General Optical Council

BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(22)38

AND

JOHN WATSON - (01-15228)

NOTICE OF INQUIRY
SUBSTANTIVE HEARING

Take notice that an inquiry will be conducted in the above matter by the Fitness to Practise Committee of the General Optical Council.

A substantive hearing will be proceeding:

Remotely
The substantive hearing will take commence at **9:30am** on **Tuesday 09 – Friday 12 and Thursday 18 May 2023** by way of video conference or telephone conference facilities.

The Inquiry will be based upon the allegation submitted by the Council (see below) and will determine whether the fitness to practise of **John Watson** is impaired by virtue of the provisions contained in section 13D(2) of the Opticians Act 1989.

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Vineeta Desai
Hearings Manager, General Optical Council

20 December 2022

ALLEGATION

The Council alleges that you, John Anthony Watson, a registered optometrist:

Patient A

1. On or around 17 November 2020, you conducted an examination on Patient A and you:

    a. failed to adequately and/or appropriately record sufficient details regarding suprathreshold visual fields as you did not state the number of stimuli out of 26;
    b. Failed to adequately and/or appropriately record clinical data by retrospectively amending Patient A's record of the test you conducted of their original intraocular pressures from:
        i. 23, 24, 26 to 20, 20, 20 in their right eye.
        ii. 25, 28, 24.to 20, 20, 20 in their left eye.

Patient B

2. On or around 07 September 2020 you conducted an examination of Patient B and you:

    a. Failed to adequately and/or appropriately record clinical data by retrospectively amending Patient A's record of the test you conducted of their 'original' Intraocular pressure (IOPs) from:
        i. 23, 23, 25 to 20, 20, 20 in their right eye.
        ii. 21, 22, 23 to 20, 20, 20 in their left eye.

Patient C

3. On or around 09 November 2020 you conducted an eye examination of Patient C and you:

    a. Failed to adequately and/or appropriately assess the depth of the anterior chamber given that:
        i. the patient was at risk of having a narrow anterior chamber which could have led to angle closure glaucoma;

    b. Failed to adequately and/or appropriately record further details of the visual test in that you
        i. Did not record what type of visual test was conducted;

    c. Amended Patient C's clinical records in that you
        i. Overwrote the IOP reading for the left eye which resulted in an inconsistency of the average data from your records with that of the general raw data

Patient D

4. On or around 17 March 2021, you conducted an examination on Patient D and you failed to adequately and/or appropriately record clinical data in that you

a. overwrote Patient D’s record of the IOP value with:
    i. 20, (18) and 20 in the right eye
    ii. Three readings of 20 in the left eye

Patient E

5. On or around 19 October 2020, you conducted an examination on Patient E and you:

    a. Failed to adequately and/or appropriately record sufficient details about their symptom of double vision which is clinically significant;

    b. Failed to adequately and/or appropriately assess the depth of their anterior chamber necessary to determine the patient’s risk factor for developing angle closure glaucoma; and

    c. Failed to adequately and/or appropriately document if advice was provided regarding patient management of his dry eye;
        i. and what that advice was.

    d. Failed to adequately and/or appropriately document whether visual fields tests were conducted; and
        i. what the outcome of those tests was.

Patient F

6. On or around 07 September 2020 you conducted an examination of Patient F and you:

    a. failed to adequately and/or appropriately record sufficient information about threshold of visual test.

Patient G

7. On or around 06 October 2020, you conducted an examination on Patient G and you:

    a. Failed to adequately and/or appropriately record sufficient information about their flashes a symptom that may be suggestive of retinal detachment;
    b. Failed to perform a dilated eye examination necessary to detect any potentially sight-threatening pathology; and
    c. Failed to adequately and/or appropriately record clinical data by retrospectively amending Patient G’s record of the IOP value from 21mmHg to 20mmHg for both eyes.

Patient H

8. Failed to adequately and/or appropriately record clinical data in that you:

    a. Did not record the presence of near visual acuity;

b. amended Patient H's record of the IOP value from;
   i. 20, 21, 22 to 20mmHg in the right eye;
   ii. 28, 24 and 23 to 20mmHg in the left eye.

Patient I

9. On or around 24 August 2020, you conducted an examination on Patient I and you

   a. failed to adequately and/or appropriately document
      i. whether there was any corneal staining within their dry eye given that the patient was already using treatment for this condition;

   b. Failed to adequately and/or appropriately record clinical data by overwriting Patient I's record of the IOP value in their left eye from:
      i. 23mmHg to 20mmHg during the first test; and then from
      ii. 22mmHg to 21mmHg.

Patient J

10. On or around 24 August 2020, you conducted an examination on Patient J and you:

    a. Failed to adequately and/or appropriately record clinical data in that you;
       i. overwrote Patient J's record of the IOP value in their right eye from 12mmHg to 14mmHg.

Patient K

11. On or around 07 September 2020, you conducted an examination on Patient K and you:

    a. failed to adequately and/or appropriately record clinical data in that you:
       i. overwrote Patient K's record of the IOP raw value reading in the left eye from 23mmHg to 20mmH; and
       ii. the average in that eye from21mmHg to 20mmHg.

Patient L

12. On or around 17 October 2020, you conducted an examination on Patient L and:

    a. failed to adequately and/or appropriately document including:
       i. whether there was any corneal staining within their dry eye given that the patient was already using treatment for this condition.

    b. failed to adequately and/or appropriately record clinical data in that you
       i. overwrote Patient L's record of the IOP raw value reading in the left eye from 25mmHg to 20mmHg; and
       ii. the average in that eye from 23mmHg to 20mmHg.

    c. failed to adequately and/or appropriately record clinical data int that you:

i. recorded the average value in the left eye as 20mmHg instead of the correct result of 21mmHg arising from clinical data of 22, 20 and 22.

Patient M

13. On or around 17 October 2020, you conducted an examination on Patient M and:

    a. failed to adequately and/or appropriately record clinical data in that you;
        i. Overwrote Patient M's record of the IOP final data in the right eye as 18mmHg,
        ii. whilst in the left, the first value altered from 21mmHg to 20mmHg;
        iii. and recorded the average value of the left eye as 20mmHg instead of 19mmHg.

Patient N

14. On or around 17 October 2020, you conducted an examination on Patient N and you:

    a. failed to adequately and/or appropriately record sufficient information regarding his diabetes such as:
        i. the type;
        ii. duration; and
        iii. quality control of the condition.

Patient P

15. On or around 17 October 2020, you conducted an examination on Patient P and you failed to adequately and/or appropriately record clinical data;

    a. Including the presence of near visual acuity

Patient Q

16. On or around 13 August 2020, you conducted an examination on Patient Q, and you:

    a. failed to adequately and/or appropriately conduct a visual test; indicated as necessary due to borderline IOPs.

    b. failed to adequately and/or appropriately record clinical data in that you overwrote Q's record of the IOP mean value from:
        i. 23, 25, 22, 24 to 20, 20, 21, 20 in the left eye; and
        ii. recorded the average value of both eyes as 21mmHg instead of the original value of 21mmHg in the right eye and 23mmHg in the left eye.

Patient R

17. On or around 19 September 2020, you conducted an examination on Patient R, and you:

a. failed to adequately and/or appropriately record further details regarding the thresholds or the number of points given during the visual test field;

b. Failed to adequately and/or appropriately record clinical data in that you
   i. overwrote Patient R’s record of the IOP mean value in the right eye.

Patient S

18. On or around 19 September 2020, you conducted an examination on Patient S, and you failed to adequately and/or appropriately record clinical data:

   a. by overwriting Patient S’s record of the IOP raw value reading from:
      i. 20, 23, 22, 20 to 20, 22, 22, 21 in the left eye;
      ii. 22, 20, 21, 25 to 22, 20, 21, 22 in the right eye; and
      iii. Reducing the averages from 22mmHg to 21mmHg in each eye.

Patient T

19. On or around 13 August 2020, you conducted an examination on Patient T and you:

   a. failed to adequately and/or appropriately record clinical data by retrospectively amending Patient T’s record of the IOP raw value reading from;
      i. 24, 23, 20,24, to 24, 20, 20 and 22 in the left eye; and
      ii. Reducing the averages from 23mmHg to 22mmHg in the left eye.

Patient U

20. On or around 13 August 2020, you conducted an examination on Patient U and you:

   a. failed to adequately and/or appropriately record sufficient information including:
      i. whether a visual field test was performed on collection; and
      ii. if so, its outcome:
      iii. to determine if Patient U’s symptoms was suggestive of retinal detachment

Patient V

21. On or around 20 August 2020 you conducted an examination on Patient V and you:
   a. Failed to adequately and/or appropriately document:
      i. whether the visual field tests in the left eye were or should be tested
      ii. Patient V’s diagnosis of leukocoria and a retinal problem in their right eye;
      iii. whether Patient V was under the care of the hospital eye service; and
      iv. if so, when their most recent and subsequent appointments as scheduled

   b. Failed to adequately and/or appropriately document sufficient information regarding the ocular diagnosis, data that is relevant to consultation and patient care; and

   c. Failed to adequately and/or appropriately record clinical data by
      i. overwriting the intraocular pressures in Patient V’s right eye from 13, 13, 13 to 10, 10, 10.

d. Failed to adequately and/or appropriately perform a dilated eye examination necessary to detect any potentially sight-threatening pathology.

Patient W

22. On or around 11 November 2020 you conducted an examination on Patient W, and you:
    a. failed to adequately and/or appropriately record sufficient information including:
        i. whether a sight test was performed given the patient's family history of glaucoma and the optic disc appearance.

Patient X

23. On or around 25 September 2020:
    a. You conducted an examination on Patient X and failed to adequately and/or appropriately record sufficient information regarding their diabetes including:
        i. The type;
        ii. The duration; and
        iii. Quality control of the condition

And by virtue of the facts set out above, your fitness to practise is impaired by reason of misconduct.

Committee Members:	Hermione McEwen (Chair) Nigel Pilkington (Lay) Vivienne Geary (Lay) Amit Jinabhai (Optometrist) Claire Roberts (Optometrist)
Legal Adviser:	Aaminah Khan
Hearings Officer:	TBC
Transcribers:	Marten Walsh Cherer Limited

If you require further information relating to this hearing, please contact the Council's Hearings Manager at hearings@optical.org.