteriorating condition.

130. It is important to emphasise that this is not a case about causation. Both experts, Mr Brown and Mr Young, agree that a fractured neck was an entirely unforeseeable consequence of the treatment being provided by Mrs Scholten. In the Committee's view there is a difference, however, between actual causation and what would have been going through Mrs Scholten's mind in the seconds and minutes after the drop technique was performed and Patient A groaned, followed by a loss of sensation in his arms. At that moment in time, the Committee considered it would be a natural human tendency for Mrs Scholten to have feared that Patient A's symptoms were somehow linked to the treatment she had just provided, however inconceivable that might have appeared. She denied ever having that thought process but, on her account, she remembered little of what happened at that crucial time, *"I don't remember much from the day".* She said in her oral evidence that she had no time to think. She had a fast evolving medical emergency and needed to help Patient A and that was all she was focussed on. She maintained that she had not sought to mislead the 999 call handler and paramedics by omitting to mention the drop technique and that she had told them the right area of the spine, just not the correct technique. She emphasised that she had been using both techniques on Patient A during his visits to her. Mrs Scholten also maintained that the drop technique and the use of the activator required the same level of manual physical force, the inference to be drawn being that there would have been nothing to gain by deliberately omitting to mention one if mentioning the other. Mr Young said the amount of force required for a drop was minimal and he demonstrated a toggle recoil whereby the force is applied rapidly and then released by the recoil. However, Mrs Scholten did not operate in that way but instead used both hands, as demonstrated in a video clip she provided, and instead of using the recoil she *"followed through, so guiding the joint."*

131. When writing up her notes she said she thinks she recorded activator instead of drop because she was *"shocked and worried at what had happened, I thought he was dying."* The Committee noted, however, that Dr Seneviratne records, "*She remembers calling a chiropractor colleague twice, before and after the hospital visit, on the day of the event, and told him the procedure that she carried out including the drop technique. She remembers this conversation occurred around 1.5 hours afterwards."*

132. The Committee considered it of note that when speaking to the 999 call handler and subsequently the paramedics, it was not a case of Mrs Scholten simply not remembering what treatment she had provided, but rather that she put a positive case to them that she had used the activator on Patient A's mid back, that Patient A had complained of discomfort and that his hands had gone numb, that she had never used any manual adjustments on

Patient A and she had even demonstrated to the paramedics the way in which the activator worked. The Committee gave this a great deal of thought. It noted its own conclusion that Mrs Scholten had in fact used the activator after the drop and, although this was never her case, considered that because it was the last treatment she had been providing to Patient A it may have been what stuck in her mind. She then told that to the call handler and the paramedics and subsequently recorded it in her notes. That she was not thinking straight that afternoon is evidenced by her completely forgetting the further four patients she treated that day and is supported by the evidence of the psychiatrists.

133. The Committee considered it possible that on some sub-conscious level there may have been an element of self-preservation due to a misconceived fear that she had somehow been responsible for Patient A's deteriorating condition, even if there was no foreseeable reason why that might be so. However, everything the Committee had seen, read and heard about Mrs Scholten was in stark contrast to the notion that she was a deceitful person who would set out to mislead everyone about what treatment she provided that day. As indicated above, the Committee was satisfied that Mrs Scholten suffered an Acute Stress Reaction and that this impacted upon the way she acted on 11 August 2017 and the things she said and did not say. From the expert evidence it would appear that outward signs of shock can be varied and the Committee did not consider Mrs Scholten's apparent initial calm and control in the face of an emergency, followed by tears and shaking once the paramedics had left and a loss of memory for parts of the unfolding events, to be incompatible with a person suffering from shock.

134. When Mrs Scholten returned from holiday a week later and was arrested and interviewed there had been time for the effects of the Acute Stress Reaction to dissipate. She did not have access to her notes and she did not have the statements from the paramedics, the 999 call handler, Mrs A or Patient B. If carrying out a deliberate deceit she could have maintained her stance that she only used an activator, but that is not what she did. She told the police about the drop technique she had performed and even volunteered that she had carried out a drop technique earlier in the week on Patient A's neck, which in fact she had not. Those were not the actions, in the Committee's view, of a dishonest woman.

135. For all the reasons given above, the Committee was not able to say it was more likely than not that Mrs Scholten acted dishonestly by deliberately misleading the various parties as to the precise details of the treatment she provided. Accordingly, the Committee found 7(c) not proved in relation to any part of Particulars 4, 5 and 6.

UNACCEPTABLE PROFESSIONAL CONDUCT

136. Having found some of the facts proved, the Committee next considered whether Mrs Scholten was guilty of unacceptable professional conduct, which is conduct falling short of the standard required of a registered Chiropractor. The Committee took into account the submissions made by both parties, together with all the evidence and the advice of the Legal Assessor.

137. Mrs Scholten, by her own admission, provided inaccurate and misleading information to the 999 call handler, the paramedics who arrived at the clinic to assist Patient A and also in Patient A's clinical records, all of which could have influenced and/or impacted upon Patient A's future care. Whilst the Committee has accepted that none of this was done deliberately, it was nevertheless unprofessional since, as the Committee had already found above (paragraphs 121-123) she failed to pass on and record important information accurately. The Committee thus found Mrs Scholten to be in breach of the following parts of The Code: Standards of conduct, performance and ethics for chiropractors (as effective from 30 June 2016):

A3 - take appropriate action if you have concerns about the safety of a patient.

B5 - ensure your behaviour is professional at all times, thus upholding and protecting the reputation of, and confidence in, the profession and justifying patient trust.

F - communicate properly and effectively with patients, colleagues and other healthcare professionals.

H - maintain and protect patient information, in particular:

H3 - ensure your patient records are kept up to date, legible attributable and truly representative of your interaction with each patient.

138. In the Committee's view, Mrs Scholten did take some appropriate action in relation to Patient A, such as calling for an ambulance and providing resuscitation. However, providing inaccurate and misleading information to the call handlers and paramedics, and failing to make accurate records, did not represent appropriate action and, therefore, she had not behaved in a professional manner, when viewed objectively.

139. Notwithstanding this observation, the Committee accepted that none of this was done deliberately, or recklessly, and that the circumstances were exceptional. It particularly had in mind its findings at paragraph 103 above, namely:

> *"In their joint report both Dr Garvey and Dr Seneviratne consider it more likely than not that Mrs Scholten was suffering an Acute Stress Reaction on the day in question. The Committee agreed. On any account it was a fast moving, traumatic, unique set of events and the Committee considered it was inevitable that Mrs Scholten would have been suffering from shock as a result of Patient A's rapidly deteriorating condition, the need to give mouth to mouth resuscitation and to call for an ambulance. The Committee was of the view that it was the impact of that combination of factors and the effects of the shock that influenced Mrs Scholten's subsequent acts and omissions."*

140. The Committee was thus cognisant of its finding, based on the joint expert report from the Consultant Psychiatrists, that Mrs Scholten was suffering from an Acute Stress Reaction at the time of this unprofessional behaviour and accordingly that behaviour was not deliberate but rather inadvertent.

141. The Committee noted that, in his addendum report on behalf of the GCC, Mr Brown said:

> *"In the event that a committee was to find that the error and/or omission in the registrant s accurate reporting of her treatment to the emergency services call handler, the paramedic crew, and the entry in the treatment records was inadvertent on each occasion, then on* [sic] *these circumstances I would not consider this to* [be] *a falling far short of the standard required of a registered chiropractor."*

142. Accordingly, although on an objective basis the Committee considered there had been breaches of the Code, those breaches occurred as a result of Mrs Scholten's state of mind at the time and not as a result of a deliberate intention on her part to be inaccurate or misleading.

143. In light of those circumstances, the Committee considered other members of the profession and fully informed members of the public would not consider her failings to be morally reprehensible or deplorable, but rather would consider them regrettable but understandable in the exceptional, albeit tragic, circumstances of this case. The Committee,

therefore, agreed with the GCC's expert witness Mr Brown and did not think Mrs Scholten's conduct fell far short of the standard required of a registered chiropractor. The Committee was not satisfied, therefore, that her behaviour amounted to unacceptable professional conduct.

144. Accordingly, the Committee found the allegation of UPC not to be well founded.

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: 2 September 2021

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. <u>The Allegation</u>: This section contains the full allegations as drafted by the Investigating Committee and as considered by the Professional Conduct Committee.
2. <u>The Decision</u>: 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. <u>The Sanction:</u> 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.