BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(21)29

AND

JOHN SNELGROVE (D-12817)

DETERMINATION OF A SUBSTANTIVE HEARING HELD REMOTELY ON 25th, 27th APRIL 2022, 14th JULY and 15th JULY

Committee Members:	Ms Sara Fenoughty (Chair/Lay) Mr Ben Summerskill (Lay) Mr Kevin Connolly (Lay) Mr Simon Pinnington (Dispensing Optician) Mr Philip Cross (Dispensing Optician)
Legal adviser:	Mr John Hamilton
GOC Presenting Officer:	Mr Alex Lawson – 33 Bedford Row Dr Francis Graydon
Registrant present/represented:	Yes and represented
Registrant representative:	Mr John Graham - WGL
Hearings Officer:	Ms Abby Strong-Perrin
Facts found proved:	Allegation 2 (by admission); Allegation 3; Allegation 4; Allegation 5
Facts not found proved:	Allegation 1
Misconduct:	Found

Impairment:	Impaired
Sanction:	Six month suspension – (With Review)
Immediate order:	N/A

ALLEGATION

The Council alleges that you John Snelgrove (D-12817), a registered Dispensing Optician:

1) *On or around 3 April 2021, whilst working at* REDACTED. *("the Practice"), you failed to maintain appropriate boundaries with Patient A in that you:*

   a. *told Patient A that you wanted to show her your inventions, or words to that effect; and/or*

   b. *told Patient A that you would be home alone that evening; drinking Jack Daniels, or words to that effect; and/or*

   c. *attempted to arrange for Patient A to return to the Practice on Monday 5 April 2021, on a day it would be (and/or you gave the impression that it would be) closed to other clients.*

2) *On or around 10 April 2021, you failed to maintain appropriate boundaries with Patient A in that you:*

   a. *sent a text message to Patient A which included the words 'If your interested I am also would you like to take this further' or words to that effect; and/or*

   b. *used the contact information the Practice obtained for Patient A to send the text message mentioned at 2a above for matters unconnected with her clinical care;*

3) *On or around 12 April 2021, you did not take Patient A's concerns about the text message mentioned at 2a above seriously and/or you did not apologise for sending this message.*

4) *Your conduct at 1) and/or 2) and/or 3 above was inappropriate in that you:*

   a. *knew or ought to have known that such conduct was not suitable in a dispensing optician-client relationship; and/or*

   b. *used your position as a dispensing optician to serve your own interest; and/or*

5) *Your conduct at 1) and/or 2) and/or 3 above was sexually motivated in that it was in pursuit of a future sexual relationship with Patient A.*

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

DETERMINATION

Preliminary matters

1. The committee confirmed with the parties that it had been provided with the following documents:

   (1) A 116 page electronic bundle of PDF documents referred to as the 'Joint Hearing Bundle' ("JB"). This contained the Council's hearing bundle and a bundle of documents provided on behalf of Mr Snelgrove ("the Registrant").
   (2) A statement from the Registrant dated 22 April 2022.
   (3) A skeleton argument prepared on behalf the Registrant also dated 22 April 2022.

2. Mr Graham on behalf of the Registrant notified the panel that a correction was required of the first line of paragraph 51 of the Registrant's statement. The word "reservedly" needed to be amended to read "unreservedly".

Admissions in relation to the particulars of the allegation

3. Mr Graham told the Committee that the Registrant admitted the facts set out in paragraph 1 (a) of the particulars of the allegation ("the particulars") but denied

that he had failed to maintain appropriate professional boundaries. The Committee decided that this should be recorded as a denial of paragraph 1 of the particulars.

4. The Registrant admitted paragraph 2 of the particulars and the facts alleged were recorded as having been proved by admission.

5. The Registrant denied paragraphs 3, 4 and 5 of the particulars in their entirety.

Background to the allegation

6. The Registrant is a registered Dispensing Optician, registration number D-12817. He was first registered in 1979. At the material time the Registrant was in practice at REDACTED.

7. The events under consideration by the Committee took place during April 2021 when Covid 19 restrictions were in force. They relate to a single patient, Patient A, who is a healthcare professional.

8. On 3 April 2021, Patient A visited the Registrant's practice as she wished to buy new spectacle frames. She said that during her visit, the Registrant engaged her in conversation and told her that he was staying home alone that evening drinking Jack Daniel's. She said that when she was unable to decide which frames to buy, he invited her to return to the practice on Easter Monday (5 April 2021) to look at frames because even though the practice would be closed, he would be working.

9. Patient A declined to return on Easter Monday. She returned on Tuesday, 6 April 2021, accompanied by a friend and chose two pairs of frames. On Friday, 9 April 2021, the Registrant informed Patient A by text that one pair of spectacles was ready and Patient A returned to the practice for a fitting on Saturday, 10 April 2021. During the course of the fitting Patient A said she tilted her head forward and bent forward in order to check that the frames fitted properly. She said she told the Registrant at the time that she was doing this because she practises yoga and was checking to see if the frames would stay in place.

10. During the afternoon of Saturday, 10 April 2021, Patient A received a text from the Registrant informing her that her second pair of frames were ready for collection. She arranged to collect them from the practice on the afternoon of Monday, 12 April 2021. Later, at 7.09pm that evening, she received a text from the Registrant in the following terms:

'Forgive me for asking
I don't want to embarrass me
or you at our next meeting when
you collect your specs
if your interested I am also
would you like to take this
further
Regards John Snelgrove'

Patient A responded at 7.11pm as follows:

'*No, thank you*.'

To which the Registrant replied at 7.12 PM and 7.15 p.m. respectively:

'*Ok thanks'* and '*I hope you don't mind me asking'.*

11. Patient A said that she felt quite shocked by what had happened and uncomfortable that her personal data had been used for non-business purposes. She says that when collecting her spectacles on Monday, 12 April she felt uneasy and uncomfortable and was cross that she had been made to feel this way.

12. Patient A says that when she collected her spectacles on Monday, 12 April 2021 the Registrant tried to speak to her about the text message and he said that he had got the wrong idea when she had bent forward while trying on the frames. He had believed she was interested in him. She said that she repeated that she wanted to see if the frames would stay on when she was practising yoga. She said she got the impression the Registrant believed she had provoked him, he did not apologise and he tried to make a joke of the incident.

13. Patient A subsequently made a formal complaint against the Registrant to the Council. This caused the matter to be investigated.

14. The case brought by the Council is that the Registrant engaged in the course of conduct that resulted in his crossing professional boundaries with Patient A, using her personal information to further his wish to enter into a sexual relationship with her.

15. In his statement, the Registrant said that:

    (1) When Patient A visited his practice on 3 April 2021 and 6 April 2021, he perceived her as flirtatious and over friendly. He considered her behaviour to be highly unusual but otherwise thought nothing of it. On Saturday, 10 April

2022, while trying on the first pair of frames, Patient A bent over from the waist vigorously shaking her head in many different directions while rotating her body in what he considered to be a provocative manner. He says she then moved in front of the door of the practice while wiggling her posterior in a manner that he considered highly unusual.

(2) He now realised that he had mistakenly taken Patient A's behaviour as an invitation for him to approach her and that as a man of advancing years he was taken aback and flattered by his mistaken belief Patient A was interested in him. He accepted that this caused him to act inappropriately and out of character by sending her the text message on 7 April 2021. He was not blaming patient for his mistake or for his failure to maintain appropriate boundaries. He was very sorry for any offence, upset or worry Patient A felt.

(3) He described what happened as "*a moment of madness on my part that has never occurred previously and never will again*". He says that when Patient A returned to collect her frames on 12 April 2021, he apologised for sending the text. He denied trying to make a joke of the situation or saying anything that could have led Patient A to believe that he thought she had provoked him.

Findings in relation to the facts

16. The Committee heard oral evidence from Patient A and the Registrant, followed by submissions from Mr Lawson and Mr Graham. The Committee accepted the advice of the legal adviser who advised on the burden and standard of proof, the dangers of attaching undue weight to a witness's demeanour and the need to take account of the fragility of human memory.

17. The Committee also took into account the Registrant's good character when considering his credibility and considered the evidence as a whole when coming to its conclusions in respect of each of the particulars of the allegation.

Paragraph 1 of the particulars:

'On or around 3 April 2021, whilst working at REDACTED. ***("the Practice"), you failed to maintain appropriate boundaries with Patient A in that you***

(a) told Patient A that you wanted to show her your inventions, or words to that effect; and/or
(b) told Patient A that you would be home alone that evening; drinking Jack Daniel's, or words to that effect; and/or

(c) attempted to arrange for Patient A to return to the Practice on Monday 5 April 2021, on a day it would be (and/or you gave the impression that it would be) closed to other clients.'

18. The Committee first considered if the factual matters set out at paragraphs 1 (a) 1 (b) and 1 (c) of the particulars had been proven. It took into account that at the outset of the hearing, Mr Graham had confirmed the Registrant admitted the facts set out in paragraph 1 (a).

19. In respect of paragraph 1 (a), the Registrant in his statement and his oral evidence accepted that he had developed an optical invention that he had on display in the practice. He also accepted that he did discuss this with patient A, as he did with other customers. The Committee therefore found the facts set out in paragraph 1 (a) proven.

20. In respect of paragraph 1 (b), Patient A was clear in her oral evidence that on 3 April 2021, the Registrant had told her that, he would be drinking Jack Daniel's alone that evening. In his statement and in his oral evidence the Registrant said he could not recollect this conversation. In his oral evidence he confirmed he was not denying this conversation could have occurred. Under cross examination, he accepted that he lived alone and would sometimes drink Jack Daniel's at home in the evening. The Committee considered this was consistent with Patient A's account. It acknowledged that coincidences can and do happen. However it considered it unlikely that it was a coincidence that Patient A mistakenly recalled the Registrant referring to drinking Jack Daniel's at home alone. The Committee therefore found the facts set out in paragraph 1 (b) proven.

21. In reaching its conclusion, the Committee took into account that Patient A had not mentioned this detail when she made her initial complaint (JB/11). However it accepted Patient A's evidence that it was because at that stage she was giving a summary of events and that when she was interviewed she had been asked to provide much more detail.

22. In respect of paragraph 1 (c), the Registrant in his statement and his oral evidence accepted that he had told Patient A she could return to the practice to try on frames on Monday, 5 April which was a Bank Holiday. In her evidence, Patient A said that she assumed that the practice would be closed, and that she had gained that impression. The Registrant said that he regularly opened his practice on a Bank Holiday, although, for various reasons, the door would be locked. Patient A formed the impression that the practice would be closed on Easter Monday, but she could not recall whether the Registrant had actually told her that the practice would be closed. The Committee therefore found the facts set out in paragraph 1 (c) not proven.

23. The Committee then went on to consider whether the facts set out in paragraphs 1 (a), 1 (b) and paragraph 1 (c) either individually or in any combination constitute a failure to maintain appropriate professional boundaries with Patient A.

24. The Committee considered that when interacting with customers and patients it was not unusual for registrants to engage in general conversation that could encompass a wide range of topics. The Committee took into account the Registrant's enthusiasm for the devices he was developing and noted that there was a display in the practice. It considered it was likely that the Registrant routinely engaged patients in conversation about this subject and offered to show them the devices he had on display. The Committee considered this was well within the relatively wide range of subjects it would be permissible for a registrant to talk about when engaging in conversation with a patient. The Committee therefore concluded that by doing this, the Registrant had not failed to maintain professional boundaries with Patient A.

25. The Committee acknowledged that the Registrant's comments about being alone at home drinking Jack Daniel's were potentially more problematic. It accepted that arguably such comments could be regarded as over-familiar. It took into account Patient A's evidence that she considered the comment inappropriate and on reflection to form part of course of conduct. However, it noted she also accepted that at the time it did not impact on her or prevent her returning to the practice. On balance, the Committee concluded that without more, the words set out in paragraph 1 (b) were, in themselves, just about within the relatively wide range of subject matter it would be permissible for a registrant to talk about in conversations with a patient. The Committee therefore concluded that by doing this, the Registrant had not failed to maintain professional boundaries with Patient A.

26. Although the Registrant admitted that he had told Patient A she could return to the practice on Easter Monday, he denied saying or implying that the practice would be closed and that he would be opening it especially for her. His evidence was that the practice was open on most bank holidays including Easter Monday and as it was the end of the tax year he had a great deal of paperwork to complete at the practice on that day. In her oral evidence, Patient A accepted that she had assumed the practice would be closed on Easter Monday and that the Registrant was offering it for her. The Committee considered this aspect of the Registrant's account plausible and accepted his evidence that the practice was open on Monday 5 April 2021. It therefore concluded that by suggesting Patient A could come to the practice of that day the Registrant had not failed to maintain professional boundaries with Patient A.

27. The panel therefore decided that the Council had not proven that the Registrant had failed to maintain professional boundaries with Patient A on 3 April 2021.

Accordingly the Committee found Allegation 1 not proven.

Paragraph 2 of the particulars

'***On or around 10 April 2021, you failed to maintain appropriate boundaries with Patient A in that you:***

(a) ***sent a text message to Patient A which included the words 'If your interested I am also would you like to take this further' or words to that effect; and/or***
(b) ***used the contact information the Practice obtained for Patient A to send the text message mentioned at 2a above for matters unconnected with her clinical care;'***

28. The facts set out in paragraph 2 of the particulars were admitted by the Registrant.

Accordingly the Committee found Allegation 2 proven by admission.

Paragraph 3 of the particulars:

'*On or around 12 April 2021, you did not take Patient A's concerns about the text message mentioned at 2a above seriously and/or you did not apologise for sending this message.'*

29. The Committee considered the wording of this paragraph narrowly. As drafted, it required the Registrant to have been aware of Patient A's concerns in order for the Council to prove that he did not take them seriously. The Registrant's evidence was that Patient A did not raise her concerns with him on 12 April 2021.

30. The Committee noted that neither in her oral evidence nor her written statement, had Patient A said she raised her concerns with the Registrant. In oral evidence she confirmed that their conversation regarding the text message had been *"minor*". It took into account that in her oral evidence, Patient A had made clear she considered the Registrant's attitude regarding what had happened had been inappropriate. The Committee considered that if Patient A had explicitly raised her concerns with him she would have said so. The Committee noted that in her initial complaint to the Council, Patient A had said that because she felt so uncomfortable about the situation, "*I tried not to make eye contact or have any further discussion on this topic*" (JB/11). The Committee found it likely that she

would have been uncomfortable about interacting with the Registrant and as a result, would have kept her conversation with him to a minimum.

31. On behalf of the Council, Mr Lawson said that the Registrant did not apologise, and attempted to joke about his mistake. The Committee concluded that this was insufficient to enable it to find that the Registrant had not taken Patient A's concerns seriously. Accordingly, the Committee concluded the Council had not shown the Registrant had failed to take Patient A's concern's seriously because these concerns were not raised explicitly with him at the time.

32. However, the Committee was clear that in finding this paragraph of the allegation not proved, there was no criticism of Patient A nor had the Committee made a positive finding that the Registrant had acted appropriately

33. The Committee then went on to consider if the Council had shown that on 12 April 2021, the Registrant had not apologised to Patient A for sending the text message.

34. The Committee did not find the Registrant's text message in which he said: '*Ok thanks'* and '*I hope you don't mind me asking'* (see paragraph 11 above) amounted to an apology. It considered this message was consistent with the Registrant regretting what he had done in the light of Patent A's negative response but that it fell far short of an apology.

35. In his statement and in his oral evidence the Registrant said that he apologised to Patient A on 12 April 2021. He denied saying to Patient A that he had got the wrong idea because she had bent over or trying to make a joke of the incident. However, he did not provide any real details about what he said to Patient A by way of apology.

36. The Committee considered that in her initial complaint, her statement and in her oral evidence, Patient A had given quite a detailed and consistent account of her interaction with the Registrant on 12 April 2021. She described him as saying he had got the wrong idea because she had bent over and laughing about the incident.

37. The Committee took into account that Patient A's account of the Registrant saying he got the wrong idea because she bent over, is broadly speaking what the Registrant says happened. The Committee could not see how, on 12 April 2021, Patient A could have known about this explanation unless the Registrant had given it to her. The Committee concluded that the fact Patient A was aware of the Registrant's explanation on 12 April 2021 was consistent with her account of events on that day.

38. The Committee also noted that at paragraph 40 of his statement, the Registrant said that he apologised when adjusting Patient A's second pair of spectacles and that she did not *"make a complaint or appear to be otherwise unhappy or uncomfortable".* However, when he gave oral evidence the Registrant said that when fitting Patient A's spectacles she had been extremely unhappy because the frames were tight and marking her nose. He described Patient A as being "*stunned"* when he told her he was unable to resolve this issue and that she had a look of "*horror*" and "*disdain*" on her face. He said that he believed that Patient A's dissatisfaction with the frames was what motivated her to make a complaint about him and was "*why we are all here today*".

39. The Registrant had not mentioned any of these details in his statement and this aspect of his oral evidence appeared inconsistent with the account given in his statement. The Registrant had not explained this inconsistency. The Committee concluded that this raised concerns about the reliability of the Registrant's account of events on 12 April 2021.

40. The Registrant was also clear in his statement that he did not blame Patient A for his inappropriate actions. The Committee acknowledge that he did repeat this in his oral evidence but considered his oral evidence was not consistent on this issue. During his oral evidence, the Registrant elaborated on his account of Patient A's behaviour. He claimed that when she first bent down towards him, she was moving her head up and down with her mouth open in what he considered was a simulation of oral sex. He said that when she moved in front of the door to the practice and had her back to him, she was "*oscillating her posterior*" in what he interpreted as an attempt to "*get my interest*" provocative of manner that caused her skirt to ride up that "*left little to the imagination*". He described Patient A's movements as "*provocative*" and "*lewd*". He said he had never seen anything like it in all his years and had been taken aback and stunned.

41. Patient A strongly denied the Registrant's description of her behaviour. She said she had told the Registrant that she wanted to check if the frames would remain on when she engaged in sport and yoga and therefore tested them out by tilting her head forward in a repetitive motion and inclining or 'inverting' her body. The Registrant accepted that Patient A had mentioned yoga and that having since carried out some research into yoga, he now believed Patient A had been engaging in a yoga position that he thought was called the "*dirty dog".*

42. Nevertheless, the Committee considered that the Registrant's oral evidence gave the clear impression that he believed at the time and continues to believe that his perception of Patient A's behaviour was reasonable. The Committee concluded

this belief made it less likely he would have apologised to Patient A on 12 April 2021 and more likely he would have instead chosen to make light of the incident in the manner described by Patient A.

43. Having considered the evidence as a whole, the Committee concluded that Patient A's account of events on 12 April 2021 was reliable and preferred it to the Registrant's account. The Committee therefore found that the Registrant had not apologised to Patient A.

Accordingly the Committee found Allegation 3 proven on the basis set out above.

Paragraph 4 of the particulars:

Your conduct at 1) and/or 2) and/or 3 above was inappropriate in that you:

a. knew or ought to have known that such conduct was not suitable in a dispensing optician-client relationship; and/or

b. used your position as a dispensing optician to serve your own interest; and/or

44. The Committee had not found the facts set out in paragraph 1 proved.

45. The Registrant had admitted (as set out in paragraph 2 of the particulars) that he had failed to maintain appropriate professional boundaries with Patient A by sending her the text message at 7.09pm on Saturday 10 April 2021 and using Patient A's contact information to do so. Nevertheless it was argued on his behalf that:

(1) When taken in context, the nature and degree of the Registrant's admitted breaches of professional boundaries were minor and brief. When Patient A indicated she did not have an interest in him, he acknowledged his error immediately by text. The incident had lasted a matter of seconds.

(2) His overriding aim had always been to serve the interest of his patient.

(3) While it was admitted that there had been a breach of professional boundaries, taken as a whole and in context, his behaviour could not be characterised as inappropriate or serving his own interest.

46. The Committee did not accept that the breaches of professional boundaries set out in paragraph 2 of the particulars could be characterised as so minor that they

could be disregarded. Patient A's contact details had been provided to the Registrant for the purpose of professional communications. On any objective view, using them to text Patient A in order to enquire whether she would like to explore a relationship was clearly inappropriate and unsuitable in a dispensing optician – client relationship. Equally, such an enquiry was clearly unconnected with the Registrant's professional relationship and in pursuit of his own personal interests.

47. In respect of paragraph 3, for the reasons given above, the Committee has concluded that the Registrant was unaware of Patient A's concerns and there cannot be said to have failed to take them seriously. In the circumstances, the Committee considered that it was not possible to find that this aspect of the Registrant's conduct could be characterised as unsuitable in a dispensing optician–client relationship or serving his own interest.

48. However for the reasons given above, the Committee has concluded that the Registrant did not apologise to Patient A for having sent her the text at 7:09pm on Saturday, 10 April 2021. The Committee considered that having failed to maintain professional boundaries by using Patient A's contact details to in order to enquire whether she would like to explore a relationship, the Registrant was under a very clear professional duty to offer Patient A a full, unequivocal and unreserved apology.

49. The Committee took into account that the Registrant has done this at paragraph 51 of his statement. However it was confident that his oral evidence in which he emphasised his claims about the provocative nature of Patient A's behaviour undermined this somewhat.

50. Furthermore, for the reasons already given, the Committee accepted Patient A's account of events on 12 April 2021. It considered it likely that the Registrant did try to make light of the incident and did give Patient A the impression he had been led on. The Committee concluded that it was also likely the Registrant had done this because he wished to deflect blame and justify his actions.

51. In the circumstances, the Committee was satisfied that the Registrant's failure to apologise to Patient A on 12 April 2021 was not suitable in a dispensing optician–client relationship and served his own interest.

Accordingly the Committee found Allegation 4 proven on the basis set out above.

Paragraph 5 of the particulars:

Your conduct at 1) and/or 2) and/or 3 above was sexually motivated in that it was in pursuit of a future sexual relationship with Patient A.

52. For the reasons already given the Committee did not consider paragraph 1 had been proved.

53. In respect of the Registrant's admitted conduct set out in paragraph 2, the Committee considered that even on the Registrant's own case as reflected in his oral evidence, he had effectively admitted this. He had said:
(1) He accepted that he was attracted to Patient A.
(2) He believed (albeit mistakenly) that she had invited him to make an a approach to her.
(3) His text message to her was an invitation to explore a relationship and he did not exclude such a relationship being a sexual one.

54. The Committee considered that using Patient A's contact details to text her in order to enquire whether she would like to explore a relationship was self-evidently motivated by a wish to pursue a sexual relationship.

55. The Committee therefore concluded that in respect of his actions set out at paragraph 3 of the particulars, the Registrant had been motivated by a wish to pursue a future sexual relationship with Patient A.

56. In respect of the Registrant's failure to apologise to Patient A, the Committee accepted Patient A's account that after Patient A had made clear she was not interested in exploring a relationship he realised that she did not in fact have any interest in him. In the circumstances, the Committee did not consider it likely his failure to apologise was motivated by any continuing wish to pursue a future sexual relationship with Patient A.

Accordingly the Committee found Allegation 5 proven on the basis set out above.

57. At this stage, the proceedings were adjourned part heard and there was a gap of 11 weeks before the hearing reconvene for the next stage of the hearing.

Misconduct and Impairment

58. The parties provided the Committee with the following additional documentation for the misconduct and impairment stage of the hearing:

1) The Registrant provided an 8 page bundle of documents that contained:

- A further reflective witness statement from the Registrant dated 13 July 2022.
- A certificate of continuing professional development ("CPD") recording that on 8 July 2022, the Registrant had successfully completed an online CPD course entitled 'Professional Boundaries in Health and Social Care – Level 2'.
- A testimonial dated 6 April 2022, from a colleague of the registrant, who had worked alongside him as a self-employed Optometrist for over 25 years including providing locum cover for his practice.

2) The Council provided brief written submissions on misconduct and impairment.

59. The Registrant gave evidence at the stage of misconduct and impairment. The parties agreed that his evidence should cover both misconduct and impairment even though the Committee would be treating them as separate issues.

60. The Registrant told the Committee:

1) The online professional boundaries CPD course had taken two hours to complete. The course did not involve interacting with any other people. He could have completed this course at any time after the hearing in April. The fact that he had completed a few days before this hearing did not mean he was not taking the situation seriously.
2) He had found the hearing in April an "*intense experience"*. He had not actively sought assistance immediately after the hearing but had considered what he would be expected to do.
3) He had thought a lot about what had happened. He had reflected on his evidence and the outcome of the fact-finding stage of the hearing and that "*there was a lot to be said for [the Committee's] perspective*". He realised that he had completely misinterpreted Patient A's actions. Although he had never seen anything like her behaviour in his life and it was "*totally outrageous behaviour*", it was not for him to judge or respond to. Previously he had thought that she was trying to elicit a response, but now he knows that he was wrong.
4) He had reflected on having used a patient's personal data. Which he believed was apparent from reading his statement as a whole.
5) He had also spoken to colleagues about what had happened, but had not mentioned this in his statement.
6) He thought that it would be "*a good idea*" to do the course before today's hearing. He took that course because he understood that he had misconstrued the circumstances that led to the complaint against him being made and wanted to *"look at where I had gone wrong*".

7) He took the course to demonstrate to the Committee that he had learned from what had happened.
8) He had learned a great deal about professional boundaries from the course. It had helped him understand why it was right for the complaint to be made. It helped him to reflect on how he needed to behave as a professional both inside and outside his practice. It made him more aware of the potential "*to overstep the mark in this day and age".*
9) He now had insight into what happened.
10) There was no risk that he would behave in a similar manner ever again.
11) He had not obtained any testimonials from patients.
12) Following the hearing in April, he had engaged in a new period of reflection. This had been an ongoing process and the professional boundaries course was part of that process.

61. The Committee heard submissions on behalf the Council and the Registrant.

62. On behalf the Council it was submitted in respect of the issue of misconduct that:

1) The facts found proven constituted misconduct because the registrant had behaved in a manner that fell far short of the professional standards to be expected of him.
2) The facts found proven in respect of Allegations 5 were particularly serious because of the sexual motivation.

63. On behalf of the Registrant it was submitted in respect of the issue of misconduct that:

1) It was for the Committee to decide whether the Registrant's behaviour had been so serious that it constituted misconduct.
2) Although the facts found proven included sexually motivated behaviour, the Registrant's conduct had been at the very lowest end of the spectrum of seriousness of this type of behaviour. He had stopped as soon as it became apparent that Patient A had no interest in him.

64. On behalf of the Council it was submitted, in respect of the issue of impairment, that:

1) The Registrant had produced inadequate evidence in support of his claim that he had remedied his misconduct and that it was highly unlikely to be repeated.
2) He had not acted promptly to address the concerns about his conduct.
3) His evidence that he thought the course he undertook would be a "*good idea*" did not suggest that he had a good understanding of the concerns raised by his conduct.

4) A two hour online course that did not involve any interaction with other people and that had only been completed six days before this hearing, was "*too little too late*".
5) The testimonial he had produced could not be given weight because it did not address the concerns raised by his conduct and was from a colleague.
6) The Committee could conclude that the Registrant's fitness to practise remained impaired because of the manner in which he had been thinking about what he needed to do to address the concerns and what he had done in order to address them.

65. On behalf of the Registrant it was submitted, in respect of the issue of impairment, that:

1) The Registrant had accepted that he was at fault, taken responsibility for his actions and did not seek to blame Patient A.
2) Reflection and insight was an ongoing process and therefore the fact that the Registrant had not taken the professional boundaries course earlier should not be held against him.
3) The Registrant had given clear evidence about how the course had benefited him.
4) In any event, impairment was not just about insight. The Committee could take into account that the Registrant had an unblemished record and that there were no concerns about his clinical practice.
5) The Committee could give weight to the highly positive testimonial regarding the Registrant's professionalism and the fact that that he had a lot to offer the profession.
6) The Committee should regard what happened as an isolated incident in an otherwise unblemished record and take into account that similar conduct had not occurred previously or re-occurred since.
7) The Registrant had engaged positively with the regulatory process and the Committee could be confident that there was no risk of a repetition of the conduct that led to the complaint against him.
8) Looking to the future there was no impairment and there was also no need for a finding impairment on the grounds of the wider public interest alone.

Misconduct

66. Although the Committee heard submissions in respect of misconduct and impairment together, it was aware that it should consider misconduct first and only go on to consider impairment if it found that misconduct had been established.

67. The Committee accepted the legal adviser's advice and bore in mind that:

1) Whether the facts found amount to misconduct is a matter for the Committee's independent judgement and it must reach its own conclusions about misconduct regardless of whether a registrant admits misconduct.

2) There is no statutory definition of misconduct, but the Committee should have regard to the guidance given in **Roylance v GMC (No2) [2001] 1 AC 311**: "*Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules standards ordinarily required to be followed by a… practitioner in the particular circumstances*".

3) The conduct must be serious and fall well below the required standards. Breaches of standards in and of themselves will not necessarily amount to misconduct.

68. The Committee noted that the Council has not referred it to any specific professional standards that were said to have been breached by the Registrant. However, the Committee took into account it had found that using Patient A's personal information in order to contact her in the hope of pursuing a sexual relationship was a clear breach of professional boundaries.

69. The Committee considered that the Registrant's use of Patient A's personal data to make his initial approach to her was self-evidently extremely serious. It considered this to be the most serious aspect of the Registrant's behaviour. However, it was also satisfied that all the facts found proven, including the Registrant subsequently failing to apologise, trying to make light of his behaviour and giving Patient A the impression he had been led on, were part of an ongoing course of extremely troubling conduct.

70. The Committee therefore concluded that all the facts proven showed that the Registrant had behaved in a manner that fell far below the professional standards expected of him.

71. Having found misconduct established, the Committee went on to consider whether the Registrant's practice was currently impaired.

Impairment

72. The Committee accepted the legal adviser's advice. It bore in mind that:

1) It must determine whether a registrant's fitness to practise is impaired today. The Committee must ask itself whether their misconduct makes him unsuitable to practise without restriction. This is a matter of judgement for the Committee. There is no burden or standard of proof.

2) The purpose of regulation is not to punish a registrant for past mistakes. The purpose is to protect the public against those who are not fit to **practice Meadow v GMC [2006] EWCA Civ 1390.**

3) Impairment is an assessment of a registrant's future behaviour. However past behaviour and insight into past behaviour have to be taken into account when making this assessment because they can be an indicator of future behaviour **Cheatle v GMC [2009] EWHC 645.**

4) In approaching the decision, the Committee should have regard to the questions identified in **CHRE v NMC and Grant [2011] EWHC 927 :**

   'Do our findings of fact in respect of the registrant's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:
   a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or
   b. has in the past brought and/or is liable in the future to bring their 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 their profession ...'

5) When answering those questions the Committee should consider if a registrant's conduct: (a) is easily remediable (b) has been remedied (c) is highly unlikely to be repeated **(Cohen v GMC [2008] EWHC 581).**

6) The Committee must take into account all relevant factors including any evidence that a registrant has demonstrated insight into their failings and any steps taken to remediate those failings.

73. In reaching its decision, the panel took into account the submissions made by the representatives and all the written and oral evidence.

74. The Committee took into account the very positive testimonial provided by the Registrant's colleague. However, it was unable to treat this as a truly independent testimonial, since it was provided by someone who was effectively employed by the registrant. The Committee felt that it would have been more helpful if the registrant had been able to provide testimonials from his patients. Nevertheless,

the panel acknowledged that obtaining such references may be difficult and did not draw any adverse inferences from their absence.

75. The Committee first considered whether the Registrant's conduct (a) is easily remediable (b) has been remedied (c) is highly unlikely to be repeated.

76. The Committee considered that the Registrant had developed a distorted image of Patient A's behaviour and that by using Patient A's personal data to contact her with a view to initiating a relationship, he was effectively acting on a supposition. Although the Committee considered this to be very concerning behaviour, it was of the view that these concerns could be addressed by reflection and if necessary appropriate training. Accordingly, the Committee concluded that the Registrant's conduct was remediable.

77. The Committee considered that given the time that had elapsed since the hearing in April, the Registrant had given ample opportunity to reflect and take remedial action. The Committee accepted that the Registrant had undertaken some reflection and that it was likely the professional boundaries course he attended had assisted him to gain some understanding of the concerns about his conduct.

78. However, the Committee found that even in his evidence today, he showed that he did not appreciate the depth of the concerns about his conduct and in many ways he had not moved on from his position at the hearing in April. In his evidence, he once again referred to Patient A's behaviour as provocative and outrageous. There was limited evidence that he had considered the impact of his behaviour on Patient A or how his behaviour could adversely impact on the reputation of the profession. The Committee considered that the Registrant's evidence showed that his thinking remains somewhat distorted and he still believes that, at the very least, Patient A's behaviour contributed to what happened. Overall, the Committee found the Registrant's claim to be taking responsibility for his actions, less than convincing.

79. The Committee therefore concluded that although the Registrant's insight into his misconduct was developing, it was far from complete. The Committee therefore decided that the Registrant's conduct had not been remedied.

80. The Committee took into account incomplete insight can be a strong indicator that misconduct will be repeated. However, the Committee considered in this case, that the regulatory process had had a significant deterrent effect on the Registrant. The Committee considered that his evidence showed that he now has a keen appreciation of what is and is not acceptable conduct in a professional context and the need to maintain strict separation between his private and professional life. The Committee considered that this conclusion is supported by

the evidence he gave about the benefits of the professional boundaries course he undertook. Furthermore, it was clear from the Registrant's written evidence that he was well aware of the serious consequences his misconduct could have for him professionally.

81. The Committee was therefore satisfied that despite the Registrant's incomplete insight, it was highly unlikely he would repeat such conduct.

82. The Committee considered that the Registrant's conduct had self-evidently put Patient A at risk of harm, had brought the profession into disrepute and that his failure to maintain professional boundaries was a breach of a fundamental tenet of the profession.

83. The Committee considered that a member of the public in possession of all the relevant facts, including the fact that the Registrant had not yet achieved complete remediation, would be very concerned indeed if a finding of impairment were not made.

84. Accordingly, despite the fact that the Committee considered that the Registrant did not pose an ongoing risk to the public, it concluded that a finding of impairment was required in order to maintain public confidence in the profession and in order to declare and uphold professional standards.

85. The Committee therefore decided that the Registrant's fitness to practice was currently impaired by reason of his misconduct.

86. The Committee proceeded to consider the issue of sanction.

87. The Committee heard submissions on sanction.

88. Dr Graydon, on behalf of the Council, referred to the Hearings and Indicative Sanctions Guidance updated in November 2021 ("the Guidance") and reminded the Committee of the principle of proportionality. He submitted that:

    1) The main purpose of sanction was to protect the public, including the wider public interest served by maintaining public confidence in the profession and promoting proper professional standards.
    2) Taking no further action was only appropriate in exceptional circumstances and would not be sufficient to address the public interest concerns in this case.
    3) A financial penalty order would normally be made in cases involving financial gain and therefore was not appropriate in this case. It would also not be

sufficient to address the public interest concerns raised by the Registrant's misconduct.

4) Suspension was appropriate in this case as there had been a finding of serious misconduct and no lesser sanction was appropriate.
5) At paragraph 69 of its decision the Committee had found that the Registrant's misconduct had been serious.
6) The serious nature of the Registrant's misconduct was aggravated by the fact it involved use of private information and was sexually motivated. These should be treated as distinct aggravating factors.
7) The Registrant's conduct was mitigated by his personal mitigation, his developing insight and the character reference he had provided.
8) Taking into account the aggravating and mitigating circumstances, no lesser sanction than a suspension order of six months would adequately address the public interest issues in this case.

89. Mr Graham, on behalf of the Registrant submitted that:

1) The Guidance made clear that the Committee's central function of sanction was the protection of the public.
2) The Committee had found current impairment on public interest grounds only. This meant that the reputation of the profession was the key issue that had to be addressed by any sanction.
3) When considering sanction, the principle of proportionality was an important consideration.
4) The Registrant had had a long career. He had been an asset to the profession and would continue to be an asset to the profession.
5) The nature of the misconduct found proven was serious, in particular the use of a patient's private information and the sexual motivation. However it was not appropriate or fair to treat these as additional aggravating features because this would mean they were being taken into account twice.
6) The mitigating features of this case were:
7) The Registrant's conduct was a one-off isolated incident.
8) His use of private data was quickly mitigated, as the Registrant ceased contact immediately.
9) The Committee had found that the misconduct was remediable and that the Registrant had developing insight.
10) There was an expectation that the Registrant's insight could be improved and developed. The Guidance (at page 34 ss.24-26) suggested that educational conditions could be appropriate in these circumstances. Appropriate courses were available to the Registrant. This would not be an unreasonable sanction bearing in mind the Registrant's unblemished career, the 'one off' nature of this misconduct and the fact he was not a risk to patients.
11) If the Committee were to conclude that suspension was appropriate, suspension should be for the minimum period possible and for no more than 2

months. This would be sufficient to address the public interest identified by the Committee.

90. In answer to a question from the Committee, Mr Graham said that the Registrant's project to provide affordable spectacles to the people in developing countries would be placed at risk because the Committee's decision would have a direct impact on the project because it would be scrutinised by investors.

91. The Committee accepted the advice of the Legal Adviser. The Committee was aware that it should:

1) Take into account the factors set out in the Guidance.
2) Consider the seriousness of the misconduct
3) Consider any aggravating and mitigating factors in the case.
4) Consider the range of available sanctions in ascending order of seriousness.
5) Bear in mind that the purpose of any sanction is not to be punitive, but is to protect the public, maintain public confidence in the profession, and declare and uphold proper standards of conduct and behaviour.
6) Bear in mind that although not intended to be punitive in its effect, an appropriate sanction may have punitive consequences for a registrant.
7) Act proportionately by weighing the interests of a registrant against the public interest.

92. The Committee took into account the following mitigating factors:

1) The Registrant's previous good character and unblemished career.
2) The positive character reference attesting to the Registrant's ability and integrity.
3) The lack of any repetition of similar conduct.
4) The Registrant's expression of remorse, the steps he has taken towards remediation and his developing insight.
5) The likely impact of the Committee's findings on his practice.

93. The Committee considered the following were the aggravating factors in this case:

1) The serious nature of the Registrant's misconduct, in particular the misuse of a patent's private information and the sexual motivation behind the Registrant's actions. However the Committee accepted Mr Graham's submission that these factors should not be considered as additional aggravating factors beyond that.

2) The Registrant was an experienced professional and should have been well aware that what he was doing was an unacceptable breach of professional boundaries.

3) The Registrant's inadequate appreciation of the impact and gravity of his actions and the impact they had on Patient A. The panel considered that the Registrant's assessment about what had happened remained somewhat distorted. He continued to hold Patient A in some way responsible for his own misconduct. He failed to show any meaningful understanding of how distressing and unnerving his actions would have been for Patient A.

4) The Registrant's inadequate appreciation of the impact and gravity of his actions would have on the reputation of the profession and the view that a member of the public would take of a professional who misused personal information in pursuit of a sexual relationship with a patient.

5) The Registrant has not developed complete insight and remediation. The Committee considered that although that on a basic level the Registrant appreciated that what he had done was not acceptable and his experience of the regulatory process meant repetition was unlikely, his insight remained limited and he had not taken adequate steps to address this important issue. The panel considered there was a pressing need for the Registrant to take further steps to address his lack of understanding of the concerns raised by his behaviour and undertake a high degree of reflection on the underlying attitudes that caused his misconduct.

94. The Committee carefully considered the sanction of no further action as set out in paragraphs 21.3 to 21.8 of the Guidance. It concluded that there were no exceptional circumstances to justify taking no action in this case. The sanctions of no further action and a financial penalty order were not proportionate or sufficient given the Committee's findings regarding the serious nature of the Registrant's misconduct.

95. The Committee concluded that conditional registration would not be practicable due to the nature of the misconduct, which did not involve identifiable clinical areas of practice in need of assessment or retraining. The Committee considered that the Registrant's conduct is attitudinal in nature. Only requiring the Registrant to undertake further steps to improve his insight would not sufficiently mark the serious nature of his misconduct or address the public interest concerns identified.

96. The Committee next considered suspension and had regard to paragraphs 21.29 to 21.31 of the Guidance. The Committee took into account the fact that using a patient's personal data to contact her with a view to pursuing a sexual relationship was a serious matter and in this case, the Registrant had not fully remediated his conduct. In his oral evidence at the impairment stage the

Registrant had demonstrated limited understanding of the impact of his misconduct on Patient A and the reputation of the profession.

97. The Committee balanced this against the Registrant's recent reflection and efforts at remediation, his previous unblemished record, his positive character reference, and the lack of repetition. The Committee also took into account the likely financial impact on the Registrant but bore in mind that it had not heard any direct evidence in respect of this issue. Although the Committee had not been provided with any independent evidence regarding the Registrant's project to make affordable spectacles available in developing countries, it had no reason to doubt the Registrant's commitment to this project and took it into account.

98. Nevertheless, the Committee concluded that a suspension order was required to address the public interest concerns it had identified. It considered that a suspension order would mark the seriousness of the Registrant's conduct, maintain confidence in the profession and declare and uphold proper standards of professional conduct and behaviour.

99. The Committee was satisfied that a reasonable member of the public, in possession of all the facts, would consider that a suspension order was a proportionate sanction in the Registrant's case.

100. The Committee did consider erasure, but was of the view that this would be disproportionate and excessively punitive in light of the low risk of repetition and the potential for the Registrant to achieve full insight and remediation. It also considered that currently erasure was not the only sanction that could protect the public by addressing the wider public interest concerns raised by the Registrant's misconduct.

101. The Committee gave consideration to the length of the order and concluded that six months was the appropriate length to mark the seriousness of the Registrant's conduct and address the public interest concerns it had identified. This would also give the Registrant sufficient opportunity to consider his route back to practice and take further steps to develop insight into his misconduct and the concerns it raised.

102. The Committee considered that a review hearing should take place prior to the expiry of the Registrant's suspension order. Although this Committee cannot bind the Reviewing Committee in any way, it was of the view that a Reviewing Committee would be greatly assisted if the Registrant provided it with:

103. A detailed reflective statement setting out the steps the Registrant has taken to achieve remediation (preferably using a recognised model such as Gibbs).

104. Independent evidence of any relevant training, education or counselling the Registrant has undertaken.

105. The Committee therefore imposed a suspension order for a period of six months and directed that a review hearing take place prior to the expiry of the suspension order.

Immediate order

106. Dr Graydon, on behalf of the Council, applied for an immediate suspension under Section 13I of the Opticians Act 1989, on the grounds that this was in the public interest because it would signify the serious nature of the Registrant's misconduct.

107. Mr Graham, on behalf of the Registrant, opposed the imposition of an immediate suspension. He submitted that the presumption under the rules is that the order does not come into effect until the appeal period has expired. He stated that there are no public protection concerns and risks to patient safety identified in this case.

108. The Committee accepted the advice of the Legal Adviser.

109. The Committee decided not to impose an immediate suspension. It could not identify any compelling reason for an immediate order. There was no risk of repetition, and the serious nature of the Registrant's misconduct did not demand that an immediate order be made. The public interest was best served by allowing the Registrant time to arrange his affairs so that his patients were not adversely affected when the suspension order came into effect. The Committee was satisfied that a member of the public in possession of all the facts would consider an immediate order was justified.

Revocation of interim order

110. There was no interim order in place

Chair of the Committee: Ms Sara Fenoughty

Signature ……S. fenoughty…… **Date: 15 July 2022**

Registrant: Mr John Snelgrove

Signature …… **Date: 15 July 2022**