General Chiropractic Council

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:	**Richard William Phelps**
Address of Respondent:	**Glasgow Chiropractic** **50 Grahams Road** **Falkirk** **Stirlingshire** **FK1 1HN**
Registration Number of Respondent:	**03143**

On 3 – 7 July 2017 and on 16, 18, 19 and 29 October 2018, the Professional Conduct Committee ("the Committee") of the General Chiropractic Council met to consider the following allegation against you, referred to it by the Investigating Committee in accordance with Section 20(12)(b)(ii) of the Chiropractors Act 1994 ("the Act"):

THE ALLEGATION:

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

PARTICULARS OF THE ALLEGATION:

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

1. At all material times you were a registered chiropractor providing chiropractic treatment to patients at The Pain and Posture Wellness Centre, Unit B5, Highland House, St Catherine's Road, Perth PH1 5YA ("the Clinic").
2. On 21 and 22 July 2016 at the Clinic you provided chiropractic treatment to Patient A, who had been a patient of the Clinic since 13 May 2016.
3. When treating Patient A on 21 and 22 July 2016, you inappropriately relied on the initial assessment and review which had previously been carried out by your colleague Person A **, who was not a chiropractor but an osteomyologist.
4. You failed to recognise that Patient A's presenting symptoms on 21 and/or 22 July 2016, which included significant bilateral neurological symptoms:
    a. represented a deterioration in her symptomology from her initial assessment, and/or
    b. suggested that she had a disc prolapse which was progressing, and/or
    c. were suggestive of a diagnosis of cauda equina syndrome, which would have warranted a referral to hospital and would have represented a contraindication to spinal manipulative therapy.
5. You failed to carry out any or any adequate orthopaedic and / or neurological assessment prior to treating Patient A.
6. During your treatment of Patient A on 22 July 2016: you adjusted, and/or attempted to adjust, Patient A's thoracic spine. Shortly following this treatment she:
    a. suffered an adverse reaction;
    b. started to complain of increased and acute pain and of increased neurological lower limb symptoms;
    c. sat and then lay down, and was then unable to sit or stand up again.
7. Your response to Patient A's adverse reaction and/or new and developing neurological symptomatology, referred to in Charge 6 above, was inadequate in that:
    a. You failed to recognise the possibility that it may indicate the presence of cauda equina syndrome;
    b. You failed to recognise that the potential presence of cauda equina syndrome constituted a medical emergency;
    c. You failed to carry out any neurological or orthopaedic assessment in response to it;

d. You failed to cease providing treatment to Patient A's spine;

e. You manipulated and/or attempted to manipulate Patient A's lumbar spine on at least two occasions. This was inappropriate in that:

   i. It was not possible for you to determine whether or not it was safe to do so in the absence of you having carried out an adequate historical enquiry and physical examination;

   ii. It would be contraindicated by the potential presence of cauda equina syndrome.

f. You inappropriately regarded Patient A's altered symptomatology as a positive indicator of "forward unwinding" as part of a healing process;

g. You advised Patient A to the effect that her altered symptomatology was a positive indicator of "forward unwinding';

h. You failed to summon emergency assistance and/or medical attention for Patient A sufficiently promptly;

i. When Patient A's mother suggested that it was necessary to call an ambulance, you expressed the opinion that an ambulance was not required.

8. During your treatment of Patient A on 22 July 2016 you continued to treat and/or attempt to treat Patient A despite her requesting on a number of occasions that you cease to provide treatment.

9. On 22 July 2016 you failed to respect Patient A's dignity, in that you failed to take the appropriate remedial steps when, during the course of your treatment of her, she drew to your attention that she felt that she was becoming exposed by her trousers riding down.

AMENDED ALLEGATION

1. At all material times you were a registered chiropractor providing chiropractic treatment to patients at The Pain and Posture Wellness Centre, Unit B5, Highland House, St Catherine's Road, Perth PH1 5YA ("the Clinic").

2. On 21 and 22 July 2016 at the Clinic you provided chiropractic treatment to Patient A, who had been a patient of the Clinic since 13 May 2016.

3. On 21 July 2016 you failed to adequately re-assess Patient A's condition to formulate an appropriate diagnosis and/or treatment plan in that:

   a) Her previous assessment was not carried out by a chiropractor registered with the GCC; and/or
   b) Her symptoms had changed significantly since her last presentation; and/or
   c) Her symptoms were suggestive of a new neurological condition.

4. On 22 July 2016 you failed to adequately re-assess Patient A's condition in that:

   a) Her symptoms had deteriorated since her previous treatment; and/ or
   b) Without reassessment it was not possible to determine whether it was appropriate for Patient A to receive further treatment.

5. On 22 July 2016 you adjusted or attempted to adjust Patient A's spine following which she:

   a) Suffered an adverse reaction; and/ or
   b) Was unable to sit or stand up; and/ or
   c) Complained of increased pain and neurological lower limb symptoms.

6. You failed to adequately respond to the reaction at 5(a) to 5(c) above in that you:

   a) did not carry out an adequate/or any neurological or orthopaedic assessment; and/ or
   b) did not recognise that these may have indicated progressive spinal stenosis; and/ or
   c) did not recognise that potential spinal stenosis constituted a medical emergency; and/or
   d) did not call for emergency medical assistance sufficiently promptly or at all; and/ or
   e) suggested to Patient A's mother that an ambulance was not required.

7. Following the reaction at 5(a) to 5(c) above you further manipulated and/ or attempted to manipulate Patient A's lumbar spine.

8. Your actions in 7 were inappropriate in that:

   a) you had not carried out an adequate re-evaluation of Patient A's condition; and/ or
   b) lumbar manipulation was contraindicated by the potential presence of spinal stenosis; and/ or

c) Patient A did not consent to this treatment.

9. During your treatment of Patient A on 22 July 2016 you failed to respect Patient A's dignity in that you did not take appropriate remedial steps when she informed you that she felt that she was becoming exposed.

DECISION

GCC Application to Amend Allegations

Upon the unopposed application by the General Chiropractic Council (GCC) to amend a number of the allegations by virtue of Rule 6(11) of the GCC (Professional Conduct Committee Rules (the Rules) –
The Committee heard submissions from both parties, took legal advice and then allowed the proposed amendments.

Rule 6(11) allows the PCC to amend any allegation, provided that such amendment is necessary and desirable.

The Committee was informed that not only did Mr Phelps not object to the proposed amendments, the experts instructed on his behalf had prepared their reports on the basis of the proposed amendments. The Committee were further informed that it was accepted by Mr Phelps that no prejudice would be caused if the amendments were made.

The Committee decided that the proposed amendments were both necessary and desirable, they made the allegations easier to follow and no prejudice would be caused by them.

The application to amend was therefore granted.

GCC Application for Screens for Patient A

Upon the unopposed application by the GCC for Special Measures to be granted in relation to Patient A to allow her to give evidence from behind a screen –

The Committee heard submissions from both parties, took legal advice and granted the application.

The Committee has a wide discretion to regulate its procedure and hear evidence in any manner it deems fit to ensure that the best evidence is laid before it.

There is no specific provision in the Rules relating to the provision of Special Measures, although assistance can be gained from the statutory provisions relating to proceedings in the criminal courts.

The Committee was informed that the Registrant did not object to the application.

Section 17(1) of the Youth & Criminal Evidence Act 1999 provides that a witness is eligible for special measures provided the Court (sic) is satisfied that the quality of the evidence given by the witness would otherwise be diminished by reason of fear or distress on the part of the witness in connection with testifying in the proceedings.

The Committee took into account the content of the report by Dr Stephen Martin dated 10th April 2017 and directed that any reference to the content of the report or the health of Patient A should be in private.

The Committee decided that, based on the content of the said report and in the absence of any opposition on the part of Mr Phelps, the evidence of Patient A would be diminished by reason of her potential distress if the application for her to give evidence behind a screen were not granted.

The Committee therefore granted the application but emphasised to Mr Phelps that this did not in any way reflect adversely on him and would not in any way prejudice his case.

Submission of No Case to Answer

At the conclusion of the case for the GCC, Mr Goldring submitted that there was no case to answer in relation to Allegations 3c, 4a, 6b, 6c, 8b.

Allegation 3c

On 21st July 2016, you failed to adequately re-assess Patient A's condition to formulate an appropriate diagnosis and/or treatment plan in that …

(c) Her symptoms were suggestive of a new neurological condition

Mr Goldring's submission was that, taken at its highest, the evidence relating to the symptoms exhibited by Patient A on 21st July 2016 was insufficient for the panel properly to find that they were suggestive of a new neurological condition.

He submitted that the case for the GCC in this regard was based entirely on the premise that Patient A's symptoms had shifted from her right leg to her left leg between May and July 2016 and further that the evidence relating to this, taken at its highest, could not support such a finding.

Mr Goldring submitted that the only evidence on this point consisted of the Clinic Notes compiled by Donata Kick on 13th May 2016 (Bundle Pg. 14) and the evidence of Patient A both in her statement and in cross-examination. He pointed out that her evidence was not consistent with those Notes.

The Clinic Notes (Pg. 13-14) record that when Patient A saw Donata Kick on 13th May 2016,

1. She revealed that she had a history of tingling and weakness in her right arm (Pg. 13);
2. She told Donata Kick that her symptoms were currently in her right leg.
    a. The contention that Patient A said that her symptoms were in her right leg is based on the Note (Pg. 14) against Paragraph R which records – 'Leg thigh & calf' which is written beside an R in a circle which, it is agreed, denotes that Patient A was complaining of symptoms in her right leg.

In her statement dated 8th November 2016, Patient A stated that

1. When she saw Donata Kick in May 2016, she was experiencing a lot of pain in her lower back and down her left leg (Pg. 385)
2. When she went to the clinic on 21st July 2016, her pain had increased to the extent that it had returned to the level it had been when she arrived at the clinic on 21st July and that the pain was in her lower back and down her left leg. She said that her back pain was worse than her usual back pain and had reverted to the level it had been when she had first seen Donata Kick in May 2016 (Pg. 386).
3. When she attended the clinic on 22nd July 2016 her pain had become worse again and was back to how it had been when she arrived at the Clinic on 21st July. She said that she was experiencing the pain across her lower back and left leg.

In Cross-Examination Patient A,

1. Stated that in February 2016 she had had pain in her right leg, but by the time she saw Donata Kick in May 2016, it had changed to her left leg
2. Agreed that in April 2016 she was complaining of *"Lower back pain affecting right hip, buttock and travelling down right leg, experiencing numbness in both legs."* She was able to agree this by reference to her GP Referral letter dated 21st April 2016 (at Pg. 297)
3. Confirmed that in May 2016 she had lower back pain and pain in her left leg; she also confirmed that she was sure that it was her left leg and not her right leg.
4. When she was referred to the Physiotherapy Letter (Pg. 294) she agreed that it may have been on 11th July 2016 that she had seen the physiotherapist and not on 22nd July as she had initially thought. She also accepted that when she saw the physiotherapist on that date, her pain had been in her right leg
5. The physiotherapy Lumbar Spine Assessment dated 11th July 2016 which relate to 10th July (Pg. 300), indicates that her pain was in the calf of her left leg and down the front of her right leg.
6. Stated that when she saw the Registrant on 21st July 2016, the pain was in her left leg and this had been the same symptoms she had when she saw Donata Kick in May 2016
7. When it was put to her that there had not been a shift in pain between May and July 2016, she said that the pain could shift from one leg to the other but that when she saw Donata Kick, the pain had definitely been in her left leg.
8. She said that when she presented to the Registrant on 21st July 2016, it would have been visually very obvious to him that her pain was in the lower back and left leg.
9. She agreed that on 21st July 2016 she had not told the Registrant that she had new symptoms. Initially her evidence was that when she first saw Donata Kick in May 2016 she did not have the lower back and left leg pain but later in her evidence she said that the pain had in fact been in her back and left leg at the initial appointment.

Mr Goldring submitted that the GCC were in error in seeking to rely on the evidence of the Clinic Notes whilst disregarding the evidence of Patient A.

He submitted that the Clinic Notes were Hearsay Evidence which had been compiled by Donata Kick who was not a qualified Chiropractor and was not sufficiently experienced to undertake an adequate assessment of Patient A at that time. He also pointed out that Donata Kick had not been called to verify the content of her Notes and submitted that, in the premises, the Clinic Notes should not be relied in preference to the evidence of Patient A. He further submitted the fact that the GCC were suggesting that Donata Kick had indeed not carried out an adequate assessment.

Mr Goldring submitted that the fact that the Clinic Notes contradicted the evidence of Patient A engaged 'Limb 2' of Galbraith which applied when the evidence relied was 'Weak, vague and inconsistent with other evidence'.

He submitted that the evidence, taken at its highest, did not entitle the panel to conclude that Patient 'A's pain had changed from the right leg to the left leg. He submitted that the only proper conclusion to be drawn from the evidence was that Patient A's symptoms had always been on the left side and that there was insufficient reliable evidence that there had been a shift in pain from one leg to the other.

The Committee concluded that, although the Clinic Notes were Hearsay Evidence, they had been admitted in evidence without objection and in any event they were entitled to take Hearsay Evidence into account. The fact that they were Hearsay would be taken into account when assessing their weight.

In relation to weight, the Committee took into account the fact that the Clinic Notes are business records and in any event under Code H Mr Phelps was under a duty to keep records that are an accurate reflection of the patient's clinical encounter and include any factors relevant to the patient's ongoing care. The Committee noted that there was no evidence that undermined the reliability or accuracy of the Clinic Notes.

Although the Committee noted the discrepancies between the Clinic Notes and the evidence of Patient A it concluded that in all the circumstance and in particular the duty imposed by Code H, the discrepancies were not such as should prevent the panel from taking them into account at this stage of the proceedings. Resolution of such discrepancies as there may be would be a matter to be considered at a later stage.

The Committee concluded therefore that there was a case to answer in relation to Allegation 3c.

Allegation 4a
"On 22nd July 2016, you failed to adequately re-assess Patient A's condition in that…

(a) Her symptoms had deteriorated since her previous treatment;

Mr Goldring submitted that there was no evidence before the Panel to suggest that there had been a deterioration in Patient A's symptoms other than the agreed fact that she had cancelled her appointment on 22nd July 2016 and that, in the circumstances, there was nothing to warrant a re-assessment.

The Committee considered the following evidence

1. **Mr Phelps's report (Pg. 24) records that Patient A's pain had become worse during the evening of 21st July after her appointment with the Registrant; it felt worse again on morning of 22nd July and the reason she had cancelled her appointment had been due to her increased pain and, in particular, her inability to move.**
2. **The Committee concluded that Patient A had wanted to come in and keep the appointment but had been unable to due to her inability to move which they concluded was a deterioration in her condition.**

3. **The increase in pain is evidenced also by the fact that she visited or was in telephone communication with her GP for that reason and that she was in need of further medication.**

The Committee concluded that there was evidence that Patient A's symptoms had deteriorated and that there was therefore a case to answer in relation to Allegation 4a.

Allegation 6b
You failed to adequately respond to the reaction at 5(a) to 5(c) above in that you: …
(b) did not recognise that these may have indicated progressive spinal stenosis; and/or

Allegation 6c
You failed to adequately respond to the reaction at 5(a) to (c) above in that you: …
(c)did not recognise that the potential spinal stenosis constituted a medical emergency

Allegation 8b
Your actions in 7 were inappropriate in that: …
(b) lumbar manipulation was contraindicated by the potential presence of spinal stenosis

Mr Goldring conceded that his submissions in relation to Allegations 6b, 6c, and 8b, all of which related to 22nd July 2016, stand or fall together. He also conceded that they depended on whether the panel could properly find that there was sufficient evidence that Patient A suffered from 'pins & needles' during her treatment that day.

The Committee considered the following evidence:

1. **The joint account of 22nd July by Mr Phelps and Donata Kick (Pg. 27) records that on that day, one of Patient A symptoms consisted of, *"Occasionally pins/needles in the feet which came and went."***
2. **The account goes on to state that there were, "*no other neurological symptoms indicative of spinal cord injury or stroke."***
3. **The panel did not find any particular inconsistency in this regard between the records and the evidence of Patient A.**

The Committee concluded that if the existence of pins/needles, albeit occasional and coming and going, were neurological symptoms which might be indicative of spinal cord injury or even a stroke, their existence:

1. **May have indicated progressive spinal stenosis (Allegation 6b)**
2. **Such a possibility would constitute a potential medical emergency (Allegation 6c)**
3. **Would be a contraindication in relation to lumbar manipulation (Allegation 8b)**

The Committee therefore concluded that there was a case to answer in relation to Allegation 6b, 6c and 8b.

The Committee considered each of the sub-allegations separately and, in relation to each, concluded that the evidence taken as a whole was not so unsatisfactory, contradictory or so transparently unreliable that they could not properly rely on it in deciding if the GCC had discharged its burden.

The Committee therefore found that there was a case to answer in relation to each of the sub-allegations upon which submissions of no case had been made.

Decision on the Facts

At the commencement of the hearing, Mr Goldring, on behalf of Mr Phelps, admitted Particulars 1, 2, 5a, 5b, 7 and 9. Consequently, the Committee found these Particulars proved under the provisions of Rule 6(3)(a) of the Rules.

Background

This case concerns treatment that Patient A received from Mr Phelps on 21st and 22nd July 2016. Prior to this, since 13th May 2016, Patient A had primarily been treated by a colleague of Mr Phelps, Donata Kick, an osteomyologist. Mr Phelps had assisted on a number of occasions with particular lumbar spine manipulations. The main allegations concern Mr Phelps's failure to reassess Patient A at the 21st July 2016 appointment when it should have been plain to him that Patient A was now complaining of low back pain and pain in the left leg when she had previously complained to Donata Kick on the 13th May 2016 of bilateral pain at the base of the spine and pain down her right leg. It was the GCC's case that on 21st July, the change in symptoms, should have been considered as a new condition, and as such, required additional historical enquiry and physical examination.

With regard to the events of 22nd July 2016, when Patient A returned to see Mr Phelps, she indicated that her level of pain had returned to the same level of severity that it had been when she had attended for the appointment on the previous day, albeit it had reduced a little by the time she had left that appointment. On 22nd July 2016, after having received some treatment, Patient A suffered a sudden increase in her level of pain and was unable to move. Patient A said that Mr Phelps continued to treat her despite her complaints as to the severity of the pain she was in and her desire that he should stop treating her. In the end, after some two hours or so, an ambulance arrived, and she was taken to the Accident and Emergency Department at the local hospital. In the course of attempting to move Patient A from the clinic out into the street in order to go to hospital in the ambulance, Patient A's clothing became displaced and Mr Phelps took no steps to preserve Patient A's modesty.

Findings on the Facts

The Committee took account of the submissions of Mr Coke-Smyth, on behalf of the GCC, and those of Mr Goldring, on behalf of Mr Phelps. It heard and accepted the Advice of the legal assessor.

The Committee first considered the witnesses from whom it had heard. It considered Patient A to be a credible witness. It concluded that she had a clear recollection about some matters, but that in other areas, in particular when she was trying to recall events that occurred when she was in great pain, the Committee considered that her memory may have become somewhat confused. As a result, it was possible that, understandably, she could be mistaken about certain events and how they, in fact, had occurred. An example of this would be with regard to her evidence as to exactly what was said about Mr Phelps either stopping or continuing treatment after the point when she had suffered pain and could not move. The Committee accepted that she must have found the circumstances very frightening but concluded that this may have affected her memory and, therefore, the evidence she was able to give. The Committee also had regard to the fact that it was clear that Patient A had a firm belief that Mr Phelps's treatment was responsible for the development of the Cauda Equina Syndrome for which she required surgery in August 2016.

The Committee next considered the witness, Person A, who is Patient A's mother. The Committee considered her to be an honest and credible witness. It noted that she is a nurse and, therefore, a health professional. In considering her evidence as a whole, the Committee took account of the fact that she is Patient A's mother and not, in that sense, totally independent and it was clear that she was wanting to do the best for her daughter and to take care of her.

The Committee went on to consider the expert witnesses from whom it had heard. It found Dr Young, the expert called by the GCC, to be an experienced witness who assisted the Committee by setting out alternative scenarios that the Committee might find on the facts and then giving his opinion on those separate scenarios. The Committee noted that, in the course of his evidence and in his reports, he tended to use technical terms rather than plain and ordinary language that could be readily understood by lay people. These technical terms did not always assist the Committee. Nevertheless, it was clear to the Committee that he recognised and understood his role as an expert witness and made concessions on the evidence when it was appropriate. As a result, the Committee considered that it was able to rely upon his evidence in reaching its conclusions.

The Committee next considered the evidence of Dr Grant who was called by the Defence. It considered that Dr Grant's evidence was less helpful than Dr Young's. The Committee found Dr Grant's evidence not to be as objective as it would have liked it to be. He appeared, on occasions, to trespass into making factual findings which was not his role. An example of this was in his main report dated 3rd July 2017 at paragraph 5.6, when dealing with the issues in Particular 6, he states: "*It is clear that the matter was being dealt with in a considered manner which does not support the suggestion of a failure to recognise symptoms".* In conclusion, the Committee found that Dr Grant's evidence was of less assistance than that of Dr Young.

The Committee went on to consider the evidence of Dr Venning who was also called by the Defence. He gave expert evidence with regard to the practice of ABC (Advanced Biostructural Correction) which is the modality practised by Dr Phelps. The Committee, as advised by the legal assessor, first considered whether Dr Venning could be described as an independent expert witness. The Committee noted that Dr Venning had worked in the same large practice group as Dr Phelps but not in the same premises at the same time. This was some seven or so years ago and they had only met a few times a year, at seminars and lectures arranged by the practice. Dr Venning worked as a locum for Dr Phelps on one occasion, again some seven years or so ago but, again, by the very nature of the relationship, they would not have been working at the same premises at the same time. The Committee considered that this evidence did not suggest a close relationship between Dr Phelps and Dr Venning and concluded that independence was not a major issue with regard to Dr Venning's expert evidence.

The Committee then considered whether Dr Venning truly understood his role as an expert witness. It noted that he had acted as an expert witness on very few previous occasions and he had not given evidence of any training he had undertaken. The Committee was not satisfied that Dr Venning fully understood his responsibilities and that, in particular, he should not be an advocate for Dr Phelps. Having reached this conclusion, the Committee, however, went on to consider that there were areas where Dr Venning was able to assist and that, consequently, his evidence was helpful to a degree. The Committee found his evidence on the concept of the "forward unwind" to be of assistance, in particular as to whether the symptoms that Patient A was displaying after the problem had occurred during her treatment, were similar to those that would be displayed during a "forward unwind".

The Committee went on to consider Mr Phelps's evidence. The Committee found Mr Phelps to be a straightforward and honest witness. It was satisfied that he had tried to be helpful to the Committee and had not been obstructive in the way he had answered any of the questions put to him. One matter, that the Committee did have regard to, was his demeanour when he was giving his evidence. It noted that, in what was obviously a stressful situation, he became increasingly animated when giving his evidence and indeed, he was animated, on occasions, when listening to other witnesses giving evidence. The Committee considered this to be an important matter to have regard to. It concluded that it could draw the inference that when treating Patient A on 22nd July 2016, after the problem had arisen, in what the Committee was satisfied were stressful circumstance he may well have become somewhat animated. The Committee felt it proper to conclude by reason of the frightening circumstances that Patient A was in, and by the stress of the situation from Mr Phelps's point of view, that neither Patient A nor Mr Phelps were particularly listening to the other and that neither would necessarily have a clear recollection of what had actually occurred.

Finally, the Committee considered the evidence of Rachel Scott who was working for Mr Phelps and, indeed still does so, as a practice assistant. The Committee concluded that she was a straightforward and credible witness who was trying her best to assist the Committee.

The Committee reminded itself that the burden of proving any fact is on the GCC and the standard of proof is the civil standard, the balance of probabilities.

The Committee went on to make the following findings of fact:

Particular 3a: Found not proved as a failure.
The Committee noted the evidence that Mr Phelps only practised using ABC techniques and the unchallenged evidence that other health professionals, besides Chiropractors, practised ABC. It noted that Donata Kick is an Osteomyologist who practises using ABC techniques. It also noted the evidence of Dr Young that it was not unreasonable, provided that a chiropractor is satisfied that a colleague has the relevant skills, for the chiropractor to rely upon that colleague's findings. There was no evidence to undermine the competence or integrity of Donata Kick. In the circumstances, the Committee was not satisfied that, given Dr Young's evidence and the fact that Mr Phelps worked with Donata Kick and they shared the treatment of patients including Patient A, he was under a duty to re-assess Patient A given his confidence in the competence of Donata Kick. The Committee also bore in mind that Mr Phelps, in his oral evidence, stated that he had assisted Donata Kick in the treatment of Patient A prior to 21st July 2016 by performing an L5 A manipulation on a number of occasions. The Committee was, therefore, satisfied that Mr Phelps was not treating Patient A for the first time, although he became her primary treating practitioner on 21st July 2016.

Particular 3b: Found proved.
The Committee noted the evidence of Dr Young that if what had occurred when Patient A attended the clinic for treatment on 21st July 2016 was a "flare up" of an existing condition, then there was no requirement for a re-assessment of Patient A's condition. If on the other hand, it was a new condition, then Dr Young's evidence was that there should be a re-assessment of Patient A. The issue for the Committee to consider was whether the pain was now in the left leg rather than in the right leg. It noted Patient A's evidence that the pain had not moved from one leg to the other. On the other hand, if Donata Kick's records were correct then she certainly recorded the pain being initially in the right leg and in the left leg on 21st July 2016. The Committee noted that there was no evidence before it that had called into

question Donata Kick's competence as a record keeper and, indeed in its finding on Particular 3a above, the whole issue was decided on the fact that Mr Phelps felt that he could rely upon Donata Kick as a competent colleague. This being the case, the Committee felt that it could rely upon Donata Kick's records. Consequently, the Committee was satisfied that the leg pain complained of by Patient A was in a different leg on 21st July 2016 and that, on that basis, Patient A's symptoms had changed significantly, and Mr Phelps was under a duty to re-assess Patient A.

Particular 3c: Found proved.
The Committee noted the evidence of Mr Phelps that he broadly accepted that there had been some change in symptoms. The Committee also had regard to the evidence of Dr Young that, if the pain had moved from the right to the left leg, then it was suggestive of the possibility of a new neurological condition. The Committee also noted the evidence of Dr Grant that if the pain had moved from the right to the left leg, then this would require a reassessment. It noted that Dr Grant did not go as far as to suggest a new neurological condition. However, from all the evidence before it, the Committee was satisfied that Patient A's symptoms were suggestive of a new neurological condition and this was a further reason why Mr Phelps was under a duty to carry out a re-assessment of Patient A's condition.

Particular 4a and 4b: Both found not proved.
The Committee considered the evidence as to whether Patient A's symptoms had deteriorated since her previous treatment which the Committee found, was the treatment that she received from Mr Phelps, the day before, on 21st July 2016. The Committee determined that the issue for it to decide was whether what Patient A reported as her symptoms on the 22nd July 2016 represented a fluctuation of the symptoms in her already existing condition or whether there was a deterioration of her symptoms requiring re-assessment. The Committee noted Patient A's evidence that the figure that she put on the level of pain she was suffering was 9/10 when she attended for her appointment on 21st July. She gave evidence that that level of pain had dropped to 8/10 by the time she left the clinic. She said that when she attended on the 22nd July, the figure for pain was back up to 9/10. She also gave evidence of some lack of movement by reason of the pain and she had delayed coming in for the appointment on 22nd July because of this.

The Committee considered the evidence and concluded that what she suffered on the 22nd July was a fluctuation in her symptoms. She had come in with a high level of pain on the previous day, during the course of her treatment, that had been alleviated slightly, but her evidence was that things had worsened again by 22nd July. On this basis the Committee determined that there did not appear to be a marked change in her symptoms between the two days and, as such, there would be no need to reassess her condition before she received further treatment. On this basis it determined that Particulars 4a and 4b were not proved.

The Committee noted that the case put by the GCC was that, effectively if there had not been a reassessment on 21st July, then there should have been one on the 22nd July. However, the Committee noted that this was not how the Particulars were drafted. Further, based upon its finding on Particulars 3b and 3c, the Committee has already found that there should have been a reassessment on the 21st July 2016 and that issue has been addressed in the Committee's findings.

Particular 5c: Found proved

The Committee again had regard to the record of Donata Kick in which she recorded that Patient A complained of increased pain and lower limb symptoms. As with its earlier finding, the Committee was satisfied that Donata Kick's records could be relied upon. The Committee was satisfied that it is clear from Donata Kick's records that Patient A complained of increased pain in that the records state: *"...patient asked to sit down because the pain became worse. The pain stayed worse and did not decrease throughout the remainder of the treatment"*. Further the Committee was satisfied that Patient A reported neurological symptoms in particular she complained of "*Occasionally pins/needles in the feet which came and went…..*" The Committee was satisfied that this Particular is proved on the basis of this evidence.

Particular 6a: Found proved
The Committee had regard to the evidence of Dr Young, who accepted that any examination of Patient A in the circumstances would be limited by the amount of pain that she was in, but that it would be possible to undertake some neurological testing to the extent of touching the skin and similar such tests. Dr Young sets out tests which he believes could have been carried out at Paragraphs 4.5.1 and 4.5.2 of his Addendum Report of 17th May 2017. The Committee also had regard to Dr Grant's evidence that testing in these circumstances could include asking the patient questions. The Committee was satisfied that Mr Phelps was under a duty to explore what had happened and to do so by undertaking some neurological and orthopaedic testing. The Committee accepted the evidence that the extent of the pain that Patient A was in may well have prevented some tests being carried out. However, the Committee concluded that some testing could and should have been carried out. On the basis of the evidence before it, the Committee was satisfied that no tests were carried out and, therefore, found this Particular proved.

Particular 6b: Found not proved.
The Committee had regard to a number of pieces of evidence. Firstly, it noted that the complaint of "occasionally pins/needles" was made to Donata Kick. The Committee accepted that Mr Phelps may have been out of the room when Patient A informed Donata Kick of this. The evidence of Dr Young was that the presence of pins and needles bilaterally in the feet was the key aspect of Patient A's symptoms which should have alerted Mr Phelps to the possibility of spinal stenosis. The Committee noted the evidence of Dr Grant that "pain is not a red flag in itself". The Committee concluded that a reaction to treatment in the form of increased pain and an inability to get off the treatment table would not, in itself, be indicative of progressive spinal stenosis, as it would more commonly be the result of muscle spasm.

There was no evidence that Mr Phelps had been informed of pins and needles by Donata Kick. Therefore, in the absence of Mr Phelps knowing about the presence of pins and needles in Patient A's feet, the Committee could not be satisfied that Mr Phelps should have recognised the potential presence of progressive spinal stenosis. The Committee, therefore, found this Particular not proved.

Particular 6c: Found not proved.
The Committee noted that there was no evidence before it that Mr Phelps had been informed of what Patient A had said by Donata Kick at the relevant time. On the basis that there was, in fact, no evidence that he did know of what she complained, the Committee concluded that it could not be satisfied that Mr Phelps knew of the possibility of spinal stenosis, in which case, he self-evidently could not know that it would constitute a medical emergency.

Particular 6d: Found proved.

The Committee considered all the evidence before it on this issue. It, in particular, had regard to the fact that Patient A was in considerable pain and that she had the greatest difficulty moving and was unable to get up from the treatment table. From this evidence, the Committee determined that any reasonable chiropractor would conclude that Patient A's back had gone into spasm and that this could constitute a medical emergency. The Committee noted that Mr Phelps did not consider seeking emergency assistance over a period of approximately an hour and a half to two hours following the adverse reaction. Both Dr Young and Dr Grant agreed that approximately thirty minutes would be a reasonable time to wait, following an adverse reaction, to allow it time to settle, before calling an ambulance if it had not settled. The Committee was satisfied that Mr Phelps did not call for emergency medical assistance promptly and, on the basis of Person A's evidence, at all, because the evidence was that it was her initial suggestion that an ambulance be called.

Particular 6e: Found proved.
The Committee had regard to Person A's evidence that when she raised the possibility of calling an ambulance, Mr Phelps essentially told her that an ambulance was not needed. Further, in his own oral evidence, he said that he did not think calling an ambulance was necessary. The Committee was satisfied that, in informing Person A that an ambulance was not needed, Mr Phelps was failing to respond adequately to what had occurred and that this Particular was proved.

Particular 8a: Found proved
The Committee noted its findings on Particular 6a. It was satisfied that this Particular was found proved on the basis of its finding on Particular 6a.

Particular 8b: Found not proved
The Committee considered that in the circumstances of this allegation, in order to find that the actions of Mr Phelps were inappropriate, he must first be shown to have been aware of the potential presence of spinal stenosis at the relevant time. The Committee noted its finding on Particular 6b and concluded that in light of it, this Particular was not proved.

Particular 8c: Found not proved.
The Committee had regard to Mr Goldring's assertion, in his closing submissions that Patient A was lying to the Committee when she stated that she had asked Mr Phelps to stop treating her. The Committee did not find this a helpful submission, in particular, because this assertion had never been put in any form to Patient A by Mr Goldring when she was giving evidence. The Committee considered the evidence it had heard. In particular, it had regard to Person A's evidence that, when she arrived, Mr Phelps was pacing up and down and appeared to be in an agitated state, Donna Kick was crouching down by Patient A's head stroking her hair and attempting to comfort her and Patient A appeared very distressed and had obviously been crying. It noted the evidence of Patient A that she had, on numerous occasions, asked Mr Phelps to stop treating her but that he had continued. The Committee was satisfied that if this was the factual position, then Patient A had clearly withdrawn her consent to further treatment. The Committee also considered the records of Donata Kick on this issue. It noted that her records showed that when Patient A was being treated after the reaction had occurred that she would be asked before each further treatment whether she consented, and she responded "yes". If after the treatment started, when the pain became too intense she would say "no" and the treatment would stop. Mr Phelps's own evidence was that he thought he had Patient A's consent to treat. He said that he explained to Patient A what he was going to try to do to get her up, he believed that he had her consent but that when she complained of pain he would stop. The Committee considered that, to an extent, his evidence appeared consistent

with the record made by Donata Kick. The Committee was faced with two versions of events that appeared completely at odds. It had regard to its conclusion when considering the credibility and reliability of witnesses. It had regard to the fact that Patient A was in pain, was clearly distressed and was very concerned at her inability to be able to get up from the treatment table. It also noted the tendency of Mr Phelps to become agitated when under pressure and it drew the inference that he very likely became somewhat animated and focussed on his attempts to improve Patient A's condition. In the circumstances the Committee was unable to decide which version of the events it preferred, in particular because, the memories of both Patient A and Mr Phelps may well have been affected by what was occurring. In the circumstances, the Committee reminded itself the burden of proof is on the GCC and because the Committee could not be satisfied on the balance of probabilities that it preferred Patient A's evidence, this Particular was not found proved.

UNACCEPTABLE PROFESSIONAL CONDUCT

The Committee had regard to the submissions of Mr Coke-Smyth, on behalf of the GCC, and those of Mr Goldring, on behalf of Mr Phelps. The Committee heard and accepted the advice of the legal assessor.

The Committee noted that Mr Goldring submitted that the facts behind the allegation in Particular 9 could not amount to unacceptable professional conduct. He further invited the Committee to consider whether the facts behind the allegation in Particular 6e could amount to unacceptable professional conduct. He submitted that the allegation of suggesting to Patient A's mother that an ambulance was not required did not cross the threshold of seriousness to warrant a finding of unacceptable unprofessional conduct. He submitted that fellow professionals would not consider the conduct deplorable, the issue was one of a judgment made in the particular circumstances. On behalf of Mr Phelps, Mr Goldring conceded that the other Particulars, if found proved, would cross the threshold of seriousness to support a finding of unacceptable professional conduct.

The Committee had regard to its findings on the facts and noted that the following Particulars had been admitted or found proved: Particulars 1, 2, 3b, 3c, 5a, 5b, 5c, 6a, 6d, 6e, 7, 8a and 9.

The Committee first considered Mr Goldring's submission on Particular 9. The Committee reviewed the evidence on this Particular. It determined that with regard to the matter of Patient A's dignity, it might have been best practice, and certainly would have been appropriate, to attend to her dignity, but the Committee agreed with Mr Goldring's submission that this failure does not cross the threshold of seriousness to warrant a finding of unacceptable professional conduct. Consequently, the Committee determined that, with regard to the facts in Particular 9, Mr Phelps is not guilty of unacceptable professional misconduct.

The Committee went on to consider the other Particulars. Particulars 1 and 2 merely set out the relevant background matters. The Committee then considered Particulars 3b and 3c. It concluded that the origins of much of what followed later could be identified as flowing from the failures alleged in these Particulars. The Committee concluded that Mr Phelps appeared to have a fixed view with regard to how he intended to treat Patient A. He appeared fixated on following the ABC protocol and appeared to be unable or unwilling to look beyond it. Consequently, he appeared to ignore possible changes in Patient A's presenting condition on

the 21st July 2016 and effectively refused to even consider undertaking examinations which might have led to a different diagnosis.

The Committee concluded that Mr Phelps appeared to lack flexibility in his approach to caring for Patient A and that the other Particulars that cover the events that occurred on the 22nd of July demonstrate a continuing lack of flexibility and awareness that he should re-assess his patient after his treatment had caused the serious reaction that it had. He appeared to conclude that it was appropriate to go on treating Patient A for a period of time approaching two hours without recognising that he should call for medical assistance after there had been a change in her symptoms. The Committee considered that Mr Phelps had not dealt with this developing emergency situation well. The Committee noted that when Patient A was finally taken to hospital, she was able to leave the hospital, after care had been provided, and to go home later that evening.

The Committee determined that Mr Phelps's conduct as set out in all the remaining Particulars, including Particular 6e, fell far below that expected of a reasonably competent chiropractor and that, consequently, he is guilty of unacceptable professional conduct.

SANCTION

The Committee took account of all the evidence that it received in the case. It had regard to the reflective statement, Certificate of attendance at a "Neurology Testing" course dated 23 July 2017 and testimonials placed before it on Mr Phelps's behalf. It also took account of the submissions made by Mr Coke-Smyth on behalf of the GCC and those of Mr Goldring on Mr Phelps's behalf. It heard and accepted the advice of the legal assessor.

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 Phelps. It took account of the GCC Guidance on Sanctions, dated April 2018, in considering the appropriate sanction in this case.

The Committee had regard to the Code, effective from 30 June 2016. It concluded that the following sections of the Code were relevant to the Committee's decision in this case:

You must:

A1 show respect, compassion and care for your patients by listening to them and acknowledging their views and decisions. You must not put any pressure on a patient to accept your advice.

A5 prioritise patients' health and welfare at all times when carrying out assessments, making referrals or providing or arranging care. Respect a patient's right for a second opinion.

C1 obtain and document the case history of each patient, using suitable methods to draw out the necessary information.

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.

C6 cease care, or aspects of care, if this is requested by the patient or if, in your professional judgement, the care will not be effective, or if, on review, it is in the patient's best interest to stop. You must refer the patient to another healthcare professional where it is in their best interests.

G5 refer to, or seek expertise from, other chiropractors or healthcare professionals, when needed.

The Committee first considered the aggravating and mitigating factors in the case. It determined that the first aggravating factor was Mr Phelps's lack of insight into his misconduct. It considered that he had some limited insight into his shortcomings but that this was yet to be fully developed. The second aggravating factor was that his conduct could have put Patient A at risk of harm. It noted that Mr Coke-Smyth had submitted that the delay in the calling of the ambulance could be considered an aggravating feature. The Committee considered this issue to be part of the incident as a whole and was not an additional aggravating factor.

The Committee considered the following to be mitigating factors. It considered Mr Phelps's good character to be a mitigating factor, also the testimonials presented on his behalf. It also considered the fact that he had practised for over two years without further incident was also a mitigating factor. Further the Committee had regard to the fact that he had admitted some of the Particulars of the Allegation.

The Committee first considered whether an Admonishment would be the appropriate and proportionate sanction to impose and determined that it would not. The Committee concluded that Mr Phelps's conduct could have caused patient harm. It accepted that he had demonstrated some limited insight into his shortcomings and made some expression of regret. The Committee accepted that these events involved an isolated incident, bearing in mind the case involved the treatment of one patient over a period of two days. The Committee noted that Mr Phelps has a previous good history. The Committee was not aware of any repetition of his conduct and had received some evidence of rehabilitative steps he has taken and noted the testimonial evidence which had been placed before the Committee on his behalf. However, the Committee considered that an Admonishment would not be the appropriate sanction in this case, bearing in mind the seriousness of the failures which the Committee found and the fact that his conduct could have put a patient at risk of possible harm.

The Committee went on to consider a Conditions of Practice Order. It determined that whilst it did not find that Mr Phelps had a deep-seated attitudinal problem, he did have a fixation with the ABC protocol which resulted in a failure to recognise the need to reassess a patient or consider other treatment options when changes in Patient A's symptoms suggested a new neurological condition to the one which she was being treated for. The Committee was satisfied that, with appropriate conditions, Mr Phelps will be reminded that the patient's

needs and the need to adhere to standards enshrined in the Code, outweigh adherence to particular protocols.

The Committee concluded that there were identifiable areas of his practice in need of ongoing review and assessment, in particular, concerning his neurological and orthopaedic examination of patients, his documentation of working diagnoses or rationales for care and his reassessment of his patients' conditions. It concluded that there has been no evidence of general incompetence. The Committee has heard that Mr Phelps would be willing to comply with Conditions. The Committee noted that Mr Phelps has been practising without incident since these events and concluded that patients would not be put at risk if he were to continue to practise, but subject to Conditions. It concluded that Conditions would be the minimum sanction necessary to protect patients and that it would be possible to formulate appropriate, practicable and workable Conditions.

The Committee considered whether it would be appropriate and proportionate to impose an order of Suspension. It had determined that, whilst there had been serious breaches of the Code, the breaches were not so serious that they could not be addressed by the imposition of a lesser sanction, namely one of a Conditions of Practice Order. The Committee noted that Mr Phelps has practised safely for two and half years following these events and there has been no repetition of the behaviour. The Committee determined that an order of Suspension would not be the appropriate or proportionate sanction to impose.

Consequently, the Committee determined to impose the following Conditions for a period of 18 months.

1. You will be subject to an audit process to be undertaken by an Auditor, who will be a registered chiropractor appointed by the GCC, to audit your practice in relation to assessments and reassessments, including but not limited to:

- orthopaedic examination
- neurological examination
- working diagnosis or rationale for care

2. You will cooperate with the Auditor and make available all such information, documentary and oral, that he/she requires in assessing the standard of your practice.

3. At each audit the Auditor will select a random sample of at least 20 records to be audited.

4. At each audit the Auditor will observe at least one patient appointment, which will include an assessment or reassessment, and will observe and assess the standard of your practice, focusing on but not limited to the following areas:

- orthopaedic examination
- neurological examination
- working diagnosis or rationale for care

5. The audits will take place at intervals of 3 months from the commencement of this Order.

6. You must arrange for the reports of the Auditor, following each visit, to be forwarded to the GCC.

7. You must advise all patients that your records and/or appointments are subject to review and audit by a registered chiropractor.

8. You shall be responsible for paying for the costs of your audit and audit reports and shall pay the relevant invoice within 28 days.

The Committee will convene a Review Hearing shortly before the expiry of this Order. At the Review Hearing, the Committee would expect to be provided with all the audit reports which will have been prepared during the currency of this Order. At the Review Hearing the Committee would expect to hear oral evidence from the Auditor.

That concludes this case.

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.

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: 30 October 2018

Richard Kavanagh
On behalf of the Professional Conduct Committee

Explanatory Notes:

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

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

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