BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(22)21

AND

ROBINDER SAGOO (D-12078)

DETERMINATION OF A SUBSTANTIVE HEARING
30 JANUARY – 03 FEBRUARY 2023

Committee Members:	Valerie Paterson (Chair/Lay) Sarah Hamilton (Lay) Ann McKechin (Lay) Catherine Kimpton (Dispensing Optician) Simon Pinnington (Dispensing Optician)
Legal adviser:	Ms Megan Ashworth
GOC Presenting Officer:	Mr Matthew Corrie
Registrant present/represented:	Yes and represented
Registrant representative:	Mr John Graham (WGL)
Hearings Officer:	Ms Nazia Khanom
Facts withdrawn	2 (withdrawn by the GOC at the close of the Registrant's evidence)
Facts found proved:	By way of admission: 3(b) and 3(c) Following evidence: 1(a), 1(b), 4 (in relation to 3(b) and 3(c))
Facts not found proved:	1(c), 3(a)
Misconduct:	Found in relation to 1(b), 3 and 4
Impairment:	Impaired on the public component
Sanction:	Concluded with no further action

ALLEGATION

1. On, or around, 11 January 2020, failed to responsibly supervise a colleague, Optometrist B, in that you:

a. Persuaded Optometrist B to come into work to complete patient appointments, despite her having told you to say that she was feeling unwell;

b. failed to address risks and/or create a safe environment for patients in that you required Optometrist B to complete patient appointments when she was not fit to do so;

c. prioritised financial interest over professional responsibilities in that you persuaded Optometrist B to attend work when she was not fit to do so;

2. On, or around, 15 January 2020, did not acknowledge and/or respond to Patient A's written complaint regarding a sight test conducted by Optometrist B on 11 January 2020, in which Optometrist B's behaviour was described as 'erratic';

3. Did not disclose Patient A's complaint in your supervisor reports for Optometrist B's Interim Order Review Hearings, which you submitted in:

a. January 2020

b. February 2020

c. March 2020

4. Your actions as set out in 3 were dishonest in that the supervisor reports that you provided to the Fitness to Practice Committee were inaccurate and misleading;

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

DETERMINATION

Admissions in relation to the particulars of the allegation

1. At the outset of the hearing, the Registrant admitted particulars 3(b) and 3(c) of the allegation. Accordingly, the Chair announced those particulars as proved under Rule 46(6) of the General Optical Council (Fitness to Practise) Rules 2013 (the Rules).

Background to the allegations

2. The Registrant is a Dispensing Optician registered with the General Optical Council (GOC). He first registered with the GOC on 31 October 2006.

3. The Registrant was the owner and manager of an optometry practice in Redacted. (the Practice). From around 2015 he employed Optometrist B as an Optometrist at the Practice.

4. At the material time, Optometrist B was subject to fitness to practise proceedings at the GOC in respect of concerns about her health, in particular regarding allegations of misuse of alcohol and being intoxicated at work. An interim conditions of practice order had been imposed pending the investigation of those concerns.

5. In 2018, the Registrant became Optometrist B's nominated supervisor approved by the GOC under the terms of the interim conditions of practice order. The Registrant's responsibilities under the interim conditions related to monitoring and reporting on Optometrist B at work.

6. On 9 December 2019, the third interim order review took place. At that time, Optometrist B was subject to condition 3, which was in the following terms:

    3. You must:

    a. *nominate as a supervisor a Dispensing Optician who will be prepared to monitor whether you are intoxicated at work;*

    b. *invite the GOC to approve the supervisor within two weeks of the date this order takes effect;*

    c. *identify another supervisor if the GOC does not agree to your proposed supervisor;*

    d. *at least every month, or upon the request of the GOC, request a written report from your supervisor to be provided to the GOC detailing his or her findings in respect of condition 3a;*

    e. *inform the GOC of any proposed change to your supervisor and again place yourself under the supervision of a supervisor who has been agreed by the GOC.*

7. As Optometrist B's nominated supervisor, the Registrant wrote reports on her behalf, pursuant to the interim conditions, including reports covering the months of January 2020, February 2020, and March 2020. The reports were submitted to the GOC on behalf of Optometrist B.

8. On Saturday 11 January 2020, Optometrist B was due to work and see patients at the Practice. She contacted the Registrant before work. It is alleged that she told him that she was feeling really ill and was not really up to the task, but he persuaded her to come into work because there were several patients booked in. Optometrist B attended the Practice and one of the patients that she saw for an eye examination was Patient A. Patient A left the Practice before the examination was completed.

9. In relation to 11 January 2020, it is alleged that the Registrant failed to address the risks and create a safe environment by requiring Optometrist B to complete patient appointments when she was not fit to do so, and that he did not want to cancel the appointments for commercial reasons, prioritising financial interest over professional responsibilities.

10. In a letter, dated 15 January 2020, and sent to the Registrant, Patient A complained about Optometrist B in respect of the appointment of 11 January 2020. It was the Registrant's position that he did not receive this letter directly.

11. On 1 February 2020, Patient A sent a second letter to the Registrant, appending her original complaint letter of 15 January 2020, explaining that she was disappointed not to have received any contact or letter of acknowledgement to the concerns she had raised. Patient A explained in the letter that, as a consequence, she had escalated her concerns to the GOC.

12. On 5 February 2020, the GOC received a complaint, dated 3 February 2020, about Optometrist B, submitted by Patient A regarding the appointment on 11 January 2020.

13. On 7 May 2020, the fourth interim order review took place in respect of Optometrist B's interim conditions of practice order. The Association of Optometrists (AoP), who were representing Optometrist B, asked the Registrant to give evidence in support of Optometrist B at the review, which he did.

14. In its reasons for maintaining the interim conditions of practice order, the fourth reviewing Committee articulated that it appeared that the Registrant had not disclosed the complaint of Patient A in the reports which he had provided on behalf of Optometrist B, as her nominated supervisor. It is alleged that the Registrant's reports submitted in January 2020, February 2020, and March 2020 omitted reference to Patient A's complaint and as a result the reports were inaccurate and misleading. It is alleged that the Registrant's actions were dishonest in this respect.

15. The fourth reviewing Committee concluded that the Registrant should not continue as Optometrist B's supervisor. It varied Conditions 3 and 4 as follows:

    3. *"You must not undertake work requiring registration with the GOC until the GOC has approved a supervisor (other than your present supervisor) nominated by you who is prepared to monitor whether you are intoxicated at work and make regular reports on your professional practice.*

    4. *You must:*

        a. *place yourself under the supervision of the supervisor agreed by the GOC;*

b. *at least every month, or upon the request of the GOC, request a written report from your supervisor to be provided to the GOC detailing his or her findings in respect of Condition 3;*

c. *inform the GOC of any proposed change to your supervisor and not continue in professional practice until a replacement supervisor has been approved by the GOC."*

16. The matter was considered by the Case Examiners as to whether or not the Registrant had a case to answer in respect of the allegations. In May 2022, the GOC received the Registrant's written representations to be considered by the Case Examiners. The Case Examiners concluded that there was a case to answer and the matter was listed for this substantive hearing.

Preliminary Matters

Application by Mr Graham for permission to take instructions from the Registrant whilst still giving evidence

17. The GOC did not call any witnesses at the fact finding stage and relied upon the evidence in the GOC bundle. The Registrant gave evidence to the Committee on the afternoon of 30 January 2023 but had not completed his evidence and the case was adjourned overnight with the Registrant still on oath. Overnight, Mr Corrie, on behalf of the GOC, had cause to read the third reviewing Committee's decision of the interim order review, which took place on 9 December 2019. That decision had not been included within the evidential bundle. Mr Corrie realised that those interim conditions were different to those set out in the fourth interim order review which took place on 7 May 2020, and upon which the GOC had based its case up to that point.

18. Mr Corrie informed the Committee that the interim conditions confirmed at the third interim order review (9 December 2019), were in fact the interim conditions in place at the relevant time. Mr Corrie explained that the material difference between the interim conditions was that those in place at the time the reports were submitted by the Registrant (in January, February and March 2020) required monitoring and reporting on intoxication at work of Optometrist B. They did not include reporting on Optometrist B's professional performance; that was a variation which was made on 7 May 2020.

19. Mr Corrie explained that the GOC bundle contained the interim conditions imposed at the fourth interim order review on 7 May 2020, the GOC had opened its case on the basis of those conditions, and that they imposed an obligation on the Registrant to report on professional performance as well as intoxication at work, but that was incorrect. Mr Corrie submitted that this was potentially of relevance and acknowledged that Mr Graham would need to take instructions from his client on the development. Mr Corrie confirmed that he would not

object to Mr Graham's application for permission to take instructions from the Registrant, even though he was still giving evidence.

20. Mr Graham submitted that an important dynamic of the case had changed. The GOC had opened its case on the incorrect basis that the interim conditions of 7 May 2020, were in place at the relevant time. The 7 May 2020 interim conditions had an obligation to report on professional practice as well as monitoring intoxication, whereas the actual interim conditions in place, those of 9 December 2019, imposed no obligation on the supervisor to provide information on professional performance.

21. Mr Graham therefore requested permission to take instructions from the Registrant on that point. He undertook to confine his discussions to the specific development.

22. The Committee heard and accepted the advice of the Legal Adviser. She advised the Committee of its responsibility to ensure that hearings are fair, and of effective case management, when unexpected issues arose during the course of a case.

23. In light of the unexpected development, and given the legal advice, the Committee was satisfied that it was fair to grant Mr Graham permission to take instructions from his client, the Registrant, even though he was still giving evidence.

Application by Mr Corrie for permission to ask the Registrant additional questions not arising from Committee questions

24. With the agreement of the parties, a redacted copy of the third interim order reviewing Committee, dated 9 December 2019, was admitted in evidence. The copy included the precise wording of condition 3.

25. Following questions asked by the Committee of the Registrant, Mr Corrie applied for permission to ask the Registrant further questions which did not arise from Committee questions but related to the interim conditions of practice approved in the third interim order review on 9 December 2019. Mr Corrie explained that he wished to explore that with the Registrant and question him on whether he accepted he still had a duty to disclose the complaint in his reports.

26. Mr Graham objected to the application. He submitted that this was a request to put new material, now that the basis of the GOC's case had changed. He pointed out that the GOC had opened its case on particular 4, the allegation of dishonesty, alleging that the Registrant did not disclose matters in his reports that he was required to disclose which meant that they were misleading. Mr Graham submitted that the Registrant should not be prejudiced in having to meet what was essentially a new allegation.

27. The Committee heard and accepted the advice of the Legal Adviser, who advised that the Committee needed to conduct proceedings in a manner which was fair, and determine whether or not the Registrant would be prejudiced by being cross examined to elicit further evidence in respect of the new evidence adduced by the GOC. The further evidence adduced was to correct the position of which relevant interim conditions were in place at the material time. The Legal Adviser also advised the Committee to consider this in the context of the over-arching objective of public protection, involving the elements of protecting the health, safety and well-being of the public, maintaining public confidence in the profession, and upholding professional standards.

28. The Committee noted the submissions from both parties. It considered that this was an application by Mr Corrie to elicit further oral evidence from the Registrant and it had regard to the considerations of relevance and fairness. It considered fairness to both parties within the context of the overarching objective, namely public protection.

29. The Committee noted that the Registrant had given evidence for several hours on 30 January 2023 and had been cross examined in detail by Mr Corrie, on behalf of the GOC regarding the case as it had been put by the GOC.

30. The Committee concluded that it would be prejudicial to the Registrant to be further cross examined by Mr Corrie about matters upon which he had already provided extensive evidence in respect thereof, based on the opening and the line of questioning pursued by the GOC.

31. The Committee was not satisfied that, in circumstances where the Registrant's representative opposed the application, it would be fair to the Registrant. It noted that he had previously provided evidence in chief, been cross examined extensively by Mr Corrie, re-examined by Mr Graham and asked questions by the Committee. At the time the Committee asked its questions, it had been provided with a copy of the correct interim condition (condition 3) effective at the relevant time. The Committee did not consider that it was fair to the Registrant that the GOC should be permitted to re-commence its cross examination based on evidence submitted for the first time on 31 January 2023, the second day of the substantive hearing, and at a time when the Registrant had ostensibly completed his evidence and was about to be released from his oath.

32. The Committee considered the interests of justice, including the need to protect the public, the wider public interest and to uphold professional standards. Having regard to the submissions of the parties, the evidence it had heard, and all the documentation, the Committee concluded that it was in the interests of justice for the Registrant not to be further cross examined regarding the most recent piece of evidence.

<u>GOC application to withdraw particular 2</u>

33. At the close of all the evidence in the case, Mr Corrie applied to withdraw particular 2. He explained that the basis of particular 2 was that the Registrant had not acknowledged or responded to Patient A's written complaint of 15 January 2020. He drew the Committee's attention to the Registrant's oral evidence to the effect that he had not received the letter of 15 January 2020 in January 2020. He said he received it with the follow up letter of 1 February 2020 when it was attached to that letter. On receipt, the Registrant said he called Patient A, discussed with her how the complaint could be resolved, and agreed that he would provide a supply of contact lenses, pay for an alternative person to conduct an eye examination; and pay her for the wasted travel costs.

34. Mr Corrie pointed out that there was no qualification of adequacy within particular 2 as drafted. He conceded that based on the Registrant's evidence, and that Patient A had declined to attend, the GOC had no evidence to rebut the Registrant's account.

35. Mr Graham consented to and supported the application.

36. The Committee heard and accepted the advice of the Legal Adviser, who advised that the Committee should not just accept the application to withdraw, but should satisfy itself that there were proper grounds to withdraw the particular.

37. The Committee granted Mr Corrie's application to withdraw particular 2. It was satisfied on an objective appraisal of the evidence that there was no realistic prospect of a finding of misconduct, given that there was no evidence to challenge the Registrant's account that he had responded to Patient A's complaint once he received it with the letter sent to him on 1 February 2020 which he received one or two days later. The Committee accepted that there was a proper basis to withdraw the application.

Findings in relation to the facts

38. The Committee was provided with an evidence bundle on behalf of the GOC, which included the following:

- Witness statement from NF, Investigation Officer at the GOC;
- Redacted copy of the third interim order review decision, dated 9 December 2019;
- Redacted copy of the fourth interim order review decision, dated 7 May 2020;
- Transcript of the Registrant's evidence given at Optometrist B's interim order review on 7 May 2020;
- Copy of Patient A's complaint, dated 15 January 2020, regarding her appointment conducted by Optometrist B on 11 January 2020 sent to the Registrant;

- Copy of Patient A's follow up letter regarding her complaint, dated 1 February 2020, sent to the Registrant;
- Copy of Patient A's complaint to the GOC, dated 3 February 2020, received by the GOC on 5 February 2020;
- Copies of the Registrant's supervisor reports in respect of Optometrist B, covering the months of January 2020, February 2020, and March 2020;
- Email correspondence to the GOC from Patient A declining to provide a witness statement;
- Emails from the AoP to the GOC providing the Registrant's supervisor reports, dated 18 February 2020 enclosing the January 2020 report, 10 March 2020 enclosing the February 2020 report, and 31 March 2020 enclosing the March 2020 report; and
- The Registrant's representations to the Case Examiners, received in May 2022.

39. The GOC did not call any live witnesses, relying on the GOC evidential bundle with the witness statement and exhibits in support of its case.

40. The Committee was provided with the Registrant's witness statement, dated 25 January 2023, as well as a reference from Mr A, a Contact Lens Optician, dated 5 January 2023. The Registrant also gave evidence.

41. The Committee heard and accepted the advice of the legal assessor. She advised that the burden of proof was on the GOC and the standard of proof required was the civil standard, namely whether it was more likely than not that the alleged fact occurred. The Legal Adviser advised that where a failure is alleged, the Committee would need to be satisfied that the Registrant was under a duty to take a particular course of action according to proper professional standards and that he did not take that course of action. In relation to dishonesty the Legal Adviser advised in accordance with the case of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords [2017] UKSC 67.* The Legal Adviser also advised that the Registrant was of good character, and that whilst good character was not a defence to an allegation, evidence of good character was relevant to support credibility and may mean that a Registrant is less likely to have acted in the way alleged.

Particular 1(a)

42. The Committee finds particular 1(a) proved.

43. The Committee had regard to the Registrant's acceptance of the factual position that he had persuaded Optometrist B to come into work to complete patient appointments despite her having told him that she was feeling unwell. In his oral evidence, the Registrant accepted that his evidence given to the interim order reviewing Committee on 7 May 2020 was accurate, namely that Optometrist B

had told him she was “not feeling 100 per cent”; “felt really ill”; and was “not really up to the task”. The Committee noted that the Registrant accepted that he had not probed for more information, saying that he did not ask, and she did not say, what her illness was.

44. The Committee went on to consider whether asking an employee to come into work having been told by them that they are unwell, meant that the Registrant had failed to responsibly supervise his colleague. The Committee considered that as an employer, the Registrant had a responsibility to take reasonable steps to ensure that his employees were fit enough to carry out their roles. The Committee noted that the Registrant himself had accepted such a responsibility in his oral evidence when cross examined by Mr Corrie. The Committee also considered that in this particular case, as the Registrant was Optometrist B’s nominated supervisor under her interim conditions of practice order, he would have had a heightened awareness of her health issues. Therefore, the Committee considered that he would have been on notice of her potential health difficulties at the time she contacted him to say that she was unwell.

45. The Committee bore in mind that Optometrist B, as a registered professional, also had a responsibility regarding her own fitness to practise, not to practise if she was not well enough to do so. Nevertheless, the Committee considered that there may be an imbalance of power between the Registrant and Optometrist B as she was dependent on him writing monthly reports to the GOC as her nominated supervisor. In the circumstances, the Committee was satisfied on the balance of probabilities that the Registrant had failed to responsibly supervise Optometrist B by persuading her to come into work to complete patient appointments, despite her having told him she was feeling unwell.

Particular 1(b)

46. The Committee finds particular 1(b) proved.

47. The Committee considered the evidence adduced by the GOC as to whether Optometrist B was not fit to complete patient appointments. Whilst Optometrist B had self-reported feeling unwell, the Committee bore in mind that it also had a copy of the comprehensive complaint letter of 15 January 2020 setting out the details of Optometrist B’s presentation at the appointment with Patient A. The Committee was mindful that this was hearsay, but noted that the Registrant had not disputed the account given by Patient A in the complaint and had sought to resolve her complaint following receipt of it. In light of the presentation of Optometrist B described in the letter of complaint, together with the Registrant’s acceptance in his evidence before the interim order reviewing Committee that Optometrist B was not feeling herself when he saw her on arrival, the Committee was satisfied on the balance of probabilities that Optometrist B was not fit to complete patient appointments.

48. In relation to whether the Registrant failed to address the risks for patients in such circumstances, the Committee had regard to the Registrant’s evidence, in

which he accepted that, on reflection, he had caused a risk to patients by requiring Optometrist B to complete the patient appointments. The Committee considered that once Optometrist B had attended work, having been persuaded to come in by the Registrant when she was unwell, he then did not check with her how she was. The Registrant, aside from checking her bag for any alcohol, did not probe further into Optometrist B's well-being. He said that there had not been time when she arrived, as a patient was already there. The Committee considered that, given the Registrant's knowledge of Optometrist B's health concerns, including alleged alcohol misuse, the Registrant failed in his responsibility to address the risks that Optometrist B may pose to patients if she were not well enough to conduct the appointments.

49. In relation to whether the Registrant had failed to create a safe environment, the Committee did not consider that this was limited to the building, consultation room, equipment and systems in place to maintain a safe place of work, such as fire safety, health and safety, and risk assessments, none of which had been identified as being in issue. The Committee considered that creating a safe environment included the practice of the professional Optometrist themselves. Therefore, if the Optometrist was adversely affected by health and so not fit to conduct appointments, then this would, in the Committee's view, impact upon the safety of the environment for patients. The Committee was satisfied that by requiring Optometrist B to complete appointments when she was not fit to do so, the Registrant failed in his responsibility to create a safe environment for patients.

50. In all the circumstances, the Committee was satisfied on the balance of probabilities that the Registrant had failed to responsibly supervise Optometrist B in that he both failed to address the risks and create a safe environment for patients when he required her to complete patient appointments when she was not fit to do so.

Particular 1(c)

51. The Committee finds particular 1(c) not proved.

52. The Committee had regard to the Registrant's oral evidence. It accepted that the three patients who Optometrist B did examine on 11 January 2020, were patients who needed to be seen as they required contact lenses. The Committee also accepted that cancelling appointments at short notice would inconvenience patients and may affect a Practice's reputation. The Committee noted that this was supported by Patient A's letter of complaint in which she set out the inconvenience she had encountered as a result of the unfinished eye examination, namely the distance she had travelled and the cost to her of a wasted journey and having to arrange a new appointment.

53. The Committee noted the Registrant's evidence given at the fourth interim order review, in which he explained that financial considerations contributed to him persuading Optometrist B to come into work when she had told him that she

was unwell. The Committee was mindful that the Registrant's evidence at that hearing was given in answer to questions regarding the review of Optometrist B's interim order as opposed to giving comprehensive information as he might if the hearing related to him.

54. In all the circumstances, the Committee considered that financial interest was one of the factors which contributed to the Registrant persuading Optometrist B to attend work. However, the Committee accepted that there were other factors which also contributed to the Registrant's decision to persuade Optometrist B to attend work, such as the consideration of the patients themselves, the service offered, and the reputation of the business. The Committee did not consider that financial interests were the Registrant's priority. The Committee was not satisfied that the GOC had discharged the burden of proving that the Registrant had prioritised financial considerations over the other factors.

Particular 3(a)

55. The Committee finds particular 3(a) not proved.

56. The Committee looked at the specific wording of particular 3(a), noting that it alleged a report "submitted in" January 2020, as opposed to a report covering January 2020. The Committee noted that the reports themselves were undated but described the month which they covered. The Committee also had the benefit of copies of the covering emails from the AoP which submitted the Registrant's reports covering the months of January, February and March 2020. The AoP's covering email submitting the report covering January 2020, was dated 18 February 2020.

57. The Committee did not have a copy of the actual report submitted in January 2020, but it appeared to the Committee that there was a pattern of reports being submitted covering the preceding month, in which case a report submitted in January 2020 was likely to be for the month of December 2019. In the absence of a report submitted in January 2020, the Committee was not satisfied that the GOC had discharged the burden of proving that the Registrant had not disclosed Patient A's complaint about the appointment of 11 January 2020 in his report submitted in January 2020.

Particular 4

58. The Committee finds particular 4 proved in respect of both 3(b) and 3(c).

59. The Committee bore in mind that the interim conditions of practice in place at the time the Registrant wrote his reports covering February 2020 and March 2020, did not have a specific requirement for the nominated supervisor to comment upon Optometrist B's professional performance; it was limited to monitoring whether Optometrist B was intoxicated at work.

60. The Committee noted that in his oral evidence, the Registrant explained that he had spoken to the AoP for guidance as to what to write in the reports as they had wanted a little more detail included about Optometrist B's work and

performance. It was apparent to the Committee from reading the reports submitted by the AoP in February 2020 and March 2020, that the Registrant had followed the AoP's guidance and included comments upon Optometrist B's performance. In the report submitted by the AoP on 18 February 2020, covering January 2020, the Registrant had included the following detail:

> *Optometrist B has continued to attend work on a regular basis, her attendance and presentation is of its usual high standard. Her patient care has also been of a high standard and I have been encouraged at her patient's comments on her abilities and her attitudes towards them.*
>
> *I again have no cause for concern; we have continued to have regular meetings 2 – 3 times a week in regards her patient care and well-being. I have no concerns of her being intoxicated at work.*

61. In the report submitted by the AoP on 10 March 2020, covering the month of February 2020, the Registrant had included the following detail:

> *Optometrist B has continued to attend work, her attendance and her presentation is of its usual high standard and her patient care continues to remain at a high standard and I have no concerns in regards her patient care.*
>
> *I continue to have no cause for concern; we continue to have regular meetings 2 – 3 Times a week in regards her patient care and well-being. She has demonstrated an increased level in particular her attention to her care for the team and her patients as she has taken on the responsibility of in placing the policies for the covid-19 virus.*

62. The Committee noted that at the time he wrote the report covering January 2020, the Registrant would have received the letter of complaint from Patient A, as it had been attached to her 1 February 2020 follow up letter and the Registrant said it had been sent by recorded delivery with him receiving it one or two days later. The Committee considered that, having decided to include information regarding Optometrist B's professional performance, the Registrant had a duty to ensure that the information provided was accurate and did not give the wrong impression about her performance. Having read the report, the Committee noted that the Registrant had omitted any reference to the complaint.

63. The Committee noted the contents of Patient A's complaint letter of 15 January 2020. It noted that it described Optometrist B as working in an erratic manner, with her clothing askew, hiccupping throughout the appointment and wobbling and swaying backwards and forwards. The letter also raised Patient A's concerns that the appointment was conducted in an unprofessional manner; she doubted the competence of Optometrist B and was concerned for the safety of her eyes. In light of the letter's contents, the Committee did not accept the Registrant's evidence that he had thought that the complaint was a commercial issue addressed to him and which he could resolve, so did not need to be

raised with the GOC. The Committee did not find it credible that a complaint raising concerns about eye safety could properly be categorised as a commercial issue.

64. The Committee was of the view that in the context of a report to the GOC in respect of potential fitness to practise proceedings, the Registrant's inclusion of comments upon Optometrist B's professional performance, but omitting any reference to Patient A's complaint regarding her appointment on 11 January 2020, rendered the report inaccurate. In the Committee's view it was misleading to a reader who may conclude that there were no complaints and consequently no undue concerns about Optometrist B's professional performance. The Committee noted that the Registrant himself had accepted in his evidence that on reflection, his report had been inaccurate and misleading.

65. The Committee bore in mind that the Registrant was of good character, and the advice it had received regarding a Registrant's good character. It noted that the character reference attested to the author's experience of the Registrant's honesty. Nevertheless, the Committee considered that on these two particular occasions, the Registrant had known about the complaint, it was evident that it raised issues of professional performance and the Registrant had not included any reference to it in either of the reports covering January 2020 and February 2020, rendering them inaccurate and misleading. The Committee considered that not having included any reference to the complaint in the report covering January, he had an ongoing responsibility to include it in the report covering February 2020.

66. The Committee then went on to consider whether by the standards of ordinary decent people, the Registrant's actions in omitting any reference to Patient A's complaint in both reports would be considered dishonest. It was satisfied that ordinary and decent people would consider it to be dishonest if a professional, writing a report in the capacity of a nominated supervisor for a fellow professional's regulatory body, wrote a report which was inaccurate and misleading because it omitted any reference to a complaint regarding potential patient safety. Therefore, in all the circumstances, the Committee was satisfied on the balance of probabilities, that the Registrant's actions in relation to particulars 3(b) and 3(c) were dishonest.

Stages of Misconduct and Impairment

67. Having noticed its decision on the facts, the Committee went on to determine whether, in accordance with Rule 46(12), on the basis of the facts found proved, the alleged ground of impairment, namely misconduct was established. The Committee understood that if it concluded that it did, it would go on to determine whether the Registrant's fitness to practise is currently impaired by reason of that misconduct, in accordance with rule 46(14).

68. In light of the Committee's finding in relation to dishonesty, Mr Graham invited the Committee to deal with misconduct and impairment together. He proposed that the Registrant be recalled to give evidence on impairment and then for Mr Corrie to make his submissions on misconduct and impairment followed by Mr Graham's submissions on misconduct and impairment.

69. The Registrant provided a reflective statement, dated with today's date (2 February 2023). He also gave further evidence, which included the following:

- The Registrant accepted the findings of the Committee;
- The Registrant accepted, as he had in his oral evidence at the fact finding stage, that there was a duty on an employer to ensure that an employee was fit to work;
- The Registrant accepted, as he had in his oral evidence at the fact finding stage, that on reflection his reports covering January 2020 and February 2020 were inaccurate and misleading;
- The Registrant regretted pushing Optometrist B to attend work on 11 January 2020, as he had expressed in his evidence to the fourth reviewing Committee on 7 May 2020;
- The Registrant was currently working professionally part time as a locum for an independent Opticians, the manager of which had provided the reference, and he still had an Opticians business which had four employees;
- The Registrant recognised that his actions at 1(a) and 1(b) would not have a very good impact on the profession, for which he was regretful and if he were in a similar situation in the future, he would deal with it differently and not persuade the employee to attend work at all. He gave a specific example of a similar situation encountered and how he had dealt with it, which involved seeking advice from a professional body;
- In relation to 3(b), 3(c) and 4, the Registrant acknowledged the potential risk to patient safety as he did not give honest reports;
- The Registrant accepted that when he had omitted disclosure of the complaint in his reports, it had been to primarily protect himself and the reputation of his business; and
- The Registrant could now absolutely see that what he did was dishonest, as he had accepted at the fact finding stage when cross examined by Mr Corrie. He said he should have contacted the GOC beforehand and discussed the matter; taken advice; and not just treated the matter as a retail issue.

70. The Committee had regard to all the evidence and the submissions of Mr Corrie on behalf of the GOC and Mr Graham on behalf of the Registrant.

Findings in relation to misconduct

71. The Committee heard and accepted the advice of the Legal Adviser. She cited the case of *Roylance v GMC (No. 2) [2000] 1 AC 311*, drawing the Committee's attention to the need for a serious departure from the standards required of a Dispensing Optician, before a finding of misconduct could be made. The Committee understood that any findings of misconduct are matters for the independent judgement of the Committee. It had regard to the GOC Standards and understood that not every breach of the standards would necessarily amount to misconduct.

72. In relation to particulars 1(a) and 1(b), the Committee bore in mind that they related to a single occasion and essentially arose from the same facts.

73. Specifically, the Committee considered that particular 1(a) did not, in and of itself, amount to misconduct. It bore in mind that the Registrant was under pressure to meet the patients' needs as they had previously been inconvenienced through missed appointments and were anxious to be provided with their contact lenses. The Committee considered that it was not appropriate for an employer to persuade an employee to come into work when they had said they were unwell, but it acknowledged that a small business owner may be tempted to persuade an employee to work. It also bore in mind the professional responsibility of the employee not to work if they were unwell.

74. The Committee considered that particular 1(b), however, did amount to misconduct. Once the Registrant had persuaded Optometrist B to come into work, the Committee considered that it was his responsibility to carry out further inquiries with her as to whether or not she was actually fit to work, so that he could address the potential risks that she may pose, and ensure that the environment for the patient was safe. The Committee bore in mind that in this particular case, the Registrant had a heightened awareness of Optometrist B's particular health issues, as he was supervising her under interim conditions. The Committee was of the view that failing to address the risks that may arise if an employee was unfit to conduct patient examinations and therefore failing to create a safe environment for patients, had implications for patient safety. It noted that in this particular case, Patient A had written that she had ended her appointment during the examination by Optometrist B due to concerns about the safety of her eyes. In light of the potential risk to patients, in the Committee's judgement, the failure was sufficiently serious as to amount to misconduct.

75. The Committee considered that particulars 3 and 4 did amount to misconduct. In the Committee's view they were more serious, as they involved preparing two inaccurate and misleading reports for a regulatory body, and doing so dishonestly. The Committee noted that the regulatory body, the GOC, is charged with the responsibility of protecting the public, in particular patients, maintaining public confidence in the profession and upholding professional standards. The Committee was mindful that an interim conditions of practice

order had been deemed necessary to protect the public and the wider public interest by the Committee convened to undertake a risk assessment in respect of Optometrist B's health. Whilst the Committee noted that it was an omission on the Registrant's part to disclose Patient A's complaint in the reports covering January and February 2020, it nevertheless considered that this was a serious departure from the proper professional standards expected of a Registrant. In the Committee's judgement, these actions amounted to misconduct.

76. The Committee had regard to Standards 11.5, 16, 16.1, and 17:

- Standard 11.5 – if patients are at risk because of inadequate… resources… or systems, put the matter right if that is possible and/or raise a concern;
- Standard 16 – Be honest and trustworthy;
- Standard 16.1 – act with honesty and integrity to maintain public trust and confidence in your profession;
- Standard 17 – do not damage the reputation of your profession through your conduct.

77. In relation to misconduct, the Committee concluded that patient safety and honesty of professionals are fundamental tenets of the profession. Accordingly, in the Committee's judgment, the Registrant's actions in breaching these fundamental tenets were sufficiently serious as to amount to misconduct.

Findings regarding impairment

78. The Committee had regard to the submissions of Mr Corrie on behalf of the GOC and those of Mr Graham on behalf of the Registrant.

79. The Committee heard and accepted the advice of the Legal Adviser. She advised the Committee to keep in mind the critically important public policy issues of: the need to protect the individual patient and the collective need to maintain public confidence in the profession as well as declaring and upholding proper standards of conduct and behaviour. She advised the Committee to consider the personal and public components of impairment, as identified in the case of *Cohen v GMC [2008] EWHC 581 (Admin),* and to assess the Registrant's current insight, remorse and remediation, all of which are relevant to the risk of repetition. The Committee understood that in relation to impairment, what has to be determined is whether there is current impairment of fitness to practise today and looking forward from today.

80. The Committee considered the personal component. It had regard to all the evidence, including the Registrant's evidence both at the fact finding and impairment stages. It had regard to the character reference provided by a current professional colleague and the Registrant's personal statement to the effect that he accepted that his actions had been dishonest.

81. The Committee considered that the Registrant had been very candid in how he had answered questions both at Optometrist B's fourth interim order review hearing on 7 May 2020 and on oath in this substantive hearing. The Committee was satisfied that with hindsight he recognised that he had exercised very poor judgement in persuading Optometrist B to attend work; requiring her to complete patient appointments when she was not fit to do so; and being dishonest by providing two inaccurate and misleading reports omitting reference to Patient A's complaint which raised patient safety concerns.

82. In respect of Patient A, the Committee considered that the Registrant demonstrated regret and sought to make amends to Patient A personally once he had received her complaint. It was clear to the Committee that he had reflected on his actions and had insight into the potential repercussions of his actions. It noted that he had identified what he would do in the future. He had also given a specific example of being in a similar situation, which he had addressed by reference to an external professional body, taking advice and receiving the information needed to address the matter. In all the circumstances, in the Committee's judgement, the Registrant had demonstrated a good understanding of the potential impact of his actions on patient safety.

83. In respect of providing inaccurate and misleading reports, and doing so dishonestly, the Committee considered that the Registrant had accepted responsibility for his actions. It bore in mind that he accepted at the outset omitting reference to Patient A's complaint in his two reports. In evidence he admitted that they had been inaccurate and misleading, and he explained that although he had not considered it dishonest at the time, he absolutely accepted that his actions had been dishonest and entirely unacceptable. It was clear to the Committee that the Registrant fully appreciated the need to provide accurate information, and that he understood the potential consequences of not doing so. The Committee was also satisfied that the Registrant understood the standards expected of a registered professional.

84. The Committee bore in mind that these incidents had occurred some three years ago, and the Registrant had been practising without incident since. It noted that he had no previous fitness to practise history. The Committee had the benefit of the professional reference from a GOC registered Optician who had full knowledge of the allegations which the Registrant faced, including the dishonesty, and continued to entrust the Registrant to cover dispensing duties for him whilst he was on holiday. In the reference, dated 5 January 2023, the Optician had stated:

> *I have always found the [Registrant's] work to be of an extremely high standard and have received no complaints or concerns regarding his conduct. He is an extremely personable man with good knowledge of all aspects of dispensing and shows a commitment to putting the patient at the forefront of his actions and decision making in a clinical setting. I*

would not allow him to conduct work for me in the two practices that I own if I did not have complete confidence in him.

I have never encountered anything that gives me cause for concern regarding his honesty or integrity…

85. In all the circumstances, the Committee was satisfied that the Registrant had developed good insight and had demonstrated remediation. Consequently, the Committee was of the view that the risk of repetition was low. Accordingly, the Committee did not find the Registrant currently impaired on the personal component.

86. The Committee went on to consider the public component. It recognised the importance of the public interest aspect, in particular the promotion and maintenance of public confidence in the profession as well as declaring and upholding proper professional standards of conduct and behaviour. Given that honesty is such a fundamental tenet of the profession, the Committee considered carefully whether the Registrant's dishonest conduct may undermine public confidence in the profession if no finding of impairment were made. The Committee understood that it is paramount that the public is able to trust the honesty of members of the profession and have confidence that they will report accurately to their professional body.

87. The Committee was mindful that the reports in question were provided to the regulatory body who, in turn, provided them to an interim order reviewing Committee charged with the responsibility of conducting a risk assessment in respect of Optometrist B, and whether she posed a risk to patient safety by reason of her health and alleged alcohol misuse. In the Committee's judgement, the inaccurate and misleading reports had the potential to place patients at risk, as the reviewing Committee may have accepted them at face value and so any potential risk Optometrist B posed may not have been identified. The Committee concluded that the dishonesty in this regard reflected badly on the profession and would undermine public confidence in the profession. Accordingly, the Committee determined that a finding of impairment was required in respect of the public component.

Sanction

88. Having determined that the Registrant's fitness to practise is currently impaired by reason of his misconduct, the Committee next considered whether it was impaired to a degree which required action to be taken on his registration. It had regard to the submissions of Mr Corrie on behalf of the Committee and those of Mr Graham on behalf of the Registrant.

89. The Committee heard and accepted the advice of the Legal Adviser and exercised its independent judgement. It had regard to the Hearings and Indicative Sanctions Guidance (the Guidance) and considered the sanctions in ascending order of severity. The Committee was aware that the purpose of a sanction is not to be punitive but to protect members of the public and to

safeguard the wider public interest which includes upholding standards within the profession together with maintaining public confidence in the profession and its regulatory process. The Committee was also mindful that any sanction must be proportionate both for the public and the individual Registrant.

90. The Committee first considered the aggravating and mitigating factors. It identified the following aggravating factors:

- There was a potential patient safety issue arising from the Registrant's dishonesty in providing inaccurate and misleading reports about Optometrist B, if the GOC had not been made aware of Patient A's complaint and had relied upon the reports.

91. The Committee identified the following mitigating factors:

- The Registrant has no other fitness to practise history and the positive character reference attests to his usual honesty and practice;
- The Registrant did not benefit financially or personally from his dishonesty, and in the Committee's judgement is at the lowest end of the spectrum of dishonesty;
- The Registrant was candid in his evidence to the interim order reviewing Committee in May 2020 and in his evidence to this Committee;
- No patient harm actually arose in this case, and the interim order reviewing Committee was not in fact misled;
- The Registrant has shown genuine regret, developed good insight and has effectively remediated his dishonesty such that the Committee considers that the risk of repetition is low;

92. The Committee then went on to consider whether a sanction was necessary. It was mindful that this was a case involving dishonesty, and so the crux of this case was the public interest aspect, in particular the promotion and maintenance of public confidence in the profession and the regulator, as well as declaring and upholding proper standards of conduct and behaviour.

93. The Committee had regard to the Hearings and Indicative Sanctions Guidance (the Guidance) as updated in December 2021. It noted the considerations as to when no further action might be appropriate, at paragraphs 21.4 and 21.7:

21.4 – There may, however, be exceptional circumstances in which a Committee might be justified in taking no action. An impairment finding with no further action is a way to mark the seriousness of the misconduct in the public interest, where a restrictive sanction cannot be justified.

21.7 – No action might be appropriate in cases where the registrant has demonstrated considerable insight into their behaviour and has already completed any remedial action the Committee would otherwise require them

to undertake. The Committee may wish to see evidence to support the action taken.

94. The Committee considered whether there were exceptional circumstances in which it may be justified in taking no further action. It bore in mind all the mitigation it had identified, in particular that the risk of repetition was low. The Committee considered that the Registrant had learnt a salutary lesson. It considered that at the time of his dishonesty he had not appreciated the gravity of his actions nor had he properly turned his mind to the level of responsibility required of him in the role of supervisor. In the subsequent three years, the Committee was satisfied that he had reflected and come to understand the potential implications of his actions on both patient safety and public confidence in the profession. The Committee did consider that these were exceptional circumstances, in the sense that they were unusual, particularly in how the Registrant had responded to address his dishonesty.

95. Having concluded that the Registrant had developed good insight and remediated his misconduct such that the risk of repetition was low, the Committee did not consider that a conditions of practice order in this case would serve any purpose, as there were no outstanding issues to address. The next available sanction, therefore, if conditions were not appropriate would be a suspension order. In the Committee's judgement, disposal by way of a suspension order, even for a short period, would be disproportionate and unduly punitive in the circumstances of this case. Consequently, the Committee did not consider that the restrictive sanction of suspension could be justified. Taking into account paragraph 21.4 (above) of the Guidance, the Committee was satisfied that a finding of impairment in itself "*would mark the seriousness of the misconduct in the public interest, where a restrictive sanction cannot be justified."*

96. The Committee was mindful that a decision to conclude a case after a finding of dishonesty with no further actions would be an unusual course, in light of the importance of maintaining public confidence in the profession. Therefore, the Committee specifically considered whether public confidence in the profession and the regulator may be damaged by such an outcome in the particular circumstances of this case, and whether the public may be left with the impression that the misconduct had been insufficiently marked.

97. The Committee considered that a finding of impairment was a serious matter; it would remain as part of the Registrant's fitness to practise history and have to be declared in any future professional roles applied for. The Committee considered that a fair-minded and reasonable member of the public would recognise that the regulator had taken the matter seriously and referred it to a Fitness to Practise Committee which had, in turn, held a five day substantive hearing into the matter. In the substantive hearing, the Committee had had the benefit of seeing and hearing the Registrant give evidence, to allow it to decide

whether or not a finding of impairment with no further action was sufficient to properly mark the misconduct found, and in particular the dishonesty.

98. In the particular circumstances of this case, the Committee has determined to conclude this case by way of no further action.

Chair of the Committee: Valerie Paterson

Signature …  … **Date:** 03 February 2023

Registrant: Robinder Sagoo

Signature … Attended remotely via MS Teams…**Date:** 03 February 2023

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.

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.