BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(22)15

AND

GARY MARSHALL (D-6494)

DETERMINATION OF A SUBSTANTIVE HEARING
15 NOVEMBER – 22 NOVEMBER 2022

Committee Members:	Ms Anne Johnstone (Chair/Lay) Mr Ben Summerskill (Lay) Ms Vivienne Geary (Lay) Mr Philip Cross (Dispensing Optician) Mr Ian Taylor (Dispensing Optician)
Legal adviser:	Mr Mike Bell
GOC Presenting Officer:	Ms Selena Jones
Registrant present/represented:	No and not represented
Hearings Officer:	Ms Abby Strong-Perrin
Facts found proved:	1 (a) – (g), 2, 3 (a) – (c) and 4 except in relation to 3 (c)
Facts not found proved:	None
Misconduct:	Found
Impairment:	Impaired
Sanction:	Suspension with review – 6 months
Immediate order:	Yes

Proof of service

1. The Committee heard an application from Ms Jones for the Council for the matter to proceed in the Registrant's absence. Firstly, the Council was required to satisfy the Committee that the documents had been served in accordance with Section 23A of the Act and Rule 61 of the Fitness to Practise Rules 2013.

2. Ms Jones referred the Committee to the Council's Service bundle and the Notice of Inquiry dated 4 August 2022. Ms Jones submitted that Notice had been properly served in accordance with Section 23A of the Act and Rule 61.

3. The Committee accepted the advice of the Legal Adviser. He referred the Committee to the Council's service bundle and Section 23A of the Act and Rule 61 of the Fitness to Practise Rules 2013.

4. The Committee considered the submissions of Ms Jones and all the relevant documentation before it.

5. The Committee was satisfied that all reasonable efforts had been made to notify the Registrant of the hearing in accordance with the Rules.

Proceeding in the absence of the Registrant

6. The Committee then went on to consider whether it would be in the public interest to proceed in the Registrant's absence in accordance with Rule 22.

7. Ms Jones, on behalf of the Council, submitted that the Committee should proceed in the Registrant's absence. She referred the Committee to Rule 22.

8. Ms Jones submitted that the GOC had made all reasonable efforts to obtain the Registrant's engagement in the hearing. She further submitted that the Registrant had not engaged in any manner with the GOC since around April 2020.

9. Ms Jones submitted that the Registrant has known about this hearing since August 2022, that there was no reason for his non-attendance and no reason to indicate that an adjournment might result in his attending on another occasion. Ms Jones submitted that it was in the public interest for the hearing to proceed in the Registrant's absence.

10. The Committee accepted the advice of the Legal Adviser. He referred it to the case of GMC v Adeogba [2016] EWCA Civ 162.

11. The Committee carefully considered the submissions of Ms Jones and all relevant representations from the Registrant and relevant productions.

12. The Committee considered that, in the circumstances, the Registrant had voluntarily absented himself from today's hearing and provided insufficient evidence to persuade it that, if the hearing did not proceed, he would engage at a future date. The Committee considered that the allegations were serious and raised issues of public protection. Several witnesses were on standby for this hearing. The matters go back to 2018, so as memories fade recall was likely to be less reliable were these matters to be adjourned.

13. The Committee determined that it would be in the public interest for the hearing to proceed in the Registrant's absence.

14. The Committee noted that should the Registrant wish to contact the Council or engage with this hearing as it progresses this course of action was open to him.

Allegation

The Council alleges that in relation to you, Mr Gary Marshall (D-6494), whilst employed as a Contact Lens and Dispensing Optician at Costco Wholesale UK Ltd located in REDACTED:

1. On one or more occasions between September 2018 and December 2020, you:

    a. failed to obtain the necessary authorisation from an Optometrist when altering the prescription of a patient;
    b. inappropriately modified the previous spectacle prescriptions of patients;
    c. failed to arrange for appropriate checks to be made by an Optometrist when dispensing new prescriptions;
    d. failed to undertake a dispensing triage;
    e. failed to keep an adequate record of your consultation with a patient, including but not limited to failing to record the patient's:

        i. visual acuity;
        ii. ocular history;
        iii. medical history;

    f. failed to refer a patient to an optometrist for further examination and/or checks where clinically indicated;
    g. failed to refer a patient for a new sight test where clinically indicated.

2. On one or more occasions between November 2020 and April 2021, you:

a. stated, when asked, that you had obtained the required approval from the resident Optometrist, Mr A, on each occasion that you had altered the prescription of patient:
b. had not obtained the required approval from Mr A to alter the prescriptions of patients on one or more occasion between September 2018 and December 2020;
c. knew that you had not obtained the required approval from Mr A to alter the prescriptions of patients on one or more occasion between September 2018 and December 2020;

3. Your actions as set out at paragraph 2 and 3 above were dishonest

Background

15. Mr Gary Marshall ("hereafter the Registrant") was employed by Costco Wholesale UK Limited ("Costco") at the company's REDACTED from 13 March 2000 to 28 December 2020.

16. An investigation was conducted by the Regional Operations Supervisor, Optical and Hearing, Mr B on 24 November 2020, due to the number of concerns which had arisen as a result of the number of spectacle remakes being required at the company's REDACTED branch. Mr B reviewed a number of patient records. It was during this review that concerns became apparent with the working practices of the Registrant.

17. It was identified that the Registrant had made changes to patients' prescriptions, had advised some patients to revert to using previous prescriptions and in other cases had advised a new prescription. The Registrant's employers could find no evidence contained within the records that either a registered Optometrist or person authorised to carry out a sight test had issued a new prescription. Neither could they find any evidence that any such person had provided the requisite authorisation to enable the Registrant to form the conclusions he had reached with respect to new prescriptions or the actions he undertook.

18. The Registrant is not an Optometrist or a person training to be an Optometrist. The Registrant does not fall within the category of Registrants who are permitted to carry out eye tests. There were a number of records identified by Mr B that indicated that patients did not appear to have been issued with a written statement which set out their updated prescription.

19. On 28 November 2020 Mr C, the General Manager and Mr B met with the Registrant, during which the Registrant conceded that he had carried out refractions and that he should not have done so. The Registrant was suspended with immediate effect.

20. An investigatory meeting was conducted on 7 December 2020 by Assistant Warehouse Manager, Mr D, with the Registrant. At this meeting the Registrant again appeared to accept that he had carried out the refractions but asserted that all changes were approved and checked by the resident Optometrist and that the resident Optometrist had failed to record these changes.

21. An investigatory meeting was conducted on 9 December 2020 with the resident Optometrist, Mr A, during which Mr A contradicted the account provided by the Registrant. The Registrant attended a disciplinary hearing on 12 December 2020 and was subsequently invited to attend a meeting so that the outcome of the disciplinary meeting could be communicated to him in person. Mr Marshall did not attend the subsequent meeting.

22. On 18 December 2020 a letter was sent to the Registrant by Mr C to inform him of the decision reached following the disciplinary hearing, namely Mr C:

    a. Had considered the Registrant's conduct to have substantially failed to meet the standards expected by Costco in his position as a registered professional.

    b. Had a reasonable belief that the Registrant's had acted outside of his scope of practice as a Dispensing Optician and in such a manner jeopardised patient safety.

    c. Was satisfied that the Registrant's actions amounted to gross misconduct and fundamentally damaged the company's trust and confidence in him.

23. Mr C outlined within the letter that there were sufficient grounds to justify the termination of the Registrant's employment contract without notice. However, Costco advised that the Registrant would be removed with immediate effect from the Optical Department, but would be permitted to work as a Cashier at another location due to his length of service within the organisation; with the view to his returning to his position subject to the determination of any GOC investigation.

24. Costco considered that the concerns identified in respect of the Registrant's practice were sufficiently serious to justify an escalation to the GOC, pursuant to "Standards for Optical Businesses".

25. Costco instructed registered Optometrist, Ms E, to provide a clinical opinion in respect of the relevant records. Ms E agreed with the concerns identified by Mr B and recommended that the affected patients be recalled for a further eye examination.

Application to Amend the Allegations

26. At the close of the GOC's case Ms Jones, on behalf of the GOC, applied to amend the allegations under Rule 46 (20).

27. Ms Jones provided the Committee with a 'marked-up copy' of the allegations with the proposed amendments highlighted. The application proposed to vary allegations 2 and 3 as follows:

    2. On one or more occasions between November 2020 and April 2021, you stated, when asked, that you had obtained the required approval from the resident Optometrist, Mr A, on each occasion that you had altered the prescription of patients between September 2018 and December 2020.

    3. a. you had not obtained the required approval from Mr A to alter the prescriptions of patients on one or more occasion between September 2018 and December 2020;

       b. you knew that you had not obtained the required approval from Mr A to alter the prescriptions of patients on one or more occasion between September 2018 and December 2020;
       c. you knew that you should not have altered the prescription of any patient without obtaining the required approval from an Optometrist.

    4. Your actions as set out at paragraph 2 and 3 above were dishonest

28. Ms Jones submitted that the proposed amendment did not change the nature of the regulatory concern underpinning the allegations nor expand the allegations. She submitted that the proposed amendment was administrative, providing clarity to any reader of the decision. Ms Jones further submitted that there was no prejudice to the Registrant in the allegations being amended and that it was in the public interest for this to be done.

29. The Committee accepted the advice of the Legal Adviser. He referred the Committee to Rule 46 (20).

30. The Committee considered that the proposed amendment did not change the nature of the allegations nor expand on the regulatory concerns underpinning them. The Committee also considered that the proposed amendment was to provide clarity for any reader of the decision.

31. The Committee was satisfied the proposed amendment could be made without any injustice to the Registrant and that to amend the allegation as suggested was in the public interest.

32. The Committee therefore granted Ms Jones' application to amend.

Submissions on behalf of the GOC

33. Ms Jones adopted her written skeleton argument and submitted that the Committee should find all the allegations proved. Ms Jones submitted that it was for the GOC to prove the allegations and the standard of proof required was the balance of probabilities.

34. She submitted that all the GOC witnesses were credible and reliable and that their evidence had 'a ring of truth'. Ms Jones further submitted the witnesses' evidence was consistent with each other and they had given evidence within their knowledge. Miss Jones further submitted that the Registrant's evidence had not been tested and was contrary to the evidence of the GOC witnesses, in particular Mr A.

Findings in relation to the facts

35. The Committee heard live evidence from Ms F, Mr D, Ms E, Mr A and Mr Trevor Hunter. All the witnesses adopted their witness statements and/or expert report and/or exhibits as their evidence in chief and answered supplementary questions from Ms Jones and questions from the Committee.

36. Ms F told the Committee that she currently worked as a full time Optical Supervisor at the optical department at Costco and at the time of the allegations she was the temporary manager of the department. Ms F explained that she commenced this role in 2019. She told the Committee that in this role her main responsibility was to oversee the day to day running of the department including writing rotas, approving staff work and dispensing spectacles. She said it was also her responsibility to deal with any issues that arose with staff.

37. Ms F explained that, in terms of refraction, the general procedure was that either Mr A or a locum Optometrist would undertake an eye test and, if a patient was experiencing any issues after collecting their spectacles, an appointment would be booked with the Registrant. Ms F told the Committee that if the Registrant found any issues with the prescription he would come and say to her that he needed to discuss his findings with Mr A. She said the Registrant would then come back and tell her that Mr A had authorised the changes and present a new prescription. Ms F stated that she had never seen the Registrant speak to Mr A and could not say definitively whether the Registrant had obtained his permission to alter any prescription.

38. Ms F stated that she was aware that the Registrant could change prescriptions with authorisation from the Optometrist. She said that it was the responsibility of the Optometrist to sign off changes to a prescription and make out a new

prescription. She said it was the Optometrist's responsibility to re-test a patient if required.

39. Ms F told the Committee that she originally became aware of the investigation into the Registrant in December 2020 when concerns were raised at the company because of the large number of remakes of spectacles being completed. She said that the Registrant had told her that the problem was with the prescriptions issued by Mr A.

40. In response to Committee questions, Ms F stated that the number of remakes and destroyed lenses had never been as high as it was during 2018 – 2020. She said she took the Registrant's word for it that remakes were due to problems with Mr A and that she, along with the Registrant and Mr D, had tried to get the district manager to investigate these concerns but he had 'kept out of it'. Ms F said when the Registrant changed the prescriptions it was always nearer to the patient's old prescription. Ms F told the Committee that when Mr A had started at Costco, he had been quiet and reserved, then became friendly with the Registrant, but latterly tensions developed between the Registrant and Mr A and they appeared less friendly. In conversation regarding the high level of spectacle remakes, the Registrant blamed Mr A for these and said to her: 'He can't test for toffee'.

41. The Committee determined that the various evidence given by Ms F was consistent and consistent with the evidence of other witnesses and the documentary evidence produced by her. The Committee considered her evidence was not inherently improbable.

42. Mr D told the Committee that he was the Assistant Manager of Costco at REDACTED and had known the Registrant in a professional capacity. He explained that in his role he was responsible for the running and oversight of ancillary departments including the optical department. He told the Committee that the manager of the optical department reported to him. Mr D explained that at the time of the alleged incidents the actual optical manager was absent due to illness and therefore Ms F was tasked with running the optical department.

43. Mr D stated that when he joined the branch at REDACTED, Mr A had recently been appointed as the resident Optometrist. Mr D explained that the 'waste figure' of spectacles which were required to be destroyed due to being remade was 'way above expectation' and abnormally high when compared to other branches.

44. Mr D explained to the Committee that he 'had a conversation' about these figures with Ms F and then the Registrant and that the Registrant had blamed the number of remakes on Mr A. Mr D said the Registrant had been 'very vocal' on this matter. Mr D said he had also spoken to Mr A about the high number of remakes.

45. Mr D stated that, as a result of these high figures, he started an investigation and asked the 'company's optical specialist' and area manager Mr B to come to the practice and investigate these technical concerns.

46. Mr D explained that Mr B had reviewed around 25 patient files and that this had uncovered evidence of a 'number of malpractices' in relation to the Registrant making changes to patients' prescription outside the Registrant's remit. He stated that the prescriptions changed included those of locums and prescriptions made by Optometrists outside Costco and that there was no documentation showing that the Registrant had permission to make these changes.

47. Mr D explained that as a result of this investigation the Registrant was suspended and subsequently interviewed. Mr D referred the Committee to the notes of investigation interviews with the Registrant produced by him. Mr D told the Committee that he had interviewed the Registrant on 7 December 2020 and that he 'was adamant' that he had made changes to prescriptions with Mr A's permission. When asked where the documentation was to confirm this, the Registrant had said that he had not checked if Mr A had documented his comments and that 'he had been foolish to trust him.' Mr D told the Committee there was no paper trail found to confirm the Registrant's assertions and that when asked about this, Mr A had stated that no such conversations had occurred and if they had he would have documented them. Mr D told the Committee that the Registrant had also made comments about obtaining permission from Mr A by leaving files on Mr A's desk for signing and it was not the Registrant's fault if this had not been done. Mr D explained that Mr A did not remember any such conversations and there was no record of them.

48. In answer to Committee questions, Mr D stated that he had checked weekly reports on waste at the branch and this is when he saw the high figures for waste and had talked to Ms F. When asked about the Registrant's suggestion in communications with the GOC that he had been the 'whistle blower', Mr D said that the Registrant had come to him to raise concerns and that the Registrant had been very vocal about his personal concerns about Mr A's practice. Mr D said that he had asked Mr A on numerous occasions about the Registrant's assertions that he had been given permission to make changes and that Mr A had initially been 'very vague' on whether these conversations had taken place. However, he subsequently became more adamant that they had not. Mr D said that the changes were 'very slight' on most occasions.

49. The Committee determined that the various evidence given by Mr D was consistent and consistent with the evidence of other witnesses and the documentary evidence produced by him. The Committee considered his evidence was not inherently improbable.

50. Ms E told the Committee that she was a qualified Optometrist and had joined Costco in 2015. She stated that she did not know the Registrant and had not worked at REDACTED.

51. She told the Committee that in November 2020 she had been contacted by Mr B who had asked her what a Contact Lens Optician (CLO) and Dispensing Optician (DO) were allowed to do with regards to amending prescriptions. Ms E said she told Mr B that, so far as she was aware, only certain parameters could be altered in specific situations, such as a change in the working distance or back vertex distance.

52. Ms E told the Committee that a few days later Mr B had called her and asked her to undertake a review of the 26 patient records where he had already identified concerns. Ms E explained how she had carried out this review and her conclusions. She stated that she concluded that a lot of prescriptions issued by an Optometrist had later been altered by the Registrant. She said she reached these conclusions based on comparisons of the handwriting on the prescription amendments with earlier samples of the Registrant's handwriting. Ms E stated that the prescriptions had been issued by external Optometrists, locum Optometrists and the resident Optometrist. She said there was no evidence of these changes being authorised other than one prescription on which the Registrant had written the words 'Ok with REDACTED [Mr A]', however Mr A's signature did not appear on that prescription.

53. Ms E explained that, whilst she had been asked to review 26 patient records, one was subsequently removed when it was discovered that the variation of the prescription had actually been carried out by an Optometrist.

54. Ms E told the Committee that she had recommended that the relevant patients be recalled for a sight test. She explained that if a prescription was changed without being checked and approved by an Optometrist there was a risk that the patient could receive the wrong prescription and that a clinical issue could be missed.

55. Ms E also told the Committee that in December 2020 she was asked to conduct an audit of the three Optometrists working at the branch and following this audit she had prepared a memo for Mr A pointing out where and how his record-keeping could be improved. She told the Committee that in this audit Mr A had scored 73.9%. She said she advised Mr A of this and when she conducted a second audit in February 2021 his record-keeping had improved and he scored 99.4%.

56. Ms E referred the Committee to the report/audits produced by her.

57. In response to questions from the Committee Ms E confirmed that she had no access to any patient records other than those provided to her. She also explained that in her original audit of Mr A's record keeping she had concluded that certain test results had not been recorded by him.

58. The Committee determined that the various evidence given by Ms E was consistent and consistent with the evidence of other witnesses and the documentary evidence produced by her. The Committee also considered that the views expressed by her were consistent with the conclusions of Mr Hunter, the expert witness for the GOC. The Committee considered her evidence was not inherently improbable.

59. Mr A told the Committee that he had qualified as an Optometrist around 2014. He explained his employment history and that he had worked as the resident Optometrist at Costco's REDACTED branch since about 2019. He explained that it was his responsibility to conduct routine eye tests as well as contact lens checks.

60. Mr A told the Committee that he first met the Registrant when he started working at the REDACTED branch and that he knew him as a colleague.

61. Mr A explained that he first became aware of concerns regarding amendments to patient prescriptions when an investigation was launched into an unusually high proportion of spectacle remakes in 2020.

62. Mr A explained to the Committee that sight tests were carried out by a qualified Optometrist. He said that if a patient was experiencing non-tolerance issues with new spectacles, the patient would initially see the Registrant to allow him to investigate the issues. Mr A stated that the Registrant would check if there were dispensing issues before considering if the prescription needed to be looked at again. After checking the fit and measurements of the spectacles and ensuring that they were made up to the correct prescription, the Registrant would then check the prescription by undertaking a refraction. Mr A said he assumed this was within the Registrant's professional remit. He said he now realised that it was not acceptable for the Registrant to perform full refractions in order to modify a prescription.

63. Mr A told the Committee that 'he did not recall' signing off, either verbally or in writing, any refractions undertaken by the Registrant and if he had done so he would have annotated the patient's record accordingly.

64. Mr A stated that the Registrant would undertake a refraction and if he found a change the Registrant would 'bypass me' and ask dispensing staff to make and dispense glasses according to the Registrant's findings. Mr A stated that these changes were not verified or authorised by him, nor did the Registrant ask Mr A to authorise any changes.

65. Mr A told the Committee that he had been interviewed by Mr D on 9 December 2020 and 8 January 2021 and referred the Committee to the notes of these interviews produced by him.

66. In answer to questions from the Committee, Mr A said he considered that Ms E's criticism of his record-keeping related to minor matters, 'just housekeeping as opposed to anything else'.

67. The Committee considered that Mr A was initially somewhat reticent when answering questions. However, the Committee overall determined that his various evidence was consistent and consistent with the evidence of other witnesses and the documentary evidence produced by them. The Committee considered his evidence was not inherently improbable.

68. Finally, the Committee heard from Mr Hunter.

69. Mr Hunter referred the Committee to his expert report that set out his remit, the documentation he had received and background to the issues upon which he was asked to express his views.

70. Mr Hunter explained that a Registered Optometrist could legally carry out a sight test and what this would consist of. He further explained that a registered Dispensing Optician was trained to interpret prescriptions supplied by an Optometrist. He further stated that if an Optometrist delegates a task the Optometrist still remains 100% responsible for that task.

71. Mr Hunter said that the records he had been asked to review were not comprehensive and, in particular, where the Registrant had carried out refraction, no visual acuity had been recorded. Mr Hunter stated that the notes he had reviewed were extremely poor in many ways. For example, he would have expected at least an initial dispensing triage to have been carried out. He said that most organisations had triage forms, but he could see no evidence of Costco having any triage forms.

72. Mr Hunter told the Committee that in general the prescriptions had been modified to a prescription between the patient's old spectacle prescription and the current spectacles. He said the changes were small changes and not fundamental, but that Dispensing Opticians should not be making these findings. Contact Lens Opticians are used to carrying out over refractions where a contact lens is in place. In every case they should be recording the visual acuities. However, when prescribing spectacles they should go back to the original Optometrist or prescriber who would issue a new prescription. Some 9 out of the 25 patient records reviewed involved external prescriptions [i.e. not from Costco] so there was no record or history for those patients. In those cases the Dispensing Optician should have spoken to the original prescriber or Optometrist to check or issue any new prescriptions. He referred, as an example, to the finding in his report concerning the record of patient H to highlight the potential for patient harm arising from the lack of appropriate patient care in the management of this patient. Patient H had a sight test in August 2019, was dispensed in Costco in February 2020 due to Covid but was not able to complain about the vision in their new spectacles until October 2020. The Registrant then altered the prescription

without referring to the original prescriber or, after a period of 14 months, organising a new sight test for the patient.

73. Mr Hunter told the Committee that his findings indicated a lack of good communication between the Optometrist/s and the Registrant and revealed a fundamental error in appropriate procedure. Notwithstanding the apparent lack of appropriate operating procedures or protocols at Costco the Registrant should have known the parameters of his practice and in justification for what he was doing should not have hidden behind his claim that it was in the patients' best interests.

74. Mr Hunter stated that he had identified 15 cases where he believed that the Registrant's standards of care were not that expected of a reasonably competent Dispensing Optician. He stated that they mainly relate to small changes in the prescription by the Registrant.

75. Mr Hunter further stated that in 10 other cases he felt that the standards of care fell seriously below the standard to be expected. He explained that in these cases the cause of the symptoms could have been due to issues other than a change in prescription. Mr Hunter stated these cases should have been referred to an Optometrist particularly where no other ocular history was available.

76. Mr Hunter also stated that a sight test was a protected function and as such falls totally under the responsibility of the registered Optometrist or Ophthalmic Medical Practitioner. He commented that certain tasks might be delegated, but nevertheless remained the responsibility of the Optometrist and therefore the Optometrist must review the results of such delegated functions and record them. Mr Hunter stated that the actions carried out by the Registrant were not merely a part of a delegated function, as he made the new spectacles to prescriptions he issued. As such Mr Hunter stated that the Registrant acted contrary to the protected function of sight testing.

77. The Committee was satisfied that Mr Hunter was an appropriate expert and that the views expressed by him were that of an expert witness. The Committee further noted that no expert opinion had been produced disagreeing with his views. The Committee accepted the views expressed by Mr Hunter in his expert report and oral evidence before it.

78. The Committee also took into account all representations before it from the Registrant. It bore in mind that these had not been tested by cross-examination or questions from the Committee and applied the appropriate weight to them.

Reasons for the Committee's Decision

79. The Committee accepted the advice of the Legal Adviser. He referred the Committee to the cases of *Suddock v NMC [2015] EWHC 3612(Admin), Dutta v*

GMC [2020] EWHC 1974 (Admin) and *Khan v GMC [2021] EWHC 374 (Admin)* in respect of witness evidence and the case of *Ivey v Genting Casinos (UK) Ltd* [2017] UKSC 67 in relation to the test for dishonesty. He gave a 'good character direction', in relation to the Registrant having no previous regulatory concerns.

80. The Committee considered each allegation and sub-limb in turn. In reaching its decision the Committee considered how the relevant witnesses' oral evidence fitted with non-contentious or agreed facts, contemporaneous documents, the inherent probability or improbability of any account of events and any consistencies and inconsistencies. The Committee took into account that it was for the GOC to prove the allegations and that the standard of proof was the balance of probabilities.

81. The Committee took account of all the evidence before it, the submissions of the Ms Jones and accepted the advice of the Legal Adviser.

Allegations

Allegation 1

1. On one or more occasions between September 2018 and December 2020, you:

a. failed to obtain the necessary authorisation from an Optometrist when altering the prescription of a patient;

82. The Committee took into account the evidence of Ms F, Mr D, Ms E, Mr A and Mr Hunter.

83. The Committee first considered whether the Registrant was under an obligation to obtain the necessary authorisation from an Optometrist when altering the prescription of a patient.

84. The Committee noted the expert evidence of Mr Hunter that, whilst the alteration of a prescription for a patient could be delegated, it remained the responsibility of the Optometrist. The Committee also noted that this was the view also expressed by Ms E and Mr A.

85. The Committee was satisfied that there was an obligation on the Registrant, during the periods set out in the allegation, to obtain the necessary authorisation from an Optometrist when altering the prescription of a patient.

86. The Committee therefore went on to consider whether such authorisation had been obtained. The Committee noted the evidence of Ms F, Mr D, Mr A, Ms E and Mr Hunter. The Committee also considered the representations from the Registrant and the relevant documentation before it.

87. The Committee considered that the evidence of all the witnesses for the GOC was that there was no authorisation recorded on the patients' records from Mr A or any other Optometrist. The Committee also took into account that the Registrant appears to accept that there is no such formal authorisation and that his position is that he had obtained verbal authority from Mr A to alter the patient's prescription and that Mr A had not recorded this. The Committee noted that Ms F had stated that the Registrant had advised her on occasions that he had obtained Mr A's authority, but she personally had never been present when such authority had been given.

88. The Committee considered that the evidence of the GOC witnesses was consistent with each other. It considered that the Registrant's representations had been untested by cross-examination or questions from the Committee and that his position was not supported by any other evidence

89. In all the circumstances, the Committee determined that on the balance of probabilities no verbal authority had been given by Mr A or any Optometrist to the Registrant.

90. The Committee also noted the evidence of Mr Hunter and the GOC witnesses that there was a lack of any authorisation on a number of patient records. The Committee considered that the evidence of the witnesses was also consistent with the patient records provided to it.

91. The Committee therefore determined that, on the balance of probabilities, on one or more occasions between September 2018 and December 2020 the Registrant failed to obtain the necessary authorisation from an Optometrist when altering the prescription of a patient.

92. Allegation 1.a is therefore found proved.

b. inappropriately modified the previous spectacle prescriptions of patients;

93. The Committee again took into account the evidence of Ms F, Mr D, Ms E, Mr A and Mr Hunter. It again took into account the representations of the Registrant.

94. For the same reasons as set out in relation to allegation 1.a, the Committee considered that the evidence of the GOC's witnesses was consistent and that the Registrant's representations were untested and not supported by other direct evidence.

95. The Committee was therefore satisfied on the balance of probabilities that on one or more occasions between September 2018 and December 2020 the Registrant had inappropriately modified the previous spectacle prescriptions of patients.

96. Allegation 1.b is therefore found proved.

c. failed to arrange for appropriate checks to be made by an Optometrist when dispensing new prescriptions;

97. The Committee again took into account the evidence of Ms F, Mr D, Ms E, Mr A and Mr Hunter. It again took into account the representations of the Registrant.

98. For the same reasons as set out in relation to allegation 1.a, the Committee considered that the evidence of the GOC's witnesses was consistent and that the Registrant's representations were untested and not supported by other evidence.

99. The Committee therefore determined that, on the balance of probabilities, on one or more occasions between September 2018 and December 2020 the Registrant failed to arrange for appropriate checks to be made by an Optometrist when dispensing new prescriptions.

100. Allegation 1.c is therefore found proved.

d. failed to undertake a dispensing triage;

101. The Committee took into account the evidence of Ms E, Mr A and Mr Hunter. It again took into account the representations of the Registrant.

102. For the same reasons as set out in relation to allegation 1.a, the Committee considered that the evidence of the GOC's witnesses was consistent and that the Registrant's representations were untested and not supported by other evidence.

103. The Committee therefore determined that, on the balance of probabilities, on one or more occasions between September 2018 and December 2020 the Registrant failed to undertake a dispensing triage.

104. Allegation 1.d is therefore found proved.

e failed to keep an adequate record of your consultation with a patient, including but not limited to failing to record the patient's:
i. visual acuity;
ii. ocular history;
iii. medical history;

105. The Committee again took into account the evidence of Ms E, Mr A and Mr Hunter. It again took into account the representations of the Registrant.

106. For the same reasons as set out in relation to allegation 1.a, the Committee considered that the evidence of the GOC's witnesses was consistent and that the Registrant's representations were untested and not supported by other evidence.

107. The Committee therefore determined that, on the balance of probabilities, on one or more occasions between September 2018 and December 2020 the Registrant failed to keep adequate records of his consultation with a patient, including, but not limited to, failing to record the patients' (i) visual acuity (ii) ocular history (iii) medical history.

108. Allegation 1.e is therefore found proved in its entirety.

f. failed to refer a patient to an Optometrist for further examination and/or checks where clinically indicated;

109. The Committee again took into account the evidence of Ms E, Mr A and Mr Hunter. It again took into account the representations of the Registrant.

110. For the same reasons as set out in relation to allegation 1.a, the Committee considered that the evidence of the GOC's witnesses was consistent and that the Registrant's representations were untested and not supported by other evidence.

111. The Committee therefore determined that, on the balance of probabilities, on one or more occasions between September 2018 and December 2020 the Registrant failed to refer a patient to an Optometrist for further examination and/or checks where clinically indicated.

112. Allegation 1.f is therefore found proved.

g. failed to refer a patient for a new sight test where clinically indicated.

113. The Committee again took into account the evidence of Ms E, Mr A and Mr Hunter. It again took into account the representations of the Registrant.

114. For the same reasons as set out in relation to allegation 1.a, the Committee considered that the evidence of the GOC's witnesses was consistent and that the Registrant's representations were untested and not supported by others.

115. The Committee therefore determined that, on the balance of probabilities, on one or more occasions between September 2018 and December 2020 the Registrant failed to refer a patient for a new sight test where clinically indicated.

116. Allegation 1.g is therefore found proved.

Allegation 2

2. On one or more occasions between November 2020 and April 2021, you stated, when asked, that you had obtained the required approval from the resident Optometrist, Mr A, on each occasion that you had altered the prescription of patients between September 2018 and December 2020.

118. The Committee again took into account the evidence of Ms F, Mr D, Ms E, and Mr A. It again took into account the representations of the Registrant.

119. The Committee also took into account the notes of various internal interviews with the Registrant that had occurred in Costco during the relevant period.

120. The Committee noted that within the notes of these interviews the Registrant had asserted on different occasions that he had obtained the verbal consent of Mr A to alter the prescriptions of patients between September 2018 and December 2020. These notes were consistent with the evidence of the GOC witnesses. Further, the Committee noted that the Registrant did not dispute that he had stated that he had obtained the verbal authority of Mr A to act in this manner.

121. The Committee therefore considered that, on the balance of probabilities, the Registrant had on one or more occasions between November 2020 and April 2021 stated, when asked, that he had obtained the required approval from the resident Optometrist, Mr A, on each occasion that he had altered the prescription of patients between September 2018 and December 2020.

122. Allegation 2 is therefore found proved.

Allegation 3

a. You had not obtained the required approval from Mr A to alter the prescriptions of patients on one or more occasion between September 2018 and December 2020;

123. The Committee has already found in terms of allegation 1 that on one or more occasions during the relevant period set out in allegation 3.a the Registrant had failed to obtain the necessary authority from an Optometrist when altering the prescription of a patient.

124. Having found this allegation proved, the Committee considered that the failure to 'obtain the necessary authority from an Optometrist' also included obtaining required approval from Mr A to alter the prescription of patients during the relevant period.

125. The Committee therefore considered that, on the balance of probabilities, the Registrant had not obtained the required approval from Mr A to alter the prescriptions of patients on one or more occasion between September 2018 and December 2020.

126. Allegation 3.a is therefore found proved.

b. you knew that you had not obtained the required approval from Mr A to alter the prescriptions of patients on one or more occasion between September 2018 and December 2020

127. For the reasons set out in respect of the limbs of allegation 1, the Committee has found that it did not accept the Registrant's assertions that he had obtained authority from Mr A to alter the prescription of patients during the relevant period.

128. The Committee therefore considered that, on the balance of probabilities, the Registrant was aware that he had not obtained the required approval from Mr A to alter the prescriptions of patients on one or more occasion between September 2018 and December 2020.

129. Allegation 3.b is therefore found proved.

c. knew that you should not have altered the prescription of any patient without obtaining the required approval from an Optometrist.

130. The Committee took into account that during the internal investigation interviews with Costco the Registrant had repeatedly asserted that he had the required approval from an Optometrist to alter the prescription of patients. Further, the Committee took into account that in the initial interview dated 28 November 2018, in reply to a statement that 'But your [sic] not qualified to see patients regarding eye examinations' the Registrant had replied 'Yeah I know I have been stupid'.

131. The Committee further took into account the evidence of Ms E, Mr A and Mr Hunter (the expert witness) that it was clear that the Registrant should not have altered any patient prescription without obtaining the required approval from an Optometrist.

132. The Committee considered that it was inherently improbable that the Registrant was not aware of this.

133. The Committee therefore considered that, on the balance of probabilities, the Registrant knew that he should not have altered the prescription of any patient without obtaining the required approval from an Optometrist.

134. Allegation 3.c is therefore found proved.

Allegation 4

Your actions as set out at paragraph 2 and 3 above were dishonest

135. In considering allegation 4, the Committee applied the test for dishonesty as set out in the case of Ivey.

136. The Committee first considered the actual state of the Registrant's knowledge or belief.

137. In relation to allegations 2 and 3.a and b, the Committee considered that the Registrant pro-actively sought to persuade others during the period between November 2020 and April 2021 that he had obtained any required approval and did so knowing this was not the case.

138. In relation to 3.c the Committee considered that the Registrant's subjective individual belief at the point at which he made these comments was that it was appropriate for him to have altered the patients' prescriptions and that it was for the benefit of the patients. In view of the culture due to past practice with former Optometrists, acceptance by current colleagues and lack of apparent relevant protocols and procedures laid down by Costco, it might explain why his practices had gone unchallenged.

139. Consequently, the Committee considered that ordinary decent people would consider the Registrant's acts in allegation 2 and 3.a and b to be dishonest but not in relation to 3.c

140. Allegation 4 is therefore found proved but only in respect of allegations 2 and 3.a and b.

Misconduct

141. Ms Jones adopted her skeleton argument and submitted that the Committee should find the facts proved amounted to misconduct. She referred the Committee to the cases of *Roylance v General Medical Council (No.2)* [2000] 1 A.C. 311 and *Remedy UK Ltd v General Medical Council* [2010] EWHC 1245 (Admin).

142. Ms Jones submitted the facts found proved fell far short of the standards to be expected of a Contact Lens Optician and, in particular, that the Registrant was in breach of Standards 16 and 17 of the GOC's Standards of Practice for Optometrists and Dispensing Opticians (the Standards.)

143. In reaching its decision in respect of misconduct the Committee had regard to the submissions of Ms Jones on behalf of the Council and the representations before it from the Registrant. The Committee took account of its prior decision on facts, the evidence of the GOC witnesses and all relevant documentation.

144. The Committee accepted the advice of the Legal Adviser. He referred the Committee to cases including *Roylance v NMC* 1 AC 311, *Calheam v GMC* [2007] EWHC 2606.

145. The Committee considered all of the allegations found proved. The Committee took into account the evidence of the expert witness Mr Hunter. In particular, the Committee accepted Mr Hunter's evidence that he considered that the Registrant's actions in relation to 10 of the patient records provided to him fell far below the standard to be expected of a Contact Lens Optician.

146. In relation to all the limbs of allegation 1 found proved, the Committee was satisfied that the Registrant's acts and failures fell far below the standard to be expected of a Contact Lens Optician.

147. The Committee considered that the Registrant's actions and failures found proved in allegation 1 constituted breaches of Standards 6,7, 8 and 10 that state:

'As an optometrist or dispensing optician you must:

6 Recognise, and work within, your limits of competence

7 Conduct appropriate assessments, examinations, treatments and referrals

8 Maintain adequate patient records

10. Work collaboratively with colleagues in the interests of patients

148. In relation to the facts found proved in allegations 2, 3(a), (b) and (c) and 4, the Committee considered that the Registrant had sought to pro-actively state that he had obtained the approval of Mr A when altering the prescriptions when he knew that this had not occurred. The Committee considered that he had breached the trust placed in him by Costco and his colleagues and patients.

149. The Committee determined that the Registrant's dishonest behaviour was not a 'one off' event,but occurred on more than one occasion. The Committee considered that the Registrant's conduct constituted breaches of standards 16 and 17 that state:

'16. Be honest and trustworthy

17. Do not damage the reputation of your profession through your conduct .'

150. The Committee determined that the Registrant's conduct was serious and fell far below the standards to be expected of a Contact Lens Optician. It considered that the conduct would be viewed as deplorable by fellow members of the profession. As such the Committee determined that the facts found proved amounted to misconduct.

Impairment

151. The Committee next went on to decide whether as a result of the misconduct, the Registrant's fitness to practise is currently impaired.

152. Ms Jones again adopted her skeleton argument. She referred the Committee to the GOC's Hearings and Indicative Sanctions Guidance (Sanctions Guidance), in particular sections 15 and 16. Ms Jones referred the Committee to the case of *CHRE v NMC and Grant* [2011] EWHC 927 (Admin) and *Yeong v GMC* [2009] EWHC 1923 (Admin).

153. Ms Jones submitted that the Registrant had not recently engaged with the GOC and had shown no remorse, insight or remediation. She submitted that the Registrant had not accepted his wrongdoing. Ms Jones stated that the allegations were serious and the public had suffered damage.

154. The Committee accepted the advice of the Legal Adviser. He referred the Committee to the cases of *Grant, Cohen v GMC* [2008] EWHC 581 (Admin) and *Sawati v GMC* [2022] 283 (Admin).

155. In this regard the Committee considered the judgment of Ms Justice Cox in the case of CHRE v NMC and Grant in reaching its decision. In paragraph 74, she said:

'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

156. In paragraph 76, Ms Justice Cox referred to Dame Janet Smith's "test" which reads as follows:

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:

a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or

b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or

c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or

d) has in the past acted dishonestly and/or is liable to act dishonestly in the future.'

157. The Committee determined that all the limbs were engaged.

158. The Committee adopted the approach for 'rejected defences' as set out in *Sawati.* In particular it noted paragraphs 103 to 108 of *Sawati* that states:

103. The principle of due process may not be sophisticated or complicated. The principle of protecting the public from practitioners who cannot accept or deal with findings of fault, and are at risk of repeating their failings, is not complicated either. Reconciling the two may however be difficult in an individual case, and is undoubtedly fact-sensitive. So the question is how best to approach the facts of a given case. I have recounted the caselaw at some length, to identify not just guidance of principle, but also the pattern of relevant factors to which the appellate courts have consistently attached importance. The following stand out.

104. First: the primary allegations against the doctor. The proper place of dishonesty (or other states of mind such as 'deliberate' and 'knowing') in the scheme of the allegations matters. A rejected defence of honesty may be more fairly relevant to an overall assessment of conduct where dishonesty (the noun) is the primary allegation - deceit, fraud, forgery or similar – than where 'dishonestly' (the adverb) is a secondary allegation, aggravating a primary allegation of other misconduct which may or may not be done honestly – or not a formal allegation at all. As Lord Hoffmann emphasised, particular alertness is needed to the 'charging trap': adding 'dishonestly' to a primary allegation to aggravate it disproportionately, colour any denial of the primary allegation with dishonesty, or characterise denial of the dishonesty as itself dishonest or lacking insight. But even short of oppressive charging, the fair relevance to sanction of a doctor's rejected honesty defence depends on its relationship to what they were primarily defending.

105. Second: what if anything the doctor is positively denying. There is a difference between denying 'primary facts' – what happened and what the doctor did or did not do – and denying 'secondary facts' – the evaluation of the primary facts through the lens of what the doctor knew or thought and the choices available to them. Resistance to the objectively verifiable is potentially more problematic behaviour (and more relevant to sanction) than insistence on an honest subjective perspective. This is not of course an exclusive binary classification: what a doctor thinks or knows will often have to be deduced evidentially from objective circumstances. A secondary fact such as dishonesty may be inferred in some defended cases from an overwhelming accumulation of primary facts. If a doctor denies their alleged state of mind with a defence at the unreal, unreasonable or 'frankly ludicrous' end of the spectrum, that may be more fairly relevant to sanction

than one where the only thing being denied is that dishonesty rather than honest mistake gives the better account of things.

106. Third: whether there is evidence of lack of insight other than the rejected defence. Before a rejected defence is held to be relevant evidence of 'lack of insight', it is necessary to consider what other evidence of insight or lack of insight is present. There are cases, including some of the sexual impropriety cases, where being 'in denial' up to and including sanction proceedings is a richly evidenced course of conduct, in which a range of supportive and restrictive interventions have demonstrably failed to bring a doctor to a proper, fair and reasonable acknowledgment of the reality of their established problems and failings. At the other end of the spectrum, there are cases in which the only evidence of failure of insight seems to be robust defence at the factfinding stage. Damascene conversions aside, a rejected defence which on a fair analysis adds to an evidenced history of faulty understanding is more likely to be relevant fairly to sanction than one said to constitute such faulty understanding in and of itself.

107. (I am not myself assisted by analogy with criminal proceedings in this respect. A plea of guilty can secure a mitigation of sentence because it spares the victim and the public purse the human and financial cost of a trial. The risk the offender may or may not pose to the public is dealt with in other ways. Insight is a genuine and proper issue in professional regulatory proceedings in and of itself. But as such it needs to be properly considered on a substantive and not just a procedural basis.)

108. Fourth: the nature and quality of the rejected defence. 'Not telling the truth to the Tribunal', when not freshly charged in separate proceedings as akin to perjury, has to amount to something more than a failure to admit to an allegation (especially a secondary allegation of dishonesty) or a putting to proof, before it can properly count against a doctor. It is likely to have to amount to more than offering an 'honest' alternative explanation of events alleged to be explicable as dishonesty, or it is hard to see how a dishonesty charge is to be effectively defended. It is going to require some thought to be given to the nature of the rejected defence. Was it a blatant and manufactured lie, a genuine act of dishonesty, deceit or misconduct in its own right? Did it wrongly implicate and blame others, or brand witnesses giving a different account as deluded or liars? Or was it just a failed attempt to tell the story in a better light than eventually proved warranted?

159. The Committee considered the Registrant's rejected defence in line with the approach as laid out in *Sawati.* The Committee considered its determination on facts and concluded that the allegation 4 found proved related to an allegation where dishonesty is the primary allegation as defined in paragraph 104 of *Sawati.* The Committee further determined that the Registrant in his defence was positively denying a primary fact, namely his actual state of knowledge that he had not obtained the approval of Mr A to alter the patients' prescriptions. The Committee also bore in mind the third and fourth limbs of the approach in *Sawati* when assessing the issue of the Registrant's current fitness to practise, namely

whether there is additional evidence of 'lack of insight' and the nature and quality of the rejected defence.

160. The Committee considered that it had no evidence before it that the Registrant had demonstrated insight into the nature and extent of his misconduct, or its consequences for colleagues, other members of the profession, or public confidence in the profession and the Council as regulator. Further, the Committee considered that the Registrant had not demonstrated any regret or remorse.

161. The Committee took into account the positive testimonials provided on behalf of the Registrant.

162. The Committee also considered that the Registrant's misconduct was potentially remediable.

163. The Committee determined that the Registrant had not demonstrated that he had addressed the regulatory concerns arising from his misconduct and concluded that he had not remediated his misconduct.

164. The Committee determined that as a result of the Registrant's lack of insight and remediation there remains a risk of repetition.

165. It therefore decided that a finding of impairment is necessary on the grounds of public protection.

166. The Committee further concluded that a finding of no impairment would be tantamount to giving an indication on behalf of the profession that the misconduct need not have regulatory consequences. The Committee determined that a finding of impairment on public interest grounds is required because public confidence in the profession and in the regulator would be undermined if a finding of impairment were not made in this case.

167. Having regard to all of the above, the Committee was satisfied that the Registrant's fitness to practise is currently impaired both on the grounds of public protection and public interest.

Sanction

167. Having determined that the Registrant's fitness to practise is impaired, the Committee has considered what sanction, if any, it should impose.

168. Ms Jones referred the Committee to the Sanctions guidance and the cases including *Bolton v Law Society* [1994] 2 All E R 486 and *Siddiqui v GMC* [2013] 1883. Ms Jones submitted that given the Registrant's dishonesty there were no conditions that could be put in place that would protect the public and maintain public confidence in the profession. Ms Jones further submitted that the Committee must act proportionately.

169. In reaching its decision in respect of sanction the Committee had regard to the submissions of Ms Jones on behalf of the Council and the representations before it from the Registrant. The Committee took account of its prior decision on facts, the evidence of the GOC witnesses and all relevant documentation.

170. The Committee heard and accepted the advice of the Legal Adviser.

171. The Committee also had regard to the Sanctions Guidance issued by the GOC.

172. The Committee has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. It recognised that the decision on sanction is a matter for the Committee, exercising its own independent judgement.

173. Before making its decision on the appropriate sanction, the Committee established the aggravating and mitigating factors in this case.

174. The Committee considered that the aggravating factors in this case were:

- The dishonesty occurred on more than one occasion;
- The Registrant attempted to divert blame for the lack of recorded authorisation to a colleague;
- Abuse of position of trust;
- Lack of insight;
- Lack of an apology or remorse;
- Failed to act collaboratively with a colleague.

The Committee considered that the mitigating factors in this case were:

- No evidence that actual harm was caused to patients;
- The Registrant had previously carried out similar alterations of prescriptions albeit with the authority of an Optometrist;
- The Registrant considered that he was acting in the best interests of the patients;
- Positive testimonials from former colleagues.

175. The Committee considered the sanctions available to it from the least severe to the most severe.

176. The Committee first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The Committee decided that it would be neither proportionate nor in the public interest to take no further action.

177. The Committee then considered whether to impose a financial penalty. However, it determined that these matters are too serious for a financial penalty to be considered appropriate or sufficient to reflect adequately the public interest.

178. The Committee next considered the imposition of a Conditional Registration Order.

179. The Committee noted the terms of paragraph 21.25 of the Sanctions Guidance which states:

21.25 Conditional registration may be appropriate when most, or all, of the following factors are apparent (this list is not exhaustive):

1. *No evidence of harmful deep-seated personality or attitudinal problems.*
2. *Identifiable areas of registrant's practise in need of assessment or retraining.*
3. *Evidence that registrant has insight into any health problems and is prepared to agree to abide by conditions regarding medical condition, treatment, and supervision.*
4. *Potential and willingness to respond positively to retraining.*
5. *Patients will not be put in danger either directly or indirectly as a result of conditional registration itself.*
6. *The conditions will protect patients during the period they are in force.*
7. *It is possible to formulate appropriate and practical conditions to impose on registration and make provision as to how conditions will be monitored.*

180. The Committee determined that there was no evidence before it of potential and willingness to retrain, there was no evidence of insight or remorse and conditions would not protect patients during the period they are in force given the Registrant's dishonest misconduct. Further, the Committee determined that, whilst conditional registration might address clinical failures, it is difficult to formulate conditions in cases where dishonesty has been found.

181. In light of this, the Committee determined that there were no practical or workable conditions that could be formulated at this time which would adequately address the concerns in this case and protect the public and the wider public interest.

182. The Committee then went on to consider whether a suspension order would be an appropriate sanction.

183. The Committee noted the Sanctions Guidance stated that in considering whether a suspension order would be an appropriate sanction a Committee should consider:

"Does the seriousness of the case require temporary removal from the register? Will a period of suspension be sufficient to protect patients and the public interest?"

184. The Committee considered the nature of the Registrant's dishonest misconduct. It noted paragraphs 22.4 and 22.5 of the Sanctions Guidance that states:

22.4 There is no blanket rule or presumption that erasure is the appropriate sanction in all cases of dishonesty

22.5 When deciding on the appropriate sanction on dishonesty, the Committee must first assess the particular conclusions about the act of dishonesty itself, then, it must consider the extent of the dishonesty and its impact on the registrant's character and, most importantly, its impact on the wider reputation of the profession and public perception of the profession.

185. The Committee carefully considered the Registrant's dishonest misconduct in the round. The Committee determined that the Registrant had not acted for personal financial gain and that his dishonesty arose from him acting in what he appears to have considered was in the best interests of patients. The Committee also noted that in the past the Registrant had altered patients' prescriptions, albeit under the supervision of an Optometrist. The Committee considered the Registrant's initial actions that gave rise to his dishonestly claiming to have Mr A's permission to alter patients' prescriptions, may have been contributed to by the lack of any clear managerial supervision within Costco. The Committee determined that the Registrant's dishonesty fell around the middle of the 'sliding scale' of dishonesty. The Committee also considered that it was in the public interest that a Contact Lens Optician with an otherwise unblemished lengthy career should not be permanently removed from the Register unless absolutely necessary.

186. Having considered the Registrant's dishonest conduct in the round the Committee concluded that the seriousness of the case requires temporary removal from the register and that a period of suspension would be sufficient to protect patients and the public interest.

187. The Committee did give consideration to an erasure order. The Committee determined that erasure was not the only sanction which would be sufficient to protect patients and the public interest. It did not consider that the Registrant's misconduct was incompatible with ongoing registration and was satisfied that public confidence in the profession could be sustained if the Registrant were not removed from the Register. The Committee considered that erasure would be disproportionate.

188. The Committee went on to determine the length of the suspension order. Considering the Registrant's clinical failings and its assessment of the seriousness of his dishonest conduct, the Committee determined that the appropriate period of suspension was 6 months.

189. The Committee further determined that a review hearing should be held prior to the expiry of the Registrant's period of suspension.

190. In addition, the Committee considers that any Review Committee may be assisted by the following:

- The Registrant's engagement in any future hearing;
- The Registrant's demonstration of insight into the regulatory concerns arising from the allegations found proved;
- Records of any training undertaken;
- Up-to-date references where available.

Immediate Order

192. The Committee then went on to consider if an immediate order was required on the grounds that it was necessary for the protection of the public and is otherwise in the public interest.

193. The Committee has heard submissions from Ms Jones on behalf of the GOC and has accepted the advice of the Legal Adviser.

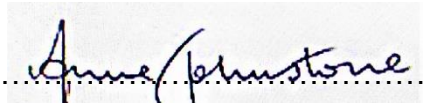
194. The Committee was satisfied that an immediate suspension order is necessary for the protection of the public and is otherwise in the public interest. The Committee had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an immediate order. To do otherwise would be incompatible with its earlier findings.

195. If no appeal is made, then the immediate order will be replaced by the substantive order of suspension 28 days after the Registrant is sent the decision of this hearing in writing.

Interim Order

191. The Committee revoked the current interim suspension order

Chair of the Committee: Ms Anne Johnstone

Signature ……  …… **Date: 22 November 2022**

FURTHER INFORMATION
Transcript
A full transcript of the hearing will be made available for purchase in due course.
Appeal
Any appeal against an order of the Committee must be lodged with the relevant court within 28 days of the service of this notification. If no appeal is lodged, the order will take effect at the end of that period. The relevant court is shown at section 23G(4)(a)-(c) of the Opticians Act 1989 (as amended).
Professional Standards Authority
This decision will be reported to the Professional Standards Authority (PSA) under the provisions of section 29 of the NHS Reform and Healthcare Professions Act 2002. PSA may refer this case to the High Court of Justice in England and Wales, the Court of Session in Scotland or the High Court of Justice in Northern Ireland as appropriate if they decide that a decision has been insufficient to protect the public and/or should not have been made, and if they consider that referral is desirable for the protection of the public. Where a registrant can appeal against a decision, the Authority has 40 days beginning with the day which is the last day in which you can appeal. Where a registrant cannot appeal against the outcome of a hearing, the Authority's appeal period is 56 days beginning with the day in which notification of the decision was served on you. PSA will notify you promptly of a decision to refer. A letter will be sent by recorded delivery to your registered address (unless PSA has been notified by the GOC of a change of address). Further information about the PSA can be obtained from its website at www.professionalstandards.org.uk or by telephone on 020 7389 8030.
Effect of orders for suspension or erasure
To practise or carry on business as an optometrist or dispensing optician, to take or use a description which implies registration or entitlement to undertake any activity which the law restricts to a registered person, may amount to a criminal offence once an entry in the register has been suspended or erased.
Contact
If you require any further information, please contact the Council's Hearings Manager at 10 Old Bailey, London, EC4M 7NG or, by telephone, on 020 7580 3898.