BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(20)20

AND

WILLIAM ANGUS KNOX HAY (01- 10817)

DETERMINATION OF A SUBSTANTIVE HEARING
MONDAY 07 – WEDNESDAY 09 JUNE 2021

Committee Members:	Ms Anne Johnstone (Chair/Lay) Ms Victoria Smith (Lay) Ms Jane Kilgannon (Lay) Mr Alexander Howard (Optometrist) Ms Judy Lea (Optometrist)
Clinical adviser:	N/A
Legal adviser:	Mr David Mason
GOC Presenting Officer:	Mr Peter Lownds
Registrant present/represented:	Yes, and represented.
Registrant representative:	Dr Austin Stoton
Hearings Officer:	Ms A Riaz
Facts found proved:	1a, 1b(iii), 1b(iv)(a), 1b(iv)(b),1b(iv)(c), 1b(vi), 2a(ii), 2b, 2c(i), 2c(ii), 2c(v), 2d(i) and 2d(ii) of the allegation.
Facts found not proved:	N/A
Misconduct:	Found
Impairment:	Impaired
Sanction:	9 months suspension without a review
Immediate order:	No

ALLEGATION

The GOC applied under Rule 46(20) of the General Optical Council (Fitness to Practise) Rules 2013(the Rules) to amend particular 1b(iii) of the allegation by deleting the word 'Venue' and substituting the word 'Venous'('A:V'). The application was not opposed and after taking advice from the Legal Adviser the Committee acceded to the application on the basis that the application referred only to a typographical error and that the amendment could be made without injustice.

The Council alleges that you, William Angus Knox Hay (01-10817), a registered optometrist:

1. On or around 26 April 2016 you examined Patient A and:

    a. Failed to refer Patient A urgently for possible wet acute macular degeneration,

    b. Failed to document the appointment adequately in Patient A's medical records in that:

        (i) You failed to record which eye your note referred to, stating "odd scattered drusen round macula (sic)"

        (ii) You failed to report the cup/disc ratio

        (iii) You failed to record the Arteriole/Venous (A:V) ratio

        (iv) You failed to add specific details to Patient A's record card about:

            (a) Reason for referral;

            (b) Urgency of the referral; and/or

            (c) Where the referral was being sent

        (v) You failed to record any details of any discussions you had with Patient A

(vi) You failed to record any details of any written information or advice you provided to Patient A

2. On or around 26 July 2017, you examined Patient A and:

a. Failed to perform an adequate internal eye examination in that;

(i) You failed to examine Patient A with a slit-lamp

(ii) You failed to carry out a dilated fundus examination

b. Failed to refer Patient A urgently for possible wet acute macular degeneration,

c. Failed to document the appointment adequately in Patient A's medical records in that:

(i) You failed to record sufficient details of any internal eye examination carried out on Patient A

(ii) You failed to record any history and/or symptoms reported by Patient A

(iii) You failed to add the reason for the referral to Patient A's record card

(iv) You failed to record any details of any discussions you had with Patient A

(v) You failed to record any details of any written information or advice you provided to Patient A

d. Failed to complete the referral form adequately in that:

(i) You added out-of-date clinical findings to the referral form; and/or

(ii) You failed to clearly record if the clinical findings related to the 2016 or 2017 test

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

DETERMINATION

Admissions in relation to the particulars of the allegation

The Registrant admitted particulars 1a, 1b(iii), 1b(iv)(a), 1b(iv)(b),1b(iv)(c),1b(vi), 2a(ii), 2b, 2c(i), 2c(ii), 2c(v), 2d(i) and 2d(ii) of the allegation.

The Registrant denied particular 1b(i),1 b (ii), 1 b(v), 2 a (i), 2 c (iii) and 2 c(iv).

Background to the allegations

Mr William Hay (the Registrant) is a registered optometrist, registration number 01 - 10817. The Registrant was first registered on 11 September 1981. At the material times to this case the Registrant was in practice at [redacted].

The allegations under consideration by the committee relate to a single patient, Patient A, and involve two consultations with Patient A on 26 April 2016 and on or around 26 July 2017.

At the consultation on 26 April 2016 Patient A's visual acuity is recorded as R 6/6 L 6/36. The record refers to 'frequent falls' and records 'small areas of bleeding above and below the macula' visualised by the Registrant during a dilated internal examination of the eyes and documented with fundus photography. It refers to the results of the Amsler test, identifying right 'distorted and left 'lines distorted – looking behind cloud.'

There is a copy of an NHS Grampian referral to Ophthalmology form dated 29 April 2016. It refers to the priority as 'Routine' and records as findings 'Reduced acuity' left eye and 'frequent falls'. It records a working diagnosis of 'Macular changes: 2x bleeds around L macula' and 'Initial thoughts: Detachment – no distortion with Amsler 'looking behind a cloud'.

It appears that the referral of 29 April 2016 was not received or in any event was not acted upon, until after 16 June 2017 when NHS Grampian Helpline and Patient A were in contact about Patient A's referral. The Helpline asked the Registrant to organise a review of Patient A due to the length of time that had elapsed since the 2016 consultation. This review was conducted on or around 26 July 2017 by the Registrant. The records for this consultation record visual acuity as Right 6/12 and Left 'FC' - count fingers. It records an Amsler test as Right 'Distort vertical' and Left 'no response'. There is no record of an internal eye examination being conducted on this date and the pupils were not dilated.

Following the 2017 consultation, a further referral was made by the Registrant to the Aberdeen Hospital Eye Service on 28 July 2017, using a Direct Referral Hospital Eye Service Cataract form. The urgency is recorded as 'Routine'. The 'AMD present'

section of the form says ‘yes’ and the Ocular Examination section refers to ‘Cataract – Drusen’ in both eyes.

Following this second referral, Ophthalmologist 1, an Ophthalmologist, saw Patient A at a cataract clinic on 20 January 2018 and as a result referred her to the macular service on an urgent basis.

As a result of this referral, Patient A was seen by Consultant 1, Consultant Ophthalmologist, who saw Patient A on 31 January 2018 and listed Patient A for urgent treatment. A diagnosis of wet Age-Related Macular Degeneration (AMD) in both eyes was made with advanced and chronic changes in both eyes.

Consultant 1 refers to the referral of 28 July 2017 as ‘very confusing’ and said ‘I felt that it was very difficult when reading the electronic referral from 2017 to have an accurate picture of what is happening with the patient in that moment in time’. Consultant 1 further said that ‘if either referral were marked as Wet AMD or urgent then Patient A would have been booked in clinic within two weeks and treatment would have started on that day.’

Following seeing Patient A, Consultant 1 reported Patient A’s treatment by the registrant using DATIX, an electronic reporting system. Consultant 1 recorded the severity of the case as ‘severe’. This brought the case to the attention of Witness 1, Optometry Lead for Aberdeen City. As a consequence, Witness 2, Grampian Lead for Optometry, convened a commissioning group, including herself, Witness 3, Locality Manager and Consultant 1. The commissioning group appointed a review team, which included Witness 1, Person A, senior manager and Witness 4, Eye Health Network Optometric Advisor.

Witness 1 statement of 6 November 2018 for the Council says the review team was asked to review Patient A’s records to ascertain whether there was evidence of wet age-related macular degeneration in either eye or other pathology in April 2016, to establish if a referral was sent in 2016 and to review contact between the practice and Patient A.

As part of the review an interview was held with the Registrant. Notes were kept and subsequently agreed by the Registrant. The notes record the Registrant as saying in relation to the April 2016 consultation ‘... the Registrant was working with a provisional diagnosis of retinal detachment which would fit with Patient A falls. The Registrant also felt that if this presentation occurred again, the Registrant would identify a macular problem and refer appropriately. This was ‘a red flag issue’’. In relation to the July 2017 consultation, when it was suggested to the Registrant that the records did not indicate any internal eye examination, it is recorded that the Registrant said: ‘Patient A was frail and the Registrant was unable to examine Patient A on the slit lamp. The Registrant did not dilate Patient A’s pupils. The Registrant felt that the Registrant probably would have examined the eye with direct ophthalmoscope. The Registrant agreed this was inadequate under the circumstances of bilaterally reduced visual acuity’ and that ‘Drop in acuity should have been a red flag’. It is further recorded in the notes that the

Registrant said that ‘On reflection they felt that the Registrant should have identified a macular problem at the 2016 visit and referred appropriate to macular disease at that time’.

The Council appointed Dr Irene Ctori, Senior Lecturer in Optometry, City University of London as an expert witness to prepare various reports on the clinical care provided by the Registrant to Patient A. Dr Ctori’s report on the April 2016 consultation Dr Ctori says in her overall assessment of the consultation: ‘In respect of the appointment 26 April 2016 the Registrant did meet the required standard of a Reasonably Competent Optometrist care with regards to conducting a full eye examination as demonstrated by the record card... However, with regards to the patient management, in my opinion the Registrant has fallen far below the required standard of a Reasonably Competent Optometrist care (sic). Although the patient was referred, the referral was not made with appropriate urgency. There are no specific details of what the referral was for on the record card...The failure to refer Patient A appropriately posed increased risk of harm to the patient, as it resulted in a significant delay in the diagnosis and treatment of wet AMD.’

In relation to the July 2017 consultation Dr Ctori says in her overall assessment: ‘In respect of the appointment 28 July 2017 it is likely that the Registrant did not meet the required standard care of a Reasonably Competent Optometrist. My opinion is based on the following reasons. At this visit there is no reason for visit documented, no symptoms recorded, but visual acuity has been measured and recorded as right eye 6/12 and left eye FC [count fingers]. The vision has significantly deteriorated since the last visit in April 2016. Amsler testing has been done with signs of distortion noted, consistent with signs of wet AMD. The reduction in vision and the distortion on Amsler should have alerted the Registrant to the possibility of wet AMD. However, the only record of an internal/external eye examination is a scribble over the circles, which I interpret as the presence of cataracts, possibly worse in the left eye. By potentially not examining the internal eye, the Registrant has fallen far below the required standard of care, as they have not conducted a full eye examination on this occasion.’

In relation to the allegations of poor record keeping of the April 2016 consultation Dr Ctori says that ‘... in my opinion, patient management has not been adequately documented. Although the word ‘refer’ was noted on the front of the record card for the visit on 26 April 2016, there are no details regarding what the referral was for, the urgency or where the referral was being sent ... There are no details of any discussions, written information or advice given to the patient on this examination date. Therefore, in my opinion the record keeping has fallen below the required standard of care.’

In relation to the July 2017 consultation Dr Ctori says: ‘In my opinion, based on the lack of information regarding the internal eye examination and the lack of information regarding the referral, on this occasion the record keeping has fallen far below the required standard of care.’

On 15 March 2018 the Optometry Lead for NHS Grampian referred the findings of the review to the GOC.

Findings in relation to the facts

The Committee recorded the admissions set out above as found proved, pursuant to rule 46(6) of the Rules.

The Registrant having made the admissions recorded above, Mr Peter Lownds, counsel on behalf of the GOC, made opening submissions on its behalf. Mr Peter Lownds, informed the Committee that the GOC was not proceeding against the Registrant in relation to the Particulars of Allegation not admitted. The Committee therefore treated Particulars 1b(i),1b(ii), 1b(v),2a(i), 2c(iii) and 2c(iv) as withdrawn.

Submissions

Mr Lownds made no substantive submissions on the facts and relied upon their opening of the case at this stage.

Dr Austin Stoton, counsel for the Registrant, made submissions on the facts on the Registrant's behalf. Dr Stoton submitted that in relation to the facts admitted and found proved, the Committee should take into account their context.

Dr Stoton referred the Committee to the GOC Bundle (C1) at page 147, the patient record for the April 2016 consultation, and asked the Committee to take into account what was recorded there which they said recorded signs suggestive of AMD. Dr Stoton, also referred the Committee to page 155, an NHS Grampian pro forma referral document completed by the Registrant following the consultation on 29 April 2016, and to its reference to 'macular changes' and '2 bleeds around L macula', which they said were classic indications of AMD. Dr Stoton, asked the Committee to note that the form does not contain a section to record the reason for the referral. Dr Stoton submitted that taken together these documents showed the Registrant had recorded a finding of AMD.

Dr Stoton referred the Committee to the report of Dr Irene Ctori, lecturer in Optometry at City University London, the expert witness appointed by the GOC in this case at pages 121-122 where it is recorded that the Registrant had met the standards of a reasonably competent optometrist in some respects.

Dr Stoton referred the Committee to page 156 of C1, a record of a phone call to NHS Grampian Helpline, which Dr Stoton said could only be interpreted as a record of a phone call by the Helpline to Patient A about the referral, not a call from Patient A making enquiries about Patient A's referral.

The Committee was referred to the pro forma at page 158, a referral to the Hospital Service cataract clinic following the July 2017 consultation where the Registrant had inserted 'yes' in relation to the question 'AMD present'. The Registrant submitted that this document again contained a record by the Registrant of a finding by the Registrant of AMD and other findings. It was submitted that whilst the patient records of that consultation

may have a dearth of detail, taken with the referral form the Registrant had made a record of most of the consultation.

Dr Stoton referred the Committee to references in C1 to various pathways for referral and submitted that these did not refer to the pathways available in 2016 and 2017. Dr Stoton, said it would be helpful to know the structure then and to have templates for that time. However, on behalf of the Registrant he conceded that the referrals the Registrant had made were made as routine referrals, when they should have been made as urgent referrals.

Dr Stoton referred to NICE documentation in C1 and submitted that NICE guidance has no application in Scotland. The Registrant also referred to Royal College of Ophthalmologist guidance in C1 and submitted that this does not apply to the Registrant because the Registrant is an optometrist.

Committee's decision on the facts

The Committee took into account the GOC's opening of its case, the submissions of Dr Stoton on the facts and the documents contained in the various exhibits before it.

The Committee accepted the advice of the Legal Advisor.

The Committee took careful account of the content of the admissions made by the Registrant. It accepted that they are admissions of fact which will require careful consideration when it considers the issues of conduct and fitness to practise at a later stage, which given the admissions made by the Registrant is inevitable. The Committee accepted that findings of fact are subject to consideration as to their context and the conclusions which should be reached over them. The Committee did not consider it appropriate at this stage to draw any conclusions beyond its determination relating to the admitted findings of fact.

The Committee, having decided upon the facts in this case, next considered whether, as a result of those facts, the Registrant's fitness to practise is currently impaired.

Submissions

GOC submissions

Mr Lownds made submissions on behalf of the GOC. Mr Lownds informed the Committee of the Registrant's fitness to practise history by placing before it the determination of a Committee in a previous fitness to practise case brought against the Registrant. That Committee concluded that acts of serious misconduct, which had been admitted and found proved, did not ultimately result in a finding of current impairment.

Mr Lownds, submitted that the Registrant had in this case fallen seriously short of the standards expected of a professional which was not a one off failing. Mr Lownds submitted there had been a pattern of repetition by the Registrant of failings in 2016 and 2017. There had been a failure to refer Patient A urgently for treatment for wet AMD in 2016 and that the failure had been repeated in 2017. Mr Lownds, submitted

that the consequences of the Registrant's failures were serious for Patient A. Mr Lownds further submitted that the Registrant had advanced no explanation for their failures except those contained in the notes of an interview as part of a (NHS Grampian) review of the case.

Mr Lownds referred the Committee to GOC skeleton argument at paragraph 43 and reminded it that there is no statutory definition of misconduct but that there is judicial guidance as to its meaning. Mr Lownds, referred the Committee to the case of Zygmunt v GMC [2008] EWHC 2643 which he said contained the approach to the issue of impairment that the Committee should adopt.

Mr Lownds submitted that the Registrant's misconduct presented a risk to patients, had brought the profession into disrepute and constituted a breach of a fundamental tenet of the profession.

Mr Lownds referred the Committee to the case of Cheatle v GMC [2009] EQHC 645 and submitted that the purpose of a finding of impaired fitness to practise is not to punish a practitioner for past failures but was to protect the public and the public interest in maintaining standards in the profession and in protecting its reputation. Mr Lownds referred the Committee to the determination of the previous GOC Fitness to Practise Committee which Mr Lownds said showed that over a period of five years the Registrant had failed to recognise deterioration in the sight of a patient caused by glaucoma. Mr Lownds, said that in that case the Registrant had admitted misconduct and that the Committee in that case found that their fitness to practise was not currently impaired because of the evidence of extensive supervision, remediation and positive reports on the Registrant's progress.

Mr Lownds submitted that the Registrant's failures in this current case were fundamental, in particular in relation to the failure to refer Patient A urgently on two occasions. Mr Lownds, further submitted that this brought the profession in to disrepute and undermined public confidence in the profession. Mr Lownds, finally submitted that on that basis the Committee should find current impairment of the Registrant's fitness to practise.

Defence submissions

Dr Stoton made submissions on behalf of the Registrant. Dr Stoton, said that the defence did not contest the issue of conduct and accepted that the facts found proved amounted to serious misconduct. Dr Stoton, made no individual submissions relating to the individual particulars of the allegation found proved and Dr Stoton accepted that taken together they amounted to misconduct.

Dr Stoton went on to submit that the Registrant's fitness to practise is no longer impaired. Dr Stoton submitted that the Registrant had engaged in an extraordinary amount of remediation to address the issues and that the Committee should not look beyond the admitted failures in deciding the issue of impairment. Dr Stoton informed the Committee that the Registrant now used only an electronic system of record keeping. Dr Stoton, referred to the two bundles of documents placed before the Committee on the Registrant's behalf. Dr Stoton said they both contained information related to various stages of this case, included audited records which had been peer reviewed and information about courses attended and CET undertaken.

Dr Stoton told the Committee that the Registrant had been made subject to conditions by an Interim Order Committee in the course of this case and that initially the Registrant had been subject to a condition of immediate and direct supervision by a senior professional. This order had continued until April 2019 when the requirement for direct supervision was replaced with an order for indirect supervision. This, Dr Stoton, said was because the reports the interim orders committee had received were extremely positive. This period of supervision had continued until September 2019 and that the Registrant had five supervisors sharing the task of indirectly supervising his work. The interim order was then revoked. Dr Stoton said that this meant that the Registrant had been in practice for nineteen months without supervision and that no concerns about his practice had been raised in that time.

Dr Stoton referred the Committee to the principle of proportionality, balancing the public interest with that of the Registrant. Dr Stoton submitted that the passage of time and the efforts made by the Registrant to improve his practice meant that there was no risk to the public and that a fully informed member of the public would not consider that any action was now required in relation to the Registrant's registration. Dr Stoton said that there had been a period of five years since the last 'significant blip' in the Registrant's standards of practice. Dr Stoton referred the Committee to the testimonials provided in both bundles of documents submitted by the Registrant and the Registrant's various reflective statement.

The Committee's decision

The Committee took into account, the submissions made on behalf of the GOC and on behalf of the Registrant and the information contained in the bundles of evidence supplied to it by both parties.

The Committee accepted the advice of the Legal Adviser.

The Committee considered the issue of current fitness to practise in two stages, first considering whether the facts found proved amount to serious misconduct by the Registrant, and if so whether that misconduct amounted to impairment of the Registrant's fitness to practise. The Committee considered the issue of impairment by applying its professional judgement and accepted that there is no burden or standard of proof at this stage of the case.

Although the defence had indicated that it was not contesting the issue of misconduct the Committee considered the issue applying its own judgment.

<u>Misconduct</u>

There is no statutory definition of misconduct. The Committee was guided in its deliberations by the decisions in the various cases to which it had been referred. It took into account the contents of the GOC Code of Conduct, April 2010 and its Hearings and Indicative Sanctions Guidance December 2018.

The Committee considered the case of Roylance v GMC [2000] AC 311 where Lord Clyde said:

‘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 foundby reference to the rules and standards ordinarily required to be followed…in the particular circumstances.’

It took account of the words of Jackson J in the case of Calhaem v GMC at paragraph 39:

‘(1) Mere negligence does not constitute "misconduct" within the meaning of section 35C(2)(a) of the Medical Act 1983. Nevertheless, and depending upon the circumstances, negligent acts or omissions which are particularly serious may amount to "misconduct".

(2) A single negligent act or omission is less likely to cross the threshold of "misconduct" than multiple acts or omissions. Nevertheless, and depending upon the circumstances, a single negligent act or omission, if particularly grave, could be characterised as "misconduct"’.

The Committee, in determining whether the acts and omissions of the Registrant amounted to misconduct, considered whether the conduct could be described as serious. It was guided by the advice of Dr Ctori, the GOC expert witness, who in various respects classified the failings they identified in the treatment of Patient A as falling ‘far below’ the standards expected of a reasonably competent optometrist. The Committee took the words falling far below as signifying acts which had placed, or could have placed, Patient A at serious risk of harm.

On the facts in the Allegation admitted and found proved, it was clear to the Committee that the Registrant had failed in relation to Patient A to properly recognise the signs of wet AMD on two occasions, failed to refer Patient A as a matter of urgency to the appropriate hospital service and failed to keep proper records of the Registrants consultations with Patient A. This resulted in serious harm to Patient A.

The Committee concluded that the facts found proved in this case amounted to serious misconduct.

<u>Impairment</u>

The Committee went on to consider whether its finding of serious misconduct meant that the Registrant’s fitness to practise was currently impaired. It accepted that it had to consider the question in the present tense, looking forward but taking in to account the events of the past in assessing the current situation.

In arriving at its decision, the Committee referred to the following passages in the Standards of Practice which it considered had been breached by the Registrant:

5. Keep your knowledge and skills up to date

7. Conduct appropriate assessments, examinations, treatments and referrals

8. Maintain adequate patient records

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

The Committee was referred to the case of CHRE v Grant [2011] EWHC 927 where the court said:

'The tribunal should consider whether [their] findings of fact in respect of the [registrant's] misconduct…show that his fitness to practise is impaired in the sense that he:

> i 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;
>
> ii. . Has in the past brought and/or is liable in the future to bring the…profession into disrepute;
>
> iii. . Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the profession;
>
> iv. Has in the past acted dishonestly and/or is liable to act dishonestly in the future.'

The Committee considers that principles i, ii, and iii applied in this case.

The Committee referred to the three questions set out in Cohen v GMC [2008] EWHC where the court said:

'It must be highly relevant in determining if…fitness to practise is impaired that first [the] conduct which led to the charge is easily remediable, second that it has been remedied, and third that it is highly unlikely to be repeated.'

The Committee took account in reaching its decisions of both the protection of the public and of the public interest in setting and maintaining standards of conduct in the profession and of maintaining public confidence in it.

The Committee therefore first considered whether the Registrant's fitness to practise was currently impaired in relation to protection of the public. It took in to account the findings of a previous fitness to practise Committee that the Registrant had been guilty of misconduct but that the Registrant's fitness to practise was not then currently impaired. It took in to account the findings of that Committee in relation to the remediation the Registrant had undergone and the positive expressions of confidence in the Registrant from professional colleagues which had led to a finding that the Registrant's fitness to practise was not currently impaired.

The Committee considered the history of this case, where the Registrant had been made the subject of an interim order of conditions, in particular the condition requiring direct supervision. That meant that all of the Registrant's work had to be observed by a senior professional colleague. It took account of the removal of that condition and the imposing of a lesser degree of supervision and the subsequent

revocation of the interim order. The Committee accepted that the result of this was that the interim orders committee, whose task was to assess current risk to the public, had concluded that the Registrant did not place the public at risk and had therefore removed all restrictions from the Registrant's practise. The result is that the Registrant has had a period of nineteen months of unsupervised practise without any further issues being raised over the Registrant's safety as a practitioner. The Committee concluded that the Registrant's fitness to practise is not currently impaired in relation to the protection of the public.

The Committee then considered the issue of the protection of the public interest in maintaining standards in the profession and upholding public confidence in it. With regards to the public interest, it considered how informed members of the public, having the information and knowledge the Committee had, would view the outcome if no action were taken by the GOC over the misconduct the Committee has found in this case.

The Committee accepts that the Registrant has carried out a considerable amount of remedial activity to address the Registrant's failings in this case. It accepts that the Registrant has now had a considerable period of unsupervised practice without further concerns being raised. It also accepts that senior members of the profession have expressed confidence in the Registrant's professional abilities.

The Committee considered the conduct of the Registrant in failing to identify signs of wet AMD and the Registrant's failing on two occasions to make an appropriate referral of Patient A for specialist treatment to be serious and fundamental breaches of professional standards. Wet AMD is a serious and well recognised condition, which has significant consequences for patients if not treated urgently when its signs are first identified. A failure to recognise it and to act with urgency in this case on two occasions had serious consequences for Patient A, which were evident at both consultations in April 2016 and July 2017 but which were not acted upon appropriately then by the Registrant.

The Committee concluded that an informed member of the public would require the professional regulator in those circumstances to take some action to mark the serious and repeated errors of the Registrant and the risks that the Registrant had posed to Patient A.

The Committee concluded that although it took into account all of the efforts of the Registrant to remedy the Registrant's failings, the Registrants long record of service to the profession and the public and the period of time in which the Registrant has practised without supervision without concerns being raised, a finding of impairment of their fitness to practise is necessary in this case to uphold standards in the profession and to maintain public confidence in it. It considered that not reaching such a finding would seriously damage public confidence in the profession.

The Committee therefore concludes that on the basis of public interest the Registrant's fitness to practise is impaired.

Sanction

Having decided that the fitness to practise of the Registrant is currently impaired on public interest grounds, the Committee went on to consider what is the appropriate sanction to be applied in this case, if any.

Submissions

GOC

On behalf of the GOC Mr Lownds said the Council had no submissions to make on the issue of sanction.

Defence

Dr Stoton made submissions on behalf of the Registrant. It was submitted by Dr Stoton that the consequences to Patient A of not being dealt with appropriately following referral by the Registrant was not entirely because of a failure to refer appropriately by the Registrant and that the Aberdeen NHS (sic) had either lost the document or failed to act upon it. Dr Stoton said at the relevant time there was no clear individual pathway for referral.

For both of these reasons Dr Stoton submitted that the consequences of the failure to act in this case do not rest solely with the Registrant but are shared with the local NHS organisation. Dr Stoton, submitted that the Hospital's triage and administrative processes were out of the control of the Registrant and that these factual circumstances reduced the gravamen of the breach and are relevant to the Committee's consideration of proportionality.

Dr Stoton submitted that this was not a case where a financial penalty was appropriate as the Registrant had not gained financially. Dr Stoton, also submitted that conditional registration was not appropriate and would serve no purpose, given the steps taken by the Registrant to remediate the Registrant's deficiencies. Dr Stoton, further submitted that erasure from the register would be disproportionate. It was submitted by Dr Stoton that the decision on sanction in this case was one between taking no action and suspension.

In support of Dr Stoton submission that the appropriate sanction in this case was to take no action, Dr Stoton submitted that there were exceptional circumstances, in particular that the Registrant had shown insight, had taken remedial action at great expense to himself and that there were extensive reports from those who had supervised the Registrant which showed that in their opinion the Registrant was safe to practise and that the Registrant presented no risk to the public. Dr Stoton also drew the Committee's attention to the 'extreme' passage of time since the relevant breaches took place and the reflective pieces provided by the Registrant.

Dr Stoton submitted that suspension would be disproportionate. Dr Stoton said that this would require the Registrant to close the Registrant's practice, at considerable financial loss, that it would be impossible to engage someone to continue the practice. Dr Stoton said that the Registrant would need to let the Registrant's administrative team go. Dr Stoton submitted that as the Registrant was almost redacted of age and would normally be considering retirement, it would be impossible for the Registrant to recover from the financial loss they would incur, and therefore, suspension would have a more punitive effect in his case.

Finally, Dr Stoton submitted that the finding of impairment in itself was sufficient sanction in this case.

The Committee's decision

The Committee took account of the GOC Hearings and Indicative Sanctions Guidance 2018 (ISG). It applied the principle of proportionality, balancing the interests of the Registrant with those of the public. The Committee took account of all of the mitigating and aggravating circumstances of the case. It considered the sanctions open to it in ascending order of seriousness. It proceeded on the basis that a sanction in this case is intended to protect the public interest, not to be punitive, although it may have that effect.

The Committee found the following mitigating and aggravating circumstances.

Mitigating

- The Registrant's efforts at remediation of their failings;
- The quality of the supervisors' reports before it;
- The testimonial evidence received by the Committee, which it gave due weight to but noting that none of those providing testimonials indicated they knew precisely the circumstances of the allegations the Registrant faced;
- The Registrant had fully cooperated with both the Grampian NHS review and with the GOC.

Aggravating

- Sustained, repeated and wide-ranging failures in relation to a serious and not uncommon eye condition;
- Failure by the Registrant to demonstrate the fundamental core competencies expected of a GOC registered optometrist;
- The potential and actual serious consequences of the Registrant's failures for a patient;
- The impact on public and professional confidence in the profession of optometry.

The Committee began by first considering the least onerous course of action, that is taking no action. That would be an exceptional course and the Committee was guided by the ISG at paragraph 31.2 which says: 'In order to be 'exceptional', circumstances must not be routinely or normally encountered …'.

In this case the Committee has found that the Registrant's fitness to practise is impaired on public interest grounds and that because of the remedial actions the Registrant has taken the Registrant no longer poses a risk to public safety. The Committee considers there to be nothing exceptional in those circumstances to justify taking no action. It notes that the Registrant has been said to be safe to practise by various supervisors but does not consider that to be an exceptional circumstance. The Committee concluded that, having deemed a finding of impairment necessary to uphold public confidence in the profession, to take no action would be inconsistent with that decision.

The Committee then considered whether it was appropriate to conclude the case by

imposing a financial penalty on the Registrant. It decided that this would not be an appropriate disposal of the case, taking account of the nature of the misconduct found, which did not include any financial gain to the Registrant, or any attempt at financial gain.

Having concluded that a financial penalty was not appropriate in this case, the Committee then considered whether the imposition of conditional registration was appropriate. The Committee considered the ISG at paragraph 33 and noted in particular paragraph 33.1 which says: 'The primary purpose of conditions should be to protect the public.' and paragraph 33.2 which says: 'Conditions might be most appropriate in cases involving a registrant's health, performance, or where there is evidence of shortcomings in a specific area or areas of the registrant's practice'.

The Committee does not consider that conditional registration would be appropriate in this case. There is no health issue, and the Committee has found that the Registrant has taken sufficient and appropriate action to remedy the deficiencies in his practice. The Committee could not devise conditions to meet the circumstances of the case and considered that a period of conditional registration was not appropriate and did not meet the need to protect the public's confidence in the profession.

The Committee then considered whether a period of suspension was appropriate in this case. It considered the ISG at paragraph 34 and in particular the factors set out in paragraph 34.1:

'This sanction may be appropriate when some or all of the following factors are apparent (this list is not exhaustive):

a. A serious instance of misconduct but where a lesser sanction is not sufficient;
b. No evidence of harmful deep-seated personality or attitudinal problems;
c. No evidence of repetition of behaviour since incident;
d. The panel is satisfied the registrant has insight and does not pose a significant risk of repeating behaviour;

……..'

The Committee considers that a period of suspension in this case is appropriate and proportionate. Sanctions are not intended to be punitive, although that may be their effect. However, having decided that the Registrant's fitness to practise is impaired on public interest grounds, to address the need to protect the reputation of the profession and to maintain standards of conduct, it considers that a period of suspension is necessary to mark the seriousness of the misconduct it has found.

The consequences of the Registrant's failures in this case resulted in extremely serious harm to a patient. The Registrant had failed to identify the signs of a sight threatening condition which a practitioner would encounter on a regular basis. It noted in this context the length of time the Registrant has been in practice.

The Committee was aware that that there had been similar incidents where the Registrant had admitted repeated failures to identify serious eye conditions over a period of years. It accepted that the Fitness to Practice Committee found that the Registrant's fitness to practise was not impaired because of the extensive remedial action the Registrant had taken. However, the Committee would expect a practitioner

having acknowledged serious clinical failures would take exceptional care in the Registrants future examination, record keeping and management of patients. It noted that the errors of April 2016 occurred whilst the Registrant was under supervision. The Committee whilst accepting the decision reached in the previous case, concluded that there was a pattern of failures of a similar nature in the Registrant's practice. It concluded that the public would expect action to be taken where that pattern could have and had caused serious consequences to a patient.

The Committee concluded that members of the public would consider that a period of suspension is appropriate to as showing that action has been taken in this case. This sends a message to the Registrant, the profession and the public, that where there is misconduct, sustained and repeated in this case, causing foreseeable and serious harm, such conduct will be marked by the regulator taking appropriate action. A period of suspension was also deemed imperative to uphold the standards of the profession of optometry, which were seriously breached in this case. The Committee is aware that a period of suspension may have financial and other consequences for the Registrant but considers that balancing the Registrant's interests and the public interest, any consequences to the Registrant are proportionate to meet the need to satisfy the public that appropriate action has been taken. It refers to paragraph 36.3 of the ISG which reads: "The reputation of the profession is more important than the fortunes of any individual member. Membership of a profession brings many benefits, but that is part of the price." (Bolton v The Law Society). The Committee considers that in this case the reputation of the profession outweighs the consequences of its decision for the Registrant.

In reaching its decision it considered the next most onerous sanction, erasure. It took account of the ISG at paragraph 36.2 which says: 'Erasure from the register is appropriate where this is the only means of protecting patients and/or maintaining public confidence in the optical profession.' The Committee does not consider that erasure is the only means of marking the Registrant's conduct in this case and that erasure would be a disproportionate disposal.

The Committee therefore decided that a period of suspension of nine months is appropriate, proportionate and necessary in this case to declare and uphold standards and maintain confidence in the profession. It considers that given the serious, repeated and fundamental errors admitted by the Registrant this is a necessary response by their regulator and that a lesser period of suspension would not meet the public interest in this case.

Immediate order

The Committee, having decided that the appropriate sanction in this case is one of suspension, went on to consider whether an immediate order of suspension is required in this case.

It considered the ISG paragraph 45.3 which reads:

'If the Committee has made a direction for suspension or erasure (or removal of an entry relating to a speciality or proficiency), it should consider whether there are reasons for ordering immediate suspension. Before doing so the Committee must be

satisfied that to do so is necessary for the protection of members of the public, otherwise in the public interest or in the best interests of the registrant.'

The Committee, having made its decision to suspend the Registrant's registration in the public interest, not on the grounds of public protection, was not satisfied that an immediate order of suspension was necessary in this case.

The Committee therefore made no immediate order in this case.

Chair of the Committee: Ms Anne Johnstone

NOTICE TO REGISTRANT:

- In accordance with Section 13C(3) of the Opticians Act 1989, the GOC may disclose to any person any information relating to your fitness to practise in the public interest.
- In accordance with Section 13B(1) of the Opticians Act 1989, the GOC may require any person, including your learning/workplace supervisor or professional colleague, to supply any information or document relevant to its statutory functions.

FURTHER INFORMATION
Transcript
A full transcript of the hearing will be made available for purchase in due course.
Appeal
Any appeal against an order of the Committee must be lodged with the relevant court within 28 days of the service of this notification. If no appeal is lodged, the order will take effect at the end of that period. The relevant court is shown at section 23G(4)(a)-(c) of the Opticians Act 1989 (as amended).
Professional Standards Authority
This decision will be reported to the Professional Standards Authority (PSA) under the provisions of section 29 of the NHS Reform and Healthcare Professions Act 2002. PSA may refer this case to the High Court of Justice in England and Wales, the Court of Session in Scotland or the High Court of Justice in Northern Ireland as appropriate if they decide that a decision has been insufficient to protect the public and/or should not have been made, and if they consider that referral is desirable for the protection of the public. Where a registrant can appeal against a decision, the Authority has 40 days beginning with the day which is the last day in which you can appeal. Where a registrant cannot appeal against the outcome of a hearing, the Authority's appeal period is 56 days beginning with the day in which notification of the decision was served on you. PSA will notify you promptly of a decision to refer. A letter will be sent by recorded delivery to your registered address (unless PSA has been notified by the GOC of a change of address). Further information about the PSA can be obtained from its website at www.professionalstandards.org.uk or by telephone on 020 7389 8030.
Effect of orders for suspension or erasure
To practise or carry on business as an optometrist or dispensing optician, to take or use a description which implies registration or entitlement to undertake any activity which the law restricts to a registered person, may amount to a criminal offence once an entry in the register has been suspended or erased.
Contact
If you require any further information, please contact the Council's Hearings Manager at 10 Old Bailey, London, EC4M 7NG or, by telephone, on 020 7580 3898.