BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(20)35

AND

ANGELINA BHOPAL (01-29224)

DETERMINATION OF A SUBSTANTIVE HEARING
4-13 OCTOBER 2021 and 10-12 January 2022

Committee Members:	Dr Pamela Ormerod (Chair/Lay) Mr Nigel Pilkington (Lay) Ms Victoria Smith (Lay) Ms Gemma O'Rourke (Optometrist) Ms Sarvat Fida (Optometrist)
Legal adviser:	Ms Lucia Whittle-Martin
GOC Presenting Officer:	Mr Ben Rich (2 Hare Court)
Registrant present/represented:	Yes
Registrant representative:	Ms Jocelyn Ledward (QEB Hollis Whiteman) Mr Adam Weston (BLM Law)
Hearings Officer:	Mr Terence Yates Ms Arjeta Shabani (10 – 12 Jan 2022)
Facts found proved:	1(b); 1(c); 1(d); 2(a); 2(b); 3(a); 3(b); 3(c); 3(d)
Facts not found proved:	1(a)

Misconduct:	Yes
Impairment:	Yes
Sanction:	Suspension Order 6 months (With Review)
Immediate order:	None

ALLEGATION

The Council alleges that in relation to you, Angelina Bhopal (01-29224), a registered optometrist:

1) On or around 19 April 2019, you conducted a MECS examination on Patient A and you:

   a. Failed to conduct an adequate assessment of Patient A's eyes in that you failed to identify signs of a vitreoretinal abnormality in her left eye, despite the patient presenting with 'black floaters, fog/mist and blurry vision'; and/or

   b. Failed to adequately and/or appropriately refer Patient A, for further investigation and/or treatment of retinal tear/detachment; and/or

   c. Wrongly referred Patient A to neuro-ophthalmology, despite the patient presenting with 'black floaters, fog/mist and blurry vision'; and/or

   d. Failed to adequately and/or appropriately advise Patient A regarding any deterioration of her symptoms and the treatment options available to her.

2) On or around the 9 and 10 May 2019, using the staff ID of Registrant A [JB] and/or your staff ID [redacted], you amended Patient A's record of the test you conducted on 19 April 2019 in that you:

   a. At the 'Additional Tests' section, added "adv on f+f "; and/or b. At the 'Reason For Visit' section, added the word(s) "intermittent" and/or "no curtain drop in vision".

3) Your action at 2a and/or 2b above were dishonest in that you amended Patient A's record retrospectively to justify your actions and in particular: a. Added "Adv on f+f" when you had not advised on flashes and floaters on the date of the examination; and/or b. Added the word "intermittent" when Patient A had not reported that her misty vision was intermittent; and/or c. Added "no curtain drop in vision" when that information had not been elicited from Patient A on the date of the examination; and/or d. Failed to indicate on the record that these amendments were made retrospectively.

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

DETERMINATION

Amendment

1. Mr Rich applied to amend the allegation by replacing the words *"retinal detachment"* in Sub-Particular 1(a) with the words *"vitreo-retinal abnormality".*
2. Ms Ledward did not object to the application.
3. The Committee accepted the advice of the Legal Adviser. The Committee concluded that the amendment could be made without causing injustice and allowed the amendment under Rule 46(20) of the General Optical Council (Fitness to Practise) Rules Order of Council 2013, as amended.

Admissions in relation to the particulars of the allegation

4. The Registrant admitted Particular 2 of the allegation and this Particular was found proved accordingly.

Background to the allegations

5. At the material time the Registrant was an optometrist at Specsavers in [redacted].

6. On 19 April 2019 the Registrant saw Patient A. Patient A had diabetes and was myopic, which meant that she was at greater risk of retinal detachment (RD). The Registrant conducted a Minor Eye Conditions Service (MECS) examination. She

recorded the presenting symptoms as “floaters couple of days Le misty eye in Le no flashes”.

7. Patient A subsequently complained about the treatment she received, which caused the matter to be investigated.

8. The case brought by the GOC is that whilst the Registrant conducted a relevant and appropriate range of tests for the Patient A’s symptoms, nevertheless she missed the signs of a vitreo-retinal abnormality (VRA) on 19 April 2019, failed to refer Patient A for investigation for retinal tear or detachment, failed to provide sufficient safety-netting advice, and then dishonestly amended the records retrospectively.

9. It is common ground that prior to seeing Patient A on 19 April 2019, the Registrant would have reviewed Patient A’s Socrates record, Specsavers’s computerised record of patient notes. The Registrant claims that she had access to a triage form, completed by one of her colleagues, which was not saved to Patient A’s record, and cannot now be found.

10. The Registrant then conducted a series of tests and examinations on Patient A, including indirect ophthalmoscopy, to assess for the presence or absence of retinal abnormalities. The Registrant did not identify any VRA’s and concluded that based on the result of the unexplained visual field tests Patient A should be referred. She sent an urgent referral to the Neuro-ophthalmology team at Colchester Hospital, meaning that the hospital would contact Patient A within 2 weeks.

11. By 29 April 2019 Patient A had not heard from the hospital, and the vision in her left eye had deteriorated. She visited another optician, SK, for a second opinion.

12. SK diagnosed a “temporal retinal detachment with a horse shoe tear” and referred her for emergency assessment and treatment to Moorfields Eye Hospital. Patient A was seen that day and on 30 April 2019 she was operated on for “retinal detachment … Left Eye Macula off”.

13. On 2 May 2019, Patient A attended Specsavers and obtained a copy of her records. She did not inform Specsavers why she wanted them.

14. On 9 May 2019, Patient A attended Specsavers to cancel her contact lens contract as a result of her diagnosis and surgery.

15. The GOC instructed an expert, Professor Robert Harper, to examine the records and other documents and provide an opinion on, among other things, whether the retinal tear or detachment was present at the time of Patient A's appointment on 19 April 2019, and if it was, whether the signs should have been detected by a reasonably competent optometrist.

16. The Registrant also instructed an expert, Mr Richard Booth.

17. As part of the GOC investigation two versions of the Socrates computer record for the appointment were obtained and analysed. The first version formed part of Patient A's complaint to the GOC and represented the record as made by the Registrant at the appointment on 19 April 2019. The second version contained additional words, namely "adv on f+f", added by her to the Additional Tests section on 9 May 2019 and "intermittent" and "no curtain drop in vision", which had been added by the Registrant to the "Reason for Visit" section on 10 May 2019. The Registrant accepted that she had added these additional words retrospectively, but claimed that they were honest clarifications and additions which she made to ensure that the record was complete and consistent. It was alleged by the GOC that these were dishonest additions designed to cover up, or mitigate, the Registrant's failure to detect a VRA, and/or to refer Patient A for emergency assessment for potential retinal tear or detachment.

18. The GOC called two witnesses, Patient A and Professor Harper.

19. The Registrant gave evidence and called Mr Booth to give expert evidence together with two character witnesses who attested to her good character.

Findings in relation to the facts

20. The Committee accepted the advice of the Legal Adviser who advised on the burden and standard of proof, expert evidence, dishonesty and good character.

21. Throughout its decision making, the Committee took account of the Registrant's good character, as supported by two character witnesses and a number of written testimonials. It weighed this in her favour when considering her credibility and the likelihood that she had conducted herself as alleged.

Witness evidence

22. The Committee concluded that Patient A was credible and reliable. This was a significant event for her, and she was clear on certain aspects of her evidence despite the passage of time. She began collecting evidence soon after the appointment albeit that she did not complete her written record until September 2019. She was prepared to concede when she did not recall something.

23. The Committee concluded that both Professor Harper and Mr Booth are clearly eminent experts in their field. It was apparent that Mr Booth had more experience of community work. However, in the context of this case, where appropriate, and in particular with regard to interpreting visual fields which was an important theme underlying the allegations 1(b), 1(c) and 1(d), the Committee gave greater weight to the evidence provided by Professor Harper because of his greater experience as a glaucoma specialist accustomed to reviewing such results.

24. The Committee concluded that the Registrant was inconsistent, both when giving her evidence to this Committee, and when comparing the evidence, she gave with evidence she had given in an earlier hearing listed in March 2021, which did not conclude. The Committee formed the view that the material parts of the Registrant's evidence lacked credibility, for example when stating at the end of her evidence, in answer to Committee questions, that she had taken advice from a senior colleague while seeing Patient A on 19 April 2019, whereas this was not something she had mentioned earlier. Overall, her evidence dealt with the generality of what she did rather than the specificity of this appointment.

25. For both the patient and the Registrant the Committee took into account the passage of time and its likely effect on memory. It was also conscious that material had been rehearsed at the March hearing and positions had shifted as to the nature of the defect alleged to have been missed. This was reflected in addendum reports from Professor Harper and a joint report prepared by both experts.

Sub Particular 1(a)

26. Professor Harper stated that given the findings of retinal tear and detachment made by SK on 29 April 2019, as confirmed by Moorfields Eye Hospital, it was *"very likely"* that there would have been some signs of a VRA on 19 April 2019. In his view, given the symptoms experienced by Patient A and the visual field and visual acuity findings, on the balance of probabilities some VRA would have been present, and should have been detected by a reasonably competent optometrist.

27. Mr Booth disagreed. He stated that he was unable to find anything in Patient A's presenting signs and symptoms to indicate that a RD was present on 19 April 2019. He did not accept that the Registrant missed any signs that would have been detected by a reasonably competent optometrist.

1(a) GOC submissions

28. Mr Rich accepted that Professor Harper had not gone so far as to conclude that it was more likely than not that all the signs of VRA would have been present and detectable at the time of the Registrant's examination of Patient A on 19 April 2019. Mr Rich summarised the relevant potential signs as vitreous floaters (or other vitreous opacity causing a "haze" effect or similar), tobacco dust, and retinal tear/emerging retinal detachment. Mr Rich submitted, however, that Professor Harper had formed the view that, on the balance of probabilities, at least one of those signs would have been detectable at the time of the 19 April 2019 examination.

29. Professor Harper's opinion was that the range of symptoms and test results found on 19 April 2019 could not have existed without something observable to cause them.

30. Mr Rich submitted that this was supported by the subsequent findings of a serious retinal detachment with macula off discovered on 29 April 2019.

31. Mr Rich submitted that Mr Booth's view that the visual field defects showed a neurological problem was less credible because:

    a. No neurological issue was ever identified, and the visual field defect in the left eye progressed as the retinal tear/detachment progressed.

    b. The results of the visual field tests on 19 April 2019 made the presentation atypical of neurological defects.

    c. The same was true of the optic tract problem put forward by Mr Booth in his report.

    d. Professor Harper was of the view that had Patient A had a history of diabetic retinopathy, or had she been observed to have had retinal complications, a retinal problem associated with her diabetes could have provided an explanation for the visual field loss. However there did not appear to be a history of any diabetic retinopathy and none was documented by the Registrant.

e. The suggestion that the field defects in the left eye on 19 April 2019 were unrelated to the retinal detachment found on 29 April 2019, led to the conclusion that the finding on 19 April 2019 was either a coincidence, or a completely separate pathology that was never found.

1(a) Registrant's submissions

32. Ms Ledward accepted that on the evidence Patient A presented on 19 April 2019 with symptoms of floaters and misty/blurred vision in the left eye, which had been present for a day or two.

33. Ms Ledward also accepted on the evidence that the Registrant observed the following signs during her examination and assessment of Patient A:
- a 1-line drop in visual acuity in the left eye;
- a field defect in both eyes, with a loss of sensitivity which appeared to be more marked in the left eye than the right. The central testing area, reflecting the immediate area of the macula, showed the same degree of loss in both eyes.

34. The Registrant recorded the following signs or absence of signs:
- the vitreous was *"clear"* in both eyes, recorded in Socrates
- in relation to the peripheral retina in both eyes *"all quadrants checked Flat/Even Pigmentation, no vitreo-retinal abnormalities",* recorded in Socrates;
- *"dilated examination revealed no obvious vitreo-retinal abnormalities" / "no signs of PVD or RD"* in the left eye, recorded in Optomanager [a parallel recording system for MECS consultations].

35. Ms Ledward accepted that the evidence was that Patient A's symptoms had worsened considerably by 29 April 2019. However, she submitted that Professor Harper had relied on the benefit of hindsight to reach his conclusions, based on the findings of 29 April 2019, whereas neither expert could be certain about the condition of Patient A's eye on 19 April 2019, or more particularly what observable signs would have been there on that day.

36. In relation to floaters, Ms Ledward accepted the evidence that these can indicate problems with the retina or can be caused by posterior vitreous detachment (PVD) and are consistent with development of PVD. Mr. Booth accepted that, with the benefit of hindsight, a PVD was more likely than not to have been present on 19 April 2019, albeit one that was not detectable by a reasonably competent optometrist. His view was that this would have progressed to a retinal tear and detachment over the course of the following 10 days. However, he confirmed in evidence there was a distinction to be drawn between a conclusion that a PVD was

probably present, and signs, as opposed to symptoms, of a PVD being evident to an optometrist upon examination. Professor Harper had agreed that an uncomplicated PVD is not necessarily something that a reasonable competent optometrist would be able to see.

37. Professor Harper had accepted that the progression from PVD to retinal detachment (RD) can easily occur within 10 days.

38. Mr. Booth had agreed that a PVD is a form of VRA. However, the GOC's allegation was not merely that there was a VRA present, but that there were signs of a VRA which the Registrant failed to identify. The GOC's case was that this must have been more than an uncomplicated PVD, of which there might be no visible sign; this must have been a PVD with some complication, which produced structural changes in the vitreous which the Registrant ought to have been able to see.

39. Professor Harper had accepted that the content of the Registrant's examination was reasonable. In evidence, he described it as *"very reasonable".*

40. Neither expert had suggested the possibility that a tear or emerging RD was necessarily present by 19 April 2019 on the balance of probabilities. Ultimately, the tear was very peripheral. Professor Harper had accepted that if a tear was present, it may not have been so easily visible upon conventional fundus examination with slit-lamp binocular indirect ophthalmoscopy, such as the Registrant had completed. Mr Booth stated that given the position of the tear, it would not have been detectable on 19 April 2019 through slit-lamp binocular examination at all. Mr. Booth gave evidence, and Professor Harper agreed, that any emerging retinal detachment would progress from the position of the tear.

41. There was no evidence of a differential drop in intraocular pressure, which Professor Harper accepted was a neutral finding. There was no evidence of "curtain drop", which is a "textbook" RD symptom according to Professor Harper. There was no evidence of flashes.

42. Misty vision was a symptom reported by Patient A and recorded by the Registrant. Professor Harper attached some significance to this symptom. Mr Booth stated that this was probably the most common symptom in community practice. He accepted that it can indicate problems with the retina, but in his view it usually does not.

43. Both Professor Harper and Mr. Booth agreed that the vast majority of floaters are non-consequential. Both experts agreed that the vast majority (90-95%) of people who get symptoms of PVD, such as floaters, do not get a tear or RD.

44. A 1-line drop in visual acuity was recorded by the Registrant. Professor Harper agreed with Mr. Booth that this may be of no clinical significance.

45. The visual field test result showed a field defect that was more significant in the left eye, but was also present in the right eye. Both experts agreed that there was nothing about the right eye result which suggested it was artefactual. Mr. Booth was of the view that it was as equally likely to be *"real"* as artefactual. Professor Harper agreed that the loss in the central field was the same in both eyes. Mr. Booth stated that field defects are often worse in the left eye because the left eye is tested after the right.

46. Professor Harper agreed that if it were not for the left eye visual field test result, it would be difficult to conclude that it was more likely than not that a VRA (in the sense of at least a PVD with some complication) of some kind was present.

47. Professor Harper agreed that the visual field test results were *"confounding"* for the Registrant and made for a *"tricky"* presentation, adding: *"in fairness to the Registrant, it did cause a problem for her"*. Both experts agreed that a visual field test is not normally done to test for RD; nor can the results alone tell you whether there is a RD or retinal problem.

48. In Mr. Booth's view it was outside the scope of an optometrist's expertise to opine on the state of the eye on 19 April 2019 based on the findings of 29 April 2019 alone; that was an exercise which only a vitreo-retinal surgeon would be capable of undertaking.

49. Professor Harper's evidence was that it is more likely than not that there was some VRA present on 19 April 2019, sufficient to cause the visual field loss in particular, which would have been visible to a reasonably competent optometrist, and which the Registrant failed to detect. He described this in evidence also as *"some structural change"* to the vitreous. However, he could not identify with precision what the sign of this VRA was likely to have been. He set out a number of possibilities:

    (a) Shafer's sign / tobacco dust – a sign which would only be present if the PVD had progressed to a tear; which Professor Harper himself considered might not have been visible to a reasonably competent optometrist.

    (b) An emerging RD, which Professor Harper no longer contended, on balance of probabilities, would have been visible to a reasonably competent optometrist;

(c) PVD with complications: resulting in vitreous floaters or haemorrhage or some kind of greater haziness / opacity / turbidity / observable change in the vitreous of the left eye as compared with the right. Professor Harper stated that this haziness might have been caused by:

- Vitreous floaters without associated haemorrhage: Professor Harper agreed that, depending on the precise type and size, such floaters may be hard to see. Mr. Booth went further and said they can be very difficult to pick out.
- Vitreous floaters with associated haemorrhage: Professor Harper accepted there was no evidence of *"frank"* vitreous haemorrhage. He suggested a more diffuse kind of distribution of haemorrhage, which would be difficult to identify as haemorrhage, but which ought to have been capable of being detected by a reasonably competent optometrist.
- Haziness / turbidity: Professor Harper opined a *"general turbidity"* or *"hazy vitreous"*. He was not suggesting that the vitreous was extremely hazy, only that there might be some detectable difference as between the two eyes.

50. Ms Ledward submitted that the GOC sought to prove Sub-Particular 1(a) on the basis of Professor Harper's evidence that the symptoms were such that there would have been a VRA, which he could not specify with clarity, *"some individual features of which may have been tricky to detect"*. Mr Booth did not agree with Professor Harper's view. Vitreous floaters (no haemorrhage), are a possible sign of PVD, no more. The same may be said of misty vision. Further a PVD, whilst likely to have been present, would not necessarily have been evident for the Registrant to see.

51. Ms Ledward submitted that the GOC's case was based on reversing the burden of proof, and that the case had been brought on the premise that the Registrant must have missed a sign, in circumstances where the GOC was unable to prove what sign that was.

1(a) Decision

52. The Committee took account of the evidence agreed by both experts that the assessment that was undertaken was comprehensive and that no relevant tests had been omitted.

53. The Committee noted that both experts had agreed that there was no certainty regarding what signs would have been there to observe upon examination on 19 April 2019.

54. Professor Harper had set out a number of signs of a VRA, namely floaters, tobacco dust, a vitreous haze, and retinal tear/ emerging retinal detachment, which in his opinion a reasonably competent optometrist ought to have detected. However, whilst his evidence was that there would have been signs of a VRA, he qualified his opinion by adding *"and/or suspected such signs",* which appeared to the Committee to introduce some uncertainty regarding what sign he was suggesting had been missed. He had conceded: *"some individual features of which may have been tricky to detect".*

55. The Committee accepted Mr Booth's view that it was not possible to be precise as to when the tear/detachment commenced and therefore it was not possible to be confident there would have been any evidence of the signs of tobacco dust or vitreous hemorrhage or the tear/detachment itself on 19 April 2019.

56. The images dated 29 April 2019, which resulted from Patient A's examination with SK as confirmed by Professor Harper were very clear and did not show significant vitreous haze, and the Committee accepted the evidence given that it is likely the haze may have been difficult to detect on 19 April 2019.

57. The Committee concluded that any variation in the vitreous material originating from a PVD, which each expert agreed was likely to have been there, may not in itself have signified serious consequences for the patient in the future.

58. Three further potential signs were available to the Registrant to detect: the intra ocular pressures, which both experts agreed was merely a neutral finding of no particular relevance to the detection of RD in this case; the one line drop in visual acuity in the left eye; and the loss of sensitivity in the visual field which was marked in the left eye but also present in the right eye. The experts agreed that the drop in visual acuity was slight and not in itself a strong indication of RD. The Committee had heard that the defects in visual fields were confusing, would not normally be relied on in relation to RD and would not generally be indicative of RD.

59. The Committee agreed with the submission mounted on behalf of the Registrant that the GOC was seeking to prove this Sub-Particular in the knowledge of the events of 29 April 2019 and working back, whereas the reality is that it had not

proved on the balance of probability what sign or signs suggestive of VRA were actually present on 19 April 2019, if any, that should have been detected.

60. The Committee accepted the reasoning and submissions put forward on behalf of the Registrant, as summarised in this determination, and in particular the point made by Ms Ledward regarding the importance of distinguishing signs from symptoms when considering the way in which this particular is drafted. The Committee further determined that a suspicion of RD as alluded to by Professor Harper cannot be characterised as a sign.

61. The Committee noted that this sub-particular alleges the Registrant failed to conduct an adequate assessment of Patient A's eyes by failing to identify the signs of a VRA in the left eye. Essentially as stated in paragraph 23 above, the Committee preferred the evidence of Professor Harper where he and Mr Booth disagreed. However, even on the evidence of Professor Harper the Committee was not satisfied that this sub-particular was proved. Professor Harper was unable to say with certainty which identifiable sign or signs were there to be seen on 19 April 2019. His evidence lacked specificity in relation to what sign he believes the Registrant may have missed. He agreed that her assessment was "very reasonable".

62. In light of this the Committee concluded that the GOC had not persuaded it on the balance of probabilities that the Registrant had failed to conduct an adequate assessment of Patient A's eyes by failing to identify signs of a VRA in the left eye, because it was unclear whether an identifiable sign or signs were observable at the time.

63. Accordingly, the Committee found Sub-Particular 1(a) not proved.

Sub - Particular 1(b)

64. It was Professor Harper's opinion that even though the Registrant had not detected the signs of a VRA, she should have referred Patient A to hospital as an emergency, given the mix of symptoms, history and test results. He said that a young, myopic diabetic patient, who presented with the symptoms described by Patient A, and who displayed a small loss in visual acuity and a visual field loss in the left eye, should have caused the Registrant to make the referral even if she could not detect a problem because she should have suspected that a retinal problem was present.

65. By contrast, Mr Booth was of the view that the reduction in visual acuity was not significant and the visual field drop was not consistent with a temporal RD. He stated that according to the College of Optometrists Guidance, Patient A's symptoms would not require an emergency referral, in the absence of actual signs of a retinal tear or detachment.

1(b) GOC submissions

66. Mr Rich relied on the conclusion reached by Professor Harper that regardless of the fact that the Registrant did not detect the signs of a VRA, she should have referred Patient A as an emergency, given the mix of symptoms and history.

67. Professor Harper had said that Patient A was a myopic, diabetic, [redacted] patient, who presented with recent onset floaters, and blurred vision, and who displayed visual field loss in the left eye, and had a fall in visual acuity in that eye, which should have caused the Registrant to suspect that a retinal problem was present, and to make the referral, even if she could not detect a problem herself.

68. Mr Rich accepted that the right eye visual field test result made assessing the case more difficult. However, he relied on Professor Harper's view that the most likely issue from the unexplained signs and symptoms was a serious retinal issue and therefore an emergency referral was necessary.

1(b) Registrant's submissions

69. Ms Ledward submitted that this Sub-Particular involved a fundamental disagreement between the two experts.

70. Professor Harper had accepted this was a *"tricky"* presentation for the Registrant to have to deal with, but he nevertheless took the view that even if she did miss or fail to identify any signs of a VRA of the order of a complicated PVD or beyond, the Registrant should have referred to the hospital as an emergency, in order to rule out that possibility. She submitted that that is not consistent with either the College of Optometrists Guidance or the local protocol which the Registrant was operating under.

71. Ms Ledward submitted that Mr. Booth had been unable to find anything in Patient A's presenting signs which would indicate a PVD; nor anything in her presenting signs and symptoms to indicate a RD was present on 19 April 2019. In cross-examination, he had accepted that if there had in fact been a PVD present (as he accepted was more likely than not), the PVD might have been detected by a vitreo-retinal surgeon if a referral to hospital had been made. However, a PVD

was not likely to cause a tear or RD: the hospital eye service was not there to confirm a non-problematic PVD. Such a condition is not treatable. Patient A may have had symptoms of a PVD but most PVDs do not require referral to the hospital eye service.

72. Professor Harper was of the view that the NICE guidance was of relevance, or at least that an optometrist ought to be familiar with it. However, he accepted that the College of Optometrists Guidance is more directly applicable to the practice of optometry.

73. Mr. Booth did not think that the Registrant had done anything that was not in line with the guidance, saying:

"[the College of Optometrists] Guidance lists emergency referrals to include: - retinal detachment, pigment in the anterior vitreous (tobacco dust), vitreous, retinal or pre-retinal haemorrhage, lattice degeneration or retinal break with symptoms. MECS guidelines state that patients with flashes and/or floaters should only be referred as an emergency to the hospital if their symptoms include a shadow in their vision, or if tobacco dust is present, or if a retinal tear has been identified. None of the above signs or symptoms were present on 19 April 2019"

74. In evidence, Mr Booth also expressed the view that "loss of vision" in the context of the College of Optometrists Guidance refers to something far more significant than the 1-line drop in visual acuity and the visual field test results of Patient A.

75. Ms Ledward submitted that in contrast to Professor Harper, Mr. Booth was strongly of the view that there was nothing on the face of the Registrant's assessment and examination findings to justify an emergency referral.

76. She submitted that the weight of the Guidance to which the Registrant had to have regard supported the opinion of Mr. Booth rather than that of Professor Harper.

1(b) Decision

77. The Committee accepted the opinion of Professor Harper in preference to that of Mr Booth who focussed on the interpretation of the VF in isolation and not in the context of the other information available.

78. Professor Harper stated that the reasons provided by the Registrant for making a referral to neuro-ophthalmology, rather than making an emergency referral to hospital, were not adequate. He said that the Registrant ought to have referred as

an emergency for a suspected RD even though she herself did not observe one, and this was principally because of the combination of symptoms and loss of visual function. A referral for a suspected RD was indicated because of the significant loss of visual field in the left eye, combined with symptoms and loss of acuity and in the circumstances of this patient's medical history and symptoms.

79. Professor Harper had stated that in particular a myopic, diabetic, [redacted] patient, who presented with recent onset floaters, and blurred vision, and who displayed visual field loss in the left eye, and had a fall in visual acuity in that eye, should have led the Registrant to suspect that a retinal problem was present. In those circumstances she should have made a referral, even if she could not detect a problem herself. The Committee agreed with Professor Harper when he stated that the Registrant ought to have been considering that Patient A may have had a RD that she herself had not detected and she should have referred as an emergency accordingly.

80. The Committee accepted that the assessment undertaken by the Registrant was comprehensive and that the appropriate tests had been conducted in the light of Patient A's symptoms. However, the classic symptoms of possible RD remained unexplained, something which the Registrant herself suspected at the early stages. It determined that she did not correctly interpret her findings, especially those obtained on the VF and VA in conjunction with the reported symptoms. She should not have divorced the reported symptoms and medical history of Patient A from the VF results in particular, even where no VRA had been detected. The VF and the VA results were confounding as stated by Professor Harper but did not contradict the proposition of a left eye abnormality.

81. Further the Committee concluded that had the Registrant taken full account of all the information available to her, as indicated by Professor Harper, the College Guidelines and the NICE guidance referenced therein would have directed the Registrant to make an emergency referral.

82. In the circumstances, the Committee was satisfied on the balance of probabilities that the Registrant failed to adequately and appropriately refer Patient A for further investigation and/or treatment of retinal tear/detachment.

83. Accordingly, the Committee found this Sub-Particular proved.

Sub-Particular 1(c)

84. The GOC's case relied on the evidence of Professor Harper, whose report stated that *"sudden onset floaters is not a symptom of a neuro-ophthalmic condition"* and that there was *"not … any convincing evidence for a neuro-ophthalmic problem from the visual field screening test".* His view was that a referral to the hospital neuro-ophthalmologist was not indicated, and should not have distracted the Registrant from the primary issue which was, or should have been, concern that there was a retinal problem.

85. The Registrant relied on the evidence of Mr Booth, who stated in his report that in his view a referral to a neuro-ophthalmologist was reasonable, given the symptoms the Patient presented with, and the results of the various tests and examinations done.

1(c) GOC submissions

86. Mr Rich relied on Professor Harper's view that the field loss in both eyes did not suggest a neurological problem but a retinal problem. Mr Rich submitted that was correct because:

    a. No neurological problem was ever identified.

    b. Mr Booth's view that the location of the field defect was not consistent with the retinal detachment applies equally to the visual field test taken by SK on 29 April 2019 when the retinal detachment was large and present.

    c. It was not credible to suggest that on both days a separate neurological problem existed of which the visual field loss was a symptom.

    d. The fact that the right eye also appeared to have a loss on 19 April 2019 was explicable as an artefact. That was more likely given that the losses in the right eye were far fewer.

    e. The pattern of the visual field loss was not typical of an optic tract issue as suggested by Mr Booth. Mr Rich submitted that this suggestion was purely speculative.

    f. There was no evidence of any systemic issue such as had been suggested by Mr Booth.

    g. A neurological problem would not explain the floaters.

87. Mr Rich submitted that the College of Optometrists Guidance and the local MECS protocol, did not justify the failure to refer as an emergency because:

    a. The Guidance for Professional Practice "… Flashes and Floaters" "Emergency referrals include:" provides a non-exhaustive list of classic signs of RT/RD. It does not deal with a situation where a significant visual field loss is found, or a loss in visual acuity.

    b. The same point applied to the local MECS protocol, which did not mandate that there must be a shadow in vision, tobacco dust, or an identified tear before a patient can be referred.

    c. The Guidance on "Examining patients who present as an emergency" mentions "loss of vision", and emphasised the need for clinical judgement on all cases.

88. Mr Rich submitted that Professor Harper's view was that the constellation of symptoms and signs was a potential RD, and at the very least required the discovery of a cause. If one was not apparent, an emergency referral was indicated. Mr Rich submitted that the Registrant's evidence supported the suggestion that she had a continuing risk of retinal tear/detachment in mind when she referred to the hospital:

    a. She had no explanation for any of the signs and symptoms on 19 April 2019.

    b. She requested an OCT scan which is generally used for retinal problems.

    c. She appeared to accept in the March 2021 hearing the possibility that she had missed tobacco dust or other signs.

    d. She expressed the view in the March 2021 hearing that she was content with an urgent referral because the hospital could upgrade it. This suggested that she was aware that something more than an urgent referral might be required, but was relying on the hospital to pick it up if thought necessary.

<u>1(c) Registrant's submissions</u>

89. Ms Ledward submitted that this Sub-Particular concerned a fundamental disagreement between the two experts.

90. Ms Ledward relied on the view held by Mr Booth, who considered that the visual field test defects indicated a neurological defect of the optic tract, that such bilateral field defects could be produced by systemic disease such as diabetes, and that an OCT scan might have revealed retinal disease in the deeper layers of the retina and choroid. Mr Booth did not accept the general proposition that, typically, neurological problems stay on one side of the midline. He had explained that whilst the textbook advice is that defects caused by neurological problems respect the vertical midline, it was not as clear cut as that in practice, and there were anatomical reasons why that was so.

91. The Registrant gave evidence that having not seen any signs of retinal detachment or tear, such as would warrant an emergency referral, she needed to act on the results of the visual fields defect that she found. She accepted the field defect distribution was not *"typical"* of a neurological problem, but said it was not *"crystal clear";* and she was concerned about a neurological issue of some kind, perhaps a condition affecting the optic nerve and about the central defect in the visual field tests. She decided an OCT scan was an enhanced test that might pick up neurological and central visual field problems, as well as issues with the deeper layers of the retina and the macula, and which would generally provide further information, so that other conditions could be ruled out, to the benefit of the patient.

92. Ms Ledward submitted that Mr. Booth confirmed in evidence that a reasonably competent optometrist would have tended to think of the visual field test results in terms of a neurological rather than retinal problem. He agreed that the Registrant had to regard the right eye defect as potentially real, and to act on it, and that is what she did. In his written evidence, he described the referral as appropriate and timely.

1(c) Decision

93. For the reasons relied on by Mr Rich, the Committee accepted the opinion of Professor Harper who stated that the visual field loss was not suggestive of a neurological condition and at the material time a suspected retinal detachment remained the most probable diagnosis. Professor Harper's view was that an optometrist needs to recognise that they themselves may not be able to make a definitive diagnosis of a VRA. Referral to the most appropriate person to undertake such a definitive examination was required in those patients at risk of a RD when presenting with symptoms and signs of concern.

94. The Committee concluded that the Registrant had been inappropriately reassured by the negative results of her internal examination, the intra-ocular pressures and

the VA test results when she should not have been. She should not have considered the VF results in isolation. On her evidence, she was aware that there was something problematic about the visual field tests, but did not arrive at a definitive explanation. The visual acuity did not contradict a RD albeit that it did not give it substantial positive support.

95. The Committee was of the view that on the basis of the information the Registrant had, the decision she made was incorrect. There was not enough information in the visual field test on which to base a referral to neuro-ophthalmology. If this was her primary concern there were other tests that she could have undertaken. Patient A's presenting symptoms, namely the sudden onset of floaters and mistiness, remained unexplained and concerning.

96. The Committee was satisfied on the balance of probabilities that the Registrant wrongly referred Patient A to neuro-ophthalmology, despite Patient A presenting with "black floaters, fog/mist and blurry vision".

97. Accordingly, the Committee found this Sub-Particular proved.

Sub-Particular 1(d)

98. The GOC's case was that the Registrant recorded on Patient A's notes of 19 April 2019 *"any probs to return"* and *"dilated adv on drops given".* There was no record of any specific advice given to Patient A regarding flashes and floaters, or on what to do if her vision worsened, and in particular that she should attend eye casualty immediately. Patient A said that she was given no such advice. Professor Harper set out the type of detailed advice he would have expected the Registrant to give in those circumstances.

99. The Registrant relied on Mr Booth's opinion, which was that the advice given by her to return if there were any problems was reasonable in the circumstances.

1(d) GOC submissions

100. Mr Rich submitted that there was no evidence in the record of 19 April 2019 that the Registrant had advised Patient A on flashes and floaters or on what to do if her floaters or blurred vision worsened, or that if it did she should attend eye casualty immediately, not the opticians.

101. He submitted that Patient A in oral evidence denied she had been given any advice to return, and said had she been given such advice she would have done

so. That was consistent with what Patient A in fact did. Her sight worsened during the ten days following the appointment with the Registrant. She waited for the hospital referral, phoned into the practice and was told to continue waiting for the referral and then went to SK for a second opinion rather than returning to Specsavers.

102. Mr Rich submitted that the Registrant accepted that she did not give specific advice on the risk of RD, or that the worsening of the floaters would be an urgent problem requiring a visit to eye casualty or immediate return to the opticians.

103. Both experts agreed that a failure to advise specifically about the risk of retinal detachment if the symptoms worsened would amount to a failing.

1(d) Registrant's submissions

104. Ms Ledward submitted that the Committee should be cautious about relying on Patient A's evidence on this point in light of the Registrant's contemporaneous note on the Socrates records that she had advised *"any probs to return".* The Registrant's evidence was that she told Patient A to return if there were any problems, as noted in her contemporaneous record. Mr. Booth regarded that advice as *"reasonable".* It was inherently unlikely that the Registrant would have given no advice to Patient A about what to do in the event her symptoms deteriorated.

105. Ms Ledward accepted that the experts agree that the Registrant should have given advice on flashes and floaters. The Registrant's evidence was that she specifically remembered telling Patient A that if she noticed her floaters getting worse she should come back. She could not now remember giving similar advice regarding the onset of flashes, but she said that the two (flashes and floaters) come as a pair, so thought she would have done. She accepted she did not give specific advice on RD.

1(d) Decision

106. Both experts had approached the matter on the basis that the Registrant advised that the patient ought to return *"if probs"*. The patient did not recall any specific advice, nor did the Registrant clearly indicate whether advice about flashes and floaters had been given on 19 April 2019. Both experts agreed that she should have advised regarding flashes and floaters if a RD was suspected.

107. The College of Optometrists Guidance on "Examining patients who present with flashes and floaters" states at A203 that *"If you suspect a retinal break or tear you*

should, as a minimum: (d) give appropriate advice to the patient which you back up with written information".

108. The Registrant's evidence was that a RD had formed an early part of her decision making regarding the management of this patient. However, she did not reflect this in her records on 19 April 2019.

109. The Committee concluded that advice given to return if there are any problems was insufficient. There should have been a reference to floaters and flashes and Patient A should have been advised of what to do if the floaters became worse, or her vision deteriorated, and warned of the potential risk of RD however remote the Registrant considered it to be. Better practice would have been to provide advice in writing.

110. The fact that Patient A did not return to Specsavers, but phoned the practice to chase the referral, supported her evidence that she had not been advised to return to the store if her floaters or blurred vision worsened in circumstances when this did occur.

111. The Committee was satisfied on the balance of probabilities that the Registrant failed to adequately and appropriately advise Patient A regarding any deterioration of her symptoms and the treatment options available to her.

112. Accordingly, the Committee found this Sub-Particular proved.

Particular 3

113. The Registrant admitted by means of Particular 2 that she amended Patient A's record retrospectively, by adding the words *"Adv f+f"* on 9 May 2019, in the section entitled *"Additional tests",* and by adding the words *"intermittent"* and *"no curtain drop in vision"* on 10 May 2019, in the section entitled *"Reason for visit"*. The issue for Particular 3 was whether she did so dishonestly.

3 (a) – (d) GOC submissions

114. Mr Rich submitted that at the time the Registrant altered the records, the facts as known to the Registrant, according to the evidence the Committee had received, included the following:

a. That any suspected retinal tear or retinal detachment required an 'emergency' referral.

b. That the patient had required surgery for a retinal detachment 11 days after she, the Registrant, had referred the patient for an 'urgent' appointment.

c. That the patient had come into the store to report this.

d. That the Socrates records as they then stood did not show that the patient had said the misty vision was "intermittent", or had "no curtain drop in vision" or that the Registrant had advised on flashes and floaters and that if they did it would tend to justify the urgent, neurological referral as opposed to an emergency retinal referral.

e. That the patient had not said "intermittent" to either her or the triage staff.

f. That the Registrant had not elicited "no curtain drop in vision"; alternatively that she could not remember if she did.

g. That the Registrant had not advised on flashes or floaters, alternatively that she could not remember whether she had.

h. That a member of staff should not use another's login.

i. That records entered retrospectively should state that.

115. Mr Rich submitted that altering the records in the light of the facts known to her at the time, was plainly dishonest if she either knew that what she was adding was not true, or could not remember if it was true and stated it anyway. Mr Rich accepted that if the Registrant genuinely believed that what she entered had happened, that would not be dishonest, even if her belief was mistaken.

116. Mr Rich invited the Committee to infer dishonesty from the facts and circumstances surrounding the amendments to the records, namely that:

a. Despite their crucial importance to Patient A's treatment, none of the points that the Registrant added retrospectively were recorded on either Socrates or Optomanager [on 19 April 2019].

b. The amendments were made after the Registrant found out that Patient A had been diagnosed with a retinal tear and detachment.

c. The amendments were made on two separate days.

d. The amendment on 9 May 2019 was made by the Registrant under the login of a colleague which the Registrant knew was forbidden and she

also knew that using someone else's log in would make the amendment harder to trace.

e. There was no evidence available from the triage form, claimed by the Registrant to be a possible source for the word *"intermittent",* as it could not now be located, but the structure of the form made it unlikely that *"intermittent"* would have been written on it. It is unlikely the Patient would have said it, and unlikely the reception staff or whoever did the triage would have asked.

f. *"Intermittent"* and *"No curtain drop in vision"* were not originally written on either the Optomanager system or Socrates. These in particular would have been reassuring indications that a retinal detachment was not present, and it is highly unlikely they would not have been recorded (in the case of *"no curtain drop in vision"),* or in the case of *"intermittent"* put on the Optomanger record or put onto Socrates.

g. The Registrant knew that these amendments tended to justify her actions; in oral evidence the Registrant clearly knew the significance of these symptoms.

h. The addition of *"adv on f[lashes] + f[loaters]"* serves to reduce the Registrant's responsibility for Patient A having simply waited for the referral letter for some time before getting a second opinion. Patient A categorically denied this was said and stated she would have returned if warned.

i. In the case of the *"adv on f and f"* and *"no curtain drop"* the Registrant claims to have a specific memory of what she says, which is unlikely given the 300 or so consultations she did in between the consultation with Patient A and the amendments to the records.

j. The Registrant did not indicate that these amendments were made retrospectively. The Registrant stated that she did not know that Patient A had been to the store, so could not have known that Patient A had an earlier version of the records which would expose the additions. Her knowledge that changes were date stamped is therefore irrelevant as, without the earlier printout, it is highly unlikely anyone would have questioned it.

k. The general credibility of the Registrant's evidence is low.

3 – points general to 3(a)-3(c) - Registrant's submissions

117. Ms Ledward submitted that at the time of the amendments, Patient A had not complained to Specsavers. All the additions to the records were relevant to the issue of a risk of RD and the appropriateness of the Registrant's response. This was not surprising, given that the amendments were made after the report came through that Patient A had suffered a RD. The Registrant's decision to access the records was prompted by a desire to check that the hospital referral had been actioned by others. Noticing that Patient A's record was not as complete as it might be, she wished to rectify that defect. She was well aware that any amendments to the Socrates record would be logged.

118. Ms Ledward accepted that the amendments made on the evening of 9 May 2019 were under the log-in of a colleague. She submitted that this was a commonplace mistake in a workplace using shared terminals. The Registrant used her own log-in for the second set of amendments the following morning, which was indicative of no intent to deceive.

3(a) Registrant's submissions

119. Ms Ledward submitted that whilst Patient A claimed to have been given no advice on flashes and floaters, it was the Registrant's case that she told Patient A to return if there were any problems, and that she specifically remembered telling Patient A that if she noticed her floaters getting worse, she should come back. The Registrant could not now remember giving similar advice to Patient A regarding the onset of flashes, but clarified in evidence that flashes and floaters come as a pair, and for that reason she thought she would have done so. The Registrant had noted contemporaneously *"any probs to return".*

120. Ms Ledward submitted that it was inherently improbable that the Registrant would falsely add something to the record that she knew had not taken place. It was more likely that the Registrant might, through a naïve desire to ensure the record was complete, have added information which she routinely tells her patients and which she believed she had done on this occasion.

3(a) Decision

121. The Committee accepted the submissions put forward by Mr Rich, and rejected those put forward by Ms Ledward.

122. The Committee took into account the Registrant's good character, and weighed this in her favour, as it did in relation to each of its decisions.

123. Patient A's evidence was that the Registrant did not advise her on flashes and floaters at any point on 19 April 2019. Patient A was credible on this point.

124. The Committee did not accept the Registrant's evidence that she did provide this advice or that she believed she may have done so. Her evidence was vague and unclear on this point and unconvincing with regard to flashes in particular.

125. The Committee did not believe the Registrant's evidence that she made the amendment for innocent reasons. It examined the Registrant's purported motivation for accessing the records. While the desire to ensure that her referral had been acted upon efficiently may have been credible, the Committee was unpersuaded of the necessity to ensure that the record was comprehensive other than to protect her own position in the circumstances of what she now knew to have happened. She claimed to have a clear memory of the consultation but agreed that she had seen perhaps 300 patients in the meantime. Only on the occasion of the patient's return visit did she claim to have remembered that she "would have advised re F&F", although at times she admitted that she couldn't actually remember advising on flashes. The Committee concluded that she made the amendment deliberately with the intention of covering up her actions and/or failure to act.

126. The Committee concluded, on the balance of probabilities, that when the Registrant added the words *"Adv on f+f"* on 9 May 2019, she did so deliberately, without any real belief that she had given that advice to Patient A, and her actions were designed to minimise her responsibility for the consequences for Patient A.

127. The Committee concluded that this behaviour was dishonest by the standards of ordinary decent people.

3(b) Registrant's submissions

128. Ms Ledward submitted that although Patient A's evidence was that she thought her misty/blurred vision was constant by the time she saw the Registrant, it might have been *"on and off"* when it started. Patient A could not recall whether she had said it was *"on and off"* or whether she had been asked if it was constant when she telephoned Specsavers on 19 April 2019. When re-examined she was sure this symptom had been constant. She conceded that she was being asked about events two and half years ago.

129. Ms Ledward submitted that unless the GOC satisfied the Committee that the word *"intermittent"* was not on the triage form, and that Patient A could not have communicated that her symptoms were intermittent to anyone at Specsavers, this allegation should not be found proved.

3(b) Decision

130. The Committee accepted the submissions put forward by Mr Rich, and rejected those put forward by Ms Ledward.

131. Patient A was clear that she did not and would not have described her condition as intermittent. The Registrant's explanation regarding possible reliance on what was written on the triage form, including the possibility that it contained the word "intermittent", was implausible and convoluted, moving as it did between referring to both floaters and mistiness and then mistiness alone. Her explanation as to the circumstances of recovering the triage form on the day after Patient A's visit and its subsequent disappearance lacked credibility. The Committee did not accept the Registrant's evidence.

132. The Committee concluded, on the balance of probabilities, that when the Registrant added the word *"intermittent"* on 10 May 2019, she knew that Patient A had not reported to her that her misty vision was intermittent, yet deliberately added the word to justify her actions, having discovered by then that Patient A had been diagnosed with a retinal tear and detachment by another optometrist, SK.

133. The Committee concluded that this behaviour was dishonest by the standards of ordinary decent people

3(c) Registrant's submissions

134. Ms Ledward submitted that it was clear that the Registrant was alert to the possibility of PVD, retinal tear and/or RD.

135. Professor Harper described "curtain drop" as the "textbook" symptom of RD. A reasonably competent optometrist, alive to the possibility of a PVD and/or retinal detachment, would be expected to ask a patient presenting with flashes and floaters whether they were experiencing a curtain drop in their vision.

136. The Registrant's evidence was that in a case of fuzzy or blurred vision she would routinely ask if the patient had noticed a curtain effect, and this is what she did with Patient A.

137. Patient A's witness statement of September 2019 was silent on the issue of whether the Registrant asked her about curtain drop. Patient A's evidence was that she had not experienced curtain drop at this or any other time. In evidence, when asked for the first time, she said that she could not recall whether or not the Registrant had asked her about this.

138. Ms Ledward submitted that the Registrant's evidence was inherently probable and there was no evidence to the contrary. The fact that "no curtain drop in vision" was not recorded contemporaneously may be suggestive of imperfect record keeping, but was not sufficient to establish, on the balance of probabilities that "no curtain drop in vision" was not in fact elicited from Patient A.

3(c) Decision

139. The Committee accepted the submissions put forward by Mr Rich, and rejected those put forward by Ms Ledward.

140. Patient A could not now, some 2.5 years later, recall whether or not she had provided the Registrant with this information. However, the Registrant had not recorded on Optomanager that she had made the enquiry. This was in sharp contrast with other parts of the record, where the Registrant did make a record of negative symptoms, for example the absence of a headache and diplopia. The Committee concluded that had the Registrant elicited information regarding "no curtain drop" from Patient A on 19 April 2019, she would have made a record of it, as it was clearly relevant to the condition that she initially suspected; the Committee had heard that "curtain drop" is a classic symptom of RD. The Committee concluded that the lack of record in Optomanager was not due to poor record keeping, and that the retrospective amendment to Patient A's records was carried out by the Registrant to justify her actions.

141. The Committee concluded, on the balance of probabilities, that when the Registrant added the words *"no curtain drop in vision"* on 10 May 2019, she did so deliberately to justify her actions, having discovered that Patient A had been diagnosed with a retinal tear and detachment by another optometrist, SK.

142. The Committee concluded that this behaviour was dishonest by the standards of ordinary decent people.

3(d) Registrant's submissions

143. Ms Ledward submitted that the Registrant had not been acting deliberately or dishonestly. She submitted that on careful analysis, it would have been obvious to anyone reading some of the Registrant's entries, that she had added to the record after the consultation: "sent referral faxed – in dips" amended on 10 May to "sent – check dips referral faxed in dips". The second reference to "dips" did not make sense unless it reflected the Registrant's evidence, namely that it was an indication that she had checked dips for the referral and confirmed it was in dips, that is something done after the referral had been sent, and therefore after the patient had been seen.

144. Ms Ledward submitted that the Registrant confirmed in answer to questions that she knew the records were time-stamped, and therefore auditable for changes. She submitted that it was inherently more likely that the failure to make clear the entries were retrospective was an honest and naïve mistake rather than a futile attempt to avoid scrutiny.

3(d) Decision

145. The Committee accepted the submissions of Mr Rich and rejected those of Ms Ledward.

146. The Registrant did not indicate on Patient A's record or elsewhere that the amendments had been made retrospectively, contrary to what would be expected of an optometrist making an honest amendment. It again considered the purported motivation and the additional amendments made regarding the dips record but did not accept that the failure to indicate that the record amendments were retrospective was a minor oversight.

147. The Registrant was unaware that, on 2 May 2019, Patient A had collected a copy of her records of 19 April 2019. Without that original version the amendments which she made on 9 May 2019 at 17.45, and 10 May 2019 at 09.01, may not have been exposed and subsequently investigated notwithstanding the fact that the computerised records are automatically date stamped.

148. The Committee concluded, on the balance of probabilities, that the reason the Registrant gave no indication on Patient A's record that the amendments had been made by her retrospectively, and only after discovering Patient A's treatment for RD, was the result of a deliberate decision on her part to disguise the fact that the amendments had been added dishonestly.

149. The Committee concluded that this behaviour was dishonest by the standards of ordinary decent people.

Misconduct

150. Mr Rich informed the Committee that the GOC was neutral as to whether the behaviour found proved in Sub-Particulars 1(b) and 1(c) amounted to misconduct. He reminded the Committee of Professor Harper's evidence that Sub-Particulars 1(b) and (c) fell seriously below the standard expected but that the issue of further advice, particularised in Sub-Particular 1(d), fell below but not seriously below the standard expected. He also indicated that whilst it was a single failing it could be described as "very bad".

151. Mr Rich submitted that the finding of dishonesty relating to Particulars 2 and 3 clearly amounted to misconduct. He submitted that the dishonesty could not be described as a single incident as it had stretched across two days, and was particularly serious in that it had occurred in a clinical context. It was a calculated piece of dishonesty, designed to cover up the Registrant's clinical error.

152. Ms Ledward reminded the Committee of Professor Harper's evidence that the failures in Sub-Particulars 1(b) and 1(c), but not 1(d), fell far below the standard of the reasonably competent optometrist.

153. Ms Ledward submitted that the clinical allegations in Particular 1(b), (c) and (d) related to a single consultation with a single patient. She argued that although there were three distinct sub-particulars, the Committee's findings amounted, in reality, to a single negligent act or omission from which the Registrant's particularised failures flowed. Despite undertaking a comprehensive and appropriate assessment, the Registrant nevertheless did not correctly interpret her other findings which ought to have led her to suspect that a retinal problem was present. It followed that she failed to refer and advise Patient A appropriately. This was in the face of a challenging and confounding presentation, particularly the repeated right VF defect, which even Professor Harper described as *"*mitigation*"* of that particular failure.

154. Ms Ledward accepted that the factual findings of dishonesty in Particulars 2 and 3 were serious and amounted to misconduct.

Advice and Finding on Misconduct

155. The Committee accepted the advice of the Legal Adviser, who advised that in considering misconduct the Committee should ask whether, in its judgement, the Registrant's behaviour had fallen seriously below the standards required of a registered Optometrist in the circumstances, and whether her behaviour would be regarded as deplorable by fellow practitioners. She took the Committee to the cases of *Roylance –v- General Medical Council No 2 [2001] 1 AC 311*, *Nandi v GMC [2004] EWHC 2317* and *Schodlok v GMC [2015] EWCA Civ 769.*

156. The Committee concluded that the Registrant had breached the following GOC Standards of Practice for Optometrists and Dispensing Opticians (April 2016):

7 Conduct appropriate assessments, examinations, treatments and referrals

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

16 Be honest and trustworthy

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

19 Be candid when things have gone wrong.

157. In considering Sub-Particulars 1(b), 1(c) and 1(d) the Committee took account of the fact that the Registrant's actions concerned a single patient. However, the Committee concluded that her actions were more than merely negligent and amounted to a serious failure to use all the information that had been available to her to make an appropriate diagnosis in an area with potentially serious consequences for the patient. The Committee concluded that the Registrant's actions in this regard amounted to misconduct.

158. The Committee concluded that the Registrant's dishonesty was clearly serious and would be regarded as deplorable by fellow practitioners. The Committee had no hesitation in concluding that Particulars 2 and 3 amounted to misconduct.

159. For those reasons the Committee concluded that the facts found proved in Sub-Particulars 1(b), 1(c), 1(d), 2 and 3 amounted to misconduct.

Impairment

160. The Committee was provided with further documentation on behalf of the Registrant, consisting of a bundle of additional testimonial references, a supplemental witness statement from the Registrant and set of written submissions.

161. In relation to Sub-Particulars 1(b), 1(c) and 1(d), Mr Rich submitted that whilst the Registrant's level of insight was limited, she had not repeated her misconduct despite a considerable gap in time between the commission of the misconduct and today's date, when she had demonstrated remediation in the form of training and continued practice. In consequence, the GOC was neutral on the issue of impairment on grounds of public protection

162. However, Mr Rich submitted that a finding of impairment was required to protect the public interest in light of the Committee's finding of dishonesty.

163. Ms Ledward submitted that the Registrant's fitness to practise is not currently impaired by reason of any misconduct founded on Sub-Particulars 1(b)-(d).

164. Ms Ledward submitted that at time of this incident the Registrant had been young. She argued that the Committee had been provided with a large body of evidence from colleagues, attesting to the Registrant's general character, dedication and skill and expertise as an Optometrist. The Registrant had redoubled her efforts at professional development and progression. She had paid particular attention to subjects relating to VRA's, undertaking extensive CET activities and post-graduate qualifications including certificates in Medical Retina and Glaucoma. She had made significant efforts to expand her professional support network, and change her practice to prevent re-occurrence. She had gained further experience and demonstrated a willingness to learn from her experience and from these proceedings.

165. Ms Ledward submitted that this was an isolated incident in an otherwise unblemished and promising early career as an Optometrist. The Registrant had remained a dedicated and competent Optometrist, who had worked hard to remedy the clinical failures and other criticisms made of her.

166. Ms Ledward submitted that the Registrant had gained insight into a number of the pressures she faced at the time of the incident and had put in place protective strategies.

167. Ms Ledward submitted that the Registrant had fully remediated her clinical failings, meaning that there was no risk of repetition. She argued that the Committee could safely conclude that, looking forward, the Registrant's fitness to practise is not impaired by reason of any clinical misconduct deriving from Sub-Particulars 1(b) – (d).

168. Ms Ledward accepted that different considerations apply in respect of the finding of dishonesty, as found proved by the Committee, which was serious, and required a finding that the Registrant's fitness to practise is currently impaired, despite the passage of time since the relevant incident.

Legal Advice on impairment

169. The Committee accepted the advice of the Legal Adviser who reminded the Committee of the criteria set out in the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Paula Grant [2011] EWHC 927*, namely whether the Registrant:

- 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
- Has in the past and/or is liable in the future to bring the profession into disrepute; and/or
- Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the profession
- Has in the past acted dishonestly and/or is liable to act dishonestly in the future

170. The Legal Adviser advised the Committee to ask, in accordance with the case of *Cohen v General Medical Council [2008] EWHC 581*, whether the Registrant's conduct is easily remediable, whether it has in fact been remedied and whether it is highly unlikely to be repeated. She advised the Committee to question whether the misconduct could be regarded as an isolated incident and whether the Registrant had demonstrated insight into her past behaviour. She also advised the Committee to consider the public interest criteria in accordance with the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Paula Grant [2011] EWHC 927*.

Decision on impairment

171. The Committee regarded Particular 1 as an isolated incident, involving one patient at a single appointment. The Committee took account of the evidence of extensive CET and postgraduate qualifications provided by the Registrant. The Committee also took account of the testimonial evidence attesting to the fact that the Registrant had continued in practice since the time of the allegation without further incident. The Committee concluded from this material that the Registrant had remediated her clinical failings. In the light of this the Committee concluded that it is highly unlikely that the Registrant will repeat her clinical misconduct. The Committee therefore concluded that the Registrant's fitness to practise on grounds of public protection is not impaired by reason of her clinical failings. The Committee also concluded that her clinical failings, as found proved in Particulars 1(b), 1(c) and 1(d), are not of sufficient magnitude of themselves to necessitate a finding of impairment on public interest grounds.

172. However, the Committee was concerned that the Registrant's dishonesty arose in the course of her professional work. Further, she had not accepted her dishonesty, and she had provided evidence in the course of this hearing that lacked credibility. The Committee had been provided with no evidence of reflection on her part regarding her dishonesty, nor had she explained what she would do if she were to find herself in the same position in future. She had not demonstrated insight into the consequences for a patient of incorrect records for their subsequent treatment or the reputation of professional colleagues of such behaviour. The Committee accepted that the Registrant's dishonesty was out of character. However, the Committee concluded that if the Registrant were to make a clinical mistake or error of a different nature in the future, there was a risk that the Registrant would revert to dishonesty once more to conceal her mistake. In those circumstances it could not be said that it is highly unlikely that the Registrant will repeat her dishonesty in the future, albeit that the risk of this is low. Accordingly, the Committee concluded that Registrant does present a risk to the public, and that a finding of impairment is required on public protection grounds, by reason of her dishonesty.

173. Further, in relation to the public interest, the Committee concluded that the Registrant's dishonesty, which breached a fundamental tenet of her profession and had brought her profession into disrepute, demanded a finding of impairment to protect the confidence held by the public in the profession and its regulator, and also to promote and maintain proper professional standards for Optometrists.

174. Accordingly, the Committee concluded that the Registrant's fitness to practise is currently impaired on public interest grounds and also on grounds of public protection, by reason of her dishonesty.

Sanction

175. Mr Rich submitted that a Suspension Order was the appropriate sanction in the circumstances. He submitted that whilst the misconduct had been serious, and the Registrant had shown limited insight, this was a one-off incident which had occurred some three years ago, with no repetition, and the Committee had found the risk that the Registrant would repeat her misconduct was low.

176. Ms Ledward submitted that a short Suspension Order was the appropriate order. She submitted that:

- the dishonesty had occurred some 2 ½ years ago and there had been no repetition of it;
- no direct patient harm or risk of harm to Patient A had resulted from the dishonesty;
- the Registrant had been young and inexperienced at the time;
- this was an isolated incident in an otherwise unblemished career;
- the incident was out of character;
- the Registrant had made significant efforts to reflect on the findings of the Committee;
- the Committee had found that the risk that the Registrant would repeat her dishonesty was low;
- the Registrant had shown such insight as could be expected in the circumstances;
- the Registrant had demonstrated an ability to reflect and to learn from the experience;
- supportive testimonials had been provided.

177. Ms Ledward submitted that the Registrant's conduct had not demonstrated that she was fundamentally unsuited for registration as a healthcare professional in a way that could not be remediated, and therefore erasure would be disproportionate.

178. The Committee accepted the advice of the Legal Adviser who advised the Committee to consider the range of available sanctions in ascending order of seriousness; to consider any aggravating and mitigating factors in the case; to act

proportionately; and to remember that the purpose of sanction is not to be punitive but is to maintain public confidence in the profession and its regulator, and to declare and uphold proper standards of conduct and behaviour. She took the Committee to the GOC's "Hearings and Indicative Sanctions Guidance" (December 2021 edition).

179. The Committee regarded the following to be mitigating factors:

- the Registrant's relative inexperience at the time of the misconduct;
- the Registrant's previous good character;
- the positive testimonials provided on the Registrant's behalf, including one from her current employer, attesting to her ability as a clinician and her character;
- the dishonesty had been a one-off incident;
- the alteration of patient notes some weeks later had not adversely affected Patient A's care in the aftermath of her initial examination;
- the dishonesty had not been repeated since the date of the incident in May 2019.

180. The Committee regarded the following to be aggravating factors:

- the dishonesty was directly related to the Registrant's profession;
- the dishonesty was perpetrated to protect the Registrant's own interests;
- in protecting her own interests the Registrant had shifted the blame onto Patient A, by recording her symptoms inaccurately and saying that she had been advised to act in the way that she had, whereas the Committee found that this was not so;
- the Registrant had not told the truth in the course of the hearing in that she had claimed that she had consulted another colleague, thereby demonstrating a lack of insight on her part;
- the Registrant's reflections appeared to focus on the impact that her dishonesty had had on her personal life and her career, whilst ignoring the effect of her behaviour on patients, the wider public and the profession. The reflections also dwelt disproportionately on the quality of the records and the need for them to be contemporaneous.

181. The Committee concluded that there were no exceptional circumstances to justify taking no action. On the contrary, in view of the seriousness of the misconduct, to take no further action would not uphold standards or maintain confidence in the profession and the regulatory process.

182. The Committee concluded that a financial penalty would also be inappropriate.

183. The Committee concluded that conditional registration would not be appropriate in the light of the nature of the misconduct. It was not possible to formulate conditions which addressed the dishonesty, and in any event the misconduct was too serious.

184. In considering the suitability of a Suspension Order the Committee took account of the fact that the Registrant's dishonest misconduct had amounted to a serious incident. However, it was effectively a single incident and had not been repeated in the 2 ½ years that the Registrant had spent in practice since then. The Registrant was of previous good character and had provided excellent testimonials in support of her ability as a clinician and her previous good character. There was no evidence of any deep-seated personality problem. Whilst the Committee had concluded that the Registrant's level of insight was limited, it had also concluded that the risk that she would act dishonestly again was low.

185. The Committee bore in mind that the purpose of sanction is not to be punitive but is to protect the public and to declare and uphold proper standards of conduct and behaviour and maintain confidence in the profession. The Committee concluded that a Suspension Order would be the appropriate order to address both criteria in the circumstances of this case.

186. The Committee gave consideration to erasure but concluded that this would be disproportionate as it could not be said there was no other appropriate option in this case. The Committee agreed with the submission made on the Registrant's behalf that the Registrant was not fundamentally unsuited for registration as a healthcare professional in a way that could not be remediated. The Registrant had provided testimonials attesting to the fact that she was a good practitioner whose misconduct had been out of character. The Committee was satisfied that public safety and the wider public interest would be sufficiently protected by a Suspension Order. The Committee took into account the public interest that lies in retaining the services of an Optometrist whose contribution to the profession is recognised by her colleagues.

187. The Committee gave consideration to the length of the order and concluded that 6 months was appropriate. The Committee decided that any lengthier period

of time would be disproportionate in the light of the mitigating features in the case and the fact that suspension would deprive patients of the Registrant's services. The Committee considered that any shorter period would not sufficiently mark the seriousness of the misconduct or enable the Registrant to reflect sufficiently on her misconduct and be in a position to demonstrate further insight at a review hearing.

188. The Committee therefore imposed a Suspension Order for 6 months in duration.

189. The Committee decided that a review hearing is required prior to the expiration of the order. The Registrant should provide a reflective statement dealing with the effect of her dishonesty on colleagues and patients, and in particular into the damaging effect of altering patient records.

Immediate Order

1. Mr Rich applied for an Immediate Order for the protection of the public. He submitted that whilst the risk that the Registrant would repeat her dishonesty was low, there was nevertheless a risk which required an immediate order to be in place.

2. Ms Ledward opposed the order on the basis that the misconduct occurred some 2 1/2 years ago, in which time the Registrant had remained in practice without further incident. Ms Ledward submitted that it could not be said that an immediate order was necessary in those circumstances.

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

4. The Committee concluded that an immediate order was not necessary to protect the public. The dishonesty had occurred some 2 ½ years ago, since when the Registrant had continued in practice without further incident. The Committee concluded that the Registrant did not pose a significant risk of harm to members of the public such as to necessitate the imposition of an immediate order on public protection grounds.

5. The Committee was aware that in deciding whether to impose an Immediate Order on the grounds of the public interest alone, the bar was set high. The Committee concluded that that high bar had not been met. The Committee

concluded that a member of the public, in possession of all the facts, would conclude that the Registrant had remained in practice since the dishonest misconduct, without further incident, and that her dishonesty had been adequately marked by the substantive Suspension Order that the Committee had imposed.

6. For those reasons the Committee decided not to impose an Immediate Order.

Chair of the Committee: Pamela Ormerod

Signature **Date: 12/01/2022**

Registrant: Angelina Bhopal

Signature present via videoconference **Date: 12/01/2022**

FURTHER INFORMATION
Transcript
A full transcript of the hearing will be made available for purchase in due course.
Appeal
Any appeal against an order of the Committee must be lodged with the relevant court within 28 days of the service of this notification. If no appeal is lodged, the order will take effect at the end of that period. The relevant court is shown at section 23G(4)(a)-(c) of the Opticians Act 1989 (as amended).
Professional Standards Authority

This decision will be reported to the Professional Standards Authority (PSA) under the provisions of section 29 of the NHS Reform and Healthcare Professions Act 2002. PSA may refer this case to the High Court of Justice in England and Wales, the Court of Session in Scotland or the High Court of Justice in Northern Ireland as appropriate if they decide that a decision has been insufficient to protect the public and/or should not have been made, and if they consider that referral is desirable for the protection of the public. PSA is required to make its decision within 40 days of the hearing (or 40 days from the last day on which a registrant can appeal against the decision, if applicable) and will send written confirmation of a decision to refer to registrants on the first working day following a hearing. 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.