BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(21)25

AND

STUART MAXWELL (01-20055)

DETERMINATION OF A SUBSTANTIVE HEARING
25-29 APRIL 2022
20- 21 OCTOBER 2022

Committee Members:	Pamela Ormerod (Chair/Lay) Jackie Alexander (Lay) Carolyn Tetlow (Lay) Danielle Ellis (Optometrist) Claire Roberts (Optometrist)
Legal adviser:	Graeme Henderson
GOC Presenting Officer:	Simon Walters
Registrant present/represented:	Present but **not** represented (25-29 April 2022) Present and represented (20 - 21 October 2022)
Registrant representative:	Rebecca Chalkley (18 Red Lion Chambers) Katharine Germishuys (AOP)
Hearings Officer:	Terence Yates (25-29 April 2022) Nazia Khanom (20-21 October 2022)
Facts found proved:	1(b)(i)&(ii), 1(c) & 2(a)(ii) (by admission) 1(a), 2(a)(i), 2(b) & 2(c) (by Committee)
Facts not found proved:	N/A
Misconduct:	Found
Impairment:	Not impaired

Warning Issued	Yes for 1 Year
Sanction:	None
Immediate order:	None

ALLEGATION

The Council alleges that you, Mr Stuart Andrew Maxwell (01-20055), a registered optometrist:

1) On or around 10 June 2017 you conducted a sight test on Patient B and you:

a) Did not obtain and/or record obtaining a detailed history of Patient B's symptoms;

b) Did not perform a dilated examination on Patient B's eyes, including:

i. checking for tobacco dust; and/or

ii. examining the peripheral fundus;

c) Did not give and/or record giving advice to Patient B on the symptoms of retinal detachment and/or action that should be taken in their occurrence.

2) On or around 8 January 2020 you conducted a sight test on Patient A and, you;

a) Did not maintain adequate patient records in that you did not:

i) record in adequate detail, or at all, a description of the signs of suspected late AMD (wet active) you saw in Patient A's eyes; and/or

ii) record the reason for the 17 day delay between the sight test and the dilation examination appointment scheduled for Patient A on the 25 January 2020;

b) Did not arrange the referral for a dilated examination in a timely manner and/or inform Patient A about the need for a dilated examination;

c) Did not provide Patient A with advice on what to do should her symptoms worsen.

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

DETERMINATION

Admissions in relation to the particulars of the allegation

1. At the start of the hearing the Hearings Manager read the allegation. The Registrant admitted particulars 1 (b) (i) & (ii), 1 (c) & 2 (a)(ii) of the allegation. The Chair announced the facts proved by way of admission in terms or Rule 46(6) of the General Optical Council (Fitness to Practise) Rules 2013 (the Rules).

Background to the allegations

2. The Registrant was first Registered as an Optometrist in August 1991. After a short period when he was not on the Council's register, he re-registered in March 2003. He has no prior fitness to practise history. The allegation relates to times he was employed as a Locum Optometrist by redacted Opticians ("the Employer"). Although he was deployed in several stores the allegation involves his handling of two patients at the redacted Superstore of the Employer. By letters dated 2 and 3 October 2019 the Employer received a complaint from Solicitors acting for Patient B. Following a "deep dive audit" of his records further concerns were raised by the Employer with regard to a sight test conducted on Patient A. The Employer was concerned that a dilation examination had been arranged for 25 January 2020, 17 days after the initial sight test. On 10 January 2020 the Employer cancelled the dilation examination for 25 January 2020 and referred Patient A to hospital. By letter dated 13 March 2020 the Employer referred the issues raised, in their investigations, to the Council in light of the fact that the Registrant was no longer engaging with them and the Employer "can no longer manage this at local level".

Admission of Hearsay Evidence

3. Prior to the Council closing its case Mr Walters invited the Committee to admit four documents. Three of these documents were telephone attendance notes of conversations between Patient A dated 27 July 2020,7 August 2020 and 12 November 2020 and a Council Investigations Officer. The remaining document was a screenshot from the Employer's record clarifying who booked the dilation appointment for Patient A and the date it was booked.
4. Mr Walters submitted that these documents were plainly relevant to the issues that the Committee required to decide. He also submitted that it would be fair for them to be admitted. The Registrant indicated that he was content that they should be admitted.
5. The Committee heard and accepted the advice of the Legal Adviser who referred them to Rule 40(1) and Rule 40(2) of the Rules as well as *El Karout v NMC [2019] EWHC 28 (Admin).*

6. The Committee was satisfied that these documents were relevant and then considered the issue of fairness. Admitting the screenshot from the Employer's record would be fair as it confirmed the Registrant's position that he did not book the dilation appointment himself. The Committee then considered the telephone attendance records. Although this was hearsay evidence of telephone conversations the Committee was satisfied that it would be fair to admit these documents. Although the Council had produced some of Patient A's medical records none of them related to the outcome following the referral of Patient A, by the employers, to hospital in 2020. It was satisfied that its duty of making due enquiry into the case required it to ascertain the outcome of Patient A's referral. The Committee would, at a later stage, consider what weight to attach to the information contained within these documents. It could also be selective in its assessment of the material that had been produced.

Evidence

7. The Council provided live evidence of four witnesses: Patient B was seen by the Registrant on 10 June 2017. Witness A and Witness B were both Optometrists employed by the Employer to investigate concerns. Witness C provided an independent expert report and spoke to her findings. Non-controversial evidence was read into the record of an unsuccessful attempt to persuade Patient A to attend the hearing.
8. The Registrant also gave live evidence and provided supporting documents.

Concerns regarding documentary evidence

9. During the course of the hearing the Registrant produced a number of references. The Chair raised a concern regarding one of them. She indicated that one of the references was written by someone who had been the subject of previous disciplinary proceedings. It was made known to the parties that both the Chair and another member of this Committee had sat on those previous proceedings. The hearing adjourned in order for the parties to consider their positions and address the Committee on any issue which may arise such as potential bias.
10. When the case resumed it was explained that the Registrant wished to withdraw the reference in question and indicated that he would be seeking to add a further reference from a different individual.
11. It was indicated by the Committee that the Reference, which had been withdrawn, would play no part in its decision making and would be excluded from the minds of the members of the Committee. On the basis that it was no longer before the Committee, the concerns which gave rise to the adjournment, were no longer engaged.

Privacy issues

12. The Registrant indicated that he would wish to provide evidence regarding his redacted and other issues that would be regarded as private.

13. The Committee was aware that Rule 25 of the Rules provides that, as a starting point, misconduct hearings should be in public. However, Rule 25 (3) makes it clear that if there is any matter "concerning the Registrant's redacted" this "must" be held in private.
14. Since the matter was not discretionary the Committee determined that the parts of the Registrant's evidence where redacted was discussed must be held in private.

Findings in relation to the facts

15. The Committee heard the oral submissions of Mr Walters on behalf of the Council and from the Registrant. The Committee was grateful to the Registrant for providing a written version of his oral submissions.
16. The Committee heard and accepted the advice of the legal adviser. He referred to *Suddock v NMC 2015 EWHC 3612* in respect of the approach that the Committee should take to demeanour and *Kennedy v Cordia Services 2016 UKSC 6* on how it should approach expert evidence.
17. It considered each of the remaining particulars of the allegation in the order that they appeared. It considered all of the evidence before it, both oral and documentary, and reached the following conclusions:

1. On or around 10 June 2017 you conducted a sight test on Patient B and you:

a) Did not obtain and/or record obtaining a detailed history of Patient B's symptoms

18. The Registrant accepted that he conducted a sight test on Patient B on 10 June 2017. There is no criticism of the general history taken by the Registrant during this visit. The allegation relates to the detailed history that he should have taken of Patient B's symptoms.
19. The Committee accepted the evidence of Patient B who was understandably vague about what was precisely said to her almost five years before this hearing. She had a clear recollection that her visit to the Registrant was prompted by her experiencing a "big black floater". She also had a clear recollection of the Registrant switching on and off the lights as she looked at a whiteboard.
20. The Council's case was that the Registrant recorded: "black floater in the left eye. No flashes. Larger floater, slow moving. Patient feels distance vision in the left eye worse."
21. The Registrant explained that he had been unable to record anything further as he had difficulty in obtaining any further information from the patient. His recollection was that she was vague in response to questioning regarding the onset of the symptoms and that it was "hard to get information from her".
22. The Committee accepted the evidence of Witnesses A, B and C that, in light of Patient B's high myopia, the Registrant ought to have taken a more detailed history from Patient B including, for example asking her whether she had

experienced cobwebs or curtains in her vision and exploring the timeframe further.

23. The Committee considered that the Registrant should have been able to have obtained a history of the floater and recorded it. He did not record any findings that he was having trouble in obtaining answers to his enquiries. In the event that the Patient could not provide a precise timescale he could have explored the matter further. For example, he should have obtained an approximate timescale for when the floater was first noticed and what developments took place.

24. In the circumstances the Committee was satisfied that the Registrant neither obtained nor recorded a detailed history of Patient B's symptoms.

25. Accordingly, it found Particular 1 (a) proved entirely.

2. On or around 8 January 2020 you conducted a sight test on Patient A and, you;

a) Did not maintain adequate patient records in that you did not:

i) record in adequate detail, or at all, a description of the signs of suspected late AMD (wet active) you saw in Patient A's eyes;

26. On initial examination of the patient with her current spectacles on, he noticed a deterioration in her vision and recorded a distortion in her left eye using an Amsler Grid. He corrected her prescription and confirmed an improvement in her vision using the letter chart.

27. In reaching its decision the Committee had careful regard to the wording of the Particular which related to the record.

28. The Registrant accepted that Patient A visited him for a routine examination on 8 January 2020. He explained to the Committee that he had selected "AMD wet" from a dropdown box on the patient electronic records and that he had made the following, free text, entry in the box next to it: "? Requires dilation". Age Related Macular Degeneration can take two forms. The wet variant can cause sudden and profound visual loss and NICE guidelines state that a referral should be made within one working day.

29. The Registrant's explanation for deciding that he required to conduct a dilated examination was because of her small pupils. He was concerned that there was a remote chance that Patient A had wet AMD in her left eye although he was "99% certain" she did not because there were other explanations. He had selected 'AMD wet' from the drop- down list as an aide memoire, to remind himself to check for wet AMD at the subsequent dilation appointment. He selected "AMD wet" from the drop-down list but he could not alter the wording. The question mark in the free text entry '?requires dilation' in the box next to the drop-down list related to the AMD wet and not to the 'requires dilation'. If the question mark had related to 'requires dilation' it would have been placed after, rather than before, the words in the free text box.

30. It was not clear why he chose to enter “AMD wet” in the drop-down box rather than another option or leaving it blank. In any event his notes contain no explanation for him making the entries that he did. It was not clear, to those professionals who read these notes, why he had arranged for further testing and what had prompted his residual concern regarding wet AMD.

31. In light of the fact that there are no further entries explaining the Registrant’s decision to perform a dilated examination the Committee found the whole of Particular 2 (a) (i) proved.

    a) Did not arrange the referral for a dilated examination in a timely manner and/or inform Patient A about the need for a dilated examination;

32. The Committee considered each part of this particular separately.

33. It was the Registrant’s evidence that he would have dilated Patient A on the day of the appointment but for the fact that she was driving. This account is corroborated by an attendance note of 27 July 2020 recording a telephone conversation between a member of the Council’s investigation team and Patient A. Patient A confirmed that there was a problem with dilation due to the fact that she was driving.

34. Although this is contradicted by telephone records of subsequent conversations with Patient A the Committee attached little weight to this subsequent hearsay evidence in light of its knowledge of subsequent events and the further time delay since the appointment.

35. The Registrant’s account was also corroborated by the fact that a dilation appointment was booked on 8 January 2020 – the day of the examination. It would be highly unlikely that such an appointment would have been booked if Patient A had not been told that there would be a follow up.

36. The Committee was satisfied that the patient was told about the need for a dilation examination so that part of the particular was not proved albeit that the Patient was not provided with a reason for it being required.

37. The Committee had regard to all of the evidence. It accepted the expert evidence of Witness C when she explained to the Committee that it was a patient’s right to make a bad decision. Even if a professional fully explained the need for a further examination it was the right of a Patient to refuse or delay the examination.

38. The Registrant explained that Patient A was reluctant to be examined, the following day as she was about to go on holiday for a fortnight. He said that the appointment was fixed for 25 January because that was his next available date after she returned from holiday. He also said that he did not mention the possibility of her having wet AMD as he did not wish to alarm her.

39. In these circumstances the Committee did not consider that the dilated examination was arranged in a "timely manner". Taking into account the potential consequences of wet AMD, the Registrant should have taken steps for Patient A to be provided with sufficient information to make an informed choice with regard to when she should have her follow up examination. In the absence of sufficient information, she was not in a position to know the risks involved were she to wait 17 days for her next appointment. Had she been presented with all of this information she may have made a different choice.

b) Did not provide Patient A with advice on what to do should her symptoms worsen.

40. In respect of this particular the Committee had regard to both the Patient Records and the Registrant's own evidence. There would be a 17- day gap between appointments and there is no written evidence that the Registrant provided advice. This was confirmed by his oral evidence to the effect that he did not wish to alarm Patient A by warning her of the possibility of wet AMD.

41. Accordingly, the Committee found Particular 2 (c) proved.

Findings in relation to misconduct.

42. The Committee heard submissions from Mr Walters on behalf of the Council and from the Registrant himself. Mr Walters invited the Committee to find that each of the Particulars found proved amounted to misconduct. The Registrant indicated that he did not consider that any of the Particulars found proved reached such a level as to be characterised as misconduct. The Committee accepted the advice of the Legal Adviser.

43. The Committee recognised that, at this stage in the proceedings there was no standard or onus of proof. The Committee was required to exercise its own professional judgement. It had to consider whether or not the Registrant's conduct in respect of each of the Particulars of the Allegation fell far below the standards expected of a competent registered optometrist. This was in accordance with the case of Roylance v GMC (No 2) [2000] AC 311. Although Witness C provided expert opinion on this issue the Committee was not obliged to agree with her either on her assessment of the relevant standards or whether any of the Particulars found proved involved a serious departure from those standards.

44. The Committee first considered what rules and standards the Registrant was required to follow. Although Witness C commented on whether or not the Registrant had departed from the GOC Stage 2 Core Competencies for Optometrists (2001) the Committee did not consider that it was appropriate to have regard to these competencies. These standards were for students to achieve in the event that they wished to enter the profession. Whilst reference to these standards was not entirely irrelevant, the Committee considered it more appropriate to have regard to the GOC Standards of Practise for Optometrists and Dispensing Opticians (2016) (The GOC Standards). These standards were also referred to by Witness C in her report and by Mr Walters in his skeleton argument and his closing submissions.

45. The Committee had regard to the GOC standards and itself considered that the following standards had been departed from:

1.3 Assist patients in exercising their rights and making informed decisions about their care. Respect the choices they make.

5.1 Be competent in all aspects of your work, including clinical practice, supervision, teaching, research and management roles, and do not perform any roles in which you are not competent.

5.3 Be aware of current good practice, taking into account relevant developments in clinical research, and apply this to the care you provide.

6.2 Be able to identify when you need to refer a patient in the interests of the patient's health and safety, and make appropriate referrals.

7.1 Conduct an adequate assessment for the purposes of the optical consultation, including where necessary any relevant medical, family and social history of the patient. This may include current symptoms, personal beliefs or cultural factors.

7.2 Provide or arrange any further examinations, advice, investigations or treatment if required for your patient. This should be done in a timescale that does not compromise patient safety and care.

7.5 Provide effective patient care and treatments based on current good practice.

8.2 As a minimum, record the following information.

8.2.4 The details and findings of any assessment or examination conducted.

8.2.5 Details of any treatment, referral or advice you provided, including any drugs or optical device prescribed or a copy of a referral letter.

17.1 Ensure your conduct, whether or not connected to your professional practice, does not damage public confidence in you or your profession.

46. Having considered that the Registrant had fallen short of these standards the Committee went on to consider whether or not any of the Particulars found proved represented such serious failings as to amount to misconduct.

47. The Committee commenced by considering the facts surrounding Particular 1.

48. Patient B visited the Registrant on 10 June 2017 and he performed a sight test on her. She was highly myopic and, with her current spectacle correction, her visual acuity was recorded as 6/6 and 6/6-2 on her right and left eyes respectively. As well as being highly myopic she reported having noticed a large floater in her left eye. Both factors are strongly associated with the prospect of retinal tear/detachment; high myopia, in particular, is considered to be a widely known risk factor.

49. In not obtaining a detailed history of Patient B's symptoms the Registrant's actings were far below the standard reasonably expected of a competent professional.

50. In addition, the Committee considered that, in light of what the Registrant was told by Patient B and the presence of high myopia, he should, as he has now conceded, have performed a dilated examination on Patient B's eyes. During the dilated examination he should have checked for tobacco dust and examined the peripheral fundus. By not performing such an examination his actions were far below the standard reasonably expected of a competent professional.

51. The Registrant admitted that he had not provided Patient B with advice regarding the symptoms of retinal tears/detachment and the action that should be taken on their occurrence, in the context of the additional risk factor associated with high myopia. The Committee also considered that this was far below the standard expected of a reasonably competent registered optometrist.

52. It therefore considered that there was misconduct in respect of each and all of the Particulars in Particular 1.

53. The Committee next went on to consider whether the departures from the standards which it had previously identified should result in a finding of misconduct in respect of Particular 2.

54. The Committee considered Particular 2(a)(i) and (ii). It noted that Witness C did not consider the Registrant's poor record keeping to be sufficiently serious to amount to misconduct and the Registrant concurred. Witness C explained her reasons for taking this view in live evidence. She explained that whilst the patient's records indicated a diagnosis, they were lacking in detail or description in recording the signs observed. This, together with the absence of an explanation for the delay, limited their narrative power. There was enough recorded for her to form the view that some aspects of the records were below the standards but not far below what was expected of a registered optometrist. The Committee gave careful consideration to this issue and formed the view that the records were below but not far below the standard required and therefore found there to be no misconduct in respect of Particular 2 (a)(i) or Particular 2(a)(ii).

55. The Committee next considered that part of Particular 2 (b) which it had had found proved. It found that the Registrant did not provide Patient A with any information that would allow her to make an informed choice on when to book a dilation examination. The Registrant had been unable to rule out a suspicion, however minimal, that she may have had late AMD (wet active). Given the delay, the potential urgency of the situation ought to have been explained to the patient. In the circumstances the Committee considered that the matter was so serious that this failure fell far below the standard expected of a registered optometrist.

56. The Committee then considered Particular 2(c). It considered that, by not providing Patient A with advice about what to do should her symptoms worsen, the patient may have waited until the next appointment before seeking advice, not having been alerted to the potential risk. The Committee considered that this was far below the standard expected of a registered optometrist.

57. Accordingly, the Committee found there to be misconduct in respect of Particular 1 entirely and Particular 2 (b) and 2 (c). It did not find misconduct in respect of Particular 2 (a)(i) and 2 (a)(ii).

Impairment

58. The hearing resumed, at the impairment stage on 20 October 2022. The Registrant was represented by Ms Chalkley instructed by Ms Germishuys of AOP. Mr Walters remained instructed by the Council.

59. Mr Walters invited the Committee to consider that the Registrant's fitness to practise was currently impaired on both public protection and public interest grounds. He accepted that the misconduct was capable of being remedied but submitted that there remained residual concerns for patient safety. He also submitted that the seriousness of the misconduct required a finding of impairment on public interest grounds.

60. Ms Chalkley invited the Committee to consider that the Registrant's fitness to practise was not currently impaired either on the basis of public protection grounds or public interest.

61. Ms Chalkley addressed the Committee on remediation issues. She invited the Committee to consider that, since the last hearing, the Registrant has reflected on and has remedied his misconduct, such that there is no material risk of repetition. In advance of the resumed hearing the Registrant had submitted a substantial bundle of evidence including a recent witness statement, evidence of training and study, reflections on three observations of shadowing in hospital clinics, testimonials and a personal development plan.

62. She submitted that the issues could be divided into four discreet questions:

- Did the Registrant appreciate the gravity of the misconduct?
- Has the misconduct been repeated?
- Has the Registrant demonstrated his skills and knowledge?
- Are patients no longer at risk?

63. Ms Chalkley took the Committee to the Registrant's recent statement and supporting documentation. She invited the Committee to consider that this, together with the supporting documents, was sufficient to demonstrate full insight.

64. She explained to the Committee that no restrictions have been placed on his practise and that in the three years since the most recent incident no further concerns had been raised.

65. Ms Chalkley then referred to the training records of the Registrant and submitted that the Registrant has remedied his misconduct and that there was no material risk of repetition. The acts of misconduct were serious; however they were also isolated failures which arose in the context of an otherwise unblemished career. Given the further learning that he has undertaken, his reflection on these matters and the impact of these proceedings on him, the likelihood of repetition was genuinely remote.

66. Ms Chalkley submitted that, in light of the foregoing, patients were not at risk if the Registrant were to continue to practise unrestricted.

67. At the close of Ms Chalkley's submissions the Registrant gave live evidence and was asked a number of questions by the Committee regarding various clarification issues.

68. The Committee heard and accepted the advice of the Legal Adviser. He referred to the test set out in the case of *CHRE v NMC and Grant [2011] EWHC 927 (Admin)* in respect of impairment and the approach taken in the case of *R (Cohen) v GMC [2008] EWHC 581* to the issue of remediation.

69. The Legal Adviser told the Committee that the case of Grant involved an NMC Panel misreading the case of *Cohen* as that Panel had failed to appreciate it involved references to the wider public interest as well as public protection. In determining impairment, this Committee had to consider both public protection and public interest issues. In *Cohen* the purpose of the impairment stage in regulatory proceedings was explained and the observations with regard to the

impairment of doctors set out in *Cohen* (Paragraph 62) applied equally to the Registrant :

> "*Any approach to the issue of whether a doctor's fitness to practice should be regarded as "impaired" must take account of "the need to protect the individual patient, and the collective need to maintain confidence profession as well as declaring and upholding proper standards of conduct and behaviour of the public in their doctors and that public interest includes amongst other things the protection of patients, maintenance of public confidence in the"... In my view, at stage 2 when fitness to practice is being considered, the task of the Panel is to take account of the misconduct of the practitioner and then to consider it in the light of all the other relevant factors known to them in answering whether by reason of the doctor's misconduct, his or her fitness to practice has been impaired. It must not be forgotten that a finding in respect of fitness to practice determines whether sanctions can be imposed…*"

70. The Committee reminded itself that determining the issue of impairment was a matter for its own professional judgement. There was no burden of proof on either party. It also reminded itself that a finding of past misconduct need not necessarily result in a finding of current impairment.

71. In order to determine the issue of current impairment the Committee had regard to the following relevant aspects of the test approved in the case of *Grant:*

> "*Do our findings of fact in respect of the [Registrant's] misconduct, show that [his] fitness to practise is impaired in the sense that [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 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 profession; …*

72. The Committee considered that the appropriate approach that it should take was to consider whether these three limbs in *Grant* were engaged with regard to the past. Once it had determined that issue it would then turn to the remediation issues, advanced on behalf of the Registrant, before considering whether any of the limbs in *Grant* were engaged with regard to the future.

73. The Committee first considered whether its earlier findings in respect of the Registrant's misconduct assisted it in considering whether the Registrant's fitness to practise was impaired in the sense that he put a patient or patients at unwarranted risk of harm. It considered that patients were put at unwarranted risk of harm in the past.

74. The Committee therefore considered that limb (a) of the Grant test was engaged. The Registrant had, in the past, put Patients A and B at unwarranted risk of harm.

75. The Committee then went on to consider whether or not the Registrant had , in the past, brought the profession into disrepute. The Committee considered that the Registrant was under an obligation to provide proper care and advice to patients. A well-informed member of the public would be concerned about the misconduct identified. Accordingly, it considered that limb (b) of the *Grant* test was engaged with regard to the past.

76. The Committee then went on to consider whether or not the Registrant had, in the past breached one of the fundamental tenets of the profession. The Committee accepted that not all breaches of the code necessarily involve a breach of the fundamental tenets. The Committee considered that fundamental tenets of the profession, incumbent on the Registrant, were to make the care of his patients his first and continuing concern. The Committee considered that the Registrant failed to make the care of patients A and B his first and continuing concern. In these circumstances the Committee found limb (c) of the *Grant* test was engaged with regard to the past.

77. The Committee then went on to consider the Registrant's recent statement and other documentation produced in support of the contention that he had reflected and remedied his misconduct.

78. The Committee also reminded itself of the observations in *Cohen* that the purpose of this stage of disciplinary proceedings involves the Committee considering that:

> *"[64] There must always be situations in which a Panel can properly conclude that the act of misconduct was an isolated error on the part of a medical practitioner and that the chance of it being repeated in the future is so remote that his or her fitness to practise has not been impaired….*
>
> *[65] …..It must be highly relevant in determining if a doctor's fitness to practise is impaired that first his or her conduct which led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated. "*

77. The Committee had regard to the Registrant's recent statement in which he indicated that he respected the Committee's findings and accepted that his conduct had fallen below the standards required of him. The Committee noted that, as well as acknowledging his errors, he also explained what he would do differently if the same circumstances arose now.

78. The Committee noted that the Registrant's recent statement contained a detailed commentary on what further learning he had undertaken.

> *".. I have carried out approximately 50 hours of CET,CPD and additional training. I have discussed retinal detachment, AMD, and communication with colleagues and I have completed 3 days shadowing retinal and macular clinics at York Teaching hospital. I have revised the way I complete case records to ensure they are readable by any optometrist. I now feel a lot more confident in my ability to manage similar patients."*

79. The Committee considered that he had demonstrated a commitment to further training and keeping his knowledge up to date. He had chosen to engage in a number of courses that were relevant to the charges that were proved. He gave examples of cases, in practice, where he had come across patients with similar conditions and gave details of his management of them. He also highlighted the extent of learning he had gained from observations of clinics in a hospital setting which he would subsequently apply to his own practice.

80. In the Committee's view the Registrant's insight into the impact of his misconduct on patients A and B was well developed. The Committee was satisfied that the Registrant had made good use of the significant delay between the misconduct and impairment stages of this hearing to take appropriate steps. He had been able to obtain legal advice, reflect in depth and carry out remedial action. The Committee was satisfied that his display of insight and remorse was genuine.

81. The Committee took into account the fact that the Registrant was otherwise of good character. His hitherto unblemished record was in respect of a career of some thirty years. The Committee also considered that his misconduct could not be classified as an "isolated error" as there were two separate incidents, separated by a considerable time interval, involving unrelated clinical issues. However, both of these incidents were potentially remediable and had been addressed through training, reflection and personal development.

82. In light of all of the evidence presented to it the Committee was satisfied that limbs (a) to (c) of the Grant test were not engaged with regard to the future. The Registrant had developed insight. He is now working as a locum with various independent opticians. The time allocated to each patient appointment, in his clinic, was longer. He had taken steps to reduce stress including cutting down on his commuting hours. He had explained to the Committee that he had developed other methods of coping with stress by engaging with therapy and developing a supportive network in order to reduce the risk of making errors in the future.

83. Having considered that there was no significant future risk the Committee then went on to consider whether a finding of current impairment was required on public interest grounds; to reaffirm clear professional standards as well as promoting public confidence in the profession.

84. The Committee did not consider that a well-informed member of the public would be concerned if a finding of no impairment was made. There is a public interest in otherwise competent health professionals being allowed to practise unrestricted. Although there had been serious departures from the standards expected of a Registrant the Committee did not consider that it was not necessary to protect the public interest by making a finding of current impairment. The Committee did not consider that such a finding was required to promote public confidence in the profession.

85. The Committee therefore determined that there should be no finding of current impairment.

Warning

86. The Committee heard submissions from Mr Walters on behalf of the Council who submitted that a Warning should be issued in this case to uphold professional standards. Mr Walters referred to the relevant factors in the Indicative Sanctions Guidance and submitted that the circumstances of this case met the criteria for the imposition of a Warning.

87. Ms Chalkley on behalf of the Registrant submitted that a Warning was not necessary given the extensive remediation and insight demonstrated by the Registrant which, she submitted, should assure the Committee that there would be no repetition of the misconduct. She also submitted that public confidence in the profession would not be affected if no Warning was issued.

88. The Committee accepted the advice of the Legal Adviser who advised the Committee that it had power pursuant to section 13F(5) of the Opticians Act 1989 to issue a Warning. It should be guided by the Council's Hearings and Indicative Sanctions Guidance ("ISG") and provide reasons for either issuing or not issuing a Warning. He reminded the Committee that it was required to take account of all of the circumstances when deciding whether a Warning was an appropriate and proportionate response The Committee should specify the expiry date of any Warning, with reasons.

89. The Committee was satisfied that the Registrant has expressed genuine regret, has an otherwise previous good history and there has been no repetition of the misconduct since the second incident. His remediation had been thorough in the areas identified in the allegations. The Committee noted its earlier findings that the Registrant had developed insight and had taken steps to prevent any repetition of the misconduct. These were all mitigating factors.

90. However, as the Committee has set out in its determination above, the Registrant misconduct was serious. The Registrant's conduct fell far short of the standards required of him in a number of areas and had brought the profession into disrepute.

91. The Committee had particular regard to Paragraph 20.6 of the ISG and considered that all four factors were engaged. There had been clear and specific breaches of the standards expected. The Registrant's conduct, behaviour and performance approached but fell short of a finding of impairment. The Committee considered that although it had found that the risk of repetition was low, a repeat of the misconduct would likely result in a finding of impaired fitness to practise. The Committee noted that although the threshold of current impairment has not been reached there was a need to formally record its concerns in order to convey to the Registrant and the wider profession that his misconduct was serious and there should be no repetition.

92. The Committee considered that the Warning should continue for a period of one year. The Committee decided that this was a proportionate period and reflected the seriousness of the misconduct whilst also taking account of the mitigating factors referred to above. The Committee considered that the Warning should be in place during which time the Registrant's working environment may alter. This period will also provide an opportunity to embed the knowledge and skills he has gained from recent placements in hospital and CPD courses.

93. The Committee was of the view that it was appropriate to warn the Registrant as follows:

"*Mr Maxwell*

The Committee found that, in respect of Patient A you did not arrange the referral for a dilated examination in a timely manner and/or inform Patient A about the need for a dilated examination; you did not provide Patient A with advice on what to do should her symptoms worsen.

The Committee also found that you did not obtain and/or record obtaining a detailed history of Patient B's symptoms; you did not perform a dilated examination on Patient B's eyes, including checking for tobacco dust; and/or examining the peripheral fundus; you did not give and/or record giving advice to Patient B on the symptoms of retinal detachment and/or action that should be taken in their occurrence.

The Committee found that these matters amounted to misconduct. These matters amounted to a serious departure from the Standards of Practice for Optometrists and Dispensing Opticians("Standards of Practice"). However, as a result of your insight and the significant remediation that you have undertaken, the Committee decided that your fitness to practise is not currently impaired. The Committee concluded

that your misconduct approached but fell short of the threshold for current impairment. However, the concerns were sufficiently serious that any repetition is likely to result in a finding of impairment and as a result the Committee feels that it is necessary to issue you with this formal Warning.

The Committee warns you that the misconduct found proved did not meet the standards required of a professional optometrist: in particular keeping your knowledge and skills up to date in all aspects of your practice; recognising that you have to work within the limits of your competence and communicating effectively with your patients. The required standards are set out in the Standards of Practice and associated guidance issued by the General Optical Council. The misconduct found proved exposed patients to risk of harm and undermined public confidence in the profession; it brought the profession into disrepute and must not be repeated. Any further matters brought to the attention of the regulator may result in a more serious outcome.

This Warning will expire on 21 October 2023."

Chair of the Committee: Pamela Ormerod

Signature…  … Date: 21 October 2022

Registrant: Mr Stuart Maxwell

Signature …Mr Stuart attended via remote hearing… Date: 21 October 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.