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

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

Name of Respondent: Mr Thomas Waller
Address of Respondent: Epoch Lincoln
Unit 28 Birchwood Shopping Centre
Birchwood Avenue
Lincoln
Lincolnshire LN6 0QB
Registration Number of Respondent: 03355

On 13-20 January 2022 the Professional Conduct Committee (“the Committee”) of the General Chiropractic Council met to consider the following allegation against you, referred to it by the Investigating Committee in accordance with Section 20(12)(b)(ii) of the Chiropractors Act 1994 (“the Act”):

THE ALLEGATION:

That being a registered chiropractor you are guilty of unacceptable professional conduct.
PARTICULARS OF THE ALLEGATION:

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

1. At all material times you were a registered chiropractor providing chiropractic care to patients at Epoch Lincoln, Unit 28 Birchwood Shopping Centre Birchwood Avenue, Lincoln, Lincolnshire LN6 0QB

2. Between around 4 November 2019 and around 24 December 2019, you:
   a. On one or more occasion, provided inappropriate care to Patient A in that spinal manipulation directed at the vertebral level of L5 was contraindicated;
   b. Failed to adequately review Patient A’s care:
      i. On or after 12 November 2019, following a report of lower back pain,
      ii. On 2 December 2019, during a formal reassessment;
   c. On one or more occasion, treated Patient A at sessions lasting approximately 3 minutes, which was an insufficient length of time to be able to adequately or properly conduct those appointments;

3. On or after 12 November 2019, you failed to adequately and/or accurately record Patient A’s:
   a. Concerns regarding lower back pain,
   b. Comments in relation to her progress;

4. In the alternative to 2 a and/or b, you failed to adequately record Patient A’s treatment in that:
   a. It was incorrectly recorded that spinal manipulation was directed at the vertebral level of L5;
   b. You did not record one or more physical examinations carried out on between 4 November 2019 and around 24 December 2019.
DECISION

Admissions

1. At the commencement of this hearing, Mr Waller admitted Particulars 1, 2 (b) (ii), 3(b), 4 (a) and 4 (b). Consequently, the Committee found these Particulars proved under the provisions of Rule 6(3)(a) of the Rules. The Committee noted that Particulars 4 (a) and 4 (b) were set out as being alternatives to the allegations set out in Particular 2 (a) and 2 b (i) and 2 (b) (ii).

Background

2. On 4 February 2020, Patient A submitted a complaint to the General Chiropractic Council (GCC) against Mr Waller. In 2014, Patient A was thrown from a horse and suffered a fracture to her sacrum and L5 vertebra. She underwent a course of physiotherapy for these injuries and, thereafter suffered no problems with her lower back. In 2018, Patient A had suffered a fall in which she had sustained a fractured wrist and also suffered a feeling that she had also sustained a displacement of a rib which caused her discomfort in the area of her liver radiating into the area of her right scapula. This discomfort continued into 2019 and in October 2019 Patient A decided to make an appointment to see Mr Waller.

3. Patient A attended Mr Waller’s clinic for the first time on 28 October 2019. She completed a New Patient History, was examined by Mr Waller and he took radiographs of her spine. On 2 November 2019, Mr Waller provided Patient A with his Report of Findings which showed that he had found vertebral subluxations at C1, C3, T6, L3 and L5. He also recorded under x-ray findings “L5 Fracture” and this was underlined in the report. Mr Waller began treating Patient A on 4 November 2019. He treated her on a total of seventeen occasions. His chiropractic records show that on all seventeen occasions he adjusted “C 1 R” (right) “T7” and “L5 LSD” (left side down). In the case of the L5 this was despite his findings as set out in his Report of Findings.

4. Following treatment on 7 November 2019, over the weekend of 10/11 November 2019, Patient A suffered pain. Patient A said that she reported this pain to Mr Waller at her next appointment on 12 November 2019. She complained that she was not able to express these concerns properly because Mr Waller’s clinic was designed so that there were four treatment tables next to each other in a raised treatment area where Mr Waller would treat up to four patients at any one time. Patient A complained that Mr Waller took approximately three minutes in treating each patient and that she was unable, in that time, to express her concerns. Patient A accepted that Mr Waller asked patients how they were before treatment,
but she considered that she did not have sufficient opportunity to explain what her position was.

5. Patient A also complained that on 2 December 2019, Mr Waller did not carry out a proper review of her care, in that a chiropractic assistant undertook the review, albeit that Mr Waller was present in the room observing whilst the assistant carried out the review. On 25 December 2019 whilst riding on a horse which was walking, Patient A suffered severe lower back pain and was taken to hospital. Following this, on 3 and 12 January 2020, Patient A had two conversations with Mr Waller about her care, which she covertly recorded without Mr Waller’s knowledge or permission. It was after this that she made her complaint to the GCC.

**Decision on the Facts**

6. The Committee heard evidence from Patient A and from Mr Waller. The Committee has also received a number of statements and testimonials from patients of Mr Waller.

7. The Committee received an expert report from Mr Richard Brown dated 28 May 2020 and an addendum report from him dated 23 October 2021. The Committee heard oral evidence from Mr Brown.

8. The Committee took account of all the evidence that it had received, both oral and documentary, including the testimonial evidence. It had regard to the submissions of Ms Bruce, on behalf of the GCC and those of Mr Waller. It heard and accepted the advice of the legal assessor.

9. In reaching its decisions on those Particulars of the Allegation which have not been admitted, the Committee reminded itself that the burden of proof was upon the GCC and the standard of proof was the civil standard, the balance of probabilities.

10. The Committee made the following findings on the facts:

**Particular 2(a): Found Not Proved**

The Committee reviewed the evidence before it on this Particular. It noted that, whilst it found Patient A to be a credible witness, she was unable to provide clear evidence as to what level of the lower spine, Mr Waller actually treated. She gave evidence that he treated the thoracic and lumbar areas of the spine when she lying prone, on her front, and then treated her neck when she was lying supine, on her back. She was asked whether Mr Waller had treated her whilst she was lying on her left side,
but she was unable to clearly recall whether this had occurred or not. The Committee found that, whilst Mr Waller was, in general terms a credible witness, his memory and therefore his evidence was hampered by the poor quality of his notes and clinical records. The Committee noted that on the first occasion that Mr Waller treated Patient A, on 4 November 2019, he would have had to enter the levels of the spine he treated manually, but after that he gave evidence that he simply used the auto-sync system on his computer to complete the entries in the “Action” section of his notes, thus repeating the entry of treating “L5 LSD”, which the Committee found he would have had to do sixteen times, that is on each of the other occasions he treated Patient A. The Committee also noted and accepted Mr Waller’s evidence that on each occasion that he opened up Patient A’s records on his computer up to a third of the screen would have been occupied by a box showing that there was a red flag, that said “L5 spondy” which was a warning not to treat at L5. Also, he had specifically recorded the fracture at L5 on his Report of Findings which he had underlined which was dated 2 November 2019.

The Committee reminded itself that the burden of proof was on the GCC. The Committee determined that it could not be satisfied that this Particular was proved. In reaching this decision, the Committee noted that Patient A could not give evidence as to the level in the spine she was treated; the red flag would be prominent on the screen, Mr Waller had specifically recorded the fracture at L5 in his report of findings and that there was no actual evidence before the Committee as to Mr Waller treating L5 except the incorrect record. Finally the Committee concluded that when Mr Waller first treated Patient A on 4 November, his examination and his findings as recorded in the Report of Findings would have been in the forefront of his mind, a mere two days later.

Particular 2 (b) (i): Found Proved

The Committee considered the evidence on this Particular. It noted that Patient A gave evidence that over the weekend of 10/11 November 2019 she had suffered low back pain. She gave evidence that that was the weekend that she would have been celebrating her birthday and stated that gave her an added reason why she would remember it. In her evidence, Patient A did state that the pain had eased slightly by the time she saw Mr Waller on 12 November 2019, the following Monday. The Committee also noted that Patient A gave some evidence concerning an issue as to whether she tried to ring the clinic, but stated in the covertly recorded discussion with Mr Waller on 12 January 2020, that she had merely thought about it but realised that the clinic was closed. The Committee concluded that this evidence did not really
assist it. It noted that Mr Waller’s evidence, which was not supported by any record, was that Patient A had complained only of some mild discomfort in her lower back on 12 November 2019.

The Committee determined that this Particular was proved to the required standard. The Committee decided that it preferred Patient A’s evidence in that Patient A had reason to remember that particular weekend because it was her birthday. The Committee concluded that Patient A had informed Mr Waller of low back pain that was more than mild discomfort. The Committee accepted that Patient A may have stated that pain had eased slightly, but Committee determined that the duty on Mr Waller was to listen to his patient’s complaint and, on the basis of what she was reporting, to have reviewed her treatment accordingly this, the Committee was satisfied, he clearly failed to do.

**Particular 2(c): Found Proved**

With regard to the facts of this matter, the Committee had regard to the expert evidence of Mr Brown. The Committee found the evidence of Mr Brown of assistance in reaching its decision on this Particular. The Committee considered that in the contents of his two reports and in his oral evidence, Mr Brown’s evidence was fair and measured and that the Committee could reply upon it. The Committee noted that there was no real dispute in the evidence between Patient A and Mr Waller as to length of the average treatment session which was agreed to be approximately three minutes. The Committee further noted that Mr Waller gave evidence that this was a sufficient period in which to speak to the Patient A, carry out palpation of the spine and then three adjustments. Mr Brown stated that, in his opinion, three minutes was an insufficient period to carry out the steps necessary for each treatment session.

The Committee considered the evidence. It concluded that the issue before it was essentially the adequacy of the period of time which Mr Waller gave himself to treat Patient A and on the other side, whether for Patient A, the specific patient with which the Committee is concerned, considered that she had sufficient time to discuss matters with Mr Waller and be treated. The Committee had regard to her evidence that she considered that it was insufficient. It also noted that she herself had been a healthcare professional for twelve years and that she therefore was bringing some professional knowledge and not just lay knowledge to the matter, although the Committee accepted that she was not a chiropractor. The Committee decided that it preferred Patient A’s evidence and the opinion evidence of Mr Brown to that of Mr
Waller and was satisfied that this Particular was found proved. In reaching its decision the Committee had regard to the factual matters set out in the testimonials by other patients of Mr Waller. Whilst the Committee accepted that these witnesses were describing their experiences, it was with Patient A and her experience that the Committee was concerned, and this evidence from other patients did not assist the Committee is resolving this particular issue.

**Particular 3(a): Found Proved**
The Committee noted its findings on Particular 2 (b) (i). The Committee then reviewed Mr Waller's records for the relevant period. It had regard to the entry for 12 November 2019. The Committee noted that under the heading “Subjective” there was no entry. Mr Waller gave evidence that any comment of Patient A at any session about how she was feeling or what had occurred would be recorded there. The Committee noted that for the entry “Subjective” for 13 November 2019 was “little easier” and for 14 November 2019 “better today”. The Committee noted that Mr Waller’s evidence on this matter was that there was nothing of relevance to record on 12 November 2019 and that the other two entries referred to Patient A’s improvement as from the commencement of the treatment. The Committee concluded that Mr Waller had failed adequately to record Patient A’s concerns with regard to her lower back on 12 November 2019 and in the following entries there was lack of clarity as to what was being referred to. Consequently, the Committee finds this Particular proved.

**UNACCEPTABLE PROFESSIONAL CONDUCT**

11. The Committee had regard to the submissions of Ms Bruce, on behalf of the GCC and those of Mr Waller. The Committee heard and accepted the advice of the legal assessor.

12. The Committee had regard to its findings on the facts and noted those Particulars found proved and those that had been admitted. The Committee took account of the fact that the Particulars which had been admitted and found proved were: 2 (b) (i), 2 (b) (ii), 2 (c), 3(a), 3 (b) and 4(a). It noted that Particular 4 (b) had also been admitted by Mr Waller, but that Particular 4 was set out as being an alternative to Particulars 2(a) and 2(b) (i) and (ii). On the basis that Particular 2 (a) was found not proved, the Committee would be required to consider Particular 4 (a) but, on the basis that Particular 2 (b) (i) was found proved and Particular 2 (b) (ii) was
admitted by Mr Waller, the Committee would not be required to consider Particular 4 (b).

13. It also had regard to all the evidence that it had heard and read. It reminded itself that whether Mr Waller is guilty of unacceptable professional conduct is a matter for its judgement. It also reminded itself that not all breaches of the GCC 2016 Code, Standards of conduct, performance and ethics for chiropractors (the Code) would necessarily lead to a finding of unacceptable professional conduct.

14. The Committee had regard to the fact that the matters it had to consider concerned clinical failings. It first considered the Code. It determined that the following sections of the Code were engaged in this matter and that Mr Waller was in breach of them. The sections of the Code relevant to this case are:

C4 - Develop, apply and document a plan of care in full agreement with the patient. You must check the effectiveness of the care and keep the plan of care under review. A more formal reassessment of the effectiveness of the plan of care must be undertaken at intervals that suit the patient and their needs. All subsequent modifications to the plan of care must be discussed and agreed with the patient and properly documented.

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

15. The Committee noted that the first matter with which it was concerned amounted to a failure by Mr Waller to adequately review Patient A on or after 12 November 2019 and a failure to adequately review Patient A on 2 December 2019. In failing to adequately review Patient A as set out in these Particulars, the Committee determined that Mr Waller was in breach of C4 of the Code. Whilst the Committee noted that not all breaches of the Code would amount to unacceptable professional conduct, the Committee considered that these two failings were serious matters and that, taken together, would amount to unacceptable professional conduct.

16. The Committee next considered its finding with regard to the length of time that Mr Waller gave to his treatment sessions with Patient A. Whilst the Committee had not had its attention drawn to any particular section of The Code which might apply, it considered that
there was a general duty on a chiropractor that sufficient time is provided to ensure that the concerns of a patient can be heard and acted upon as well as the provision of the appropriate treatment. The Committee found that this had not occurred in the case of Patient A. The Committee had regard to the opinion evidence of Mr Brown that this failure would fall far below the standard expected of a reasonable chiropractor. The Committee concluded that, in the circumstances of this case, concerning Patient A, this would be a matter which would concern fellow chiropractors to the extent that they would consider this to be poor practice. On this basis the Committee was satisfied that this failure did amount to unacceptable professional conduct.

17. With regard to the findings of poor record keeping, the Committee noted the decision of the learned judge in the case of Spencer v GOsC [2012] EWHC 3147 (Admin) that a small number of errors in record keeping would not cross the threshold of seriousness to warrant a finding of unacceptable professional conduct but that serious shortcomings in record keeping may do so. The Committee noted, in particular, that Mr Waller accepted that on seventeen occasions he recorded the wrong entry for the level of the lumbar spine treated as well as a failure to record a report of low back pain, which the Committee found Patient A had reported. The Committee noted that Mr Waller was, at the time, a sole practitioner. Nevertheless, the Committee considered that record keeping is important. If another practitioner were to have to treat Mr Waller’s patients, the records must be sufficiently clear and detailed so that any practitioner would be able to treat Mr Waller’s patients safely and appropriately. The Committee reviewed its findings with regard to record keeping and determined that the multiple failures to record correctly or at all by Mr Waller did cross the threshold of seriousness to warrant a finding of unacceptable professional conduct.

18. The Committee therefore found that Mr Waller is guilty of unacceptable professional conduct.

SANCTION

19. The Committee took account of all the evidence that it received in the case. It also took account of the submissions made by Ms Bruce on behalf of the GCC and those made by Mr Waller. It heard and accepted the advice of the legal assessor.

20. The Committee reminded itself that the purpose of a sanction is not to be punitive but to protect the public, in particular, patients and the wider public interest which would include the maintenance of public confidence in the profession and the declaring and upholding of proper standards of conduct in the profession. It further reminded itself that it must act
proportionately, balancing the public interest with that of Mr Waller. It took account of the GCC Guidance on Sanctions, dated April 2018, in considering the appropriate sanction in this case.

21. The Committee considered the mitigating and aggravating factors which were present in the case. With regard to the mitigating factors, the Committee considered that Mr Waller had demonstrated sufficient insight into the matters that had brought him before the Committee. The Committee noted that Mr Waller had made a number of early admissions. He had already recognised that his record keeping was poor, he had conducted with the practice manager an in-house audit of notes and had undertaken two record keeping courses in September 2020 and in July 2021 one of which was hosted at his practice. The Committee considered all this to be further evidence of Mr Waller’s insight. He tendered apologies in both his first and second statements and he had apologised to Patient A during meetings on 3 and 12 January 2020 when the covert recordings of the conversations where made by Patient A. The Committee also took account of Mr Waller’s submission that he now only has two treatment tables rather than the previous four and that he practises at a slower pace. The Committee noted that there are now four chiropractors practising at his clinic which, as Mr Waller described, means that the workload is now spread amongst a number of chiropractors. Further, Mr Waller has introduced a peer review process for the chiropractors in his clinic where they meet monthly, discuss and review samples of each other’s work.

22. The Committee noted that there has been no submission by Ms Bruce to the effect that there was any question of Mr Waller not complying with the principles of good practice or working outside his own sphere of practice. The Committee noted that there was no evidence provided by Mr Waller of any hardship he might suffer as a result of any sanction it might impose on Mr Waller’s registration. The Committee did take account of the fact that Mr Waller has no previous regulatory findings against him.

23. With regard to aggravating factors, the Committee considered the following to be present. The Committee considered that there was a potential risk of patient harm in that Mr Waller’s records suggested that he was adjusting Patient A at L5 and if another chiropractor had replaced Mr Waller for any reason, despite the fact that he was, at the time, a sole practitioner, Patient A could have suffered harm. The Committee noted that the treatment received by Patient A took place at seventeen appointments over a period of seven and a half weeks. The pattern of unacceptable professional conduct lasted for that period of time in the sense that the error in record keeping persisted until Patient A’s last attendance on 24
December 2019; but beyond this failing, there were no other long term failings which the Committee considered that it should take into account.

24. The Committee had regard to the six testimonials which had been placed before it. It noted that all six writers of the testimonials had been informed of the allegations which Mr Waller faced before the Committee and described their positive experiences of being treated by Mr Waller in terms of initial assessment, periods of treatment, sufficiency of time with Mr Waller and regular reviews. Further, the Committee noted that these testimonials are from patients who appear to be currently being treated by Mr Waller and who can speak to Mr Waller’s current practice.

25. The Committee first considered whether to impose an admonishment in the case. It noted the factors set out in the Guidance on Sanctions which it should consider when determining whether admonishment would be the appropriate and proportionate sanction to impose. It noted its conclusion that there was a potential for some harm to Patient A by reason of the incorrect referral to L5 in the records, if another chiropractor was to take over her care. The Committee considered that Mr Waller had demonstrated sufficient insight into his failings. His failings only concerned one patient, however did take place over a number of appointments, but his actions were not deliberate. The Committee was satisfied that Mr Waller had made a number of genuine expressions of regret for his actions and apologised both to Patient A within a short time of the matters and had also apologised in the course of the hearing. The Committee also noted that Mr Waller has a good history, there has been no repetition of the conduct and he has provided evidence of the rehabilitative steps he has taken.

26. The Committee determined that the facts of this case fall towards the lower end of the spectrum of unacceptable conduct and, having found that most of the factors it should consider are present, concluded that the appropriate and proportionate sanction to impose is one of admonishment. The Committee considered that the sanction of admonishment was sufficient in all the circumstances to protect the public and to mark the fact that Mr Waller’s conduct was unacceptable and must not be repeated. In these circumstances, the Committee was satisfied that this sanction addresses the wider public interest. The Committee therefore determined that the higher sanction of a Conditions of Practice Order would not be an appropriate or proportionate sanction.
27. Mr Waller, you should be in no doubt that any finding of unacceptable professional conduct by your regulatory body is a serious matter and you should not take this admonishment lightly.

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

That concludes this case.

Chair of the Professional Conduct Committee

In accordance with provision of Rule 18(1)(a) of the General Chiropractic Council (Professional Conduct Committee) Rules 2000, we must reminds 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: 20 January 2022

Satpal Singh Bansal
On behalf of the Professional Conduct Committee

Explanatory Notes:

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

1. **The Allegation**: This section contains the full allegations as drafted by the Investigating Committee and as considered by the Professional Conduct Committee.

2. **The Decision**: This section contains the findings of fact reached by the Professional Conduct Committee on the allegation and the reasons therefore. In particularly complex cases the reasons may be given separately from the findings of fact for purposes of clarity.
3. The Sanction: This section contains details of the sanction applied by the Professional Conduct Committee. In certain cases the section may be subdivided for the purposes of clarity.