2025 Report to the Investigating Panel from the Independent Complaints Moderator for BAcC

This report is my fourteenth one as Independent Moderator of complaints for the British Acupuncture Council (BAcC). It covers the period 1 January – 31 December 2025 under the following headings:

1. Background
2. Moderator role
3. The BAcC complaints procedure
4. Complaints this year: summaries and observations
5. Conclusions and recommendations

Background

The BAcC is a membership body and a professional regulator accredited by the Professional Standards Authority for Health and Social Care under its Accredited Register scheme.

All BAcC member practitioners are bound by a Code of Professional Conduct (last updated in January 2015), a Code of Disciplinary Procedures (last updated in September 2025) and a Code of Safe Practice (revised in 2016). The Guide to Safe Practice is also relevant; it is good practice guidance and is not mandatory. It was last updated in January 2025, but the March 2023 update is the relevant one for all but one of the complaints covered in this report. In addition, the BAcC has produced guidance for the Investigating Panel on vexatious and malicious complaints (2019) and on issuing a Letter of Advice (2022). [CJ to check this.]

The Codes are enforced by the BAcC's three Ethics Committees: Investigating Panel (IP), Professional Conduct and Competence Panel (PCCP) and Health Committee (HC). The panels/committees are supported and administered by the Professional Conduct Department (previously known as the Ethics Department) of the BAcC and its Professional Conduct Officer (PCO). The BAcC has expanded the Professional Conduct department, as noted below.

Complaints about a practitioner who is a member of the BAcC (the 'registrant') can be made by a member of the general public, professional regulator, patient, fellow practitioner or member of any committee or employee of the BAcC. The PCO considers if a complaint falls within the scope of the BAcC's Code of Professional Conduct and/or the Code of Safe Practice; if it does, then the PCO will notify the registrant and progress the complaint,

including referring it to the IP. The PCO has discretion not to refer the complaint to the IP if, for instance, the complaint is 'unspecific or anonymous' and it is not reasonably practicable to obtain any further details of the alleged behaviour.

The IP is made up of three members (one lay person, one acupuncturist and one person who is either lay or an acupuncturist) and is managed and supported by the BAcC's PCO. It is referred to as a filtering panel. Its powers are explained in the BAcC Code of Disciplinary Procedures. The process is intended not to punish a registrant but to consider if the registrant's conduct has fallen short of the standards expected and is potentially in breach of the Codes.

The IP itself has no power to sanction a member through fines or disciplinary action. Its role is to determine whether allegations should be referred to the PCCP or HC, specifically where it considers there is a realistic prospect of a finding of 'impairment' in relation to any allegation. ('Impairment' is defined in the Information for Complainants leaflet as '*any circumstance which impacts or may impact upon the ability and capability of an individual to undertake safe and effective practice*'.)

Complaints raising significant safety concerns may be identified by the PCO and can be referred, before investigation, to the Interim Orders Panel (IOP), which has the power to place temporary restrictions on registrants (Interim Suspension Order). The IOP does not investigate the complaint and cannot resolve disputes of fact; it makes a decision on whether an interim order is necessary for the public interest or the interests of the registrant. The IP, on the other hand, considers each allegation in the complaint, weighs evidence, and decides if there is a realistic prospect of a finding of impairment. The IP process therefore takes place following the IOP process, where the IOP is involved, and any interim order is only in place for as long as the full BAcC disciplinary progress takes to conclude.

If an Interim Order has not already been imposed and the IP considers, following investigation, that the seriousness of the issues warrants temporary suspension of the registrant, the IP will refer the matter to the IOP for a hearing. The IP can also decide there is no case to answer, and it can exercise its discretion not to refer a complaint to the PCCP where it identifies minor breaches of the Codes. In some cases, the IP will provide feedback to the registrant and/or make recommendations for service improvements ('Letter of Advice'). These are disclosed to the registrant's current employer, but they are not published. The Letters of Advice are kept on record and may be used to identify patterns of behaviour in any subsequent investigation related to that registrant.

Moderator role

My role as Moderator is set out in the BAcC Code of Disciplinary Procedures, Section 12. I have been appointed to review complaints made to the BAcC which the PCO decided not

to refer to the IP and complaints that were referred to the IP but which the IP decided not to refer to the PCCP or HC.

My role is to review those complaints, describe how they were handled, and comment on the way they were handled in terms of communication and consistency. Where possible, I attend one IP meeting per year as an observer. Where appropriate, I can make recommendations for improvements in the way complaints are handled.

The BAcC complaints procedure

The complaints procedure sets out the steps in the complaints process, from the statement and supporting documents submitted by complainants through to the IP's decision. Registrants complained of are required to provide a written response within 28 days of the BAcC requesting this (changed in 2025 from 14 days), including copies of relevant patient notes. The PCO then convenes an IP to meet and consider the complaint.

The IP is entitled to ask for further information, including, where it deems it appropriate, to request the complainant's comments on the registrant's response, further relevant registrant's notes and records, and a report from an independent Technical Assessor. The IP is also entitled to seek information and evidence from third parties and to seek advice from a lawyer or doctor. The IP then reviews any further information at its next scheduled meeting.

The IP must decide, following its consideration, whether there is a realistic prospect of a finding of impairment in relation to any allegation. Complainants and registrants are to be informed of the IP's decision and the reasons for it within 10 working days of the meeting at which the decision was made, although the aim is to do this as soon as possible.

A guide to its complaints procedure (Information for Complainants), which clearly explains the role of the IP, the procedure, and what is required to submit a complaint, is sent to complainants and is also available on the BAcC website.

Under the Code of Disciplinary Procedures, there is no right for the complainant and the registrant to appeal against a decision (including a decision not to refer a complaint to the PCCP or HC) made by the IP. However, complainants are invited to submit additional significant evidence, within 14 days of the date of the decision, which the PCO will then consider. It is in the PCO's discretion whether to refer this additional evidence to the IP for consideration.

Complaints this year: summaries and observations

For this report I have reviewed seven complaints that were decided by the IP in 2025.

Overall, in 2025 the BAcC received four complaints, all of which were referred to me. As noted above, the complaints that go to the PCCP are not included in my review. However, in two of those cases that concluded in 2025 and were referred to me, some allegations were referred to the PCCP, and I therefore excluded those aspects of the complaint from my review. One complaint technically concluded in early 2026, but I have included it in this year's review because the IP decision was in 2025, although the Letter of Advice was sent in early 2026.

I also received three additional cases that concluded in 2025: two from 2024 and one from 2023.

Unusually, I did not observe an IP meeting in 2025 because of scheduling difficulties.

I refer to the cases by the numbering system used by the BAcC. I provide a brief description of the issues only, and do not include any names of the complainant (referred to as 'C') or the registrant ('R'), in order to protect the anonymity of individuals involved.

Case 7 of 2023
Issues: adverse reaction; unsafe practice

C complained of an adverse reaction following two treatments from R. Her symptoms began quite quickly but worsened over the 20 months following her initial contact with the PCO. The symptoms she reported included loss of appetite, weight loss, pain, bowel damage, vision problems, toxic taste in her mouth, reduced mobility, and discomfort at the needling sites. She had informed R following the first treatment that she felt unwell. She had, however, booked a second appointment and continued to feel her symptoms worsen after that. She reported that she had had to take three months off work, had had numerous investigations to identify the cause, without success, and had developed osteoporosis and other conditions, which she believed were due to the acupuncture treatment. C also said that R had reused a needle, contrary to the Code of Safe Practice.

R explained in response that the symptoms C described had been reported to R prior to treatment and documented by R in the medical history notes. She had been aware of C's symptoms and had aimed to reduce her anxiety and distress. R also explained that she had documented the exact points used in her treatment notes. She submitted copies of her notes, both typed and handwritten. She had explained to C after the first treatment that it is not uncommon to feel unwell after a first treatment, and that it was C's choice to book a second appointment. R said that she had used a new needle when moving a needle from one position to another, as her notes documented.

C suggested in response that R should have established before the treatment that acupuncture was inappropriate, given C's symptoms and medical history. She supplied a

number of research documents reporting on evidence of harm caused by acupuncture treatment.

R responded through her solicitors that she was not able to practise currently because of the stress caused by the complaint. It was suggested that the complaint should be dismissed as vexatious. Numerous testimonials were submitted. R also noted that she had held a long phone call with C prior to the first appointment and the first session had lasted 2 1/2 hours, with a great deal of time spent discussing C's medical conditions.

The IP's consideration:
The allegations put to the IP were 1) R carried out treatment that resulted in adverse reactions and 2) unsafe practice in re-using a needle. The relevant Codes considered were the Code of Professional Conduct (sections 1-4) and the Code of Safe Practice (sections 7 and 11 and p.9).

The IP clarified that its role is not to establish a causal link between treatment and symptoms but to establish whether there was a breach of the Codes. It found that there was no evidence the treatment caused or exacerbated C's symptoms and that it was appropriate for R to proceed with treatment despite the list of C's pre-existing symptoms and conditions. The IP found that R's notes of the medical history were comprehensive and the treatment notes were accurate and contemporaneous. The IP felt the research documents submitted by C were either of low quality or not relevant to C's symptoms. The treatment notes clearly indicated that a second needle had been used and thus there was no breach of the Code of Safe Practice.

The IP concluded that that there was no prospect of the facts being proved on the allegations and no evidence to suggest a realistic prospect of finding R's fitness to practice was impaired. The IP recommended that no further action was needed.

Learning Points:
Two Learning Points arose from this complaint and will be taken forward. The BAcC will consider drafting the allegations (with reference to the relevant BAcC Codes) before the complaint is submitted to the R. This is in response to a separate complaint made about the process by another registrant who was concerned about the impact on the R who was the subject of the complaint. The BAcC will also investigate why the support for R from a Confidential Practitioner Support from the BAcC was delayed.

Observations:
There was a significant period of time between the complaint first being submitted to the BAcC and the IP meeting, of more than two years. This was due to a delay in C gathering medical evidence and confirming her complaint with the PCO. There was then an attempt to resolve the matter informally by addressing C's concerns about what had happened medically, which appeared to be her primary concern. The PCO sought advice for C from a colleague (the PCO has noted that it is not uncommon for patients/members of the public

to contact BAcC to discuss what has happened at their treatment, but this is usually before a complaint is made). This advice did not resolve the complaint, and it was taken forward. R's insurers were concerned they had not been notified when the complaint was first raised, but all the steps taken by the PCO during this period were reasonable ones to take, and the delay was not one caused by the BAcC.

There was an unfortunate drip-drip effect of additional detail from C, which was sent to the BAcC and sent on to the R. In Feb 2024 C confirmed with the BAcC that she wished to proceed with her complaint, which had originally been raised in October 2023. C was concerned that if she agreed that no further information would be submitted this might compromise her complaint, as her symptoms were further worsening. The PCO suggested to C that she provide what medical evidence she had and, if there is a significant change, she can provide further information. It is unfortunate that C provided further evidence after the complaint had been sent to R, but it did not disadvantage R because she was given sufficient time to consider it. It may, however, have added to R's distress.

The BAcC also offered to seek the views of two acupuncturists on the BAcC staff, and reported back to C that neither had seen a situation like this and that neither thought it was possible for acupuncture to cause the symptoms described. Typical symptoms following treatment would be tiredness and bruising. In April 2024, the PCO asked if C wanted to proceed with the complaint. C did not reply until June and said she would contact the PCO with further information. She did not hear back from C, and in February 2025 she contacted C to ask if she had decided to proceed and to remind her of the three-year limitation period. C submitted her complaint following this email.

The decision sheet suggests that the IP did not consider the allegation that the complaint was vexatious. It did, however, consider that the allegations in the IP bundle did not fully capture the complaint, and so an amendment was made, adding additional alleged conditions caused by the treatment. It is unclear why the IP did not consider the issue of vexatious complaint, as it was raised by the R's insurers and is part of the Checklist that goes to the IP.

In June 2025, C followed up the IP decision with a letter, and there appears to have been some delay in acknowledging that letter, from 1 June to 17 June, which was due to shortage of staff while the PCO was on sick leave and the cover was for only one day a week. In response to C's concerns that the process had not given her the answers she was seeking, the interim PCO explained the role of the complaints process, stating that it is not a general complaints resolution process and is not designed to resolve disputes between Registrants and patients and/or clients.

This exchange suggests that the purpose of the complaints procedure might not be evident to complainants – especially those who are looking for medical assessments, for resolution, and/or for compensation – and there could be scope for clarifying this when a complaint is first raised. The PCO has agreed that it might be useful to add to the

Information for Complainants leaflet the statement in the Code of Disciplinary Procedures (section 1.3) which reads: '*Fitness to Practise proceedings are about protecting the public. They are not a general complaints resolution process. They are not designed to resolve disputes between Registrants and patients and/or clients.*' This could help complainants identify if other processes (such as mediation or litigation) would be more appropriate and help avoid disappointment at the end of the BAcC process.

In addition, seeking advice from acupuncture colleagues was an attempt to resolve C's concerns about her health rather than part of the disciplinary process for R. It might have complicated and delayed matters, however, so the PCO plans not to do this in future once a complaint has been made.

Case 5 of 2024
Issues: adverse reaction; unsafe practice; breaches of professional conduct

C raised a complaint that she had suffered severe adverse reactions to an acupuncture treatment and that R had failed to use new needles, had given too strong a treatment, and had breached the Code of Professional Conduct on a number of aspects. She had an underlying immune condition and believed the acupuncture treatment had severely worsened her condition. She was in distress and pain and had researched whether acupuncture could cause such adverse effects.

Before making the formal complaint, C and her father had corresponded with R, requesting information and treatment notes, and had also asked the BAcC Research and Policy Manager (RPM) to investigate. Because it had not yet been raised as a complaint, the RPM agreed to do so and produced a report that reviewed the relevant literature and found it was impossible either to determine or rule out a causal link between the treatment and the symptoms experienced by C. C was dissatisfied with the report and called it biased and a whitewash. C's complaint was made subsequent to that report, and it included the complaint against R and a complaint about the BAcC.

R responded to C's complaint via his solicitors and submitted his treatment notes. C's response to this was shared with R, and R made a response to this. Although R denied all of the alleged misconduct and unsafe practices, one point was accepted – that R had failed to record C's GP details and emergency contact in his notes. This was explained as an oversight caused by the usual procedures not being followed, and R explained that he had changed his practice to ensure these details are recorded.

Because R was a member of the BAcC disciplinary panels, and to avoid any perception of a conflict of interest, the BAcC went to additional efforts when setting up the IP meeting. Three panel members were identified who had no knowledge of R. The PCO did not attend, as she usually would, and instead an Independent Legal Assessor (ILA) attended.
It appears that C made a request to withhold the RPM report from the IP's consideration. Normal practice would be to decline such requests. However, because the PCO was not

herself advising the IP, she left it to the ILA to decide on the request. The report, and a letter from C's consultant, were both withheld from the bundle for the IP.

The IP's consideration:
The IP determined there was not sufficient evidence to decide if there was a realistic prospect of a finding of impairment. It requested that the PCO gather further evidence – expert medical evidence on C's condition and expert acupuncture evidence – and adjourned until that evidence could be considered.

Subsequently, the BAcC instructed independent solicitors to manage the process, and a second IP meeting was scheduled for the end of that year.

There was an extended period of obtaining legal advice until the issue went to the BAcC Governing Board in December 2025, which decided that, in light of R having been in an accident and having resigned membership of the BAcC, and pursuant to Clause 5.3 of the Code of Disciplinary Procedures, it would not be reasonable nor in the public interest to proceed with the professional conduct process concerning the complaint against R. C was informed following the Governing Board meeting.

Section 5.3 of the Code of Disciplinary Procedures was changed on 1 July 2025. The previous wording described a default position that the BAcC will proceed with a complaint even after R resigns from membership, unless the PCO determines it would not be reasonable or in the public interest to do so. The new wording changes that default position to one in which the BAcC does not proceed with a complaint, unless the PCO determines it would be reasonable or in the public interest to do so. It was decided that as the complaint was made before the change took effect, the decision whether or not to proceed following R's resignation should be based on the previous wording.

Learning Points:
There were a number of Learning Points arising from this complaint, all for the PCO. These were to note preliminary checks on file checklist [actioned]; prepare guidance on when to apply for Interim Orders [commenced but not completed]; review Interim Orders as part of a general review of the whole complaint/professional conduct process in 2026 [to be actioned]; prepare guidance on procedure to adopt when conflict of interest arises for the PCO [actioned: new policy prepared and approved by Governing Board]; change time for response to be provided to 28 days, instead of 14 days [actioned]; and make it clearer in initial letter to complainants that they are not a party to the proceedings, only a witness – change initial letter [actioned].

Observations:
This was a complex case that involved not only a complaint against a registrant but also against the BAcC itself. Another complication is that during this period, in the initial stages before the formal complaint was submitted by C, the PCO was on long-term leave and the post was covered by an interim PCO but on a very part-time basis.

The first IP decision is unusual, as the decision sheet suggests members were considering the issue of causation – but the BAcC is clear that the IP's role is not to determine if there is a causal link between the treatment given and any adverse effect but to determine if there has been a breach of the professional codes.

The IP also concluded that C's complaint was not a 'proper statement' – as in signed, dated, and verified by a declaration of truth, as in a witness statement – and questioned whether to even admit it in evidence. The IP also indicated they believed C's correspondence with third parties was 'opinion evidence' and therefore inadmissible. They requested that the PCO obtain a witness statement from C. This seems a disproportionate response and one I have never seen an IP make. This IP was advised by an experienced ILA, but the advice he gave suggested his experience is primarily with advising at PCCP stage rather than IP stage. It is important for the BAcC to be confident in the advice given to an IP by an ILA.

Case 1 of 2024
Issues: Unprofessional conduct; unsafe practice

The complaint related to alleged breaches of professional conduct and safe practice codes. C described herself as vulnerable and had mobility issues, which she had informed R about. It was agreed that R would treat her on the ground floor of her premises rather than her dedicated treatment rooms upstairs. C complained to the BAcC that she had been left waiting outside and had to take the stairs rather than be helped to use the wheelchair lift; that she was treated in R's kitchen where R's husband was in a bed; that she was treated on a low-backed stool and was fearful of falling; that R did not protect her confidentiality or privacy; that a cat was present; and that R had not taken or recorded informed consent, among other issues.

R denied the allegations and said C had ignored her request to wait in her car until R could come and meet her with the lift. She accepted that her husband was in the kitchen where she treated C but that he was too far to hear or see them and she did not converse with him as alleged. She said she treated C on a sturdy high-backed chair. She accepted that a cat was in the room but did not jump on C. She denied that the setting was unhygienic and confirmed that she washed her hands before the treatment.

Responding to the BAcC after receiving R's response to the complaint, C said she wanted to put the matter to rest as she was finding it stressful. The PCO wrote to her to explain that she was not required to add further comments, but the PCO would allow a few days in case she wanted to. The complainant confirmed that she did not want to add further comments but was interested in the outcome. The PCO took this to mean that the complainant was content for the IP to proceed and was not withdrawing her complaint.

The IP's consideration:
The IP met and requested a Technical Assessor be appointed. Note that the Independent Complaints Moderator attended this meeting as an observer.

The BAcC had difficulties in identifying a Technical Assessor. The first who was appointed failed to respond to correspondence, one declined, and several others had retired. One was appointed some months later and submitted a report, which went to the IP. The Technical Assessor noted that R's upstairs treatment rooms were compliant with the BAcC requirements but identified breaches of the Code of Professional Conduct and the Code of Safe Practice in the use of the kitchen for this treatment. In discussion, R acknowledged that for this particular treatment she had not been in full compliance. R explained that she was attempting to offer treatment to someone in need who could not get to the upstairs treatment rooms. The Technical Assessor concluded this was an isolated incident.

The IP met a second time and requested further information from R, including a copy of her license issued by her local council; her CPD log, and details of supervision. R sent a photo of her license and explained that she did CPD by reading books. The license was dated many decades ago, and when the BAcC requested a more recent one, R said it was still valid and referred the BAcC to her local Council.

Upon receiving this information, the interim PCO attempted to arrange another IP meeting but there were significant delays. The IP met a third time, six months after the previous meeting, and reconsidered the allegations. The IP found in all that there was a realistic prospect of the facts being proved and that if proved, the allegation would amount to misconduct. However, the IP concluded that there was not a realistic prospect of a finding of impairment because R had acknowledged the lapse in judgement and the behaviour was unlikely to be repeated. Based on the Technical Assessor's recommendations, the IP then ratified the Action Plan for R and requested a few additional items related to CPD be added to the Plan.

Following the IP decision, the Technical Assessor made a complaint to the BAcC about the delay in the process, which she said took a year from the complaint being submitted to the Assessor being appointed. She was concerned about the emotional toll on R. The Technical Assessor said this raised questions about the efficiency and responsiveness of the investigative processes and suggested that the BAcC should review and reform its procedures.

In response, the BAcC noted that the Technical Assessor had been appointed 10 months after the complaint was submitted, and this delay was due to the original Technical Assessor not responding and to R's delay in responding.

Learning Points:
Two Learning Points arose from this complaint. One is for the BAcC to remind registrants about hygiene and location of giving treatments and also confidentiality and

modesty. Another Learning Point is for the PCO to obtain an updated list of Technical Assessors.

Observations:
This case raised issues for the BAcC about accessing Technical Assessors; they are infrequently needed and ones they have used in the past have since retired, while others are unavailable. This is noted in the Learning Points resulting from this case.

Case 4 of 2025
Issues: Unprofessional conduct; unsafe practice

The complainant was the partner of a patient of R and initially contacted the BAcC soon after the patient's death following the final of four treatments. Nearly three years later, C submitted a formal complaint, alleging that R had failed to take the patient's medical history and could not have taken consent because the patient was confused. C complained that R should not have treated the patient in light of his medical condition and that the treatment contributed to the patient's death.

R responded to the complaint and explained that treatment had been approved by the patient's consultant and that R had completed a pre-treatment medical questionnaire. The four treatments provided were very similar, and the final and fourth treatment was the same as the second treatment. R had been overly cautious in the treatment and acted in line with the BAcC guidelines.

The IP's consideration:
The IP met and considered four allegations: 1) failure to take or record a full medical history; 2) failure to take informed consent; 3) performing acupuncture despite contraindications within the patient's medical history; and 4) performing acupuncture which contributed to the patient's death.

On the first two allegations, the IP concluded that although R's notes were comprehensive, they did not include a family medical history, which is a requirement of the Code of Professional Conduct. The IP noted that C had power of attorney and had requested the treatment, and the patient was aware of the treatment and appeared to consent. However, R had not recorded the patient's consent on the patient form, which is also a requirement of the Code of Professional Conduct. The IP decided that a Letter of Advice was appropriate that advised R to redesign his patient form to include a section on family history and a section to record consent.

On the other two allegations, the IP concluded that R had used a cautious approach in treatment, taking account of the patient's condition. The IP could see no evidence that the acupuncture performed contributed to the patient's death. On both allegations, the IP concluded that there was not a realistic prospect of the facts being proved.

Learning Points:
One Learning Point arose from this complaint: for the BAcC to remind registrants to include relevant family history in the patient notes and to note consent being given. The BAcC will consider a webinar or Enews article on patient notes.

Observations:
This was clearly a sensitive complaint to deal with as it involved the death of a patient following acupuncture treatment. I have no concerns about the way it was handled by the BacC, the PCO, or the IP.

Case 3 of 2025
Issues: adverse incident; unprofessional conduct

The complaint related to adverse reactions experienced by C following a series of seven acupuncture treatments and to unprofessional conduct by R. C said that R and his receptionist had made belittling comments when she described her reactions; that R had promised a cure for her pain and had said he had cured thousands of similar patients; and that R had not taken or recorded her informed consent before treatment. She was still suffering adverse effects eight months after the final treatment and had had to spend money on additional treatments from another practitioner.

R refuted the allegations, and in his response, sent via solicitors, he explained that he had taken a medical history in the initial consultation with C and that during treatment he had described what he was doing, giving her the opportunity to consent. He said he answered her numerous questions and denied the alleged comments made. He accepted that his receptionist had made a comment that was misinterpreted; the receptionist apologised at the time and R confirmed he will ensure the receptionist has no input in future treatment. R explained that he used electro-acupuncture in one treatment session but that he obtained verbal consent before attaching the machine to C. He also used a technique he had developed himself. He had made changes as a result of the complaint, including implementing a formal consent form.

The IP's consideration:
The allegations before the IP were:

1) R had promised to cure C's pain.
2) R had claimed he had cured thousands of similar patients.
3) R's treatment had caused C to develop a rash.
4) R had failed to inform C clearly of the nature and purpose of the proposed treatment
5) of electro-acupuncture.
6) R did not take or record explicit, informed consent for acupuncture treatment or electro-acupuncture treatment.
7) R's treatment caused ongoing 'pins and needles'.
8) R behaved inappropriately towards C with his comments.

9) R used the title 'Dr' when it was inappropriate to do so.
10) R failed to undertake an appropriate course of structured training in therapy.
11) R failed to keep accurate, comprehensive, easily understood, contemporaneous and dated case notes.

The IP considered whether the complaint was malicious or vexatious and concluded that the allegations did not fall into the category of 'little or no merit' and that it was appropriate to consider them.

On several of the allegations, including the alleged comments, the IP concluded that there was a conflict of evidence and decided that the only way of determining this conflict of evidence was by oral evidence which could be tested at a hearing.

Regarding the failure to explain treatments and take and record informed consent, the IP noted that R had implemented a new patient consent form, but it did not address the requirement to inform patients of the nature and purpose of treatment. Because there was a public interest issue, the IP decided to refer this allegation to the PCCP.

The IP noted that because R had developed the therapy, he would not have undergone training in it, which is a requirement before undertaking any treatment. Also, the IP noted that R's notes were scantily written and did not include the required information, including clearly referencing the acupuncture points used. These allegations were also referred to the PCCP.

On the alleged adverse reactions to treatment, the IP concluded that various things could cause the adverse reaction and there was no evidence that the treatment had caused them, and therefore the IP did not think that there was a realistic prospect of the facts being found proved.

Learning Points:
The PCO is awaiting the outcome of PCCP hearing, after which there may be Learning Points for the membership.

Observations:
I have no concerns about the handling of this complaint in relation to the PCO and the IP. However, I raised a question about an issue that arose in the evidence and whether this suggests a change is needed. In this case, C said she had never experienced pins and needles before. But her patient notes had 'pins and needles' ticked. The IP noted that it could not determine when it had been ticked – presumably suggesting it might have been after the complaint was raised, which would have been a breach if proved.

This is usually the first time a patient is seeing their notes, and the first time they can spot errors, errors that might have a bearing on the way the complaint is approached by the IP.

The PCO has agreed and indicated that this would suggest that the BAcC should consider reverting to the process whereby Complainants are sent R's response, which should contain patient notes, to comment on. This process had been changed because it did not lead to fresh information or insights and potentially aggravated the situation. There are benefits and disadvantages for the BAcC to take into account when considering reversion to the previous practice.

Case 2 of 2025
Issues: Unprofessional conduct

This complaint related to a treatment C had received from R that had caused her discomfort and distress. She said that R had not respected her modesty when he asked her to undress to her underwear, appeared to be looking at her during treatment, touched her underwear without consent, and appeared to be looking down her bra.

R responded to the BAcC and denied the allegations. He said that C had been wearing a sports bra, which is not a garment he would have considered might have made C feel exposed, and she gave no sense that she was uncomfortable during the treatment. He explained that that level of exposure is common and was necessary to access the needling site. He explained that blankets have not been provided since Covid, but patients are invited to bring their own or to use an article of clothing to cover themselves. His practice is now to stay in the room with the patient during treatment in order to observe. He agreed that a practitioner should get consent when touching a patient's underwear but was unclear what the threshold was. He was not looking for a lost needle but accepted he might have fumbled when removing a needle but could not remember.

C responded and said that she was feeling vulnerable and was not able to vocalise her discomfort at the time. She believed that R should have checked her level of discomfort with that level of exposure. His movements were frenetic and confusing when he lifted her bra.

The complaint and response were received in late March and April 2025. BAcC prepared to establish an IP panel and a date was set for May, then delayed to June when no acupuncturist member was available. However, in late May the BAcC received a letter from R's solicitors with a formal response. This response also refuted the allegations and said the allegations had caused R distress.

There was then a delay in convening an IP, due to staff shortages at the BAcC. In September the PCO returned from leave and informed C and R that she would convene an IP. The IP meeting was held in November. Before the IP meeting, the BAcC requested R's patient notes, and R's solicitors informed the BAcC that R had been unable to find his patient notes.

The IP's consideration:
The IP considered the following allegations: a) that R asked C to undress to her underwear; b) that R watched C during treatment; c) that R touched C's underwear without consent; and d) that R looked inside C's underwear.

The IP acknowledged C's uncomfortable experience. The IP also noted the absence of patient notes.

On allegation a), the IP said that blankets should now be provided by the clinic but accepted that it was reasonable for R to ask C to undress in order to access the needling point that was used. On allegation b), the IP noted that there had been a failure to communicate the change in arrangements, whereby R now is present during treatments, but also noted that this is considered good practice. On allegation d), the IP found that C was very clear that R had looked inside her bra. R could not remember the appointment as clearly, and the IP stated that this is why patient notes are so important. The IP said that it was possible that R fumbled slightly on removing the needle, and acknowledged that there are occasions when it might be necessary to look at the location where the needle had been. This might be due to a lost needle or to check if there is any blood spotting. On allegations a), b), and d), the IP found that there was not a realistic prospect of a finding of misconduct and therefore no further action was needed.

On allegation c), the IP concluded that touching C's bra was likely to have a clinical justification. However, there was no evidence that R had obtained C's consent before doing so. Nevertheless, the IP determined that there was not a realistic prospect of a finding of misconduct. The IP decided to issue a Letter of Advice in relation to allegation c.

The Letter of Advice advised R:

- that it is good practice to ensure to obtain patient consent whenever touching their clothes and, in particular, their underwear. A note should be made of this in the patient notes. This is important so that patients feel safe and comfortable and do not have any questions in their minds about what is happening.
- That C was put in a confusing and unsettled position due to a lack of clear communication regarding the change in practice and the change in points which were to be used at this treatment, requiring removal of clothes. The IP emphasised how important it is that actions are not open to misinterpretation.
- to ensure that R complies with the requirement to have enough clean blankets and gowns available for patient modesty and warmth, now that the emergency Covid measures are no longer necessary.

The IP noted that it was also very concerned that the patient notes had been lost, given how important patient notes are for the protection of both R and his patients. The IP suggested that R undertake some additional CPD in relation to record keeping and communication.

Learning Points:

One Learning Point arose in this complaint, for the BAcC to include a statement in the initial letter to registrants to make registrants aware that once solicitors are instructed, the BAcC cannot speak directly to them about the case.

Observations:
This complaint involved a number of delays, which were due in part to staff absence but also to the delayed involvement of solicitors on behalf of R. There was therefore a relatively long period between the complaint being made and the IP meeting between held, of about eight months. Given this delay, the IP was reluctant to request an adjournment, although the PCO agrees that with hindsight, an adjournment might have resulted in a better decision. If does happen again, the IP should be advised accordingly.

The IP's consideration raises numerous questions, including about consistency as to how conflicts of evidence are dealt with, particularly in comparison with the approach taken by other IPs in other complaints. There was an acknowledged conflict of accounts in this complaint, but unlike in a previous complaint (3 of 2025), the IP did not see this as requiring testing through oral evidence.

C described a distressing experience and feeling frozen at the time, and the fact that she did not make her complaint until 14 months after the treatment could indicate trauma. The IP does not appear to consider this. The PCO has agreed that this will in future be highlighted to all IP members.

It is unclear whether this complaint was an alleged sexual assault, but the PCO did ask C if she had reported the incident to the police, indicating she was aware it was a potential alleged sexual assault. C replied that she did not want to report it to the police. It was correct, therefore, for the PCO to progress the complaint.

I am concerned that despite finding no realistic prospect of a finding of misconduct, the IP appeared to accept that there were a number of concerns about R's practice, including not obtaining explicit consent before treatment on a sensitive part of the body and not having patient notes to record consent or treatment. The Code of Professional Conduct s.8 requires registrants to keep patient records for a minimum of seven years, which was not done in this case. This is a potential public interest issue if R is unable to access notes of treatment for patients who make complaints and/or experience adverse reactions following treatment. The absence of patient notes also meant there was no information available to the IP identifying the condition being treated or the treatment used, so it is difficult to determine how the IP concluded what level of exposure was clinically justified. In my view, the absence of notes should have been included in the allegations to be considered by the IP, and the IP should have referred this point to the PCCP.

In addition, the IP appears not to have included in its decision any consideration of the issue of whether R had offered a chaperone, as required under s. 24 of the Code of

Professional Conduct. This was a serious omission on the part of the IP. The BAcC haas agreed to consider producing a case study for panel members on this issue.

Case 1 of 2025
Issues: Unprofessional conduct; unsafe practice

This complaint related to a severe reaction to acupuncture treatment that had occurred three years previously. C complained of continued debilitating pain and had been diagnosed with Complex Regional Pain Syndrome in her feet and said she was also experiencing PTSD from the trauma. She had been seen by a number of specialists and was undergoing pain management. She complained that during the treatment R did not remove the needles although she was in pain, that he twisted the needles despite her being in pain; and that he gave too strong a treatment, all of which she believed resulted in longlasting injury. She also complained that R mimicked her and patronised her during the treatment, that she was not in a position to give consent, and that after she raised her concerns following the treatment, he did not tell her she could make a complaint to the BAcC and made errors on the Adverse Incident Report (AIR) he submitted.

R responded via solicitors and refuted the allegations. He said that his treatment complied with the Gudie to Safe Practice; that C had not cried out in pain during treatment, and if she had he would have removed the needles; and that in any case it is not for the IP to determine causation. He also denied using the word 'dear', and he noted that he had submitted an AIR once he became aware of her difficulties following treatment. R explained that he has since taken steps to improve his notetaking and to include medical history, and had plans to create a new treatment form with a consent form that will give clearer pre-treatment explanations. Included with his response was a reflective piece with his reflections on and his learning from the complaint.

C submitted comments on R's response, and R's solicitors submitted a further response.

The IP's consideration:
The 8 allegations before the IP were that R:

1) failed to remove needles when C expressed pain and/or discomfort
2) twisted the needles despite C indicating she felt pain and/or discomfort
3) placed needles in inappropriate locations
4) behaved inappropriately
5) didn't take informed consent that warned C of risk fo nerve damage
6) failed to keep full case notes
7) failed to inform C she could make a complaint to the BAcC
8) submitted an AIR with inaccurate information and date

In terms of allegations 1, 2 and 4, the IP noted there was a conflict of evidence between C's and R's accounts. The IP concluded that there was a realistic prospect of a finding of misconduct and of impairment, and they referred these allegations to the PCCP.

On allegation 3, the IP considered that the points used by R were common ones and were appropriate for insomnia and anxiety. They concluded that no further action was needed on this allegation.

On allegations 5, 6 and 7, the IP agreed that consent was not recorded in the patient notes, that the patient notes did not contain the required information, and that R had not informed C that she could make a complaint to the BAcC. However, the IP noted that R acknowledged these breaches and had made changes to his practice to remedy that. The IP concluded that no further action was needed on this allegations.

On allegation 8, the IP considered these these issues were either out of time because they related to notes that dated more than three years before the complaint was made or they were mere administrative errors that should not be considered as part of fitness to practice.

Learning Points:
Several Learning Points for PCO arose in this complaint:

1. Limit the time given to complainant to make comments on the response, and explain this at an earlier stage. Also explain to complainants that the comments should only be used to clarify points that have arisen in the response and not to re-iterate what has already been said.
2. Do not allow the Complainant to redact their own medical notes/letters. If they do, make it clear that the unredacted documents will be needed if the matter goes to a hearing. This has been added to the initial letter to complainants.
3. Make it clear to Registrants that they are not sworn in as a witness. This is already within the witness information.
4. Review what is said to complainants/potential witnesses when told about PCCP hearing, and consider making it clearer/more explicit that if only certain allegations are referred to the PCCP, only material relating to those specific allegations will be referred to in the hearing and that other material will be redacted and not discussed. [actioned]
5. Review what witnesses are told, specifically about redactions. Explain their statements may be redacted to remove inadmissible or irrelevant information – for example their opinion or information about an allegation that is not being considered at the hearing. [actioned]
6. Review the declaration on the Complaint Form and especially make it clear that information about the patient's medical condition/history may be raised and scrutinised in the public hearing. [actioned]

Observations:
The PCO responded sensitively to C's request for an extension, although it put pressure on the timescale for the IP. The process was clearly distressing for C and this was acknowledged.

Following the PCCP meeting, C wrote to the PCO to complain about the gruelling experience of being a witness at a PCCP hearing. She was concerned about sensitive personal information being shared and said greater safeguards are needed to protect complainants. As noted in the Learning Points, the PCO has changed the Information for Witnesses document, taking into account C's comments and with the intention of better preparing witnesses and managing their expectations in future.

Among the allegations the IP determined, several were clear breaches of the Code of Professional Conduct (re inadequate notes and informing C how to make a complaint). I note that the IP concluded that because R had made promises to address these and therefore no further action was needed. However, I would have expected a Letter of Advice to be given. The guidance suggests this is the type of situation in which a Letter of Advice is appropriate. The BAcC has agreed to issue a reminder to IPs about the use of Letters of Advice.

Conclusions and recommendations

This has been a difficult year for the BAcC in terms of dealing with complaints. The PCO was on sick leave for a period and the interim PCO was only covering one day a week of the usual PCO time of three days a week. In some complaints this contributed to unnecessary delay and to frustration. It is good to know that a new PCO has been appointed who will work alongside the PCO, working two days a week.

It is very positive that in 2026, the BAcC has created a new system for learning. It has developed a Universal Learning Points document, primarily for safe practice and operational issues but also other issues. Any member of staff can report something on this document, but those most likely to are the Professional Conduct Department (arising from complaints), the Safe Practice Department (arising from AIRs or other reports) and PSA recommendations and conditions. This document should provide a clear route for all Learning Points. In addition, later this year a new member of staff will be recruited, part of whose role will be to follow up all Learning Points.

The Learning Points from cases in 2025 are:

1. The BAcC will consider drafting the allegations (with reference to the relevant BAcC Codes) before the complaint is submitted to the R.
2. The BAcC will also investigate why support for R from a Confidential Practitioner Support from the BAcC was delayed in one case.
3. Note preliminary checks on file checklist. [actioned]
4. Prepare guidance on when to apply for Interim Orders. [commenced but not completed]

5. Review Interim Orders as part of a general review of the whole complaint/professional conduct process in 2026. [to be actioned]
6. Prepare guidance on procedure to adopt when a conflict of interest arises for the PCO. [actioned: new policy prepared and approved by Governing Board]
7. Change time for response to be provided to 28 days, instead of 14 days. [actioned]
8. Make it clearer in initial letter to complainants that they are not a party to the proceedings, only a witness – change initial letter. [actioned] The following has been added to the Information for Complainants leaflet the statement in the Code of Disciplinary Procedures (section 1.3) which reads: '*Fitness to Practise proceedings are about protecting the public. They are not a general complaints resolution process. They are not designed to resolve disputes between Registrants and patients and/or clients.*'
9. Remind registrants about hygiene and location of giving treatments and also confidentiality and modesty.
10. PCO to obtain an updated list of Technical Assessors.
11. Remind registrants to include relevant family history in the patient notes and to note consent being given, and consider a webinar or Enews article on patient notes.
12. Include a statement in the initial letter to registrants to make registrants aware that once solicitors are instructed, the BAcC cannot speak directly to them about the case.
13. Limit the time given to complainant to make comments on the response, and explain this at an earlier stage. Also explain to complainants that the comments should only be used to clarify points that have arisen in the response and not to re-iterate what has already been said. [Note: One aspect of this Learning Point is to consider not routinely sending the response to complainants for comment. Other regulators such as the HCPC do not do this. This could help avoid delay in arranging an IP meeting. Currently the BAcC Rules say the response 'may' be sent to the complainant; this is in the discretion of the PCO. As one complaint this year highlighted, sending the response, with patient notes, to the complainant might provide a useful opportunity for the complainant to identify any errors in the notes that might have a material impact on the IP's decision.]
14. Do not allow the Complainant to redact their own medical notes/letters. If they do, make it clear that the unredacted documents will be needed if the matter goes to a hearing. This has been added to the initial letter to complainants.
15. Make it clear to Registrants that they are not sworn in as a witness. This is already within the witness information.
16. Review what is said to complainants/potential witnesses when told about PCCP hearing, and consider making it clearer/more explicit that if only certain allegations are referred to the PCCP, only material relating to those specific allegations will be referred to in the hearing and that other material will be redacted and not discussed. [actioned]
17. Review what witnesses are told, specifically about redactions. Explain their statements may be redacted to remove inadmissible or irrelevant information –

for example their opinion or information about an allegation that is not being considered at the hearing. [actioned]

18. Review the declaration on the Complaint Form and especially make it clear that information about the patient's medical condition/history may be raised and scrutinised in the public hearing. [actioned]

The initial stages of accepting a complaint can involve determining if a formal complaint is being made, and there can be substantial correspondence before a complaint is submitted. In one case this year, the PCO attempted to help C by seeking clinical advice from an acupuncturist colleague; this was a recognition that some complainants are seeking answers rather than wanting to pursue a fitness to practice process. However, in this case the clinical advice did not resolve the issue and the complaint proceeded. The PCO has explained that she plans not to do this in future once a complaint has been made.

I endorse all the above Learning Points. My additional recommendations are:

1. When using an Independent Legal Assessor, ensure appropriate advice is given to the IP.
2. Continue to provide hard copies to those registrants who request it.
3. Consider reverting to the process whereby Complainants are sent R's response, which should contain patient notes, to comment on.
4. Feed back my observations to the IP in case 2 of 2025.
5. Remind IPs of the need to record their consideration of allegations that a complaint is vexatious or malicious.
6. Remind IPs of the guidance on Letters of Advice.

Previous recommendations:

Below I set out previous years' recommendations and action points and their current status:

- Clarify obligations of interim practitioners and patient notes. **[actioned]**
- Mediation - In previous reports I have suggested that the BAcC consider incorporating independent mediation into their process, for complaints that do not involve concerns about safe practice and have an element of potential communication and customer service failures. I am pleased that the BAcC has been investigating a mediation service used by other professional bodies and may run a pilot later in the year. **[actioned]**
- Sharing complaints with relevant regulators**. [actioned?]**
- Guidance to address lack of clarity on term 'patient' vs friend. **[actioned – guidance on treating family and friends was produced in 2023]**

Last year was a difficult one for the BAcC in terms of handling complaints. This was due to staff shortages, causing delays; to a conflict of interest that arose; and also to the

complexity of the cases. Despite that, the BAcC continues to handle complaints well and to treat both complainants and registrants fairly and with compassion. The correspondence from the PCO to complainants and registrants is clear and sensitively worded. Improvements are made in the support and information given to IP members to enable them to consider and assess all the evidence, and further improvements are now logged as Learning Points.

Thank you for the opportunity to review the complaints made in 2025. I would like to acknowledge the continued support and cooperation of Caroline Jones, the BAcC Professional Conduct Officer.

Margaret Doyle
Independent Complaints Moderator, BAcC
April 2026