Section 29 Case Meeting

2 October 2019

157-197 Buckingham Palace Road, London SW1W 9SP

professional standards authority

Mr Andrea Franchini

Members present

Alan Clamp (in the Chair), Chief Executive, Professional Standards Authority
Mark Stobbs, Director of Scrutiny and Quality, Professional Standards Authority
Simon Wiklund, Head of Legal (Senior Solicitor), Professional Standards Authority

In attendance

Peter Mant of counsel 39 Essex Chambers Legal Advisor

Observers

Priya Gungadin, Senior Finance Officer, Professional Standards Authority
Rebecca Senior, Lawyer, Professional Standards Authority
Rebecca Moore, Scrutiny Officer, Professional Standards Authority
Isabel Lucas, Scrutiny Officer, Professional Standards Authority
Georgina Devoy, Senior Scrutiny Officer, Professional Standards Authority

1. Definitions

1.1 In this meeting note, standard abbreviations have been used. Definitions of the standard abbreviations used by the Authority, together with any abbreviations used specifically for this case are set out in the table at Annex A.

2. Purpose of this note

2.1 This meeting note records a summary of the Members' consideration of the relevant decision about the Registrant made by the regulator's panel, and the Authority's decision whether or not to refer the case to the court under Section 29 of the Act.

3. The Authority's powers of referral under Section 29 of the Act

3.1 The Authority may refer a case to the relevant court if it considers that a relevant decision (a finding, a penalty or both) is not sufficient for the protection of the public.

3.2 Consideration of whether a decision is sufficient for the protection of the public involves consideration of whether it is sufficient:

- to protect the health, safety and well-being of the public

- to maintain public confidence in the profession concerned, and
- to maintain proper professional standards and conduct for members of that profession.

3.3 This will also involve consideration of whether the panel's decision was one that a disciplinary tribunal, having regard to the relevant facts and to the object of the disciplinary proceedings, could not reasonably have reached; or was otherwise manifestly inappropriate having regard to the safety of the public and the reputation of the profession (applying *Ruscillo*[1]).

4. Conflicts of interest

4.1 The Members did not have any conflicts of interest.

5. Jurisdiction

5.1 The Legal Advisor confirmed that the Authority had jurisdiction to consider the case under Section 29 of the Act. Any referral in this case would be to the High Court of Justice of England and Wales and the statutory time limit for an appeal would expire on 3 October 2019.

6. The relevant decision

6.1 The relevant decision is the Determination of the Panel following a hearing which concluded on 29 July 2019.

6.2 The Panel's Determination which includes the charges and findings is set out at Annex B.

7. Documents before the meeting

7.1 The following documents were available to the Members:

- Determination of the panel dated 29 July 2019
- The Authority's Detailed Case Review
- Transcripts and exhibits of the hearing
- Counsel's Note dated 1 October 2019
- The HCPC's Indicative Sanctions Guidance, March 2019 – in force at the time of sanction stage
- The Authority's Section 29 Case Meeting Manual.

7.2 The Members and the Legal Advisor were provided with a copy of a response from the HCPC to the Authority's Notification of s.29 Meeting.

[1] CRHP v Ruscillo [2004] EWCA Civ 1356

8. Background

8.1 The Registrant was employed as a Physiotherapist. Service User A ('SUA') had attended the clinic on 10 August 2016 having sustained an injury to her neck at home. The Registrant had asked SUA some questions about her medical history and asked her to remove her top and proceeded to carry out treatment which it was alleged included touching of SUA's breasts. SUA 's breasts had remained exposed throughout the appointment.

8.2 After the appointment, SUA had spoken to Person C, her partner and reported what had happened at the appointment. Person C spoke to the Registrant on the same day and raised concerns about the treatment provided to SUA.

8.3 SUA sought a second opinion from another Physiotherapist (CH-B) at another clinic at which appointment she had been very distressed about the registrant's actions. CH-B made enquiries with the HCPC and was advised that SUA should make a referral and contact the police.

8.4 Service User B ('SUB') attended the clinic on 20 May 2016 for a physiotherapy appointment in relation to a thumb injury following a bicycle injury. The first appointment was without incident. At the second appointment on 31 May 2016 SUB was asked to remove her top, leaving her wearing a vest top.

8.5 The Registrant had done some work on her shoulder and then progressed towards her chest. SUB's evidence was that he had performed sweeping motions on her right breast, placed his hands inside her vest top and bra, coming close to but not touching her nipple. Those manoeuvres then stopped and SUB sat up on the plinth and the Registrant positioned himself behind her placing his chest and torso against her back. SUB's evidence was that the Registrant was behind her breathing directly on to her neck with his mouth close to her neck.

8.6 SUB had made a complaint to her private health providers Nuffield Health although had not indicated that she wished to be involved further. The Registrant's treatment of SUB only came to light when he was questioned about earlier complaints about his practice.

8.7 Allegations against the registrant in relation to SUA relate to him, asking her to remove her bra, failing to obtain informed consent, massaging and/or touching around, between the middle and under her breasts, touching her nipples, massaging her belly button/pubic area, rubbing up and down her arms and leaning or applying pressure with his body on her body.

8.8 Allegations in relation to SUB relate to the registrant failing to obtain informed consent, touching and/or massaging her breasts, placing his hands in her bra, pressing his chest up against her back and breathing onto her neck/or down her chest.

8.9 The Registrant appeared before a Crown Court on sexual assault charges in relation to the above. He was acquitted on all counts. The allegations were charged as sexually motivated and without clinical justification. The registrant denied the allegations against him.

8.10 The panel found that the treatment by the registrant was clinically justified but that the touching of the breasts was not. It considered that this was accidental

or the result of poor technique. Sexual motivation was found not proved in its entirety, on the grounds that the touching of SUB's breasts was as a result of poor clinical practice rather than to seek sexual gratification.

8.11 The panel found proved that the registrant's actions were without clinical justification in relation to him failing to ensure SUA's breasts were covered, not obtaining informed consent in relation to SUA, rubbing SUA's arms, failing to obtain informed consent from SUB and for touching SUB's breasts, although again, the panel noted this was more likely to be as a result of poor technique.

8.12 Misconduct was found only in relation to the registrant not having covered SUA's breasts and touching her breasts and not having obtained informed consent in respect of both service users.

8.13 The panel found that the registrant's fitness to practise was impaired on personal and public interest components regarding the absence of informed consent and imposed a caution order for a period of two years.

9. Applying Section 29 of the 2002 Act

9.1 The Members considered all the documents before them and received legal advice.

9.2 Prior to their consideration of the matters below, the Members noted the nature of the behaviour concerned and acknowledged that they should be mindful of the impact on the female service users and their experience as witnesses before the Panel.

9.3 The Members discussed the following concerns about the decision:

Did the charges against the registrant capture the full extent of the misconduct and was the finding that the registrant's conduct was not sexually motivated wrong?

9.4 The Members considered whether a failure to charge the Registrant with squeezing SUA's left shoulder and stating, *"that feels good, no?",* moving his hands lightly over SUA's back and brushing the side of her breasts and the registrant manoeuvring a towel to uncover SUA's breasts, after SUA had tried to cover them up, could be considered as a serious procedural irregularity and whether this would have made a material difference to the outcome of the case.

9.5 The Members noted that whilst the above matters had not formed specific charges, they were before the Panel in the evidence presented. The Members considered the matters not charged to have been contextual and noted that they were relevant to the Panel's decision on whether to draw inferences given the treatment was in a sensitive area, that the treatment was not clinically justified and sexually motivated. For example, the Members noted that although the Panel did not specifically address SUA's evidence about where the towel was placed or moved, they Panel did make a clear finding that her breasts were exposed.

Did the Panel err in finding no misconduct in relation to the touching of SUB's breasts?

9.6 The Members were concerned that the Panel had failed to acknowledge the seriousness of any inappropriate touching of a Service User's breasts, even where it is not deliberate. The Members noted that the Registrant has failed to apologise at any time and had left both Service Users feeling extremely distressed and violated.

9.7 The Members considered that it was inappropriate for the Panel to have separated consideration of the touching from the lack of consent and failure to ensure that SUA was properly covered. Had the Registrant explained the technique he was due to perform on SUB and what he was about to do during the consultation by obtaining informed consent and then offered an apology having touched her breasts and put his hand inside her bra, it may have been clearer that the touching should not amount to misconduct. However, the Registrant's initial failings contributed to the impact his subsequent touching had on the Service Users. The separation on these matters when determining misconduct appeared artificial.

Was the sanction sufficient on the findings made by the Panel?

9.8 The Members were concerned that the Panel had found there was a low risk of repetition of the registrant repeating such conduct in future. The decision was based upon what they considered to be minimal evidence, namely a single on-line course that the Registrant had undertaken the day before sanction stage.

9.9 These concerns were further exacerbated given the Panel had previously found at the impairment stage that there was a risk of repetition as it had received no evidence that the Registrant's practice had changed, nor that he recognised the requirement for consent to be an ongoing process.

9.10 The Members also noted that the Registrant had been subject to a 24-month interim conditions of practice order where he was required to remain chaperoned. Given this period of conditions, the Members were surprised that the Registrant had not explained to the Panel how he might do things differently in future, again leading them to question how the Panel could conclude the risk of repetition was low.

9.11 The Members were further concerned that the Panel had failed to identify material aggravating factors, including the seriousness of inappropriate touching, the failure to consider patient dignity, the vulnerability of both Service Users, the fact that the misconduct was repeated, the lack of any apology, or regret and the failure to demonstrate any insight.

9.12 In addition to their failure to identify material aggravating factors, the Members were concerned that the Panel had placed undue weight on mitigating factors, including: compliance with interim conditions, when these were mandatory requirements, the absence of concerns during the period of interim conditions, when the Registrant knew he was under scrutiny and was likely to act as professionally as possible and the online learning that had been undertaken the day before the sanction decision was made and which was not accompanied by any reflection.

9.13 Last, the Members were concerned that the Panel had failed to properly consider and apply the HCPC Sanctions Policy. The Members considered that this was a case that did not fit with the factors that suggested a caution order in the guidance and that it was more suited to restrictive, reviewable sanction, where the Registrant's, remorse and remediation could be further assessed.

Conclusion on insufficiency for public protection

9.14 The Members concluded that the Panel's decision to impose a caution order was insufficient for public protection in the following respects; the Panel failed to fully appreciate the seriousness of the inappropriate touching, deliberate or not and the effect that it had on both Service Users, the Panel erred in finding that the risk of repetition was low and placed reliance on the incidents being isolated, when there were two very similar incidents, thirdly, the Panel failed to consider the issue of insight and placed significant weight on the online course that had been completed the day before the sanction decision was given. Finally, the Panel failed to properly identify material aggravating factors and failed to properly consider and apply the HCPC's sanctions policy to these aggravating factors, which would have indicated that a caution order was not the appropriate sanction.

10. Referral to court

10.1 Having concluded that the Panel's Determination was insufficient for public protection, the Members moved on to consider whether they should exercise the Authority's discretion to refer this case to the relevant court.

10.2 In considering the exercise of the Authority's discretion, the Members received legal advice as to the prospects of success and took into account the need to use the Authority's resources proportionately and in the public interest. The Members also considered the potential impact of any referral on the Registrant but did not consider there were alternative means of achieving the required level of public protection.

10.3 Taking into account those considerations, along with advice on the prospects of success, the Members agreed that the Authority should exercise its power under Section 29 and refer this case to the High Court of Justice of England and Wales.

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Alan Clamp (Chair) **Dated**

Annex A – Definitions

In this note the following definitions and abbreviations will apply:

The Authority	The Professional Standards Authority for Health and Social Care
The Panel	A Health and Care Professions Tribunal Service of the Health and Care Professions Council
The Registrant	Mr Andrea Franchini
The Regulator	Health and Care Profession Council
[Regulator's abbreviation]	HCPC
The Act	The National Health Service Reform and Health Care Professions Act 2002 as amended
The Members	The Authority as constituted for this Section 29 case meeting
The Determination	The Determination of the Panel sitting on 29 July 2019
The Court	The High Court of Justice of England and Wales
The Code	Regulator's Code of Practise in force at time of incident plus
The ISG	Regulator's Indicative Sanctions Guidance dated March 2019 in force at sanction stage
Service User A	SUA
Service User B	SUB