BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(23)11

AND

ANDREW MAYNARD (01-32510)

DETERMINATION OF A SUBSTANTIVE HEARING
16-19, 24-26 Oct, 30 Oct – 01 Nov & 07 Nov 2023

Committee Members:	Sara Fenoughty (Chair/Lay) Sarah Hamilton (Lay) Ubaidul Hoque (Lay) Gemma O'Rourke (Optometrist) Sanna Nasrullah (Optometrist)
Legal adviser:	Aaminah Khan
GOC Presenting Officer:	Gavin Irwin
Registrant present/represented:	Yes and represented
Registrant representative:	Stephen Smith
Hearings Officer:	Terence Yates
Facts found proved:	2(a)(i), 2(b) and 3 were found proved at the start of the hearing following the Registrant's admissions. 1(a),(b),(c), 2(a)(ii) and (iii), 4, 5, 6, 7(a) and (b)(i), (ii) and (iii) were found proved after evidence was heard.
Facts not found proved:	7(c)(i), (ii) and (iii) were not found proved.
Misconduct:	Found
Impairment:	Impaired
Sanction:	Conditions for a period of 18 months – With Review
Immediate order:	Immediate order imposed

ALLEGATION

The Council alleges that you, Mr Andrew Maynard, a registered Optometrist, whilst employed by Boots Opticians:

Patient A

1) *On or around 23 July 2021 you examined Patient A and you failed to keep an adequate record of your consultation with Patient A in that you did not record:*
   a. *the number of times per day the chloramphenicol was to be administered by Patient A, and / or*
   b. *the duration of use of the chloramphenicol by Patient A, and / or*
   c. *to which eye the chloramphenicol should have been administered;*

Patient B

2) *On or around 18 July 2021 you examined Patient B and you failed to:*
   a. *carry out an adequate examination and/or assessment of Patient B in that you did not:*
      i. *check for staining with fluorescein, and / or*
      ii. *make any or sufficient enquiries about Patient B's:*
         1. *care system, and / or*
         2. *compliance with the cleaning regimen, and / or*
         3. *poor comfort,*
      iii. *establish contact lens age and / or condition,*
   b. *keep an adequate record of you consultation with Patient B in that you did not record:*
      i. *which eye the symptoms of dryness and / or stickiness occurred in, and / or*
      ii. *details regarding the 'poor comfort', and / or*
      iii. *whether the problem occurred when the contact lenses were new as well as old, and / or*
      iv. *the number of days per week or month the contact lenses were worn, and / or*
      v. *details of Patient B's care system, and / or*
      vi. *details of Patient B's compliance with the cleaning regimen, and / or*
      vii. *contact lens age, and / or*
      viii. *contact lens condition;*

Patient F

3) *On or around 25 June 2021 you examined Patient F who present with signs and symptoms suggestive of neurological disease, including but not limited to:*
   a. *headaches, and / or*
   b. *patchy vision, and / or*
   c. *swollen right optic disc, and / or*
   d. *reduced visual acuity in the left eye, and / or*
   e. *hemianopic visual field defect;*
4) *You sent Patient F home without discussing with and / or advising them that a very prompt referral was necessary to investigate the signs and symptoms.*
5) *You failed to appreciate that Patient F's presentation required an emergency referral.*
6) *As a result of 4 and 5 above you exposed Patient F to the risk that the specialist assessment of their condition would be inappropriately delayed.*

Patient G

7) *On or around 17 August 2021 you examined Patient G and you failed to:*
   a. *keep an adequate record of your consultation with Patient G in that you did not record details in respect of the action plan, and / or*
   b. *make an urgent referral regarding Patient G's:*
      i. *presenting intra-ocular pressures, and / or*
      ii. *reduced acuity, and / or*
      iii. *deteriorated visual fields, and / or*
   c. *identify signs suggestive of advancing glaucoma, including but not limited to:*
      i. *elevated intra-ocular pressures, and / or*
      ii. *reduced acuities, and / or*
      iii. *deteriorated visual fields.*

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

DETERMINATION

Preliminary issues

1. At the outset of the hearing, it was raised by both Optometrist members of the Committee, Ms Nasrullah, and Ms O'Rourke, that they had previously had a professional connection with Boots Opticians. However, neither Ms Nasrullah nor Ms O'Rourke had any connection to the specific Boots store, nor the Boots witnesses, involved in this case. Both Mr Irwin, on behalf of the Council, and Mr Smith, on behalf of the Registrant, confirmed that they had no issue with this and were content for Ms Nasrullah and Ms O'Rourke to continue hearing this case.
2. The Chair outlined the documentation that the Committee had received, which included a redacted hearing bundle. Mr Irwin, on behalf of the Council, explained that the redactions had been made to the bundle in order to remove information relating to patients (C, D and E) who were not part of the Allegation. However, Mr Smith, on behalf of the Registrant, sought permission to include in the bundle the material that had been redacted, on the basis that he wished to ask the Boots witnesses questions about these patients.
3. Furthermore, Mr Smith sought permission to put before the Committee evidence which had not yet been served upon the Council, which included an expert's report from the Registrant's expert, Mr Quah, an Ophthalmologist. Mr Smith explained that he had instructed Mr Quah as an expert witness in September 2023 but had only received the report from him the day before the hearing and the Council had not yet seen a copy of it.
4. In addition, the Registrant was intending to provide a witness statement, which could not be finalised, and the admissions confirmed until Mr Quah's report had been received and agreed by the Registrant. Mr Smith confirmed that he could finalise the Registrant's statement now and serve it by 6pm on the first day of the hearing.
5. In addition to these matters, there were outstanding disclosure issues, raised by Mr Smith, in relation to further documentation that he had requested from Boots. Mr Irwin set out the Council's position that whilst it was aware of these requests prior to the hearing, the relevance of the requests could not be properly assessed earlier without knowing the Registrant's case.
6. Mr Irwin explained that the Council's expert, Dr Kwartz, would need time to consider Mr Quah's report and to prepare a supplementary report in response. As a result of this, Mr Irwin proposed a change in the witness timetable, with both expert witnesses to give evidence on Thursday, the fourth day of the hearing, and the Boots witnesses to give evidence before then once the preliminary issues were resolved.
7. The Chair directed that the unredacted bundle be provided to the Committee, together with the Registrant's written admissions to the Allegation. The parties were given time to consider the expert report of Mr Quah and the Registrant's statement once served. When the hearing resumed for an update on the afternoon of the first day, Mr Irwin indicated that a supplementary report was being prepared by the Council's expert Dr Kwartz and that there may be admissibility issues in respect of Mr Quah's report, as there was a concern that he had strayed outside his area of expertise.

8. At the start of the second day of the hearing, Mr Irwin updated the Committee on the outstanding disclosure issues and confirmed that what information was held, and could be provided by Boots, had already been disclosed to the Registrant. There were some further documents which the Registrant wished to be put before the Committee, which included an audit document, pharmacy records in respect of patient A and further patient records for the previously redacted patients (C, D and E). The admission of this material was not objected to by the Council.
9. The Committee was also provided with the expert report of Mr Quah, dated 15 October 2023, the supplementary report of Dr Kwartz, dated 16 October 2023, and the witness statement of the Registrant. Mr Irwin confirmed that the Council was not taking an issue with the admissibility of Mr Quah's report at this stage, but rather would explore his experience in cross examination and may revisit the issue in due course.

Admissions in relation to the particulars of the Allegation

10. The Registrant admitted particulars 2(a)(i), 2(b) and 3 of the Allegation at the start of the substantive hearing. These facts were announced as found proved following the Registrant's admissions pursuant to Rule 46(6) of the General Optical Council (Fitness to Practise) Rules Order of Council 2013 ("the Rules").
11. The Registrant sought to make some qualified admissions, however given that these were not full admissions to the facts as pleaded, these were not announced as proved but recorded as denied. The Committee proceeded to hear evidence in relation to the remaining particulars of the allegation that were disputed by the Registrant.

Background to the allegations

12. The Registrant was first registered as an Optometrist in February 1985. At the time of the events subject of the Allegation, the Registrant was working as an Optometrist in the [redacted] practice of Boots Opticians, which was a role that he commenced in June 2021. Prior to starting with Boots Opticians, the Registrant had been on a break from practice for over a year. The Registrant has no past fitness to practise history.
13. The allegations relate to the Registrant's failings in relation to four patients (A, B, F, G) whom he examined between 25 June 2021 and 17 August 2021.
14. On 25 June 2021, the Registrant carried out an eye examination on Patient F who presented with signs and symptoms of neurological disease, which included headaches and patchy vision for some six weeks previously. The examination revealed that Patient F had swollen optic discs (the right severely swollen), reduced visual acuity in the left eye and a bilateral visual field defect. The Council's case is that these symptoms were indicative of a serious diagnosis such as a brain tumour or stroke and Patient F was subsequently diagnosed with a brain tumour.
15. The Registrant had examined Patient F in the morning and after the examination allowed Patient F to leave the practice, informing her that there would need to be

a hospital referral. It is alleged that the Registrant failed to appreciate that Patient F's presentation required an emergency (i.e. within 24 hours) referral. The Council's case is that the Registrant failed to discuss with and/or advise Patient F that a very prompt referral was necessary to investigate the serious clinical signs and symptoms that had been detected.

16. It is alleged that the Registrant sought advice from a colleague, Witness C, at lunchtime as to the correct referral tab to use on the SCI Gateway, the electronic referral system, which has options for routine or urgent referrals. This prompted that colleague to review the patient record of Patient F and advise that the hospital needed to be telephoned for an appointment that day, as an electronic referral on the SCI Gateway could take up to seven days even when marked as urgent. It was the opinion of Dr Kwartz that the Registrant did not heed a very strong combination of clinical signs strongly suggestive of an abnormality and that Patient F should not have left the practice without being informed of the seriousness of the concerns and the potential implications of the same.

17. On 18 July 2021, the Registrant carried out a contact lens aftercare on Patient B, who attended for a contact lens appointment. It is alleged that the Registrant's examination of Patient B was incomplete, as he did not use fluorescein, in order to conduct an examination of the cornea. Further, it is alleged that the Registrant did not make any or sufficient enquiries about Patient B's: care system, and/or compliance with the cleaning regimen, and/or poor comfort, establish contact lens age and/or condition, as these matters were not recorded within Patient B's patient record.

18. There are further failings alleged in relation to the standard of the Registrant's record keeping, with there being a number of omissions identified by Dr Kwartz, for example in relation to the scant history of the dryness and stickiness experienced by Patient B and their lens fitting characteristics.

19. On 23 July 2021, the Registrant carried out an eye examination on Patient A, who had injured his right eye on a tree branch when running several weeks earlier. The Registrant had examined Patient A at an earlier examination on 19 July, when he recommended that Patient A be re-examined in 5 days. At the follow up examination on 23 July, the Registrant advised the use of an antibiotic, chloramphenicol.

20. The allegations in respect of Patient A allege failings in the Registrant's record keeping, by not keeping an adequate record of his consultation with Patient A. It is alleged that he did not record the number of times per day the chloramphenicol was to be administered by Patient A, and/or the duration of use of the chloramphenicol by Patient A, and/or to which eye the chloramphenicol should have been administered. When the Registrant's colleague, Witness B, examined Patient A in a further follow up appointment on 27 July 2021, she struggled to decipher the Registrant's notes.

21. On 17 August 2021, the Registrant carried out an eye examination on Patient G, who had been previously diagnosed with glaucoma, which had been initially difficult to manage. Patient G attended on 17 August for a community glaucoma check, which at that time, due to COVID, was being carried out by Boots Opticians. The Registrant's examination of Patient G identified significantly elevated intra-ocular pressures ('IOPs') at a level very likely to cause damage to the eye (34mmHg), reduced acuities and a deterioration in her visual fields, which

could indicate advancing glaucoma which warranted referral back to the glaucoma clinic in the hospital.

22. It is alleged that the Registrant's assessment and record keeping in respect of Patient G was inadequate in that an inadequate history was recorded, it did not record whether the patient was compliant with her eye drops and no action plan was stated. Further, there was no urgent referral of Patient G to the Hospital Eye Service (HES), which was required. Whilst a referral appears to have been drafted by the Registrant on the practice's electronic referral system, this was 'parked' as a draft referral and not sent until 29 September 2021, when it was picked up and sent by the Registrant's colleague, Witness A.

23. Concerns were raised by the Registrant's colleagues and the Registrant was suspended by Boots Opticians on 28 September 2021, whilst the concerns were investigated further. Following an investigation meeting on 7 October 2021 and a disciplinary meeting on 21 October 2021, the Registrant was dismissed from his employment. On 2 December 2021, Boots Opticians made a referral to the Council regarding the Registrant.

The hearing

24. The Council opened its case. The Council called as witnesses Witness A, Witness B and Witness C, who are Optometrists and Witness D the Practice Manager, who all worked with the Registrant at Boots Opticians during the relevant time period. These witnesses gave oral testimony remotely and were questioned by the parties and the Committee.

25. The Council relied upon the agreed evidence of Patient F. As the evidence of this witness was not challenged by the Registrant they were not required to attend for cross-examination.

26. The Council also relied upon the live expert evidence of Dr Anna Kwartz, who provided two expert reports dated 6 July 2022 and a supplementary report dated 16 October 2023. Prior to giving evidence, Dr Kwartz observed the evidence of the Registrant's expert witness Mr Quah, who had provided an expert report dated 15 October 2023. The expert witnesses gave evidence out of the usual sequence given the limited availability of Mr Quah to attend the hearing.

27. The Registrant also gave live evidence to the Committee and was questioned by the parties and the Committee.

28. The Committee was also provided with a bundle (unredacted) of documentary evidence on behalf of both parties, and additional material as the hearing progressed. The documents in the bundle included, but was not limited to, the witness statements and exhibits of the Boots Opticians witnesses, records relating to the disciplinary process, and Boots Opticians patient records for the patients concerned.

29. Following hearing from the witnesses and the Registrant, the Committee then heard closing submissions from both parties on the seventh sitting day of the hearing, 26 October 2023. The oral submissions were supplemented by written closing submissions from both parties.

30. In summary, Mr Irwin's principal submission on behalf of the Council was that the Committee had heard sufficient relevant evidence to come to findings of fact

against the Registrant and that each part of the Allegation had been proved on the balance of probabilities. Mr Irwin submitted that the Council's Standards should be kept at the forefront of the Committee's mind, particularly Standard 6, which required all Optometrists to recognise and work within the limits of their competence. Mr Irwin summarised this case as the Registrant's competence had been compromised over the summer of 2021, when these events occurred, and the Registrant ought to have recognised that.

31. Mr Iwrin invited the Committee to find that the Boots witnesses had all given clear and compelling evidence, were endeavouring to assist the Committee and had '*no axe to grind*'. Further, Mr Irwin submitted that the expert evidence of Dr Kwartz ought to be preferred over the evidence of Mr Quah, as although Mr Quah was clearly an experienced Ophthalmologist, his area of expertise was secondary care focused rather than primary care focused, as Dr Kwartz's experience was.

32. Furthermore, Mr Irwin submitted that Mr Quah applied the wrong test in relation to the standards to apply, as he only considered that conduct would fall seriously below where actual harm occurred, rather than risk of harm. In contrast, Dr Kwartz correctly considered the risk of harm and made fine distinctions when assessing the standard, giving the Registrant credit when appropriate.

33. In relation to Patient A and particular 1 of the Allegation, Mr Irwin conceded on behalf of the Council that it was accepted on the balance of probabilities that some kind of note was given by the Registrant to Patient A, which may have had dosage instructions written upon it, as it was unlikely that a pharmacist would dispense the medication chloramphenicol without such a note. However, this does not detract from the inadequacy of the Registrant's record keeping. Further, Mr Irwin reminded the Committee that there was no specific charge regarding the Registrant's advice on the use of chloramphenicol, therefore this did not, Mr Irwin submitted, mitigate anything.

34. In summary, Mr Smith, on behalf of the Registrant, submitted that the Registrant had accepted that there were some deficiencies in his practice, however he did not accept that these amounted to misconduct either individually or cumulatively. Further, the Registrant had accepted where his practice needed to change and was candid about what he would do differently in future.

35. In relation to Patient F, Mr Smith stated that the Registrant does not seek to contradict anything Patient F has said in her statement, however the Registrant maintains that from what he did explain to her regarding the hospital referral, there was some urgency. Patient F stated in her witness statement that she could not recall anything being said about the urgency, so was not in a position to confirm that.

36. Mr Smith highlighted the expert opinion of Mr Quah that the Registrant had correctly sought help from a colleague in relation to Patient F. Mr Smith accepted that Dr Kwartz was more of an expert in relation to Optometry than Mr Quah and that Mr Quah had applied the incorrect test when assessing the standards of care. However, he invited the Committee to not reject Mr Quah's expert evidence entirely, as he has extensive experience and Mr Quah had not been partisan, as he had made a number of criticisms of the Registrant.

37. The Committee heard and accepted advice from the Legal Adviser at the end of the facts stage, which included advice that the burden of proof throughout lies on the Council to prove, on the balance of probabilities, each of the facts alleged in

the Allegation. The Committee was advised to consider each particular of the Allegation separately and in turn, taking account of all of the evidence and submissions heard, but not to speculate about evidence not before it. Further, that it did not need to resolve every matter in issue, but rather to focus upon the disputed facts in the Allegation. The Committee were reminded that they could take into account the Registrant's good character in two ways, firstly, in relation to credibility and secondly, in relation to propensity.

38. In relation to those particulars of the Allegation that refer to an alleged failure upon the Registrant, the Committee were advised by the Legal Adviser that they should firstly consider whether a duty or obligation exists upon the Registrant to act in that manner, before going on to consider if the failure is established.

39. Further, the Legal Adviser confirmed that she agreed with the statement made by Mr Irwin that although there had been a number of references in the evidence to matters of insight, reflection and changes to future patient care, these were matters that were not relevant to the fact-finding stage. These matters may become relevant at a later stage if the Committee goes on to consider fitness to practise.

40. After retiring in camera to deliberate, the Committee reconvened the hearing briefly in order to clarify with Mr Smith a submission that he made in closing, which related to particulars 2 (ii) and (iii). Mr Smith had referred to the Registrant conceding these matters, on the basis that although it was his usual practice to ask a contact lens patient these questions, he had no specific memory of having asked Patient B them and he accepted that he had not recorded them on the patient record card. The Chair confirmed that in light of this concession the Registrant was now in effect making admissions to the whole of particular 2 (Patient B), which Mr Smith confirmed was correct.

Findings in relation to the facts

41. The Committee considered all of the evidence in this case, including the documentary evidence, the uncontested evidence of Patient F, the live evidence of the witnesses from Boots Opticians, the documentary evidence, the expert evidence of Dr Kwartz and Mr Quah (both live and their reports) and the evidence of the Registrant. The Committee also considered the oral and written submissions from the parties.

42. The Committee was mindful that it did not need to resolve every issue that was in dispute between the parties/witnesses and instead focused upon the facts alleged as set out in the Allegation. The Committee noted that one area of dispute between the parties was the extent to which concerns had been raised by the Registrant's optometrist colleagues to management and/or directly to the Registrant. Whilst this is not a point that is specifically raised by the Allegation, the Committee was satisfied that the Boots optometrist witnesses had raised their concerns regarding the Registrant's record-keeping, including speaking to the Registrant about this issue. In particular, they were able to give clear and consistent evidence regarding conversations with the Registrant, which he was unable to recall. The Committee was satisfied that such conversations had occurred.

43. The Committee had regard to all of the documentary evidence before it, which included the unredacted bundle and patient records of other patients (C, D and E), which were not directly relevant to the Allegation. The Committee considered this evidence, together with the Boots self-audit records, as it noted that the Registrant wished to rely upon this evidence. However, the Committee did not find this evidence particularly relevant or helpful to the matters in question, as set out in the Allegation, nor did it appear to advance the Registrant's case. The Committee considered this evidence but did not rely upon it to come to the findings set out below.

44. The Committee considered the denied particulars of the Allegation in turn.

Particulars 1 and 2 (Patients A and B)

45. The Committee noted that in relation to Patients A and B, in light of the concessions made by the parties, as set out in paragraphs 33 and 40 above, these were now admitted in their entirety, by the Registrant, albeit that he asked the Committee to note that he had made a hand-written note containing the relevant information, and passed it to the patient to pass to the pharmacist. Accordingly, the Committee found these particulars of the Allegation proved.

Particulars 4, 5 and 6 (Patient F)

46. The Committee noted that the Registrant had admitted particular 3(a)-(e), which set out the signs and symptoms, suggestive of neurological disease, that Patient F had presented with on 25 June 2021, when the Registrant examined her. These included headaches, patchy vision, swollen right optic disc, reduced visual acuity in the left eye and hemianopic visual field defect.

47. The Committee agreed with the approach taken by the parties to consider particular 5 first, before particular 4, as that was the order of events.

48. Particular 5 alleges that the Registrant failed to appreciate that Patient F's presentation required an emergency referral. The Registrant had given evidence to the Committee that although he had been unable to put a name to Patient F's presentation, he appreciated that it required a referral to hospital either that same day or within 2-3 days. He denied that he had intended to refer Patient F via the SCI Gateway system, which would have taken 7 days as an urgent referral and stated that he knew such a method of referral would have been totally inappropriate for this patient. The Registrant's evidence was that he went to speak to his colleague Witness C for a second opinion on how quickly Patient F needed to be referred (either same day or within 2-3 days) and to put a name on the condition, which he had a mental blank about.

49. The Committee carefully considered the evidence of Patient F, which was uncontested evidence, set out in her witness statement dated 24 February 2023. Patient F stated that after having undergone tests (one of which was a visual field test that Patient F struggled to complete),

> "*The Registrant then took me back into a room and said that he could not see that anything was wrong and could not clearly see why I was experiencing blurred vision. The Registrant said there must be something because of the difficulties I had with the Test. The Registrant told me he would refer me to*

the Ophthalmologist at [redacted]*, the local hospital. I cannot now recall if the Registrant said anything about the nature of the referral, only that he would refer me to them and that it may take longer than normal due to COVID-19.*

Following this, I drove back to work which takes around 20-30 minutes. At around lunchtime the same day, the Registrant called me and said that he was still not happy and had telephoned [redacted] *and they had an appointment for me that afternoon if I was able to get there. I attended* [redacted] *and found that I had swollen nerve endings that had been damaged and were causing the migraines. In addition, I also had a brain tumour…* "

50. The Committee was of the view that whilst Patient F could not recall if the Registrant had said anything about the nature of the referral, it did not appear from her description of events that she appreciated the potential seriousness of the condition that she had presented with. In particular, Patient F had left the appointment with the Registrant to drive back to work and she states that she found that she had swollen nerve endings when she attended at the hospital later that day (rather than as a result of a conversation with the Registrant).

51. The Committee also had close regard to the Registrant's early accounts given by him in his interviews with Boots Opticians. In the first interview on 7 October 2021, the Registrant was asked about why he let Patient F go home and what he was thinking at the time. The Registrant's responded,

"*I've been thinking about this one a lot. Especially after she came back and I was made aware it was a tumour. This has really bugged me, For whatever reason I had the evidence in front of me I just wasn't connecting…I had a total blank. I was looking at optic nerve head but I was just blank…"*

52. The Registrant gave the following account for why he asked for Witness C's opinion,

"*I couldn't figure out what was going on. The more I looked, the more unhappy I was so I brought* [Witness C] *in. I think I had a lack of confidence after a year out. It feels like confidence has come back now. I wasn't looking at the bigger picture, I was looking at everything in isolation. At the point* [Witness C] *came in I saw disc swelling in the right eye but didn't register the degree of swelling*."

53. When asked if he knew if he wanted to refer and how urgent, the Registrant responded,

"*Yes…Before* [Witness C] *came in, I thought within a few days. I didn't at the time register. When I look back, I can't believe I didn't get it all to add up…."*

54. The Committee noted that the Registrant's accounts in relation to Patient F had varied slightly between the initial account given in the first Boots interview on 7 October 2021, as set out above and his later accounts, particularly the evidence given to the Committee during the hearing. The Committee considered that the Registrant's first account would be likely to be the most reliable, given that it was the most contemporaneous to the material time and the events in question. It would be fresher in the Registrant's memory than now.

55. The Committee took the view that the Registrant's early account was in some respects consistent with the evidence of Patient F. His first account showed that at the time Patient F left the practice, before the Registrant had spoken to his colleague Witness C, he had not at that stage appreciated the emergency nature

of the referral, which he only realised after speaking to Witness C at lunchtime. For example, the evidence set out above demonstrates that the Registrant only saw the disc swelling at the point that Witness C came in.

56. The Committee also noted that the Registrant had repeatedly stressed in his evidence that he believed that the referral should have been either that day or within several days. The Committee accepted the expert evidence, upon which both experts were agreed, that whilst it was not a '*blue light*' scenario, requiring an ambulance, there ought to have been a referral within 24 hours of the appointment with the Registrant. This was due to the very serious set of clinical symptoms that Patient F presented with and the serious implications of the same.

57. The Committee had regard to the expert evidence of Dr Kwartz who described Patient F's set of symptoms as '*barn door*', and that they should have been obvious as an emergency referral. The Committee was satisfied that a referral of even 2-3 days was not appropriate in the circumstances, and it ought to have been obvious to a reasonably competent optometrist that Patient F needed to be referred as an emergency that same day.

58. Therefore, the Committee was satisfied that whilst the Registrant may have appreciated that there needed to be a hospital referral for Patient F, he failed to appreciate, until discussing the case with Witness C at around lunchtime, that Patient F's presentation required an emergency same day referral. Accordingly, the Committee found Particular 5 proved.

59. The Committee next considered particular 4, which alleged that the Registrant sent Patient F home without discussing with and/or advising them that a very prompt referral was necessary to investigate the signs and symptoms. This was denied by the Registrant on the basis that he told Patient F that their symptoms required further investigation, that a referral to hospital was necessary and that she would be contacted about this. Further, she was contacted a couple of hours later and referred to the hospital the same day.

60. The Committee considered Patient F's evidence, as set out at paragraph 47 above. The Committee was of the view that Patient F's account did not convey that she understood that a very prompt referral was necessary, nor did she appear to appreciate the potential seriousness of her symptoms until she was seen by the hospital. Whilst Patient F could not recall if anything was said to her by the Registrant about the nature of the referral, she stated that "*he would refer me to them and that it may take longer than normal due to COVID-19*."

61. The Committee considered that this statement supported that Patient F was left with the impression that the referral may take some time. It noted that although COVID-19 may have been a factor, in fact when the hospital was contacted about Patient F, they arranged to see her later that day. The Committee was of the view that had the seriousness of the symptoms and the urgency of the referral been explained to Patient F by the Registrant, this is likely to have been recalled by Patient F, given the gravity of the situation.

62. The Committee was also satisfied, as found above, that at the time that Patient F left the practice, the Registrant was still unsure of what he was looking at and the nature of the referral, which only became clear after he spoke to Witness C at lunchtime. The Committee was satisfied that whilst the Registrant appreciated that something was wrong with Patient F, when she left the practice, he did not yet understand what he was dealing with. In the Committee's view, this supports

that the Registrant sent Patient F home without discussing with them, or advising them, that a very prompt referral was necessary. Accordingly, the Committee found particular 4 proved.

63. The Committee then went on to consider particular 6, which alleged that, as a result of particulars 4 and 5, the Registrant exposed Patient F to the risk that the specialist assessment of their condition would be inappropriately delayed. This was denied by the Registrant, as there was a referral made later that day and no delay to the specialist assessment of Patient F.

64. The Committee considered that in relation to this particular, the allegation was in relation to the potential risk in the Registrant's failure to appreciate the emergency nature of the referral and/or in sending Patient F away without them having been advised of a very prompt referral being necessary. It was not concerned with what actually occurred, given that Patient F was seen by a specialist later that day, with an operation the next day, following the involvement of Witness C.

65. In this respect, the Committee preferred the evidence of Dr Kwartz over the evidence of Mr Quah, as the correct test was to consider the risk of harm to patients, rather than actual harm, as conceded by Mr Smith. In addition, the Committee considered that where there was a dispute between the experts, particularly on the applicable standards to be expected, the Committee found the evidence of Dr Kwartz to be more helpful to the Committee, as she had greater direct experience of primary care optometry.

66. The Committee was of the view that it would have been appropriate for the Registrant to seek a second opinion from Witness C, given that he was struggling to recognise what he was looking at and that following that second opinion the risk to Patient F was mitigated. However, had that involvement of Witness C not occurred, the Committee considered it unlikely that the Registrant would have referred Patient F as an emergency same day referral. Further, the Committee considered that there was a risk if Patient F did not appreciate that a very prompt referral was required that they may not respond appropriately, for example delaying an appointment if they had another pressing commitment.

67. The Committee came to the conclusion that without the intervention of Witness C, there would not have been an emergency same day referral, as it accepted the clear and consistent evidence of Witness C. Witness C described throughout her evidence, from her initial Boots interview, her witness statement, and her live evidence, that when the Registrant came to speak to her he was asking for her opinion on which SCI Gateway referral to make, either urgent or routine, neither of which would have been appropriate for Patient F given the seriousness of her presentation.

68. The Committee noted that the Registrant denied that he was going to refer via the SCI Gateway and stated that he did not know where Witness C had got that from, as he knew that an SCI Gateway referral would be inappropriate. However, the Committee considered that the Registrant's evidence throughout has not been clear on this issue. In particular, his witness statement served shortly after the start of the hearing does not make the position clear and does not state that he was not going to use the SCI Gateway, as that would be inappropriate.

69. Whereas the Committee considered that the evidence of Witness C was clear and consistent, not just internally but also with Patient F's evidence and with the Registrant's first account given in his first interview with Boots Opticians. The

Committee did not form the view that the Registrant was being untruthful in his evidence, rather that his recollection of events was not as reliable as that of Witness C. Further, the most contemporaneous and therefore likely reliable account of the Registrant, his first account to Boots, does fit, in the Committee's view, with Witness C's account.

70. Taking into account all of the above, the Committee was satisfied that on the balance of probabilities particular 6, which alleged that, as a result of particulars 4 and 5, the Registrant exposed Patient F to the risk that the specialist assessment of their condition would be inappropriately delayed, was proved.

Particular 7 (Patient G)

71. The Committee went on to consider particular 7, which alleged that on or around 17 August 2021, when the Registrant examined Patient G, he failed to keep an adequate record of the consultation, as he did not record details in respect of the action plan (particular a), and/or did not make an urgent referral regarding Patient G's presenting intra-ocular pressures ('IOPs'), reduced acuity, and/or deteriorated visual fields (particular b) and/or failed to identify the same as signs suggestive of advancing glaucoma (particular c).

72. The Committee firstly considered particular c, the Registrant's identification of the clinical signs listed, being first in time. The Committee noted that the Registrant denied this allegation on the basis that he attempted to make a referral to Patient G's consultant on 20 August 2021, and believed at the time of his suspension on 28 September 2021 that this had been sent, when it had not. The Committee carefully considered the referral document that it had in the bundle, which had originally been completed by the Registrant and later added to and sent by Witness A on 29 September 2021.

73. The Committee noted that the Registrant's evidence was that he did recognise the signs that Patient G's glaucoma was not stable, and this required an urgent referral of Patient G back to their consultant. The Registrant gave evidence that he marked the referral as urgent, which was not disputed by any other evidence. Further, the patient record card for Patient G and the referral, both prepared by the Registrant, recorded the results of the IOPs and documented the visual field results.

74. The Committee was of the view that the Registrant had appreciated that Patient G's IOPs were high and there needed to be an urgent referral back to the hospital, which he had attempted to do via the SCI Gateway system, however unsuccessfully. In the circumstances, the Committee was satisfied that the Registrant had identified the signs of advancing glaucoma, realising that an urgent referral was required, and found particular c not proved.

75. The Committee then turned to consider particular 7(a) and whether the Registrant has kept an adequate record of the action plan for Patient G. This was admitted by the Registrant on a qualified basis, as he explained that the records contained the referral he made on 20 August 2021, with the test results from the Registrant's consultation.

76. The Committee considered the Registrant's qualified admission and was of the view that even though the information could be found within the referral, this action plan was not contained within the patient's record card and that should be

a complete record of the management of that patient, so that a subsequent clinician could clearly understand the position. The Committee noted that there was no information on Patient G's record card to indicate that there had been a referral and in the circumstances the Registrant had failed to keep an adequate record of his consultation with Patient G, as it did not record details in respect of the action plan. Accordingly, the Committee found particular 7(a) proved.

77. The Committee went on to consider particular 7(b), whether the Registrant failed to make an urgent referral regarding Patient G's symptoms. The Committee was satisfied that an urgent referral was required in the circumstances, particularly given the expert evidence that agreed that the IOP level experienced by Patient G could cause irreversible damage to the eye. Further, the Registrant's evidence was that he had intended to make an urgent referral and believed that he had done so.

78. However, there was clear evidence that the Registrant's draft referral was not sent and was found after the Registrant's suspension as a parked referral on the SCI Gateway system, subsequently being sent by Witness C some six weeks later on 29 September 2021. The Committee considered what was meant in the allegation as making an urgent referral and what that required the Registrant to have done.

79. The Committee had heard and accepted the evidence from both Dr Kwartz and the other Boots optometrist witnesses, that the onus was on the individual registrant to ensure that a referral was sent. The Boots optometrist witnesses further gave evidence that they would regularly check the status of their own referrals on the SCI Gateway system. The Registrant's evidence was that he would use the SCI Gateway referral system a couple of times a week, up until he was suspended, and did not notice that he had a parked unsent referral for Patient G.

80. Considering all of the above, the Committee took the view that a referral was not made until it had been sent and whilst the Registrant may have intended to send an urgent referral in respect of Patient G, this was not completed by him. This was evidently the case, given that the parked referral was found by his colleagues on the system after his suspension and was then sent by Witness C.

81. The Committee understood that the Registrant found the system difficult to use and often had to ask for help to use it. Further, the Committee accepted that the Registrant had failed to realise that it had not been sent rather than any deliberate action. However, the Committee considered that it remained the Registrant's responsibility to check that the referral had been successfully sent and to follow up on it, if necessary, which he failed to do. Accordingly, the Committee found particular 7(b) proved.

Findings in relation misconduct

82. The Committee proceeded to consider whether the facts admitted and/or found proved, amounted to misconduct, which was serious.

83. The Committee heard submissions from Mr Irwin, on behalf of the Council, and from Mr Smith, on behalf of the Registrant. No further material was put before the Committee at this stage.

84. Mr Irwin reminded the Committee that but for particular 7(c), all of the facts alleged had been found proved and submitted that these facts establish misconduct. He submitted that the proved facts were not limited to record-keeping deficiencies, but also clinical failings, some of which were acknowledged by the Registrant during the hearing.

85. In relation to Patients F and G, Mr Irwin submitted that the facts found proved were '*troubling*', as they gave rise to a grave risk of harm for those patients.

86. Mr Irwin acknowledged that the Registrant had practised for 35 years without any prior fitness to practise findings against him. Further, the Committee had not found that he had been untruthful in his evidence, but nonetheless, in important respects his evidence had been rejected.

87. Mr Irwin referred the Committee to the "*Council's Standards of Practice for Optometrists and Dispensing Opticians*", effective from April 2016. Mr Irwin submitted that the Registrant has departed from the following standards by virtue of his conduct:

    • *Standard 7: Conduct appropriate assessments, examinations, treatments and referrals;*

    • *Standard 8: Maintain adequate patient records.*

88. In relation to the Registrant's record-keeping, Mr Irwin submitted that just because the Registrant relied upon the record-keeping of Patient C, does not mean that this showed there had been an improvement in his record-keeping over the summer. Furthermore, although the Registrant had completed almost 30 hours of CET in the weeks before starting work at Boots Opticians, he had failed to get up to the required standard for contact lens patients, as could be seen from his management of Patient B.

89. Mr Irwin reminded the Committee of Dr Kwartz's evidence in relation to Patient F, that they presented with symptoms that were '*barn door*' and the Registrant failed to take immediate action. In relation to Patient G, the Registrant failed to take appropriate action and ensure that the referral letter was sent to the hospital, which put Patient G at risk of irreversible damage to the optic nerve and sight loss.

90. Mr Irwin submitted that the Registrant's failures alone and together constitute serious misconduct, which were particularly serious due to the grave potential consequences for the patients concerned. Mr Irwin invited the Committee to find that there had been fundamental breaches of the standards, which were serious and constituted misconduct.

91. In relation to misconduct, Mr Smith submitted that the Registrant contested that the facts found proved amounted to misconduct, albeit he would concede that they amounted to deficient professional performance. He submitted that although the facts had been contested by the Registrant, he accepted the findings of the Committee.

92. In relation to Patient B, the Registrant accepted that there were deficiencies in his assessment, as he had not checked for staining with fluorescein. However, in respect of the other cases, Mr Smith submitted that the Registrant's assessments of the patients were carried out to an adequate standard.

93. Mr Smith submitted that the Registrant's conduct could be described as deficient professional performance, referring the Committee to the case of *Calhaem, R (on the application of) v General Medical Council* [2007] EWHC 2606 (Admin), which states that in relation to deficient professional performance,

> "(3)… *It connotes a standard of professional performance which is unacceptably low and which (save in exceptional circumstances) has been demonstrated by reference to a fair sample of the doctor's work.*
>
> *(4) A single instance of negligent treatment, unless very serious indeed, would be unlikely to constitute "deficient professional performance*".

94. Mr Smith submitted that as there was evidence relating to seven patients before the Committee (including patients C, D and E, not part of the Allegation), this could be regarded as a sufficient sample in order to assess deficient professional performance. Mr Smith also referred to the expert evidence of Mr Quah, which he submitted supported a finding of deficient professional performance rather than misconduct. Mr Smith highlighted that the Registrant had examined Patient F at the very start of his employment with Boots Opticians and that there had been no repeat of that conduct since.

95. Mr Irwin responded on the law relating to misconduct and deficient professional performance, referring the Committee to the relevant guidance on both statutory grounds for impairment, as set out in the Council's '*Hearings and Indicative Sanctions Guidance (Revised November 2021)*'. Mr Iwrin submitted that it was conceded that conduct has to be serious and to a high degree to establish misconduct, however both aspects of that test were met in this case.

96. Mr Iwrin submitted that misconduct can be found from a single act, if it was sufficiently serious, and that undoubtedly applied to both Patients F and G. Mr Iwrin conceded that Patients A and B alone may not cross the threshold for misconduct, however taken together and with Patients F and G, they would cross the threshold for misconduct, which is serious. Mr Irwin submitted that everything set out in the guidance leads to the conclusion that the correct category is misconduct and highlighted the following passage from the case of *Calhaem*:

> "*It is neither necessary nor appropriate to extend the interpretation of "deficient professional performance" in order to encompass matters which constitute "misconduct"."*

97. The Committee heard and accepted the advice of the Legal Adviser, who advised that deficient professional performance and misconduct were distinct statutory grounds for impairment and that conduct should be classed as one or the other. In this case, the Council had alleged misconduct and brought the case on that basis, rather than deficient professional performance, which required the assessment of a fair and sufficient sample of the Registrant's work.

98. In relation to misconduct, the Legal Adviser referred to the case of *Roylance v General Medical Council (no2)* [2000] 1 AC 311, regarding the two principal kinds of misconduct, either conduct linked to professional practice or conduct that otherwise brings the profession into disrepute. The Committee was reminded that misconduct was a matter for its own independent judgement and no burden or standard of proof applied at this stage. Further, that the Committee needed to consider whether the conduct was sufficiently serious to amount to professional misconduct.

99. This threshold of serious misconduct has been described in the case of *Meadow v GMC* [2006] as being conduct which would be regarded as deplorable by fellow practitioners. However, it does not necessarily require moral turpitude; an elementary and grievous failure can also reach the threshold of serious misconduct, as held in the case of *Preiss v General Dental Council* [2001] 1 WLR 1296.

100. The Legal Adviser gave advice on the issue of whether it was permissible for the Committee to take a cumulative approach to finding serious misconduct, given that the expert evidence in relation to Patient A was that the Registrant's record-keeping deficiencies fell below, but not seriously below, the standards expected.

101. The Legal Adviser referred the Committee to the case of *Schodlok v GMC* [2015] EWCA Civ 769, which suggests that it may be permissible, in an appropriate but rare case, for a tribunal to undertake the exercise of cumulating findings of misconduct on some charges to make a determination of serious misconduct on others. However, that approach has to be taken with caution following the more recent case of *Ahmedsowida v The General Medical Council* [2021] EWHC 3466 (Admin), which stated that in relation to cumulation for a finding of serious misconduct,

> *"If that is permissible at all, the exercise is supposed to involve the cumulation of non- serious with other non-serious misconduct findings; not of one non-serious misconduct finding with another finding(s) of misconduct that is serious in its own right. In the latter context, there is no good reason to cumulate; the quality of the conduct is already correctly expressed, without the need for any cumulation."*

102. The Committee firstly considered the submission of Mr Smith that the facts found proved ought to be categorised as deficient professional performance, rather than misconduct. The Committee noted that the Allegation had been pleaded on the basis of misconduct, rather than deficient professional performance.

103. Furthermore, cases brought by the Council on the basis of deficient professional performance would ordinarily include a performance assessment, conducted by expert witnesses, assessing a fair sample of the Registrant's work. Such evidence was not before the Committee in this case and Dr Kwartz had given her opinion that although there were further records introduced by the Registrant (in relation to Patients C, D and E), these were not considered to be a sufficient, nor varied enough, sample of records to assess any improvement in the Registrant's record-keeping. The Committee were therefore of the view that given there was an insufficient sample of work and no appropriately focused expert evidence, it would be inappropriate to make a finding of deficient professional performance on the evidence before it.

104. The Committee therefore went on to consider misconduct. It considered the "*Council's Standards of Practice for Optometrists and Dispensing Opticians*" and the standards which it had been referred to by the Council, namely 7 (conduct appropriate assessments) and 8 (adequate record-keeping), which the Committee was satisfied both applied in this case. The Committee was satisfied that there were failings in this case both in respect of record-keeping and clinical failings in the assessment and/or management of patients. In respect of both standards 7 and 8, the conduct of the Registrant, as found proved, had fallen below the expected standards of what was proper in the circumstances.

105. The Committee was mindful that not every falling short of the standards was sufficient to amount to misconduct, as it must be serious. The Committee went on to consider whether the Registrant's failures were serious in relation to each Patient referenced in the Allegation. The Committee had regard to the expert evidence in the case of Dr Kwartz and Mr Quah.

106. Whilst the Registrant's expert Mr Quah had only found that the Registrant's conduct fell below the standards expected, not far or seriously below, the Committee was mindful that the parties agreed that Mr Quah had applied the wrong test when considering the assessment of standards. The Committee had found at the facts stage that the evidence of Dr Kwartz, who had made fine distinctions between whether conduct was adequate, below, or far below, and clearly explained her assessments of the Registrant's conduct, was preferred by the Committee over that of Mr Quah.

107. The Committee accepted the evidence of Dr Kwartz that, in her expert opinion, the Registrant's conduct in relation to Patient F, by not recognising the '*barn door*' presentation of Patient F and by letting her leave the practice without explaining to her the seriousness of the findings and that a very prompt referral was necessary, fell very seriously below the standards expected of a reasonably competent optometrist. The view of Dr Kwartz was supported by the Royal College Guidelines, which advised that a referral for the symptoms presented by Patient F ought to be made within 24 hours.

108. Further, in Dr Kwartz's opinion the Registrant's assessment of Patient B fell far below expected standards due to his failure to use fluorescein to check the health of the cornea, as this was a fundamental part of a contact lens check. The Committee noted that Mr Quah was also in agreement that the use of fluorescein was a fundamental part of the examination. In addition, Dr Kwartz was of the opinion that the Registrant's record keeping in respect of Patient B fell seriously below the standards expected due to the number of omissions from the record, which was missing information fundamental to patient care.

109. Furthermore, Dr Kwartz considered that the Registrant's record-keeping and management of Patient G fell seriously below the standard expected, by not making an urgent referral to the hospital, in light of the very high IOPs that the Registrant detected. Although the Registrant may have intended to make the referral, by not ensuring that it was sent, Patient G's referral was delayed by approximately 6 weeks. During this time period there was a risk to Patient G from the very high IOP, which Dr Kwartz explained will have caused damage at that level if sustained. The Committee accepted the evidence of Dr Kwartz that this was a significant departure from the standards expected of a reasonably competent optometrist.

110. In relation to these three patients, F, B and G, the Committee was satisfied that the Registrant's conduct fell sufficiently far below the standards expected of a reasonably competent optometrist to amount individually to misconduct, which was serious.

111. The Committee noted that Dr Kwartz's view in respect of Patient A was that the Registrant's record keeping fell below the standard expected of a reasonably competent optometrist but not seriously below the standard. In the circumstances, in relation to Patient A, the Committee was of the view that the

Registrant's conduct was not serious enough conduct to meet the threshold of misconduct on an individual basis.

112. The Committee considered the issue of cumulation, as invited to do so by the Council, and whether it could amount to misconduct, which was serious, when taken together with the other patients where findings of serious misconduct had been made. However, the Committee was mindful of the case of *Ahmedsowida v GMC* and the Legal Advice it had received, as set out in paragraph 98 above. In the circumstances of this case, the Committee was not satisfied that it was appropriate to take a cumulative approach and to include the Registrant's conduct relating to Patient A, in its findings of serious misconduct.

113. Accordingly, the Committee found that the facts admitted and/or found proved do amount to misconduct, which was serious, in respect of Patients F, B, and G.

Findings regarding impairment

114. The Committee next considered whether the fitness to practise of the Registrant was currently impaired, as a result of the misconduct found. Mr Irwin made brief opening submissions outlining the relevant legal principles on impairment, expanding upon his written submissions. He submitted that there was a close alignment between the Council's standards and fitness to practise.

115. Mr Irwin highlighted to the Committee that the purpose of fitness to practise proceedings was not to punish the Registrant but to protect the public. He submitted that the Committee ought to consider the issue of insight, whether any remedial steps had been taken by the Registrant and the risk of repetition. Further, the Committee would need to consider the need to uphold professional standards and confidence in the profession and whether these would be undermined if a finding of impairment was not made.

116. Mr Irwin referred the Committee to the guidance in the case of *CHRE v (1) NMC and (2) Grant* [2011] EWHC 927 (admin) and the test that was formulated by Dame Janet Smith in the report to the Fifth Shipman Inquiry. Mr Irwin submitted that limbs (a)-(c) of this test are engaged in this case, namely conduct which put patients at unwarranted risk of harm, brings the profession into disrepute, and conduct which breaches one of the fundamental tenets of the profession. Mr Irwin indicated that he would make further submissions once the Registrant had given evidence.

117. The Registrant then gave further evidence under affirmation and was questioned by Mr Smith, Mr Irwin, and the Committee.

118. The Registrant gave evidence that he was not currently practising, as he had been suspended since January 2023. He did not renew his registration in April 2023 and was currently unemployed. The Registrant stated that he intended to return to practice, if he was permitted, as optics had been his life and the only type of work he had known all of his working life. The Registrant explained that after leaving Boots in October 2021, he was out of work until he started employment with Specsavers in February 2022. However, he soon lost this position, as they were unsupportive of his interim order of conditions, which required ten patient records to be submitted for review each month. He was unable to secure alternative employment as an optometrist.

119. Mr Smith took the Registrant through a small bundle of training records, which had been produced by the Registrant at this stage of the hearing. This documentation included CPD certificates for two online glaucoma courses, a CET statement for the period 2019 – 2021, a CPD statement for the current period of 2022 – 2024 and a list of CET courses undertaken by the Registrant in 2020. The Registrant described the independent reading that he had completed in relation to papilledema, visual fields terminology, and record-keeping. He stated that he had read articles and looked at the BCO and GOC websites regarding the standards of record-keeping required.

120. Mr Smith questioned the Registrant regarding what he would do differently in respect of each patient and the extent to which the Registrant accepted what had been said about his practice. The Registrant gave evidence that he had '*taken on board*' all criticism from Boots and the experts in this case and had tried to learn from everything that had been brought to his attention. In relation to Patient F, he explained that if he dealt with a similar case again, it would be very unlikely that he would not recognise papilledema, unless it was very subtle. He would explain to the patient that something was pressing on the optic nerve and that this needed to be assessed as soon as possible. He stated that he would ring the hospital, whilst the patient was there and if he was in any doubt about the referral he would leave it to the judgement of the HES.

121. In relation to Patient B, the Registrant explained that he had changed his practice regarding the use of fluorescein to check the health of the cornea. In relation to his record-keeping, the Registrant stated that this would be substantially different in future, as he had taken on board the deficiencies highlighted in this case. He would ask a colleague to review his records in future to check they are legible, as he did not want to be put in the same position again.

122. In relation to Patient G and the referrals on the SCI Gateway, the Registrant gave evidence that he had learnt from his former Boots Opticians colleagues and would adopt their practice of regularly checking the system to see if referrals had been actioned by the hospital.

123. Mr Irwin questioned the Registrant regarding the extent of remediation that he undertaken since the events in question. The Registrant confirmed that the records produced by him at this stage were the full extent of the CPD records that he was able to locate for this hearing and he explained that he had not logged or kept reflections of it all. He may have made some notes but would not know where they are now. The Registrant denied Mr Irwin's suggestion that his lack of records regarding his CPD was indicative of his record-keeping not improving and responded that patient records were a different matter to his personal record-keeping.

124. Mr Irwin suggested to the Registrant that he was in a similar position now, having not worked for the past 20 months, as he was when he started at Boots and if he returned to work now as an optometrist, he would be very rusty. The Registrant responded that he had previously been rusty in respect of the papilledema, however he rectified that in the weeks after his examination of Patient F. If he returned to work tomorrow, he stated that he would do the job thoroughly and properly, although he may need a little time to '*get into the swing of things*'. When asked by Mr Smith about how much time he would require to do that, the

Registrant stated two weeks, and this was a pessimistic estimate, as he suspected it would be less.

125. The Committee asked the Registrant questions, including but not limited to, whether he was aware that when the Council's rules changed regarding CPD in 2022, it had become his own responsibility to upload details of his CPD to the Council's website, rather than the course provider, as was previously the case. The Registrant stated that he did not recall that change, which he was surprised about. He confirmed that he had not been uploading details of the CPD he had undertaken, such as the two glaucoma courses, to the Council's website and stated that he would ensure that he did so in future.

126. Mr Irwin, in his closing submissions on impairment, referred the Committee to the paragraphs on determining impairment in the Council's '*Hearings and Indicative Sanctions Guidance (Revised November 2021)*' ('the Guidance'). He reminded the Committee that relevant factors to consider at this stage included whether the conduct was remediable, whether it has been remedied and whether it is likely to be repeated.

127. Mr Irwin referred the Committee to paragraph 16.6 of the Guidance, which relates to the principle that insight needs to be approached carefully where a Committee had found facts proved following a denial by a Registrant. Mr Irwin additionally referred to the case law in relation to this issue and accepted that the mere fact that the Registrant had denied the Allegation did not in itself give rise to an issue regarding lack of insight. However, Mr Irwin submitted that in relation to Patient G, the Registrant had maintained a position that a referral had been made when it plainly had not, which he submitted was a matter that the Committee could take into account when considering insight.

128. In relation to the training materials relied upon by the Registrant, Mr Irwin submitted that it was relevant to insight that the Registrant had provided all of the records that he can and there were significant gaps, for example nothing relating to the period between March 2021 and June 2023. Mr Iwrin submitted that whilst there may have been financial restraints to completing CPD courses, nothing would have prevented self-reflection. Whilst the Registrant maintained in evidence that there were a further 5 or 6 hours of CPD that he completed, there were no records to confirm this. Mr Irwin submitted that the Registrant's record-keeping and current awareness of CPD compliance remains of real concern.

129. Mr Irwin submitted that the following matters were relevant to insight. In the summer of 2021, the Registrant had not appreciated how far he had fallen below the standards expected and in this respect standard 6 of the Council's standards was relevant, which requires Registrants to recognise shortcomings. The Registrant had refused help from colleagues once he started to work at Boots Opticians and demonstrated a '*wilful refusal*' to complete the on-boarding training which he did not consider relevant. The Registrant maintained his position that a referral had been made for Patient G when it had clearly not been, which Mr Irwin submitted was relevant to insight. The Registrant had not kept training records and his '*woefully inadequate*' record-keeping, as borne out by his evidence, shows a lack of insight.

130. Furthermore, Mr Irwin submitted that the fact that the Registrant had not worked for the past 20 months was also relevant to his fitness to practise, as he had not been able to practise and hone his skills during this time. Mr Irwin acknowledged

the difficulties that the Registrant had in working with the interim orders in place, but this made the need to address these concerns with CPD even more important.

131. In concluding, Mr Iwrin submitted that the Registrant's current fitness to practise was clearly impaired. The failings in this case were fundamental and serious, with several clinical failings, resulting in a risk to patient safety, a breach of fundamental tenets of the profession and brought the profession into disrepute.

132. Mr Smith, on behalf of the Registrant, submitted that in relation to the factors for the Committee to consider, as set out in paragraph 16.1 of the Guidance, the Registrant's position was that the conduct is remediable, that it had not yet been remedied but the Registrant was capable of doing so and there was no risk of repetition. Mr Smith referred the Committee to paragraph 16.2 of the Guidance, which he invited the Committee to follow in this case, which states,

> *"a proven allegation that is less serious and considered in the context of an otherwise unblemished career and remedial steps taken by the registrant, may lead the Committee to conclude that, looking forward, fitness to practise is not impaired despite the misconduct."*

133. Mr Smith invited the Committee to take account of the fact that the Registrant had practised for 35 years with an unblemished career and no prior fitness to practise history until these three findings of misconduct. Mr Smith stated that he disagreed that the evidence supported that there had been a risk to patient safety. Neither had the Registrant brought the profession into disrepute, nor had he breached a fundamental tenet of the profession.

134. In relation to whether the Registrant had remediated the conduct, Mr Smith submitted that the main source of evidence was the Registrant's own evidence and whether he had impressed upon the Committee that he had taken on board all of the criticisms. Mr Smith submitted that taking into account the Registrant's evidence to the Committee and that given to Boots Opticians in his interviews, it could find that the conduct in relation to Patient F would not happen again. He submitted that this aspect of the case was remediable and unlikely to be repeated.

135. In relation to Patients B and G, Mr Smith submitted that the Committee had heard the Registrant's evidence and could assess the genuineness of his responses, to determine whether the conduct was likely to be repeated. The Registrant had set out in his evidence how he would now double check whether any referrals had been properly sent. This was remediable and not likely to be repeated.

136. Mr Smith submitted that when considering whether the conduct has been remediated, there were reasons why there was not further corroboration. Firstly, the Registrant had not been able to work since these matters, so he had no recent employment history to reassure the Committee. Secondly, whilst the Registrant had not taken opportunities open to him in relation to CPD and training, he had [redacted] during this time period, as well as [redacted], which he stated had '*dragged him down*.' The Registrant had produced today all of the records that he was able to find and had been candid about this. Mr Smith invited the Committee to not find this demonstrated a lack of insight, given the external factors impinging upon the Registrant.

137. In relation to insight, Mr Smith stated that the Registrant did not accept that he had rejected colleagues' offers of help, but he could not recall these offers. Neither did he accept that there had been a wilful refusal to complete the training

at Boots Opticians, rather he says that this was not completed as his patients were the priority. In relation to the Registrant's position maintained in respect of Patient G's referral, Mr Smith invited the Committee to consider the proper context, which was that records had been requested, such as the original referral and the other parked referrals and these were unable to be produced by Boots Opticians. In these circumstances, where the Registrant was reluctant to accept the Council's case without sight of the records, this should not be used against him. Mr Smith confirmed that the Registrant does accept the Committee's findings that the referral had not been completed.

138. In conclusion, Mr Smith invited the Committee to find that the Registrant was not currently impaired. He submitted that the Registrant had taken on board the concerns in this case and indicated how he would do things differently in future. Any issues which relate to training are remediable and the Registrant has given evidence on what he intends to do to address them.

139. The Committee heard and accepted the advice of the Legal Adviser who advised the Committee that the question of impairment was a matter for its independent judgement taking into account all of the evidence it has seen and heard so far. She reminded the Committee that a finding of impairment does not automatically follow a finding of misconduct and outlined the relevant principles set out in the case of *Cohen v GMC* [2008] EWHC 581 (Admin). The Legal Adviser confirmed that she agreed with Mr Irwin's summary of the case law on the issue of insight and rejected defences.

140. The Legal Adviser referred the Committee to the test for considering impairment as set out by Dame Janet Smith in the fifth report of the Shipman Inquiry (para 25.67), and cited with approval in the case of *CHRE v NMC & Paula Grant* [2011] EWHC 927 (Admin), para 76, by Mrs Justice Cox, which is:

"Do our findings of fact in respect of the…misconduct, show that his fitness to practise is impaired in the sense that he:

(a) *Has in the past acted and/or is liable in the future to so act so as to put a patient or patients at unwarranted risk of harm and/or;*

(b) *Has in the past brought and/or is liable in future to bring the medical profession into disrepute and/or;*

(c) *Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession and/or;*

(d) *….."*

141. The Committee considered whether the Registrant's conduct was remediable, whether it had been remedied and whether the conduct is likely to be repeated in future.

142. The Committee noted that the misconduct which it had found, relating to Patients F, B, and G, related to issues of record-keeping and clinical issues relating to the assessment and management of patients. The Committee was of the view that the nature of the misconduct in this case, involving clinical issues, was such that it was capable of being remedied.

143. In relation to whether the misconduct had been remedied by the Registrant, the Committee noted the submission of Mr Smith, which conceded that the conduct had not yet been remedied, but that the Registrant was capable of doing so. It

appeared that the Registrant was wanting the Committee to accept his assurances that he had taken on board the concerns raised in this case and that he would do things differently in future. However, the Committee was of the view that whilst the Registrant may have good intentions to improve his standards, little action had been taken by him since the conduct, to demonstrate that there had been remediation of the concerns raised in this case. Further, the Committee was mindful that when determining impairment, it had to consider whether the Registrant is currently fit to practise, as of today, rather than at some future point.

144. The Committee considered the level of insight demonstrated by the Registrant. It bore in mind the evidence that it had heard from the Registrant, both at this stage and when he gave evidence earlier in the hearing, as well as the selection of training records that he had produced. The Committee remained of the view that the Registrant was seeking to be open and honest with the Committee when giving evidence and it had no concerns regarding his truthfulness and genuineness. However, the Committee considered that the Registrant's insight into the concerns arising in this case was limited and it was concerned, having heard the Registrant's evidence, that he did not yet appear to have a full understanding of why those concerns arose and how to remedy them.

145. The Committee concluded that the Registrant still has work to do in relation to his insight and remediation in order for the Committee to be reassured that he has remediated his misconduct. The Committee accepted that the Registrant had [redacted] in completing CPD courses, given his limited means. However, the Committee was of the view that the Registrant could have still completed self directed learning at no cost to himself and kept a record of his reflections in relation to that, which he did not do.

146. Although the Registrant maintained that he had completed more CPD, he was unable to locate these records. He was only able to demonstrate that he had attended two relevant CPD webinars, amounting to two hours learning, over the past two years, which in the view of the Committee was insufficient to address the various concerns in this case. In relation to the Registrant's position that he had not yet, but would, remediate the conduct, the Committee noted that the Registrant had not put forward any definite plan for how he would do so and how he would be able to meet the standards required of him if returning to practice.

147. Furthermore, the Committee agreed with the submission of Mr Irwin that as the Registrant had not worked as an optometrist for the past 20 months, with his registration lapsing, he was in a similar scenario to when he started at Boots Opticians before the events in question (which was a return to work after a break of 16 months). The Committee was of the view that the Registrant's estimation that he could return to practise without difficulty, only requiring a couple of weeks to settle in, was not realistic in the circumstances, given the lack of remediation and training to ensure that he had kept his skills up to date. Further, the Committee was concerned that the Registrant's evidence on this issue showed a lack of insight by the Registrant.

148. Given that the Registrant's insight into his conduct is not yet developed and the Registrant has not adequately demonstrated that the conduct has been remedied, the Committee was of the view that there is a real risk of repetition.

149. The Committee bore in mind that the Registrant has practised as an optometrist for 35 years, with a previously unblemished career and considered Mr Smith's

submission that in some cases such a context could mitigate the misconduct to the extent that no finding of impairment was necessary. However, given the serious and varied nature of the concerns in this case, together with the lack of remedial steps taken by the Registrant since the misconduct in 2021, and the risk of repetition, such an approach would not be appropriate in this case.

150. The Committee therefore concluded that whilst the conduct is remediable, it has not yet been remedied by the Registrant and there is a real risk of repetition. Accordingly, the Committee determined that the Registrant's fitness to practise is currently impaired on the personal component.

151. The Committee also had regard to public interest considerations and to the case of *CHRE v (1) NMC and (2) Grant* [2011] EWHC 927 (admin), particularly the test that was formulated by Dame Janet Smith in the report to the Fifth Shipman Inquiry. The Committee agreed with the submission of Mr Irwin that limbs (a)-(c) of this test are engaged in this case, namely conduct which put patients at unwarranted risk of harm, brings the profession into disrepute and breaches a fundamental tenet of the profession. The Committee was of the view that maintaining adequate records, assessing, and managing patients appropriately and working within one's competence, were fundamental tenets of the profession. The Committee considered that these limbs of the test were engaged on past conduct in relation to misconduct found proved, and that the Registrant was also '*liable in future*' to act in a similar manner, given that the Committee is unable to rely solely upon the Registrant's assurances that he will not repeat the conduct.

152. As the Committee concluded that there was a real risk of repetition of similar conduct, it was of the view that the public would be concerned if no finding of impairment was made, given the lack of remediation and the Registrant's limited insight. The Committee determined that it was also necessary to make a finding of impairment in this case in order to maintain confidence in the profession and in order to uphold proper professional standards, particularly in respect of the Registrant's failings in respect of Patient F.

153. Accordingly, the Committee found that the fitness of Andrew Maynard to practise as an optometrist is currently impaired.

Sanction

154. The Committee went on to consider what would be the appropriate and proportionate sanction, if any, to impose in this case. It heard submissions from Mr Irwin, on behalf of the Council, and from Mr Smith on behalf of the Registrant.

155. The Committee had regard at this stage of the hearing to one further document presented on behalf of the Registrant, which was a testimonial from the Registrant's former employer, Mr A.

156. Mr Irwin outlined the Council's position that the imposition of conditions on the Registrant's registration would be the most appropriate and proportionate sanction in this case. He submitted that conditions would meet the gravity of the conduct and ameliorate the risk of repetition.

157. Mr Irwin acknowledged that the Registrant had a previously unblemished career of 35 years. The Committee had found that the Registrant's integrity was not in question and he had shown a willingness to improve. Furthermore, the Council

accepted that the Registrant had experienced significant pressures and difficulties in his personal life, which could be taken into account.

158. Mr Irwin highlighted to the Committee the relevant public interest concerns, namely, to protect the public, maintain public confidence in the profession and to uphold and maintain proper standards.

159. Mr Irwin invited the Committee to have regard to the GOC's '*Hearings and Indicative Sanctions Guidance*' (updated November 2021) ('the Guidance'). He reminded the Committee to begin with the least restrictive sanction first, which was taking no action. However, Mr Iwrin submitted that there were no exceptional circumstances, and taking no action would not meet the public interest, nor properly reflect the gravity of the misconduct.

160. Mr Irwin submitted that this was not a financial penalty case and in any event the Registrant's ability to pay would have to be considered, which was limited in this case.

161. Turning to the sanction of conditions, Mr Irwin submitted that conditions were necessary in this case to address the clinical concerns and were important to ameliorate risk. He reminded the Committee that the Registrant's failings in respect of Patients F and G were grave. Mr Irwin submitted that in this case workplace supervision was necessary to protect the public. He acknowledged that the Registrant had struggled previously to find work with interim conditions in place and accepted that conditions should not be so stringent that they become tantamount to suspension. However, he suggested that the clear risks in this case could only be mitigated by the imposition of workplace supervision.

162. Mr Irwin further submitted that the Committee might find that educational conditions would also be appropriate. However, he acknowledged that the Registrant would need to complete a significant amount of CPD to re-register, which may bring him up to speed, in which case the Committee may not consider that further educational conditions were necessary.

163. In any event, Mr Irwin submitted that there ought to be conditions requiring that the Registrant complete targeted CPD, in relation to record-keeping, how to deal with emergencies, communication with patients, including how to deliver bad news sensitively, and glaucoma. Whilst it was accepted that the Registrant had undertaken two glaucoma courses in June 2023, this was only two hours and Mr Iwrin submitted that more than this was necessary.

164. Mr Irwin also invited the Committee to consider imposing targeted CPD in relation to contact lens after care, given that the Registrant had only recently accepted that he should be routinely using fluorescein, and a course on prescribing practice, which was relevant to the advice given to Patient A to use chloramphenicol when not indicated.

165. Mr Irwin submitted that conditions would meet the public interest and pass the '*blush test*' of the right-minded, properly informed, member of the public, who in this case would not consider conditions to be inappropriate or underwhelming. A suspension was another possible sanction, but if the Committee agreed that conditions were appropriate, as submitted by the Council, then suspension should not be considered. Mr Iwrin submitted that this was not an erasure case and that as a sanction would be disproportionate.

166. Mr Irwin invited the Committee to impose conditions upon the Registrant's registration for a period of 18 months, with an initial review after three months and potentially further reviews thereafter.

167. Mr Smith, on behalf of the Registrant, submitted that he agreed with the majority of the submissions made on behalf of the Council, and the conclusion that conditions were the appropriate sanction, but there were some points of disagreement. Mr Smith submitted that in relation to targeted CPD, the Registrant agreed that record-keeping and contact lens care would be appropriate courses and proposed a course on '*e-learning*', given the Registrant's issues with the use of computers.

168. However, Mr Smith submitted that the evidence in the case did not support the need for further educational courses in respect of glaucoma, nor prescribing practice. He submitted that the prescribing concern was an ancillary issue and not the focus of this hearing. Furthermore, he did not accept the duration of the order suggested of 18 months. Mr Smith accepted that a six-month period would be too short, and not enough time for the Registrant '*to put matters right*', but a 12-month order would not be unduly long.

169. Mr Smith indicated that in respect of any financial orders being contemplated he had a bank statement and a benefits document that he could put before the Committee, if they required confirmation of the Registrant's limited means. The Chair of the Committee confirmed that this was not necessary, as the Committee had heard evidence from the Registrant regarding his current financial position, which was not in dispute.

170. Mr Smith accepted that if the Registrant was allowed to return to practice, under conditions, it would be some time before he was able to do so, as he would need to complete the required amount of CPD in order to re-register, which may take a couple of months. The Registrant would also need to find employment, and the earliest he could return to work was likely to be January 2024.

171. Mr Smith invited the Committee to impose conditions for a period of 12 months, with a review hearing so that the Registrant could come back and demonstrate that he had remediated. Whilst the Registrant had struggled to find work under conditions previously, with this sanction being an order for a finite period, it would be more likely that conditions could be workable for a future employer and the Registrant.

172. The Committee accepted the advice of the Legal Adviser, which was for the Committee to take into account the factors on sanction as set out in the Guidance; to assess the seriousness of the misconduct; to consider and balance any aggravating and mitigating factors; and to consider the range of available sanctions in ascending order of seriousness. Further, the Committee is required to act proportionately by weighing the interests of the registrant against the public interest.

173. When considering the most appropriate sanction, if any, to impose in this case, the Committee had regard to all of the evidence and submissions it had heard, as well as its previous findings at the misconduct and impairment stage.

174. The Committee firstly considered the aggravating and mitigating factors present. In the Committee's view, the aggravating factors in this case are as follows:

    1) The limited remediation undertaken by the Registrant;

2) The lack of timely development of insight.

175. The Committee considered that the following were mitigating factors:

1) The Registrant demonstrated remorse and some insight, to the extent that he has accepted that he should have behaved differently;

2) The conduct occurred in the context of a long and unblemished career;

3) The personal mitigation of the Registrant, in that he had gone through difficult personal circumstances at around the time of the events in question;

4) The positive testimonial of the Registrant's former employer.

176. The Committee considered the sanctions available to it starting with the least restrictive.

177. The Committee firstly considered taking no further action and considered paragraphs 21.3 to 21.8 of the Guidance. It was of the view that there were no exceptional circumstances present that could justify taking no action in this case. It further considered that taking no further action was not proportionate, nor a sufficient outcome, given the public protection concerns in the case, and the Committee's findings on risk of repetition.

178. The Committee next considered the issue of a financial penalty order. However, it was of the view that such an order was not appropriate on the facts of this case, given that the Registrant's conduct was not financially motivated and had not resulted in financial gain. In any event, this would not be an appropriate sanction given the Registrant's very limited financial means.

179. The Committee carefully considered the Guidance in relation to the imposition of conditions. The Council noted that the primary purpose of conditions was to protect the public. It noted in particular that at paragraph 21.17 of the Guidance it states,

"*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."*

180. The Committee considered that this was a type of case where conditions may be appropriate, as the misconduct related to shortcomings in specific areas of the Registrant's practice. Further, it had found that the conduct was remediable, and that the Registrant was willing to remediate.

181. The Committee considered the factors in the Guidance set out at paragraph 21.25, which indicated when conditions may be appropriate:

Conditional registration may be appropriate when most, or all, of the following factors are apparent (this list is not exhaustive):

a. No evidence of harmful deep-seated personality or attitudinal problems.

b. Identifiable areas of registrant's practise in need of assessment or retraining.

c. Evidence that registrant has insight into any health problems and is prepared to agree to abide by conditions regarding medical condition, treatment, and supervision.

d. Potential and willingness to respond positively to retraining.

e. Patients will not be put in danger either directly or indirectly as a result of conditional registration itself.

f. The conditions will protect patients during the period they are in force.

g. It is possible to formulate appropriate and practical conditions to impose on registration and make provision as to how conditions will be monitored.

182. The Committee was of the view that the above factors applied in this case. Furthermore, conditions would allow the Registrant to demonstrate that his standards had improved and that those improvements could be maintained over a period of time.

183. The Committee was satisfied that the imposition of conditions would be an appropriate and proportionate response to the misconduct in the case, taking into account the Registrant's 35 years of practice, that he had no prior fitness to practise history, and he has shown a willingness to improve. Furthermore, the Registrant's misconduct was limited to shortcomings in his clinical practice which conditions could address in order to protect the public.

184. The Committee determined that conditions would be the appropriate and proportionate sanction in this case, and that workable and measurable conditions could be formulated to protect the public and adequately meet the public interest. The Committee did have concerns at the impairment stage regarding the Registrant's level of insight and remediation, however conditions would give the Registrant the opportunity to develop his insight and to remediate further. In the circumstances, it was not necessary for the Committee to go on to consider a more serious sanction, such as suspension.

185. The Committee next turned to formulate workable and measurable conditions in this case. The Committee noted that at paragraph 21.19 of the Guidance, it states that,

> "*The objectives of any conditions placed on the registrant must be relevant to the conduct in question and any risk it presents*."

186. The Committee agreed with the submission of Mr Iwrin that workplace supervision was necessary in this case, together with targeted CPD. However, the Committee did not consider that further educational conditions, in addition to the targeted CPD, would be required, given that the Registrant would also need to complete a significant amount of CPD in the coming months to re-register.

187. The Committee was of the view that the targeted CPD necessary in this case should cover the following areas of practice, which would address the shortcomings in the Registrant's practice:

i) Record-keeping;

ii) Contact lens aftercare;

iii) IT skills;

iv) How to deal with emergency cases;

v) Communication skills, including how to deliver bad news;

vi) Glaucoma;

vii) Refresher course on returning to practice after a break.

188. The Committee noted that the Registrant considered that he did not need to undertake any further training on glaucoma, as he had completed two hours of CPD on this area in June 2023. However, the Committee considered that it was necessary for the Registrant to undertake further CPD in relation to glaucoma, as this was a routine issue, often seen in primary care, that all optometrists need to keep abreast of. Further, the Registrant did not provide to the Committee any record of his reflections upon or learnings from the two hours of CPD already undertaken, therefore it was not clear to the Committee how much he had learnt from these courses.

189. The Committee next turned to consider the appropriate length of the order of conditions and noted that the parties agreed that six months would be too short. The Registrant had suggested that 12 months would be appropriate and the Council 18 months. The Committee noted that the Registrant had a significant amount of CPD to complete to re-register, and that it was expected to be at least January 2024, if not longer, that he would be in a position to return to practice. Further, the Registrant also had to find suitable employment, which could take some time.

190. The Committee was of the view that the Registrant had a lot to do to return to practice and it would take some time for him to settle into a new position, get up to speed and start seeing patients again, at which point the workplace supervision could commence. The Committee considered that the Registrant needed time to complete and absorb the learnings from the targeted CPD, to embed them into his practice, remediate and develop his insight further and to show improvement, consistent over a period of time.

191. In the circumstances, the Committee determined that 18 months would be an appropriate length of order in this case, but agreed with the suggestion of the parties that there should be an earlier than usual review hearing in order that the progress of the Registrant in complying with these conditions could be monitored. The Committee determined that a review hearing will be held three months into this order, in order to establish what progress is being made by the Registrant.

192. The Committee appreciates that the Registrant may not have completed all of the CPD, nor have obtained employment, at the time of the first review hearing. However, it considers that it would be helpful to review the order at that stage to assess the Registrant's compliance to date with these conditions, particularly in respect of re-registering, the formulation of his personal development plan and completing his CPD.

193. It is anticipated that there may need to be a further review hearing in due course, at a period to be set at the three-month review, so that a future Review Committee can be reassured that the Registrant is fit in due course to resume unrestricted practice, or to practise with less stringent conditions.

194. The Committee therefore imposed an order for conditions for a period of 18 months, with a review hearing to take place after three months.

Immediate order

195. The Committee invited representations from the parties on whether an immediate order should be imposed.

196. Mr Irwin, on behalf of the Council, invited the Committee to exercise its discretion to impose an immediate order of conditions under Section 13I of the Opticians Act 1989. He highlighted that the Registrant had been subject to interim orders of conditions and more recently an interim order of suspension, which was last reviewed on 2 November 2023.

197. Mr Irwin submitted that imposing an immediate order of conditions would be less onerous and problematic on the Registrant. He reminded the Committee that if the Registrant appealed, the order for conditions would not come into effect whilst the appeal was pending.

198. Mr Smith, on behalf of the Registrant, submitted that the Registrant was neutral on the issue of an immediate order. He highlighted that it will take some time for the Registrant to re-register and so he is not immediately ready to return to practice in any event.

199. The Committee accepted the advice of the Legal Adviser, which was that to make an immediate order, the Committee must be satisfied that the statutory test in section 13I of the Opticians Act 1989 is met, i.e., that the making of an order is necessary for the protection of members of the public, otherwise in the public interest or in the best interests of the Registrant.

200. The Committee had regard to the statutory test, which required that an immediate order had to be necessary to protect members of the public, be otherwise in the public interest or in the best interests of the Registrant.

201. The Committee was mindful that the Registrant had been subject to an interim order of suspension, which would be revoked at the conclusion of this hearing.

202. The Committee considered that given the nature of the misconduct, which raised a range of clinical concerns, the fact that the Registrant had not been in practice for a considerable period of time, and its findings that the Registrant is not currently fit to practise unrestricted, there was a current risk to patient safety.

203. The Committee was therefore concerned that if no immediate order of conditions was made, the Registrant could potentially return to practise unrestricted, once re-registered, as no order would be in place during any appeal period. The Committee therefore concluded that an immediate order was necessary to protect members of the public in this case.

204. In the circumstances, the Committee decided that it was also in the public interest that an immediate order be imposed, given that the Registrant is not currently fit to practise unrestricted, so there would not be a delay before the order came into effect and to cover the 28-day appeal period and any ensuing period should the Registrant appeal.

205. Accordingly, the Committee imposed an immediate order of conditions.

Revocation of interim order

206. The Committee hereby revokes the interim order for suspension of registration that was previously imposed.

Chair of the Committee: Sara Fenoughty

Signature **Date: 7 November 2023**

Registrant: Andrew Maynard

Signature *remotely present and received via email* **Date: 7 November 2023**

List of conditions

A1.1 Informing others	You must inform the following parties that your registration is subject to conditions. You should do this within two weeks of the date this order takes effect (or within two weeks of obtaining employment, if later). a. Any organisation or person employing or contracting with you to provide paid or unpaid optical services, whether or not in the UK (to include any locum agency). b. Any prospective employer or contractor where you have applied to provide optical services, whether or not in the UK. c. Chairman of the Local Optometric Committee for the area where you provide optometric services. d. The NHS body in whose ophthalmic performer or contractor list you are included or are seeking inclusion.
A1.2 Employment and work	You must inform the GOC if: a. You accept any paid or unpaid employment or contract, whether or not in the UK, to provide optical services. b. You apply for any paid or unpaid employment or

	contract to provide optical services outside the UK. c. You cease working. This information must include the contact details of your prospective employer/ contractor and (if the role includes providing NHS ophthalmic services) the relevant NHS body.
A1.3 Supervision of Conditions	You must: a. Identify a workplace supervisor who would be prepared to monitor your compliance with numbers 4.4 and 4.5 of these conditions. b. Ask the GOC to approve your workplace supervisor/learning supervisor within two weeks of the date this order takes effect. If you are not employed, you must ask us to approve your workplace supervisor before you start work. c. Identify another supervisor if the GOC does not agree to your being monitored by the proposed supervisor. d. Place yourself under the supervision of the supervisor and remain under his/her supervision for the duration of these conditions. e. At least once a month meet your supervisor to review compliance with your conditions and your progress with any personal development plan. f. At least every three months or upon request of the GOC, request a written report from your supervisor to be provided to the GOC, detailing how you have complied with the conditions he/she is monitoring. Inform the GOC of any proposed change to your supervisor and again place yourself under the supervision of someone who has been agreed by the GOC.
A1.4 Other proceedings	You must inform the GOC within 14 days if you become aware of any criminal investigation or formal disciplinary investigation against you.
A1.5 Registration requirements	You must continue to comply with all legal and professional requirements of registration with the GOC. a. A review hearing will be arranged at the earliest opportunity if you fail to:- b. Fulfil all CPD requirements; or

	Renew your registration annually.
A4.4 Assessment of records	You must: a. In consultation with the Chairman of your Local Optometric Committee or your workplace supervisor, identify an independent assessor, who may be your workplace supervisor, willing to review a random selection of your patient records. b. Arrange for the assessor to review 10 randomly selected patient records within one month of starting employment and monthly thereafter. At least two weeks before the next review hearing, provide the GOC with a written report from the independent assessor (if appointed at that stage), setting out his/her views on the quality of the records reviewed.
A4.5 Personal development plan	a. You must work with your workplace supervisor to update and monitor your progress with a personal development plan, including the completion of CPD, which should be specifically designed to address deficiencies in the following area(s) of your practice: i) Record-keeping; ii) Contact lens aftercare; iii) IT skills; iv) How to deal with emergency cases; v) Communication skills, including how to deliver bad news; vi) Glaucoma; vii) Returning to practice after a break. b. Submit a copy of your personal development plan to the GOC for approval within one month of these conditions taking effect.

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.