BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

AND

ROSS HUTCHESON (01-24464)

DETERMINATION OF A SUBSTANTIVE HEARING
AGREED PANEL DISPOSAL(APD)
18 JULY 2022

Committee Members:	Mr Ian Crookall (Chair/Lay) Mr John Vaughan (Lay) Ms Vivienne Geary (Lay) Ms Gemma O'Rourke (Optometrist) Ms Louise Sarjeant (Optometrist)
Legal adviser:	Ms Emma Boothroyd
Clinical adviser:	**Dr Desmond Dunleavy**
GOC Presenting Officer:	Ms Kathryn Sheridan – Kingsley Napley
Registrant:	Present and unrepresented
Hearings Officer:	Ms Abby Strong-Perrin
Facts found proved:	1-12, 14, 15(a) and 16-19
Facts not found proved:	13 and 15 (b)
Misconduct:	Found
Impairment:	Impaired
Sanction:	12 months suspension – (With Review)
Immediate order:	**Yes**

ALLEGATION

The allegation made by the Council against, Ross Hutcheson 01-24464, a registered Optometrist is as follows:

1. On 3 March 2018, you did not conduct tests for binocular function on Patient 3;

2. On 14 March 2018, you did not provide advice to Patient 11 regarding age related macular degeneration;

3. On 16 March 2018, you did not conduct tests for binocular function on Patient 13;

4. On 28 March 2018, you did not carry out a visual fields assessment on Patient 21;

5. On 11 April 2018, you did not carry out a visual fields assessment on Patient 40;

6. On 14 April 2018, you did not provide advice to Patient 44 regarding returning for full examination or follow up;

7. On 18 April 2018, you did not conduct a cycloplegic refraction on Patient 47;

8. On 18 April 2018, you did not carry out a visual fields assessment on Patient 49;

9. On 18 April 2018, you did not conduct tests for binocular function on Patient 50;

10. On 25 April 2018, in relation to Patient 54, you:

a) did not ask questions to fully investigate the patient's symptoms, and/or history, including general health, medication and/or ocular history and/or family history;

b) did not perform ophthalmoscopy to examine the front and/or inside the eye to assess ocular health;

c) did not carry out an anterior chamber assessment and/or a visual fields assessment;

d) recorded information relating to symptoms and/or history that was not asked;

e) recorded results and/or findings of tests that were not conducted; and/or

f) your conduct at 1 d and 1 e above was dishonest in that you knew that the

information you recorded was not discussed and/or tests were not conducted;

11. On 18 May 2018, you did not conduct a muscle balance test on Patient 61;

12. On 30 May 2018, you did not carry out an intraocular pressure measurement on Patient 69;

13. On 13 June 2018, in relation to Patient 75:

a) you did not carry out a visual fields assessment;

b) you issued a prescription that was not clinically necessary; and/or

c) your conduct at 13b above was dishonest in that you knew this prescription was not clinically necessary;

14. On 24 June 2018, in relation to Patient 83, you:

a) did not ask questions to fully investigate the patient's reported symptom of a dull ache in the left eye;

b) did not record that the patient reported symptom of a dull ache in the left eye;

c) recorded findings for ophthalmoscopy for both the right and left eyes when you only examined the patient's right eye;

d) did not perform a slit lamp aided anterior eye examination and/or visual fields assessment;

e) did not give correct advice relating to the patient's symptom of the dull ache; and/or

f) your conduct at 14c above was dishonest in that you knew you only examined the right eye;

15. On 28 June 2018, in relation to Patient 83, you:

a) amended the clinical records in relation to slit lamp from "yes" to "no" to indicate that a slit lamp was not done; and/or

b) your conduct at 15 a above was dishonest in that:

i. you knew the patient completed a customer feedback form for the sight test you conducted and the patient stated within the feedback that a slit lamp examination was not performed; and/or

ii. you knew that a slit lamp examination was not performed and therefore you retrospectively amended the records and you did not add a note to confirm that retrospective amendment was made;

16. On 18 January 2019, in relation to Patient 85, you:

a) incorrectly recorded the optic disc findings;

b) did not carry out an intraocular pressure measurement and/or visual fields assessment;

c) did not detect signs of papilledema;

d) did not provide appropriate advice to the patient about changes to the optic disc; and/or

e) did not make an emergency referral to the hospital eye service;

17. On 30 January 2019, in relation to Patient 86, you:

a) did not detect presence of indistinct optic disc margins and/or haemorrhages across the fundus, and/or tortuous vessels;

b) did not detect signs of vascular changes of a hypertensive nature during the fundus examination;

c) incorrectly recorded the fundus examination's findings;

d) did not provide appropriate advice to the patient about the fundus examination's findings;

e) did not record the patient's habitual correction, muscle balance tests and visual field assessment; and/or

f) did not make an urgent referral to the hospital eye service via the GP requesting a full vascular workup;

18. On 15 February 2019, in relation to Patient 87, you:

a) did not investigate vascular changes in the peripheral retina;

b) did not carry out a dilated eye examination;

c) incorrectly recorded the fundus examination's findings;

d) did not provide appropriate advice to the patient about the fundus examination's findings;

e) did not make an urgent referral to the hospital eye service via the GP requesting a full vascular workup;

19. You failed to maintain adequate records for some or all of the patients listed in Schedule A in that you did not record:

a) relevant and significant symptoms and history;

b) relevant general health and medication;

c) relevant family history;

d) relevant and significant findings of ocular alignment;

e) vision with current or habitual prescription;

f) ophthalmoscopy and relevant and significant findings; and/or

g) relevant and significant advice and management of patients.

Schedule A

- Patient 1
- Patient 2
- Patient 3
- Patient 4
- Patient 5
- Patient 6
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- Patient 85
- Patient 86
- Patient 87

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

At the outset the GOC applied to withdraw allegation 13 and 15 b as there was insufficient evidence, and this reflected the Registrant's consistent position with regard to the admissions made. Further, in the light of Dr Shah's supplemental report it was not alleged that allegations 6 and 9 amounted to misconduct. As a result, the Committee noted these submissions and considered the consensual panel determination agreement in the light of this agreed position.

CONSENSUAL PANEL DETERMINATION AGREEMENT

At the outset of this hearing, Ms Sheridan, on behalf of the GOC, informed the Committee that prior to this hearing a provisional agreement of a consensual panel determination had been reached with regard to this case between the GOC and Mr Hutcheson (the Registrant).

The agreement, which was put before the Committee, sets out the Registrant 's full admission to the facts alleged in the charges, as clarified above, and that the Registrant 's actions amounted to misconduct and that his fitness to practise is currently impaired by reason of that misconduct. It is further stated in the agreement that an appropriate sanction in this case would be a 12-month suspension order with a review.

The Committee has considered the provisional agreement reached by the parties. The Committee has not set out within this determination the full factual background

and this is described in the full agreement which is appended to this determination. However, the relevant section of the provisional agreement reads as follows:

Nature of the Recommended Disposal

1. *Upon the Registrant's admissions and upon the Council and Registrant agreeing to this recommendation, the parties jointly seek and recommend to the FTPC that this matter is disposed of by a determination on the following basis:*
   i. *The Registrant admits particulars 1 to 13 (a), 14, 16, 17, 18 and 19 of the allegation. In respect of 13(b) and (c) he states: "it appears that I did not issue a prescription but stated that the patient was happy with their current specs". The FTPC will note Dr Shah's comments in respect of particular 13 of the allegation. In respect of particular 15 of the allegation, the Registrant states: "upon being informed of the patient feedback I reviewed my sight test notes and was shocked to see I had ticked "yes" for slit lamp. I amended this as I recalled that I had not done this". The Council is content with this position.*
   ii. *The admitted conduct amounts to misconduct.*
   iii. *That the Registrant's fitness to practise is impaired by reason of misconduct; and*
   iv. *The appropriate and proportionate sanction is a 12 month suspension with a further review.*

DETERMINATION

The Committee decided to accept the agreed panel determination.

The Committee heard and accepted the advice of the legal adviser who advised the Committee to have regard to the "Agreed Panel Disposal Policy" which sets out the proposed approach and the powers of the Committee. She advised that the decision was a matter for the Committee, and it was not bound by the recommendations within the provisional agreement. She advised the Committee that it should satisfy itself that the outcome was appropriate and proportionate, keeping in mind the overriding consideration of protection of the public and the public interest.

The Registrant admitted particulars *1-12, 14, 15(a) and 16-19* of the allegation by way of the consensual panel determination. The Committee therefore found these facts proved by virtue of these admissions pursuant to Rule 40(6) of the General Optical Council (Fitness to Practise) Rules 2013 (the Rules).

As set out above the Committee noted the position with regard to allegations 13 and 15(b) and agreed that the papers did not support these allegations and it would be appropriate to make no finding in relation to these allegations.

In respect of misconduct the Committee noted in particular the reports of the expert Dr Shah dated 23 August 2020 and 23 March 2022. The Committee considered that the failings identified by Dr Shah and admitted by the Registrant were significant and encompassed a wide range of patients over a prolonged period of time. The Committee noted the standards that were alleged to have been breached and considered that these were all applicable and demonstrated a serious falling short of the standards expected. The Committee was in no doubt that this amounted to misconduct. The Committee considered that these failings encompassed basic clinical and record keeping skills and placed patients at risk of harm.

The Committee concluded that in relation to allegations 6 and 9, as Dr Shah did not consider these amounted to a serious falling short of the standards to be expected, these did not amount to misconduct. The Committee also took into account Ms Sheridan's submission that the Council did not seek a finding of misconduct in relation to these paragraphs of the allegation.

The Committee then went on to consider whether the Registrant's fitness to practise is currently impaired. Whilst acknowledging the agreement between the GOC and the Registrant, the Committee has exercised its own independent judgement in reaching its decision on impairment.

In the Committee's view, the Registrant has demonstrated insight into the seriousness of his misconduct and its potential impact on patients and the wider profession. The Committee considered that the Registrant's frank admission that he was not yet ready to return to unsupervised practise to be demonstrative of a genuine understanding of his failings.

The Committee had careful regard to Silber J's guidance in Cohen v GMC [2008] EWHC 581 (Admin) that Committees should take account of:

- Whether the conduct which led to the charge is easily remediable;
- Whether it has been remedied; and
- Whether it is highly unlikely to be repeated.

The Committee considered that with retraining and development of clinical skills together with REDACTED the misconduct could be remediated. The Committee noted that the failings took place at a time of significant stress. The Committee noted that the Registrant had practised effectively and successfully before these matters, and it noted the progress that the Registrant had made REDACTED.

The Committee took into consideration REDACTED. The Committee considered that the Registrant was open and honest about his difficulties and it placed considerable weight on his admission that he was not yet ready to return to unrestricted practice. The Committee took into account that the registrant had continued to make basic errors when subject to conditional registration. In these circumstances the Committee was satisfied that the Registrant's fitness to practise was currently impaired on public protection grounds.

The Committee went on to consider whether a finding of impairment is necessary on public interest grounds. In addressing this component of impairment, the Committee had careful regard to the critically important public issues identified by Silber J in the case of Cohen when he said:

> *"Any approach to the issue of whether .... fitness to practise should be regarded as 'impaired' must take account of…the collective need to maintain confidence in the profession as well as declaring and upholding proper standards of conduct and behaviour."*

The Committee considered this matter carefully. The Committee concluded that there was the potential for significant harm to patients and the Registrant's failings resulted in recalling a number of patients for review. This, in the Committee's view, would have caused stress and upset to those patients. In addition, the Registrant's failings caused significant damage to the reputation of his employer and the Registrant's misconduct had the potential to seriously undermine public trust in the profession.

The Committee had regard to the remorse, remediation and insight shown by the Registrant and weighed them into the balance with all the factors set out above. The Committee considered that public confidence in the profession and the regulator would be undermined if a finding of current impairment was not made taking into account all of the circumstances of this case.

For these reasons the Committee finds that the Registrant's fitness to practise is currently impaired.

The Committee next considered the proposed sanction and had regard to the Indicative Sanctions Guidance. It considered the sanctions available to it from the least necessary to the most severe (no sanction, financial penalty, conditional registration, suspension, erasure) and measured these against the findings it had made. The Committee had regard to the principle of proportionality and noted that whilst a sanction is not intended to be punitive it may have that effect. In considering whether the proposed sanction was appropriate and proportionate the Committee

had at the forefront of its mind the need to protect the public and uphold proper professional standards.

The Committee had regard to the submissions made by the parties in the Agreed Panel Report and in particular those contained at paragraphs 110 and 111.

The Committee considered that there were no exceptional circumstances that would justify no further action in this case. The Committee considered that a financial penalty would not be appropriate as this case related to clinical failings and dishonesty and was not motivated by financial gain.

The Committee considered whether conditional registration would be appropriate, in light of the fact that the Registrant has previously been working under supervision. However, it considered that the failings were extensive and put patients at serious risk of harm. In addition, the Registrant had acted dishonestly and attempted to cover up his failings by amending clinical records. The Committee considered that the public interest and confidence in the profession would not be upheld if a period of conditional registration were to be imposed.

The Committee considered that a period of 12 months suspension was the appropriate and proportionate sanction to reflect the gravity of the findings made. It considered that the maximum length of suspension was required to uphold proper professional standards and maintain confidence in the profession. The Committee took into account the effect that this would have on the Registrant, but nevertheless considered it was necessary given the risk to patients and the reputational damage caused by his misconduct.

The Committee noted the mitigation put forward by the Registrant and recognised the steps he had taken to address his REDACTED. The Committee noted that the Registrant had engaged fully in the disciplinary process, had self-referred and made early admissions. For these reasons the Committee considered that his conduct was not fundamentally incompatible with continued registration and erasure would be a disproportionate outcome.

A review hearing will be held between four and six weeks prior to the expiration of this order. The Review Committee will need to be satisfied that the Registrant:

- has fully appreciated the nature of the misconduct,
- has maintained his skills and knowledge and
- that the Registrant's patients will not be placed at risk by resumption of practice or by the imposition of conditional registration

Whilst not binding on any Review Committee, this Committee considered that it would be helpful to a future reviewing Committee if the Registrant set out his intentions with regard to returning to practice together with an update REDACTED.

Immediate order

The Committee has accepted the submissions in the agreed panel disposal report that an immediate order is both appropriate and necessary to protect the public and is in the public interest.

The Committee has decided to impose an immediate suspension order on the basis that to do otherwise would be inconsistent with its determination. The Committee considers that an immediate order is necessary and proportionate given its findings relating to impairment and the sanction of 12 months suspension. The Committee considers that the public would be at risk if the registrant was permitted to practice unrestricted during any appeal period.

Revocation of interim order

The Committee hereby revokes the interim order for conditional registration that was imposed on 30 November 2018.

Chair of the Committee: Ian Crookall

Signature  . **Date: 18 July 2022**

Registrant: Ross Hutcheson

Signature …… **Date: 12 July 2022**

FURTHER INFORMATION
Transcript
A full transcript of the hearing will be made available for purchase in due course.
Appeal
Any appeal against an order of the Committee must be lodged with the relevant court within 28 days of the service of this notification. If no appeal is lodged, the order will take effect at the end of that period. The relevant court is shown at section 23G(4)(a)-(c) of the Opticians Act 1989 (as amended).
Professional Standards Authority
This decision will be reported to the Professional Standards Authority (PSA) under the provisions of section 29 of the NHS Reform and Healthcare Professions Act 2002. PSA may refer this case to the High Court of Justice in England and Wales, the Court of Session in Scotland or the High Court of Justice in Northern Ireland as appropriate if they decide that a decision has been insufficient to protect the public and/or should not have been made, and if they consider that referral is desirable for the protection of the public. 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.


General Optical Council