BEFORE THE FITNESS TO PRACTISE COMMITTEE OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(19)34

AND

HONEY ROSE (01-25372)

DETERMINATION OF A REMITTED SUBSTANTIVE HEARING
4 JULY – 26 JULY 2022

Committee Members:	Jayne Wheat (Chair) Paul Curtis (Lay) Asmita Naik (Lay) Gaynor Kirk (Optometrist) Amit Jinabhai (Optometrist)
Legal Adviser:	Graeme Henderson
GOC Presenting Officer:	Martin Forde QC (Counsel) Tracy Sell-Peters (DWF Law) Rebecca Dymott (DWF Law)
Registrant present/represented:	Yes and represented
Registrant Representative:	Sandesh Singh (Counsel) Ella Franci (AOP) Emma Brindley (AOP)
Hearings Officer:	Terence Yates
Misconduct:	Found
Impairment:	Impaired
Sanction:	Erasure
Immediate order:	Imposed

CONTENTS

DETERMINATION

Background

1. This case is a remitted case from the High Court. In a Judgment, dated 1 November 2021, Mrs Justice Collins Rice explained why she remitted these proceedings to a differently constituted Fitness to Practise Committee. The original Committee issued a lengthy determination which forms an appendix to this determination. The original Committee found some of the facts proved; that the facts proved amounted to misconduct and that the Registrant's fitness to practise was impaired as a result of her misconduct on public interest grounds only. The original Committee imposed the sanction of suspension for nine months. It declined to impose an immediate order and did not direct that there should be a review at the end of the period of suspension.

2. There was no challenge to or criticism of the original Committee's findings of fact and their decision on misconduct. The original Committee's determinations on impairment and sanction were quashed. The effect of the court order meant that these proceedings started again at the impairment stage of the General Optical Council (Fitness to Practise) Rules 2013 (the Rules). Rule 46 of the Rules sets out the order of proceedings for fitness to practise hearings. Rule 46 (14) directs that once a committee announces a decision on grounds of impairment being established (in this case the finding of misconduct by the original Committee) the Committee should then receive further evidence and further submissions on the issue of impairment. If this Committee were to make a finding of impairment it would then go on to consider sanction and other issues potentially arising in the latter stages of Rule 46 .

3. The findings of the original Committee on facts, together with its findings on misconduct were matters that required careful scrutiny. Since these decisions were not disturbed by the Judgment of the High Court, this Committee was required to step into the shoes of the original Committee. It had to reach its decision on the basis of what the original Committee found, together with any further evidence, introduced at the impairment stage, and taking into account the submissions on impairment made by the parties.

4. The events that gave rise to these proceedings took place on 15 February 2012. The Registrant was working as a locum optometrist in the [Redacted] Branch of Boots Opticians. She examined three members of a family that day. Witness X was the mother and Patients A and B were her son (aged 7) and her daughter (aged 4). Photographic images, taken prior to his eye examination, showed that the optic nerve and retinal blood vessels of both Patient A's eyes were abnormal. They suggested a rare condition called papilloedema: swelling of the optic nerve. Papilloedema is typically caused by increased intracranial pressure, for example by a build-up of fluid in the brain.

5. It was not in dispute that the examination of Patient A was challenging for the Registrant. The original Committee accepted the Registrant's evidence that this was

the first time that she had been unable to complete a normal examination of the internal eye using an ophthalmoscope. She had already looked at photographic images of the central retina and optic nerves prior to starting Patient A's eye examination. However, the images that she viewed were those of a different patient which "*showed a healthy eye*". It was her responsibility to check that she was looking at the retinal images of the correct patient. The name and identity number of the patient were readily visible on the screen. The Registrant accepted that had she looked at the correct images she would have referred Patient A to hospital for an urgent appointment.

6. The original Committee also found that she made a dishonest entry in Patient A's records in relation to having examined his retinal peripheries. Other aspects of her patient record keeping were found to be inaccurate and misleading.

7. What the Registrant did, and did not do, became the subject of intense scrutiny in tragic circumstances. On 13 July 2012, Patient A fell ill whilst at school. Despite the efforts of medical staff, he died in hospital within hours. The cause of his death was hydrocephalus. This is a condition which involves the build-up of fluid in the brain. Bilateral papilloedema is a sign that hydrocephalus may be present.

8. The regulatory case was delayed because criminal proceedings had been brought against the Registrant. The criminal proceedings concluded, with the Registrant being acquitted, on appeal, in 2017. The Council received disclosure from the criminal investigation in November 2017, and the hearing before the original Committee commenced on 20 July 2020. The decision of the original Committee was issued on 12 November 2020.

Impairment

Commencement of the hearing

9. At the commencement of this remitted hearing, Mr Martin Forde QC appeared for the Council and Mr Sandesh Singh, Counsel, appeared for the Registrant. The Committee was told that it had only been possible to reach agreement on what material the Committee should consider shortly before the hearing commenced. Members of the Committee had only received the "agreed bundle" of documents at approximately 18:30 on the Friday evening immediately before the hearing commenced on Monday 4 July 2022. Since it would have been impossible for them to scrutinise the bundle during normal business hours, the Committee required significant time to read and assimilate the material. The Committee was assured that the representatives of the Council and the Registrant had considered the timetable and that this resumed hearing should conclude within the allotted time.

10. The Committee was advised that although attempts had been made to whittle down all available material to that which was relevant, it was open for the Committee to request further documentation. The Committee agreed that it would inform parties whether it required further documents once it had an opportunity to consider all of the material before it.

11. The Committee was advised that the Registrant would not be providing live witness evidence. It was envisaged that the only live evidence would be the evidence of two expert witnesses. Professor Bruce Evans and Mr Richard Booth were experts who provided evidence to the original Committee. Professor Evans provided a report dated 6 June 2022 and Mr Booth provided a report dated 30 June 2022 which commented upon it. The Committee was informed that a further supplemental report from Professor Evans was awaited. The Committee indicated that it wished to be addressed on the nature and relevance of these reports at a later stage.

12. The Committee was asked to consider whether it wished to retire to consider the written material prior to hearing opening submissions. The alternative was to hear opening submissions first. The Committee determined on the latter course.

13. Mr Forde referred the Committee to his written "Case Summary and Outline Opening". It commenced with the following paragraph "*This is a tragic case with a lengthy history."*

14. Mr Forde then took the Committee through the background facts and what the Committee found proved. He then referred to the decision of the High Court that resulted in this hearing. He made it clear that the case for the Council was not about "outcome". He submitted that the focus of the hearing should concentrate on the Registrant's degree of culpability for her failures rather than the tragic death of Patient A. The determination of the High Court, which was supplied to the Committee, had been heavily redacted, by agreement between the parties, to avoid any issue of prejudice.

15. Mr Singh also provided the Committee with written "Introductory remarks" on behalf of the Registrant to supplement his oral submissions. It commenced with a review of the original Committee's determination from the perspective of the Registrant. He then went on to address the issues raised in the new expert reports. He submitted that there was no 'straight line' to be drawn between a fundamental failure and/or exposure to an unwarranted risk of harm, on the one hand, and a conclusion that fitness to practise is impaired, on the other. The significance of those matters could not properly or fairly be assessed in the abstract. The particular facts and context of the failure must be considered. He submitted that the public interest required that culpability be assessed and explained fairly.

16. The Committee retired and read all of the material. When they returned to the virtual hearing room, the Chair informed parties that the Committee had considered all of the documents and had decided that it did not seek any further material.

17. Mr Singh informed the Committee that he and Mr Forde had discussed the issue of the expert evidence. By this stage a further supplementary report from Professor Evans had been submitted. This was dated 5 July 2022. It was submitted that the parties had agreed that there was no requirement to lead live evidence on this issue. Both parties agreed, however, that the evidence was admissible in accordance with the Rules. Accordingly, the Committee was invited to receive these three reports as evidence. Before retiring to consider this issue the Committee heard and accepted the advice of the Legal Adviser. The Committee noted that it had the power to admit evidence provided it was fair and relevant to do so. It also noted that the Rules envisaged the introduction of new evidence at the stage of considering impairment. The Committee decided to admit the evidence, as relevant to the impairment stage, contained in the three expert reports despite the experts not being called to give oral evidence at this stage.

18. Having announced its decision on admitting the three recent expert reports into evidence the Committee then invited submissions on impairment.

19. Mr Forde invited the Committee to consider that the Registrant's fitness to practise was currently impaired on both public protection and public interest grounds. He submitted that although the Registrant was of otherwise good character, her short career should be a factor to take into account when considering the issue of remediation. This was not a situation where the Committee should readily find that there was reassurance that matters would not be repeated. The original Committee considered her actions fell far below the acceptable standards expected of a Registrant.

20. Mr Forde took the Committee through the evidence that the Registrant provided to the original Committee and invited this Committee to consider that, on the basis of the evidence and other factors, she had limited insight. He accepted that as a general rule it would be unfair for a Registrant, who contested charges, to have that fact held against them at the impairment stage but that this rule was subject to exceptions. He

submitted that this case should be distinguished from the general rule more fully commented on in *Sawati v GMC [2022] EWHC 283(Admin).* During the course of his submissions and those of Mr Singh there was reference to other cases where the issue of "the rejected defence" was discussed. These included *GMC v Awan [2020] EWHC 1553 (Admin); Towuaghantse v GMC [2021] EWHC 681(Admin)* and *Amao v NMC [2014] EWHC 147 (Admin).*

21. Mr Forde's position was that there was a difference between primary and secondary allegations of dishonesty. A primary allegation involved conduct which is intrinsically dishonest, like fraud or forgery. A secondary allegation meant conduct which is capable of being performed honestly or dishonestly. The Registrant's defence of dishonesty involved a primary allegation of dishonesty. She did not have sufficient insight to accept dishonesty at the outset, it was only as a result of cross examination that the Registrant admitted dishonesty.

22. Mr Forde referred to Professor Evan's report dated 6 June 2022. The Council, he submitted, accept the rarity of the situation which presented itself, however, he submitted that emphasis on the rarity of the presenting condition, when asymptomatic, was of limited value in assessing impairment. He submitted that basic errors and making assumptions in the absence of symptoms meant that the Registrant did not see obvious signs of papilloedema. He submitted that the issue of foreseeability was a red herring. He invited the Committee to prefer the evidence of Mr Booth, which concentrated on the fundamental errors made, not the rarity of the condition.

23. Mr Forde referred to the evidence submitted by the Registrant. He accepted on behalf of the Council that matters have moved on since the last hearing. Her reflective statement, dated June 2022, involved her reporting that she attended a lecture on dishonesty. Mr Forde submitted that it demonstrated an understanding of the gravity and impact upon the profession, but it was necessary to ask why it was not appreciated at the time. He submitted that where there were documents before the Committee, but the Registrant has not given evidence, it was a question of the weight that could be attached to the documentary evidence.

24. Mr Forde reminded the Committee of the observations made by Mrs Justice Collins Rice in her decision to remit. Insight was an acknowledgement and appreciation of failure, its magnitude and its consequences for others. It was an essential prerequisite to a confident conclusion that a problem had been properly understood, addressed and eliminated for the future (Paragraph 73).There was a difference between finding that the Registrant had done all that could be reasonably asked of her and a conclusion that she was fully fit to practise (Paragraph 79).

25. Mr Singh invited the Committee to consider that the Registrant's fitness to practise was not currently impaired on the basis of public protection grounds. He submitted that the engagement of the wider public interest was a matter for the judgement of the Committee but drew attention to items of case law. He submitted written submissions to supplement his oral submissions. In his written submissions he referred the Committee to the case of *Samuel v RCVS [2014] UKPC 13* with regard to the public

interest. The "reasonable member of the public" must be appraised of the particular facts and circumstances of the case.

26. He submitted that when the exceptional facts of this case are considered, they are not intrinsically so serious as to be irremediable or incompatible with being a registered optometrist. Patient A showed no signs other than the sign that was missed. The expert evidence of Professor Evans suggested that there was a one in a million chance that papilloedema was in fact present. Given the absence of symptoms/signs and the exceptional rarity of Patient A's presentation, no optometrist could have appreciated that such pathology was present and would be missed if the internal eye exam was not completed. He submitted that, given the exceptional factual matrix in this case, the Registrant's level of culpability for her failings was no different to an optometrist who failed in those ways in respect of a patient who had no underlying pathology.

27. He referred to submissions which were made on behalf of the Council at the misconduct stage. The original Committee heard submissions that exposure to risk was "*inadvertent*" – "*A child was exposed to serious risk, albeit inadvertently, by the failure to complete the basic task of checking the back of the eye and a failure, in your finding, to perform another basic duty to check the name on the image".*

28. Mr Singh concluded this chapter, of his submissions, by submitting that the public interest required that culpability in this case was assessed and explained fairly; not understated but, also, not overstated.

29. Mr Singh then took the Committee to what he submitted was the relevant case law this included *Cohen v GMC [2008] EWHC 581 (Admin); Cheatle v GMC [2009] EWHC 645 (Admin); CHRE v NMC & Grant [2011] EWHC 927 (Admin); Amao v NMC [2014] EWHC 147 (Admin);* and *PSA v HCPC & Doree [2017] EWCA Civ 319.*

30. He submitted, under reference to *Doree,* that the Registrant was under no requirement to provide live evidence in order to satisfy the Committee that she has sufficient insight. He invited the Committee to consider that the case of *Sawati* applied. He suggested that the means of resolving the disputed issue of the "rejected defence" would be for the Committee when it retired to consider all matters of impairment it should have all of the relevant case law before it and consider how the relevant case law should be applied to the particular facts of this case.

31. Mr Singh then went on to address the Committee on remediation issues. He invited the Committee to consider that the Registrant has reflected on and has remedied her misconduct, such that there is no material risk of repetition. He submitted that the evidence in support of this proposition could be broken down into three chapters:

    - Evidence of the Registrant's conduct in practise in, before and after February 2012.

- Remediation; the Registrant's further learning and reflection on the matters arising from the Committee's findings.

- The impact of this case on the Registrant and its effect on her approach to examination and record keeping.

32. Mr Singh took the Committee to those parts of the Registrant's reflective statement which dealt with the making of assumptions, checking patient details, and dishonesty. He concluded by submitting that the Registrant has remedied her misconduct and that there was no material risk of repetition. Her acts of misconduct were serious but were also isolated and momentary failures which arose in exceptional circumstances in the context of an otherwise unblemished career. Given the further learning that she has undertaken, her reflection on these matters and the impact of these proceedings on her, the likelihood of repetition is genuinely remote. Alternatively, if the Committee was not minded to accept that submission, any risk of repetition is to a low level given the factors set out above.

Legal Advice

33. The Committee heard and accepted the advice of the Legal Adviser. He advised them that they should retire with the relevant case law to consider how "rejected defence" cases should be applied to the particular facts of this case. He referred to the test set out in the case of *Grant* in respect of impairment and the approach taken in the case of *Cohen* to the issue of remediation.

34. The Legal Adviser told the Committee that the case of *Grant* involved an NMC Panel misreading the case of *Cohen* as the Panel had failed to appreciate it involved references to the wider public interest as well as public protection. In determining impairment, this Committee had to consider both public protection and public interest issues. In *Cohen* the purpose of the impairment stage in regulatory proceedings was explained and the observations with regard to the impairment of doctors set out in *Cohen* (Paragraph 62) applied equally to the Registrant:

> "*Any approach to the issue of whether a doctor's fitness to practice should be regarded as "impaired" must take account of the need to protect the individual patient, and the collective need to maintain confidence in the profession as well as declaring and upholding proper standards of conduct and behaviour of the public in their doctors…… 'In my view, at stage 2 when fitness to practice is being considered, the task of the Panel is to take account of the misconduct of the practitioner and then to consider it in the light of all the other relevant factors known to them in answering whether by reason of the doctor's misconduct, his or her fitness to practice has been impaired. It must not be forgotten that a finding in respect of fitness to practice determines whether sanctions can be imposed…"*

Material before the Committee

35. Before reaching its decision the Committee had regard to all of the material that had been submitted to it. This fell into three distinct groups.

36. Most of the material presented to the Committee was with a view to place this Committee in the same position as the original Committee. It was provided with the original Committee's determination dated 12 November 2020 and various excerpts of transcripts of live evidence from the original hearing. The Committee had regard to the Registrant's evidence, the evidence of the mother of Patient A (Witness X) and the evidence of the two experts (Mr Booth and Professor Evans). It was also provided with an expert report dated February 2019 and an Optometric Record Review dated 7 April 2016 from Mr Booth together with appendices. In addition, it was provided with Professor Evans' report dated 22 April 2020 and a joint report (from both experts) dated 4 June 2020. It received a redacted version of the Judgment of Mrs Justice Collins Rice dated 1 November 2021. It was also provided with physical evidence in the form of photographs of Patient A's central retina and optic nerves from 5 February 2011 and 15 February 2012.

37. The Committee also received and had regard to the remediation evidence submitted on behalf of the Registrant. This consisted of her reflective statement dated June 2022, a Personal Development Plan (PDP) for November 2020 to May 2022, her Continuing Education and Training (CET) record, now known as Continuing Professional Development (CPD), a letter from [Person C], director of [Redacted] dated 27 May 2022, confirming the Registrant spent a day observing optometry clinics, and a statement from her mentor, [Person D], Clinical and Regulatory Adviser at [Redacted], dated 30 May 2022. Also, for the Committee to consider was the 'Remediation bundle' prepared for the hearing before the original Committee.

38. The final group of documents consisted of the three expert reports that were prepared for this hearing. These were the Report from Professor Evans dated 6 June 2022, Mr Booth's Report dated 30 June 2022 and a further Report from Professor Evans dated 5 July 2022.

Committee Considerations

39. The Committee reminded itself that determining the issue of impairment was a matter for its own professional judgement. There was no burden of proof on either party. It also reminded itself that a finding of misconduct need not necessarily result in a finding of current impairment. The Committee took account of the misconduct found and considered it in light of all the other relevant factors known to it in answering whether, by reason of the misconduct, the Registrant's fitness to practise is currently impaired. The Committee acknowledged that it is required to look forward, not back, but in order to form a view as to current fitness to practise, may need to take account of the way the Registrant has acted or failed to act in the past.

40. The Committee had regard to the General Optical Council's overarching objective:

(a) To protect, promote and maintain the health, safety and wellbeing of the public;

(b) To promote and maintain public confidence in the professions regulated under the Opticians Act;

(c) To promote and maintain proper professional standards and conduct for members of those professions….

The Committee gave equal consideration to each of its limbs.

41. In order to determine the issue of current impairment the Committee had regard to the following questions posed by Dame Janet Smith in her 5th Shipman Report, approved in the case of *Grant:*

"*Do our findings of fact in respect of the [Registrant's] misconduct, show that her fitness to practise is impaired in the sense that she:*

a. *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
b. *has in the past brought and/or is liable in the future to bring the 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 profession; and/or*
d. *has in the past acted dishonestly and/or is liable to act dishonestly in the future."*

42. The Committee first considered these questions in relation to past behaviour.

43. The Committee considered whether the original Committee's findings in respect of the Registrant's misconduct assisted it in determining whether she had put a patient or patients at unwarranted risk of harm. The Committee had regard to the evidence before the original Committee and had regard to its determination, on misconduct, where it said:

"*The likelihood of identifying clinical pathology in a primary school age child may have been low, but this was a significant failing because it exposed Patient A to an unwarranted risk of harm. Had the Registrant complied with her duty she would have detected the bilateral papilloedema and urgently referred Patient A for treatment."*

The original Committee also found that:

"Although no direct harm was caused to Patient A as a consequence of the misleading record there was a risk of harm because incomplete and inaccurate clinical records have the potential to adversely impact patient care."

44. The Committee considered the issues of culpability and foreseeability raised on behalf of the Registrant in both submissions and the expert reports. It also considered that it was in the interests of the Registrant and the wider public interest that it should provide a clear explanation for any findings that it made regarding culpability and foreseeability. The Registrant was under a statutory duty to carry out a full internal examination of Patient A's eyes but failed to do so. She would have detected the bilateral papilloedema had she made sure that she was looking at the correct retinal images or indeed had she completed a full examination of the internal eyes. The Registrant accepted that, had she seen the correct images, she would have referred Patient A to hospital.

45. Professor Evans provided a Report dated 6 June 2022. He commenced his opinion by dealing with the issue of whether "*If an optometrist does not carry out an adequate examination of the internal eye in an asymptomatic child with no red flag clinical signs what is the risk that: papilloedema will be missed; other life-threatening pathology will be missed."* He indicated that he had not seen any paper or textbook that addressed these questions. He came to the conclusion that "*the risk of a child having papilloedema from either idiopathic intracranial hypertension or secondary to a tumour without symptoms or red flag signs is approximately one in a million per annum*."

46. The original Committee had already observed that the likelihood of identifying clinical pathology in a primary school age child was low. It was the view of this Committee that Professor Evans simply provided statistical evidence confirming how low that likelihood was in these particular circumstances. However, the Committee did not consider that the specific "risk/likelihood of harm" of papilloedema had relevance to the decision that it had to make. It was of the view that the Registrant was under a statutory duty to examine Patient A's eyes and in failing to undertake that statutory obligation she subjected Patient A to unwarranted risk of harm.

47. The Committee then had regard to Professor Evans' commentary on culpability in the last part of his report dated 6 June 2022. He submitted that:

"for a patient with papilloedema to present without any symptoms or red flag signs...this is incredibly unlikely and not something that the Registrant could have foreseen."

48. He concluded by stating that "*I opine that her level of culpability for not detecting papilloedema in Patient A (which was in fact present at the time of the sight test but was, exceptionally, asymptomatic) was low."* Professor Evans accepted that fundamental failures were found proved by the original Committee. The Committee looked for any observation of Professor Evans, that may have supported his conclusion on culpability. He stated that *"The main purpose of an optometric sight test is to detect and correct refractive error. Optometrists' role in detecting pathology is opportunistic."*

49. The Committee noted that Mr Booth was critical of this passage, in his report dated 30 June 2022. He observed that it was a statutory requirement for an optometrist to

make an internal and external examination of the eyes to detect signs of injury or disease. A failure to do so would be a breach of the regulations and consequently would fall far below the standard of a reasonable competent optometrist. In his more recent (5 July 2022) report Professor Evans explained that this passage was misconstrued and was taken out of context and that "*there is a different nature of sight tests for different age groups*". He further explained that reference to the statutory requirements for sight tests was to be found in his earlier report dated 6 June 2022.

50. Professor Evans restated his opinion, on culpability, in his report dated 5 July 2022:

"I opine that the Registrant's culpability for failing to detect the papilloedema is low for the following reason. No optometrist could have forseen that a patient with no recent symptoms and normal visual function would have papilloedema. This is exceptionally rare and the research I have reviewed confirms this. Furthermore the Committee's findings regarding viewing the wrong photograph and prematurely abandoning ophthalmoscopy in part due to reliance on those photographs represents an exceptional chain of events."

51. The original Committee found that the Registrant had exposed Patient A to an unwarranted risk of harm. Professor Evans accepted that there were risks in missing other life-threatening and non-life-threatening pathology in asymptomatic patients. The Committee agreed with Mr Booth's observations and concerns that it is a statutory requirement for an Optometrist to make an internal and external examination of the eyes to detect signs of injury or disease. This duty is not varied by the age of the patient or the rarity of a condition that is subsequently diagnosed.

52. The Committee considered that the foreseeability of papilloedema issue raised by Professor Evans introduced an outcome-based discussion in a case where the Committee was urged not to have regard to the outcome. The failure, of the Registrant, to examine and record accurately was grave and serious in its own right. The "*exceptional chain of events*", referred to by Professor Evans, were found by the original Committee to have been a series of interrelated failures by the Registrant. She abandoned the ophthalmoscopy prematurely having previously failed to check the photographs were of the correct patient's eyes. The Committee was also concerned that Professor Evans did not factor in or explain the findings of the original Committee with regard to record keeping, including dishonesty, in his assessment of culpability. The original Committee stated that the "*inaccurate, misleading and dishonest record keeping demonstrates an attitudinal failing*". The Committee accordingly, considered that the Registrant's culpability for her failings, and not for the outcome, was high. The original Committee considered that the Registrant's acts and omissions "*fell far below the standards expected of a registered optometrist."*

53. The Committee therefore considered that limb (a) was engaged. The Registrant had, in the past, put Patient A at unwarranted risk of harm.

54. The Committee then went on to consider whether or not the Registrant had, in the past, brought the profession into disrepute. The Committee considered that the Registrant was in a position of trust and was expected to conduct a full eye examination. She was under a statutory obligation to do so. A well-informed member of the public would be concerned about the fact that a full eye examination was not carried out and that dishonest and misleading entries were made in the records regardless of the outcome. Accordingly, it considered that limb (b) was engaged with regard to the past.

55. The Committee next went on to consider whether or not the Registrant had, in the past, breached one of the fundamental tenets of the profession. The Committee accepted that not all breaches of the Code of Conduct in place at the time necessarily involve a breach of one of the fundamental tenets of the profession. The Committee considered that the fundamental tenets of the profession incumbent on this Registrant were: to make the care of her patients her first and continuing concern; conduct eye tests in accordance with her legal obligations, keep adequate records and be open and honest. The Committee considered that the Registrant failed to make the care of Patient A her first and continuing concern. She had failed to identify the correct photographic images, discontinued her internal examination of Patient A's eyes prematurely and without sufficient justification. She also failed to make an appropriate record of discontinuing the examination, which was "*a unique event*" for her. She had breached her statutory obligation to conduct a full examination. Her record keeping, where she recorded Patient A's peripheries as normal, thereby giving the impression that she had seen the peripheries when she had not, was dishonest. In these circumstances the Committee found that limb (c) was engaged with regard to the past.

56. The Committee next considered whether the Registrant had been dishonest in the past. The original Committee made a finding of dishonesty in respect of the recording of the peripheries of Patient A's eyes as normal when in fact both peripheries were not examined by the Registrant. Accordingly, it determined that limb (d) was engaged.

Insight and Remediation

57. The first issue which arose for the consideration of the Committee was how to resolve the debate detailed in both parties' submissions, concerning the "rejected defence" argument and the question of insight. The Committee had been supplied with copies of the relevant case law which had been the subject of discussion (*Sawati v GMC [2022] EWHC 283 (Admin); GMC v Awan 2020; EWHC 1553 (Admin); Towuaghantse v GMC [2021] EWHC 681(Admin)* and *Amao v NMC [2014] EWHC 147 (Admin*).

58. As a starting point the Committee accepted the following proposition from *Sawati* [Paragraph 103] which accorded with the guidance issued to it by the Legal Adviser:

"*The principle of due process may not be sophisticated or complicated. The principle of protecting the public from practitioners who cannot accept or deal with findings of*

fault, and are at risk of repeating their failings, is not complicated either. Reconciling the two may however be difficult in an individual case, and is undoubtedly fact-sensitive. So the question is how best to approach the facts of a given case."

59. The Committee determined that it should consider all of the cases before considering how they should be applied, if at all, to this case.

60. *Towuaghantse* was a case where it was considered not to be procedurally fair for a registrant to face the risk of enhanced sanctions by virtue of having robustly defended allegations made against him before the Medical Practitioners Tribunal, and before another court. The facts of *Towuaghantse* and *Sawati* were different, in that, in this case, the Registrant had made an admission to dishonesty during her evidence to the original Committee.

61. The Committee considered that the case of *Amao* was not analogous as it involved an unrepresented registrant being questioned by an NMC Panel at the impairment stage, where the fairness of the questioning was discussed at paragraph 161;

"Moreover, as it seems to me, Ms Amao was perfectly entitled to say that she did not accept the findings of the panel: she had a right of appeal which she was entitled to exercise. In all the circumstances it was thoroughly inappropriate, almost Kafkaesque, to cross-examine Ms Amao in a way which implied that she would be acting improperly if she did not "accept the findings of your regulator". She was at a loss, and confused, as to how to deal with this line of questioning. The remainder of the proceedings did nothing to make Ms Amao any less confused."

62. The Committee noted that the Council provided guidance on this issue in its "Hearings and Indicative Sanctions Guidance (November 2021)" ('The 2021 Guidance') which observed that a committee needed to approach the issue of insight carefully. It quoted the following passage from *Awan [Paragraph 37]:*

"I think that it is too much to expect of an accused member of a profession who has doughtily defended an allegation on the ground that he did not do it suddenly to undergo a Damascene conversion in the impairment phase following a factual finding that he did do it. Indeed, it seems to me that to expect this of a registrant would be seriously to compromise his right of appeal against the factual finding, and add very little, if anything, to the principal allegations of culpability to be determined."

63. The Committee considered that further observations made in *Awan*, were pertinent to the facts of this case:

"39. *It is for this reason that explicit admissions of culpability tend not to be given in the impairment and sanctions phase. Rather, language alters to the passive voice and statements in the genre of "I am sorry if what I have said has caused you to take offence" are made. Thus, in the case of General Medical Council v X [2019] EWHC 493, which has some striking similarities to this one, the "admission" following the*

factual finding was (at para 32): "Dr X had instructed [counsel] to admit on Dr X's behalf that what the tribunal had found proved was serious and deplorable.

40. That is some distance away from admitting explicitly the truth of what the tribunal had found proved. ***In my judgment, in the absence of any significant hiatus between the factual finding and the impairment/sanctions phase in which full reflection can be undergone,*** *that is as much as can reasonably be expected of an accused professional who has defended the case on the ground that he did not do what was alleged."* (Words placed in bold for emphasis by the Committee)

64. Having considered these cases the Committee determined that this was not a case where the Registrant was maintaining her defence at the impairment stage. It had careful regard to her reflective statement dated June 2022 and considered that she accepted the findings of the original Committee. This was a situation where there had been a "significant hiatus" between the original factual stage and the impairment stage. The benefit, to the Registrant, of the further unfortunate delay between the misconduct and impairment stages was that she has had time to further reflect. The Committee considered that, in light of her current reflection, it should not solely focus on what the Registrant's attitude to the Allegation was at the time of the earlier part of the hearing. She had not readily admitted dishonesty at the earlier stages of the hearing. The issue that this Committee was required to determine was whether or not she was currently impaired. What was most important was her current approach, and level of insight, in July 2022.

65. The Committee then went on to consider the Registrant's reflective statement and other documentation produced in support of the contention that she had remediated. The Committee reminded itself that it is not an absolute rule that insight, remorse or remediation requires to be demonstrated through oral evidence and the registrant subjecting themselves to cross-examination (*Doree*). However, the Committee accepted submissions, on behalf of the Council, that not giving evidence at this stage but relying on documentary evidence may have limitations in relation to the weight that can be attached to the evidence received.

66. The Committee also reminded itself of the observations in *Cohen* that the purpose of this stage of disciplinary proceedings involves the Committee considering :

"[64] There must always be situations in which a Panel can properly conclude that the act of misconduct was an isolated error on the part of a medical practitioner and that the chance of it being repeated in the future is so remote that his or her fitness to practise has not been impaired….

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

67. The Committee took into account the fact that, although the Registrant was otherwise of good character, her hitherto unblemished record was in respect of a relatively short career. The Committee found that her misconduct could not be classified as an "isolated error" or a momentary failure. The original Committee found that the Registrant did not check the names of any of the retinal images that she viewed on 14 and 15 February 2012. The original Committee also found at Paragraph 105 of its determination that:

"*The Registrant failed to carry out an adequate internal eye examination. The Committee concluded that this failure encompassed a chain of events including premature curtailment of the examination and viewing the wrong retinal image. The failures to assess properly the optic nerve head, to assess and accurately record the cup to disc ratio and to detect the presence of bilateral papilloedema were inevitable consequences of the Registrant's fundamental failure to perform her basic statutory duty."*

68. The original Committee also found at Paragraph 110 of its determination that:

"...the failure to carry out an adequate eye examination is inextricably linked to the record keeping failures in two interrelated respects. First, the Registrant having discontinued Patient A's internal eye examination failed to make an appropriate record of the fact. Secondly, the inaccurate, misleading and dishonest record keeping demonstrates an attitudinal failing."

69. Therefore, the Committee concluded that rather than an "isolated error" or a momentary failure her misconduct arose as a result of a fundamental failure on her part to perform her statutory duty and the attitudinal failings identified by the original Committee.

70. The Committee had regard to the Registrant's reflective statement and noted that it contained a correction to the evidence that she presented to the original Committee. What she had told the original Committee was that following her suspension from Practise she had "not worked in optometry or otherwise". What she had meant to convey was that she had not worked in optometry since 2013. In fact, she began working outside the profession by training as a financial adviser in 2019. She was working towards obtaining professional status. The Committee considered that it was unfortunate that she did not obtain references and testimonials from the people that she has worked with or from other areas in her life. She may have been able to provide the Committee with some independent evidence regarding, for example, her attitude to record keeping and her probity.

71. The Committee have already observed that the reflective statement contained a full acceptance of the original Committee's findings. The reflective statement also contained an apology:

"*I would like to apologise to Patient A and Patient B's family, and to everyone who has been affected in any way in this case, for my failings."*

72. Mr Forde informed the Committee that, so far as he was aware, this was the first time that the Registrant had apologised to Patient A's family. His observation was not contradicted.

73. The Committee noted that the Registrant was able to express some of the actions that she should have carried out at the appointment. *"I didn't ask Patient A's mum for help, but I would now."… "I didn't check the name on the photograph but would now." …"I would never make a record in the same way as I did for Patient A's periphery again."*

74. The Committee had regard to a short statement, dated 30 May 2022 from [Redacted], Clinical and Regulatory Adviser at [Redacted], who has continued to act as a mentor for the Registrant. Her role was to support her in her return to practise. She reported that the Registrant had recently spent a day in an observational role at an ophthalmic practice. This was confirmed in a letter dated 27 May 2022 from the practice she visited. She also stated that the Registrant demonstrated her conscientiousness in undertaking CET/CPD covering a wide range of topics. She stated that she found the Registrant to be engaged in her remediation and had shown a willingness to learn in order to facilitate her return to optometric practise. The Committee considered the Registrant to have demonstrated an enduring commitment to the profession, despite not being in practise.

75. The Committee noted that the Registrant's reflective piece and PDP contained a detailed commentary on what further learning she had undertaken. She had attended 2 shadowing opportunities at Moorfield Hospital which helped her understand papilloedema. She also attended a number of lectures some of which were 'in person' and some of which were online. She had made efforts to maintain her knowledge and clinical skills despite being out of practise for some considerable time. Her PDP and reflections demonstrated she had undertaken courses in being able to recognise the significance of papilloedema, dealing with children and the importance of examining the retinal periphery. The Committee was satisfied with the level of understanding of these issues that the Registrant shows.

76. The Committee considered that some aspects of the Registrant's misconduct were more easily remediable than those characterised as attitudinal in nature. The original Committee made reference to "ambiguous" record keeping as well as dishonest record keeping. The use of the word "ambiguous" originates from the evidence of Professor Evans on the third day of the hearing in relation to allegation 1 (c). This also had an impact on allegation 4 (f). He used the word "ambiguous" in live evidence under reference to part 4.2.1. of his report dated 22 April 2020. He was critical of the Registrant's recording by presenting visual acuities across two boxes where there was provision for entering them as "R" and "L". This was further explained in Paragraph 61 of the determination of the original Committee. This Committee determined that although there have been findings of misconduct which take into account the importance of record keeping, a purely clerical error or inadequacy in record keeping is, in general terms, more likely to be remediable than an attitudinal failing where

record keeping is concerned. The Committee was left in no doubt that the Registrant had brought her knowledge of the practical aspects of good record keeping up to date.

77. However, the Committee was more concerned with what the documentary evidence and reflective piece did **not** contain in terms of insight and remediation into the attitudinal failings identified by the original Committee. In particular, in relation to the Registrant's casual attitude to record keeping and the finding of dishonesty. Insight is often characterised as where a registrant understands what went wrong, appreciates the gravity of their misconduct, accepts they should have acted differently and understands how they should act in the future to ensure similar concerns do not arise again.

78. The original Committee found that, on 15 February 2012, the Registrant had faced a situation she had not encountered before in that she had not discontinued an internal examination previously. This Committee considered that there was no significant evaluation of her misconduct beyond assurances that the events of that day would not be repeated. The Registrant has made no attempt to explain her thought processes on that day, for example why she relied upon assumptions instead of sound clinical investigation and reasoning. She did state that she would not make assumptions in relation to an asymptomatic patient in future by virtue of having completed a webinar, but no explanation was advanced as to why she derogated her basic statutory duty and made such assumptions in the first place. In her reflective statement she accepted that she failed to carry out an internal examination and accepted there were things that she could have done differently. However, in the Committee's view her final conclusion that "*it is important to complete ophthalmoscopy*" was an insufficient recognition of an essential obligation of an Optometrist and demonstrated underdeveloped insight.

79. It was the Committee's view that it was not provided with a detailed explanation for what can be characterised as the attitudinal elements of the misconduct found.

80. In relation to the Registrant's casual attitude to record keeping, the Committee noted her acceptance of the fact that she did not make an adequate note of Patient A's incomplete examination which was misleading, and that she should have made a note. The Committee considered that there was no explanation or critical self-analysis for her complacency in failing to record this, particularly as it was a unique event for her.

81. The Committee found that the Registrant has offered no explanation for why she had recorded clinical results for the peripheries despite not having examined them which she knew to be dishonest and misleading. In her reflective statement she said:

*"I made a misleading and dishonesty (*sic*) entry in relation to the periphery. I recorded that the periphery was normal but the periphery had not been examined as I had been unable to complete ophthalmoscopy and it was not visible on the photographs. I therefore had no observable basis for writing that it was normal; I had made an assumption. I understand that the way I made the record would have given future practitioners the impression that I had examined the periphery when in fact I had not*

done so. If I was unable to examine the periphery, for whatever reason, I should have made this clear on the record and noted why this was so that other practitioners would known (sic) *what had happened."*

82. The Committee was concerned that this reflective statement involved a categorisation of her dishonest conduct as more of a record keeping issue and did not address the reason for her dishonesty beyond stating that she had made her records based on an assumption. This constituted a lack of critical self-analysis and demonstrated insufficient insight into the gravity of her dishonest conduct that was directly related to her duty to ensure that the patient's care was her first and continuing concern.

83. The Registrant's insight into the impact on the profession and the public has developed and is acknowledged in her reflective statement. The Committee fully appreciated how difficult the last ten years must have been for the Registrant. However, there was an imbalance in terms of the effect of these, and earlier, proceedings on her personally, rather than the wider implications of her fundamental and attitudinal failings on the reputation of the profession and the upholding of professional standards.

84. In all the circumstances the Committee was not satisfied that the Registrant had developed sufficient insight to satisfy the Committee that her dishonest conduct, fundamental failure to perform her basic statutory duty and casual attitude to record keeping had been properly understood, addressed and eliminated for the future. It concluded that there remained a risk of repetition as a result.

85. Having considered that the Registrant's current level of insight, whilst developing, remained incomplete, and that there had been only partial remediation, the Committee returned to consider the limbs of Dame Janet Smith's questions as endorsed in the case of *Grant* and how they would apply to the future.

86. The Committee first considered limb (a). The Committee considered that, in the absence of well-developed insight into all aspects of her misconduct, there remained a risk that the Registrant would, in the future, place patients at unwarranted risk of harm. This risk arises from her complacent approach to basic patient detail checks and record keeping, and dishonesty, all arising from unaddressed attitudinal issues. Accordingly, limb (a) was engaged with regard to the future.

87. The Committee then considered limb (b) and concluded that with incomplete insight, particularly into attitudinal failings, such as dishonesty, the Registrant was liable, in the future, to bring the profession into disrepute. Accordingly, limb (b) was engaged.

88. The Committee next considered limb (c). It considered there remained a risk that the Registrant was liable, in the future, to breach a fundamental tenet of the profession where insight and remediation were developing but remained incomplete. Accordingly, limb (c) was engaged.

89. The Committee next considered limb (d). It considered that, in the absence of fully developed insight and remediation there remained a risk in the future of the Registrant acting dishonestly. Accordingly, limb (d) was engaged.

90. In light of the foregoing the Committee determined that it was required to make a finding of impairment on the basis of public protection.

91. Finally, the Committee considered whether a finding of current impairment was also required in the wider public interest. It determined that where the Registrant's misconduct involved a fundamental failure to perform her basic statutory duty, demonstrated a complacent approach to record keeping, and dishonesty in record keeping, public confidence in the profession would be undermined if a finding of impairment were not made. A finding of impairment was also necessary to declare and uphold proper professional standards of conduct and behaviour.

92. Therefore, the Committee determined that the Registrant's fitness to practise is currently impaired by reason of her misconduct.

Sanction

93. Following the Committee announcing its decision on current impairment, the parties were provided with an opportunity to consider the issue of sanction in light of that decision. Time was afforded to the parties for Counsel to consider the lengthy determination on impairment and obtain instructions.

94. When the hearing resumed, the following afternoon, Mr Forde invited the Committee to consider sanction. He explained that he had agreed with Mr Singh that the only sanctions guidance that the Committee should have regard to was the 2021 Guidance and not the guidance that was in force at the time of the case being heard before the original Committee. This was because the guidance was a working document and the Committee should consider the most recent version. He submitted that the more recent guidance was more favourable to the Registrant. He submitted that although the Committee had to follow the 2021 Guidance by starting with the least restrictive sanction first and then considering each sanction upwards, it was likely that the Committee would consider that the only sanctions that should be under consideration were suspension or erasure. He indicated that having had regard to the Committee's decision on impairment and having taken instructions, that erasure was the only appropriate disposal. He had intimated the position of the Council to Mr Singh.

95. In inviting the Committee to make a determination on erasure Mr Forde took the Committee to Mr Booth's Report and the Committee's determination on Impairment. It was to the credit of the Registrant that she accepted that, had she viewed the correct images there would have been a referral. However, his position was that the Registrant had committed basic and egregious errors.

96. Mr Forde observed that, so far as he was aware, no other health profession was required by statutory provision, to carry out a full examination, in a way that optometrists were. Most were bound by codes of conduct which may, for example, give a discretion to carry out examinations in a manner that they considered appropriate. The Registrant did not comply with the statutory requirement that was placed upon her. This was of tremendous importance when looking at the degree of culpability. Patients were entitled to expect those basic statutory minimums to be adhered to. The presence or absence of pathology was not relevant. What was material was that a patient was placed at an unacceptable risk of harm.

97. He further submitted that this was compounded by the fact that the Registrant's record of what happened was found to be misleading and, in one case, dishonest. If these entries were taken at face value there would be a false picture of what went on. The only reason that this false picture was discovered was because Boots provided free retinal images to children in addition to carrying out statutory eye tests. But for these images the Registrant's records would have been accepted as being a true assessment of Patient A's eyes at the time she examined Patient A. Mr Forde submitted that this was very damaging to public confidence in the profession.

98. Mr Forde took the Committee to paragraphs in its Impairment determination and to paragraphs in the High Court Judgment. He invited the Committee to consider what he contended should be the mitigating and aggravating features in the case. By indicating relevant paragraphs in the 2021 Guidance, he then made submissions on why erasure should be regarded as the appropriate sanction in all of the circumstances.

99. Mr Singh invited the Committee to impose a sanction of suspension with a review and suggested that the sanction of erasure would be disproportionate. He invited the Committee to have in mind the principle of proportionality and to take the least restrictive and proportionate measure.

100. He indicated that the Registrant had been suspended on an interim basis for a significant period of time. At another stage she had been on interim conditional registration. She has also served the substantive suspension of nine months which was imposed by the original Committee. At present she is effectively under voluntary suspension having provided an undertaking to the Council not to practise. Her interim suspension commenced on 13 March 2013. She had not worked in her chosen profession since then.

101. Mr Singh submitted that her inability to practise due to interim suspension and other reasons may be relevant to the issue of the length of the period of suspension that the Committee may wish to impose. He referred the Committee to the cases of *Kamberova v NMC [2016] EWHC 2955 (Admin); Akhtar v GDC [2017] EWHC 1986 (Admin); and GMC v Ahmed [2022] EWHC 403 (Admin)*.

102. Mr Singh also reminded the Committee that the guidance did not suggest that a finding of dishonesty should result in a particular penalty. It contained no blanket rule to that

effect. He referred to the relevant passage, in his written submissions for impairment, that a finding of dishonesty need not necessarily even result in a finding of impairment. This was a reference to paragraph 22.4 of the 2021 Guidance. He also referred to an earlier part of the 2021 Guidance (17.8) and made reference to the case of *Lusinga v NMC [2017] EWHC 1458 (Admin)* where it advised the Committee to have regard to the scale of the dishonesty.

103. He referred the Committee to the case of *O v NMC [2015] EWHC 2949* where the Indicative Sanctions Guidance, provided to the Nursing and Midwifery Council's conduct and competence committee was similar to the Council's. Like this Committee the NMC Panel had to consider sanctions for misconduct in ascending order of gravity. However, where the appropriate sanction was between suspension or striking off, it was critical that all the available mitigation was considered at both stages, not just at the striking-off stage.

104. Mr Singh submitted, with reference to the 2021 Guidance what factors ought to be regarded as mitigating.

105. Mr Singh then directed the Committee to various passages of the 2021 Guidance and submitted that, having regard to that guidance, suspension, with review, was the more proportionate disposal than erasure.

106. There was panel questioning with regard to paragraph 21.29 b) of the guidance which states that suspension may be appropriate if there was *"No evidence of harmful deep-seated personality or attitudinal problems"*. Mr Singh had submitted for the Committee to make a finding of "harmful or deep-seated" some form of expert evidence was required to satisfy it that there was either a personality problem or an attitudinal problem. In answer to a question from a member of the Committee as to whether an alternative interpretation of the wording could mean that an attitudinal problem was not required to be a harmful or deep-seated one for that provision to apply he did not accept this interpretation. Mr Forde indicated that he preferred the latter, alternative, interpretation.

107. The Committee heard and accepted the advice of the Legal Adviser. He reminded the Committee under reference to the case of *Doree* that the 2021 guidance was simply guidance. It did not have the force of a statute nor was it to be regarded as something that set a tariff. It was a means to providing a fair and transparent result. Part 2.2 of the guidance made it clear that it was not a source of legal advice. However, there were one or two matters that he required to comment upon that were pertinent to the facts of this case.

108. The Case of *Lusinga* made it clear that the Committee was required to adopt a nuanced approach to the finding of dishonesty. It should consider the scale of dishonesty and where it appeared on that scale.

109. The Cases of *Kamberova, Akhtar* and *GMC v Ahmed* all involved the issue of the length of the period of suspension that a Registrant should be subjected to. This would

only arise if the Committee determined that suspension was the appropriate sanction. The length of time spent on interim suspension would be a factor that the Committee could take into account in determining the length of the substantive suspension that it could impose. This was only one factor that the Committee should consider. The fact that the Registrant had been subject to a lengthy interim suspension need not, necessarily, result in a reduction in length of the period of the substantive suspension at all. If there was to be a reduction then it would not involve anything other than the reduction of a period measured in months. This was not a situation where there should be an arithmetical calculation analogous to time spent on remand in a criminal jurisdiction.

110. The Legal Adviser concluded by referring to part 21.31 of the 2021 Guidance. That provision made reference to the case of *HK v General Pharmaceutical Council [2014] CSIH 61*. He pointed out that the decision of the Extra Division of the Inner House was overturned, on appeal, by the Supreme Court under reference to [2016] UKSC 169. Accordingly, that part of the Guidance should be disregarded.

Committee deliberations

111. The Committee appreciated that in considering sanction there was no burden of proof and that it had to reach its decision based upon its own professional judgement and based upon the 2021 Guidance. The Committee had regard to the introduction to the Guidance which contained a reminder of the over-arching objective of the Council. The Committee had equal regard for each of its limbs. It was the responsibility of this Committee to make fair, consistent and just decisions that fulfil the over-arching objective.

112. Throughout its decision making, the Committee had regard to the principle of proportionality, and weighed the interests of the Registrant with the public interest. It appreciated that it is often appropriate in serious cases to give greater weight to the public interest, than to any consequences of sanction for a registrant. The primary purpose of a sanction was to achieve the over-arching objective. Even if a sanction may have a punitive effect on a registrant, it would still be appropriate if its purpose was to achieve the overarching objective.

113. The Committee started by identifying what it considered to be the aggravating and mitigating factors in the case.

Aggravating factors (part 14.3 of the 2021 Guidance).

- The Committee had already determined that the Registrant still lacked insight into the gravity of her failings, particularly with regard to the fundamental failure to perform her basic statutory duty and into the attitudinal aspects of her misconduct, those being complacency and dishonesty. Despite the passage of some considerable time, insight in these areas was still underdeveloped.

- Patient A was vulnerable by virtue of being a child. He could not make decisions about his own care and his mother should have been informed that the eye examination was not completed.

- The Registrant was dishonest. The Committee considered this dishonesty to be serious and at the higher end of the scale, although it was neither persistent nor repeated. It did, however, create a false impression that the peripheries of Patient A's eyes were normal, when in fact they were not examined. The dishonesty was directly linked to a fundamental aspect of patient care.

- The records that the registrant compiled were also misleading in a number of other aspects. In addition, she should have recorded that the examination was not completed. When combined with the dishonest entry, these factors created the impression on the record card that everything was fine, and this false impression would not have been discovered but for subsequent events and the existence of the photographs.

Mitigating factors (part 14.2 of the 2021 Guidance)

- The Registrant was a person of otherwise good character. Her career was short but otherwise unblemished. There was no suggestion of repetition albeit that the Registrant practised only for a short length of time after the appointment of 15 February 2012.

- Whilst the misconduct cannot be described as an isolated error or momentary, given that it was comprised of several elements and involved two patients, the misconduct took place on one day within the context of a short career.

- The Registrant has expressed remorse and regret for her misconduct. The issue of whether and when an apology was made to the parents of Patient A was resolved by the Committee accepting that there had been a willingness to apologise expressed in the criminal trial, and a full apology was set out in the Registrant's Reflective Statement before this Committee.

- The Registrant has shown some insight, which has developed to include a full acceptance of the Committee's finding on fact and expressions of how she would act differently in future.

- The Registrant has displayed a strong commitment to remaining in the profession. She has demonstrated full engagement with her regulator and the regulatory process, which has included the signing of an undertaking not to practise whilst these proceedings are ongoing. She has attended a number of courses, some in person, and other strategies to try keep her knowledge and skills up to date, even during a time when the global pandemic disrupted her opportunity to interact, in person, for training and development.

114. The Committee noted that paragraph 8.2 of the guidance required it to have regard to personal mitigation. Much of what the Registrant advanced by way of personal mitigation, is acknowledged in the Committee's overall assessment of mitigation. The Committee considered it should also acknowledge the unfortunately lengthy and protracted legal proceedings in both the criminal and the regulatory process. Undoubtedly, this protraction has had a defining and detrimental effect on the Registrant, who described her life as being "on hold" as a result.

115. In its evaluation of the proportionate and appropriate sanction which would uphold the overarching objective, the Committee considered the aggravating and mitigating factors it had identified and gave them appropriate weight when reaching its decision.

116. The Committee considered the sanctions available to it from the least restrictive to the most severe.

117. It considered whether to take no further action but considered that this would not be appropriate. It would not satisfy the public interest in a case as serious as this, especially with the aggravating factors identified. Furthermore, the public would not be protected.

118. The Committee then went on to consider a financial order but determined that such an order was not appropriate either by way of a substantive order or in addition to any order that it could make. There was no suggestion that the Registrant made a financial gain. The Committee determined that such an order was an inappropriate sanction as it was not relevant to the misconduct found proved and it would neither protect the public nor satisfy the public interest.

119. The Committee then went on to consider conditional registration. It did not consider that such an order would protect the public, nor would it satisfy the public interest, having regard to the seriousness of the case and the weight it placed upon the aggravating factors identified. There were no easily identifiable, purely clinical skills which could be improved and monitored via conditional registration.

120. The Committee was also unable to formulate any conditions to address the issue of dishonesty and the more general attitudinal issues which were identified in the earlier stages of this hearing. It would not be possible to formulate conditions that were appropriate, proportionate, workable or measurable. Considering the Committee's concern regarding the Registrant's level of insight, and the other aggravating factors it has identified, it concluded that the seriousness of the case would not be met by conditions.

121. In considering whether or not it should suspend the Registrant the Committee also deemed it necessary to consider the issue of erasure. This was because paragraph 19.2 d of the guidance, which deals with decision making required it to:

"…explain why the Committee feel that a particular sanction is the most appropriate sanction for them to apply..."

Unless the Committee considered both sanctions it would not be possible to explain why and how it had alighted upon the most proportionate and appropriate sanction.

122. The Committee, in considering whether or not to suspend the Registrant's registration, considered the aggravating and mitigating factors set out in the earlier paragraphs. It had regard to paragraphs 21.29 of the 2021 Guidance in order to assess whether any of the factors set out in that provision were engaged:
"This sanction may be appropriate when some, or all, of the following factors are apparent (this list is not exhaustive):

a. Serious instance of misconduct where a lesser sanction is not sufficient.

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

c. No evidence of repetition of behaviour since incident.

d. The Committee is satisfied the registrant has insight and does not pose a significant risk of repeating behaviour…"

123. The Committee had already determined that this was a serious case of misconduct involving multiple elements, including a fundamental failing of a basic statutory duty and dishonesty, rather than a single serious instance of misconduct. It did consider this was a situation where lesser sanctions were not sufficient and therefore concluded that factor (a) was partially engaged.

124. The Committee had careful regard to the wording of factor (b). On balance, it preferred Mr Singh's interpretation of that provision. It considered that the expression "harmful deep-seated" should apply to any attitudinal problems and not simply personality problems. It considered that this was the plain meaning of this provision. It could think of no reason for differentiating between attitudinal problems and personality problems. On one view the words were synonymous and interchangeable. Although both the original Committee and this Committee had made findings of attitudinal problems neither had made findings that were so extreme that the attitudinal problems could result in them being described as "harmful deep-seated". However, the Committee was reminded of, and gave considerable weight to the aggravating factors it had identified, particularly in relation to the underdeveloped insight into the attitudinal failings found, which led in part to the Committee's earlier conclusion that there remained a risk of harm in the future. It concluded that factor (b) was engaged in a limited way.

125. The Committee had regard to the fact that, although the Registrant only worked for a short time after the events, and has not worked since then, there was no suggestion of other similar concerns. There was evidence of a small sample of her work being audited and no concerns were raised. Accordingly, factor (c) was engaged.

126. The Committee considered that factor (d) was related to the concerns it identified when considering impairment. The Registrant's level of insight was not sufficiently developed and the Committee have determined that there was a risk significant enough for it to make a finding that the Registrant would, in the future, put patients at risk of harm, bring the profession into disrepute, breach fundamental tenets of the profession, and be dishonest. As such factor (d) was not engaged.

127. The Committee considered these factors in conjunction with the preamble to paragraph 21.29 of the 2021 Guidance:

"Consider: Does the seriousness of the case require temporary removal from the register? Will a period of suspension be sufficient to protect patients and the public interest? "

128. The Committee considered the two questions in turn. Whilst the seriousness of the case suggested that the temporary removal of the Registrant from the Register was an option, it gave rise to the question as to whether removal from the Register should be temporary or permanent when all the relevant guidance had been considered. In answering the second question, the Committee concluded that having found some of the factors for suspension to be engaged only in a limited or qualified way, considerations of public protection and public interest outweighed the mitigating factors it had identified.

129. The Committee next considered whether or not erasure was the appropriate sanction and had regard to the aggravating and mitigating features as well as the factors set out in part 21.35 of the 2021 guidance:

"Erasure is likely to be appropriate when the behaviour is fundamentally incompatible with being a registered professional and involves any of the following (this list is not exhaustive): (The Committee has added the bold emphasis).

a. *Serious departure from the relevant professional standards as set out in the Standards of Practice for registrants and the Code of Conduct for business registrants;*

b. *Creating or contributing to a risk of harm to individuals (patients or otherwise) either deliberately, recklessly or through incompetence, and particularly where there is a continuing risk of harm to patients;*

c. *Abuse of position/trust (particularly involving vulnerable patients) or violation of the rights of patients;*

d. *Offences of a sexual nature, including involvement in child pornography;*

e. *Offences involving violence;*

f. *Dishonesty (especially where persistent and covered up);*

g. Repeated breach of the professional duty of candour, including preventing others from being candid, that present a serious risk to patient safety; or

h. Persistent lack of insight into seriousness of actions or consequences. "

130. The Committee considered that factors (d) and (e) were not relevant as they related to criminal offences.

131. In relation to factor (a) the Committee concluded that there had been a serious departure from the standards expected of the Registrant. The Registrant abandoned her statutory duty to conduct a full internal examination of both eyes and relied on incorrect central retinal images because she had failed to identify the correct patient's images. This was serious in its own right. What made the situation worse was the Registrant's unexplained recording of misleading, and on one occasion dishonest information. This was not simply a departure from the multiple standards identified in the misconduct determination. It involved a breach of a statutory duty and breaches of fundamental tenets of the profession as identified in the impairment determination. Accordingly, factor (a) was engaged.

132. The Committee found that the Registrant created a risk of harm to Patient A irrespective of the outcome, which the Committee has had no regard to. The Committee has clearly identified that Patient A was put at an unwarranted risk of harm and that there remained a future risk of harm to the public. Accordingly, factor (b) was engaged.

133. The Committee has identified that Patient A, through his age, was a vulnerable patient. The Committee did not find that there was an abuse of position or violation of the rights of patients in this case. However, the Committee had already determined, at the impairment stage, that the Registrant was in a position of trust and was expected to conduct a full eye examination. Accordingly, factor (c) was engaged in a qualified way.

134. The Committee had already determined that the Registrant's dishonesty was serious and at the higher end of the scale. It had already identified a concern with regard to the level of insight shown in relation to dishonesty. Whilst it did not find that the dishonesty was persistent or covered up, it concluded that factor (f) was engaged.

135. The Committee did not consider that factor (g) was applicable.

136. With regard to factor (h), the Committee had previously identified that there were problems with the Registrant's insight being underdeveloped and was concerned about the significant amount of time that had passed in which full insight could have been demonstrated but was not. However, it was unable to describe her lack of insight as "persistent". For that reason, it found factor (h) to be only partially engaged.

137. The Committee noted that a significant number of factors in favour of erasure were engaged, and could not identify any reason to depart from them.

138. The Committee also had regard, in considering this issue, to the preamble to paragraph 21.35 of the 2021 guidance which states:

"Consider: Is erasure the only sanction which will be sufficient to protect patients and the public interest? Is the seriousness of the case compatible with ongoing registration? Can public confidence in the profession be sustained if this registrant is not removed from the register?"

139. The Committee considered all three of the issues raised. Despite her continued engagement with the regulatory process the Registrant remains a risk to patients. The risk is not in respect of purely clinical skills. The original Committee identified that there were attitudinal issues. The Committee were of the view that any right-thinking member of the public would be concerned if the Registrant were permitted to remain on the Register. A well-informed member of the public would be further concerned that the Registrant had abandoned her statutory duty to conduct a full internal examination of the eyes and relied on incorrect central retinal images because she had failed to identify the correct patient's images.

140. The well-informed member of the public would also be concerned that the Registrant had made misleading, and on one occasion, dishonest entries in the patient's file. They would have concerns regarding the exposure, of patients, to risk arising from all of these actions and that the continuing exposure to risk some years after the events still existed. The Committee formed the view that public confidence in the profession would not be maintained if the Registrant remained on the Register. The seriousness of the case was incompatible with ongoing registration.

141. The Committee were careful to take into account the mitigating factors it had identified before reaching the conclusion that erasure was the appropriate and proportionate sanction. The Committee recognised the Registrant's long-term commitment to the profession of optometry. It appreciated that her continued participation in the regulatory process has been throughout the course of an exceptionally long period of time. The Committee also recognised that the events that gave rise to the misconduct took place over one day. However, it could not ignore the serious nature of that misconduct and the fact that the Registrant is yet to provide an insightful explanation of how this misconduct occurred. As such, it gave greater weight to the aggravating factors it had identified than the mitigating. The Committee had regard to the issue of proportionality and accepted that the sanction of erasure would take away the Registrant's ability to work in her chosen profession as well as affecting her status and reputation. It determined that the protection of the public and wider public interest concerns that it had already identified outweighed the interests of the Registrant.

142. In all of the circumstances the Committee directed that the Registrant's name should be erased from the Register.

Immediate Order

143. The Committee has heard submissions from Mr Forde on behalf of the Council who applied for an Immediate Order. Mr Singh on behalf the Registrant indicated that he had taken instructions in advance of the decision being announced and did not oppose the application. He did not make a submission. The Committee accepted the advice of the Legal Adviser.

144. The Committee has decided to impose an immediate suspension order for the following reasons. It determined that such an order was necessary for the protection of the public and was otherwise in the public interest. To not impose such an order would be inconsistent with its earlier sanction determination that the seriousness of the case was incompatible with ongoing registration.

145. Accordingly, it directed an immediate order of suspension in terms of Section 13 (I) of the Opticians Act 1989.

Chair of the Committee: Jayne Wheat

Signature **Date: 26 July 2022**

Registrant: Honey Rose

Signature present via video **Date: 26 July 2022**

APPENDIX

Decision from the original Committee:

12 November 2020

ALLEGATION

That the fitness to practise of Honey Rose is impaired by reason of the following:

1) On 15 February 2012, you conducted a routine sight test of Patient A and you:

a) failed to carry out an adequate internal eye examination of each eye;

b) failed properly to measure and/or properly record unaided vision, separately of each eye;

c) failed properly to measure and/or properly record best corrected visual acuities of each eye individually;

d) failed properly to measure and/or properly record the oculomotor balance;

e) failed properly to measure and/or properly record pupil reactions [**No Case to Answer (in relation to measurement)**];

f) failed to differentiate between the right and left eye in recording the clinical picture;

g) failed adequately to assess the cup-to-disc ratio in each eye;

h) failed properly to assess the optic nerve head;

i) failed to detect the signs and/or presence of bilateral papilloedema; or (in the alternative) -

j) failed urgently to refer Patient A for further investigation and / or treatment despite a referral being clinically indicated [**Withdrawn by GOC**].

2) In relation to your examination of Patient A on 15 February 2012 you:

a) purported to record an internal examination of both eyes when you had not performed such an examination;

b) noted that the periphery of both eyes was 'normal' when you had not examined the internal aspects of the eyes sufficiently to make such a note [**Admitted and Found Proved**];

c) purported to record the cup-to-disc ratio of each eye as 0.5 when in fact it was significantly less than that.

3) Your record in relation to the matters listed in paragraph 2 (a) (b) and (c) above was:

a) inaccurate [**Admitted and Found Proved (in relation to Particular 2(b))**];

b) misleading [**Admitted and Found Proved (in relation to Particular 2(b))**];

c) dishonest.

4) On 15 February 2012, you conducted a routine sight test of Patient B and you:

a) failed properly to measure and/or properly record the oculomotor balance;

b) failed properly to measure and/or properly record the pupil reactions [**No Case to Answer (in relation to measurement)**];

c) failed properly to measure and/or properly record unaided vision for each eye separately;

d) failed properly to assess and/or properly record the external examination of each eye separately [**No Case to Answer**];

e) failed properly to assess and/or properly record the internal examination of each eye separately [**No Case to Answer**];

f) failed properly to measure and/or properly record best corrected visual acuity for each eye separately;

g) failed to differentiate between the right and left eye in recording the clinical picture.

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

Background

1. Ms Rose ('the Registrant') is a registered optometrist. She trained as an optometrist in REDACTED and practised in REDACTED between 2004 and 2005. In 2005 the Registrant REDACTED. The Registrant was first registered with the College of Optometrists on 13 February 2008. On 15 July 2010, the Registrant became a fully qualified optometrist.

2. Between July 2010 and March 2013, the Registrant worked as a self-employed locum optometrist at numerous locations including stores operating as part of a national group and independent practices. She worked over 100 days at various REDACTED Opticians stores between 2 March 2011 and 29 August 2012.

3. On 15 February 2012, the Registrant worked as a locum optometrist, at the REDACTED branch of REDACTED Opticians REDACTED. Witness X attended the branch for routine eye test appointments for herself and her two children - Patient A and Patient B. Witness X's scheduled appointment for a contact lens appointment with Witness E was at 10.00am. Her scheduled appointment with the Registrant was 10.25am, Patient A's was 10.50am

and Patient B's was 11.15am. Patient A was aged 7 years 9 months and Patient B was aged 4 years 11 months. This was Patient B's first routine eye test. However, Patient A had had previous routine eye tests in 2010 and 2011.

4. Witness X was myopic (short-sighted) and suffered occasional migraines, which started as a child. The first time that she could recall Patient A complaining of headaches was over the Christmas break in 2011. On New Year's Eve he appeared a '*little under the weather*' and went to bed '*rather than see in 2012'*. He complained of a headache the following day and slept during the afternoon on New Year's Day which was unusual. Witness X thought '…*there might be an issue with his eyes and the fact that he had been on the computer a lot over Christmas*…' Patient A's headaches were on and off over the next few days but he was not '*poorly*'. After the Christmas break Witness X contacted the REDACTED branch of REDACTED Opticians. As Patient A was no longer complaining of a headache and appeared to have no visual problems, she kept the annual appointment which was scheduled for 15 February 2012.

5. The Registrant carried out sight tests on Witness X, Patient A and Patient B. The three appointments took place between 10.25am and 11.40am. REDACTED Opticians offered retinal images free of charge for all children under the age of 16 and prior to the first appointment, Patient A and Patient B's retinal images were taken with a fundus camera by an optical consultant. During Patient A's examination, the Registrant recorded no issues of concern and reported to Witness X that he did not need glasses. The Registrant recorded that there were also no issues of concern with regard to Patient B's eyesight and she also did not need glasses. The Registrant recorded on the patient record that the next appointment for both children should be in 12 months' time.

6. Five months later, on 13 July 2012, Patient A was taken ill whilst at school. Witness X collected him and took him home. Patient A's condition deteriorated during the afternoon and he died later that day. The post-mortem revealed that the cause of Patient A's sudden and unexpected death was hydrocephalus, a condition where excessive fluid builds up on the brain. A patient with hydrocephalus would normally present with associated symptoms, such as headaches and vomiting. Patient A did not have these symptoms which was unusual.

7. There was no dispute that the retinal images of Patient A, taken on 15 February 2012, clearly revealed papilloedema (swelling of the optic nerve) which required an urgent referral to hospital. Papilloedema is rare, but the consequences can be devastating.

8. On 7 March 2013, the Registrant was interviewed by the police. She stated that she had not seen Patient A's retinal images and if she had seen them, she would have made an urgent referral to the hospital. She was subsequently charged with gross negligence manslaughter and her trial took place at Ipswich Crown Court in July 2016. The Registrant was convicted. However, her conviction was overturned on appeal by the Court of Appeal on 31 July 2017. There was no appeal to the Supreme Court.

9. The GOC obtained disclosure from the police in November 2017. The GOC case examiners subsequently decided that an Allegation of impairment by reason of misconduct should be referred to the Fitness to Practise Committee.

10. During the course of the hearing various witness statements were read including that of Witness J one of the optical consultants on duty at REDACTED on 15 February 2012. The GOC called the following witnesses to give oral evidence:
    - Witness X – the mother of Patient A and Patient B;
    - Witness A – Technology Innovations Manager;
    - Witness B – Deputy Manager;
    - Witness C – Former Practice Manager;
    - Witness D – Optometrist;
    - Witness E – Contact lens optician;
    - Witness F – REDACTED Manager;
    - Mr Richard Booth – Optometrist and Member of GOC Panel of expert witnesses.

11. The witness statement of Witness G, Solicitor and Director of Legal and Regulatory Services for the Association of Optometrists, was read on behalf of the Registrant. The Registrant chose to give evidence and the following witnesses were called to give oral evidence on her behalf:
    - Witness H – Optometrist and Head of Clinical and Regulatory for the Association of Optometrists;

- Professor Bruce Evans – Optometrist and Visiting Professor of Optometry at South Bank University.

Admissions

12. At the outset of the proceedings the Registrant admitted the following factual particulars:
    - Particular 2(b) – '*noted that the periphery of both eyes was 'normal' when [she] had not examined the internal aspects of the eyes sufficiently to make such a note*;';
    - Particular 3(a) - 'inaccurate' and Particular 3(b) - 'misleading' in relation to Particular 2(b).

13. The Committee announced that these factual particulars had been found proved.

Factual Findings

The Committee's Approach

14. The Committee accepted the advice of the Legal Adviser. The Committee was aware that the burden of proving the facts was on the GOC. The Registrant did not have to prove anything, and the factual particulars of the Allegation could only be found proved, if the Committee was satisfied, on the balance of probabilities.

15. The Committee was mindful that the relevant events took place more than 8 years ago and that this is bound to have affected the ability of the witnesses including the Registrant to recall certain details. The Committee also took into account separately the potential impact the delay may have had on the Registrant's presentation of her case and proceeded with caution in reaching its factual findings.

16. The Committee was also aware that where the GOC alleged a 'failure' the GOC first had to prove that the Registrant had a duty to perform a specific action (e.g. to measure and/or record) and secondly that it was not done. If the Registrant did not perform an action that she had a duty to perform, the Committee was required to determine whether this was for

good and sufficient reason. In reaching its decision, the Committee took into account the written and documentary evidence, and the oral submissions from both parties.

17. The Committee noted that in accordance with the Supreme Court decision in *Ivey v Genting Casinos* [2017] UKSC 67 the test for dishonesty is an objective test only. The Committee first had to determine subjectively the Registrant's actual knowledge or belief as to the facts and then determine whether her act or omission was, on the balance of probabilities, dishonest by the ordinary standards of reasonable and host people.

Decision

Particular 1(a) – **Found Proved**

'failed to carry out an adequate internal eye examination of each eye [Patient A];*'*

18. Witness X made six witness statements during the criminal proceedings. On 16 December 2018, she signed a witness statement exhibiting those previous witness statements for the purposes of these proceedings.

19. Witness X's oral evidence was consistent with her witness statements. In her witness statement, dated 6 March 2014, she explained that after the retinal images were taken in the '*open area near the [first floor] reception*' she went into the testing room with her two children. She believed that Patient A had his eyes tested first and Witness X stated that he '*behaved perfectly doing everything he was asked*.' She stated that Patient A '*read letters from the board and appeared to have a full eye examination*.' In her witness statement dated 25 May 2016, Witness X stated that the Registrant used an instrument which looked '*like a torch…with a bright light at the top*', which she now knows to be an ophthalmoscope. She remembered the Registrant '*getting very close to [Patient A] shining the light in his eyes thinking "he won't like that", not due to the bright light but because she was physically really close to him and "right in [his] face*".' Witness X stated that the Registrant did not make any comment about Patient A being sensitive to the light. Patient B then had her eyes tested and '*this appeared to be a full eye test'.* Witness X could not recall the Registrant bringing any images up on the screen in the testing room and '*was fairly confident [the Registrant] did not leave the room during the appointment.*'

20. The Registrant acknowledged, in her witness statement, dated 29 April 2020, and during her oral evidence, that her recollection of the examination of Patient A was now limited due to the passage of time. In giving her evidence she primarily relied on the contemporaneous record card, her normal practice, the transcript of her police interview and the evidence she gave during the criminal trial.

21. The Registrant stated in her witness statement that she examined Witness X before Patient A and Patient B. During her oral evidence she explained that she had come to this conclusion because she normally sees her patients according to the order on the patient list and because the record card indicates that Witness X's eye pressure was tested at 10.50am which is a test she would normally have undertaken at the end of an appointment. Patient A was examined next followed by Patient B. The Registrant stated in her witness statement that due to '*technological issues'*, she was not able to view Patient A's retinal images on the computer screen in the testing room. She stated that the computer had also not been working the day before (14 February 2012). She had informed '*the staff'* on 14 February 2012 and two of the optical consultants had checked the computer, but they could not get it to work. Therefore, on 15 February 2012, she went to the pre-screening area and asked the optical consultant (which may or may not have been Witness CC) to bring up Patient A's photographs on the computer in the pre-screening area. During her oral evidence, the Registrant stated that the computer in the testing room was working, to the extent that she could access other programmes, but she could not access the retinal images. She also stated that she viewed Patient A and Patient B's retinal images in the pre-screening area before calling the family into the testing room.

22. The Registrant, in her witness statement, stated that she had '*done [her] best*' to carry out an internal examination of Patient A's eyes using ophthalmoscopy. However, she had not been able to complete the internal examination because Patient A was showing signs of photophobia (abnormal sensitivity to light) and/or poor fixation (poor ability to maintain visual gaze in a specific direction). As a consequence, the Registrant sought to rely on the retinal photographs which were shown to her in the pre-screening area prior to the examination. She stated that she had no reason to doubt that she was shown Patient A's retinal images because she '*made a reasonable check by showing the Optical Consultant the patient record card or giving her Patient A's name, and the Optical Consultant pulled*

up the photographs shortly after [she] had asked.' During cross examination the Registrant referred to Patient A demonstrating '*slight*' photophobia. She accepted that if Patient A had photophobia '*he would have reacted to the other tests, but all the other tests went well.*' She stated that it was more a case of poor fixation and that as a consequence she '*did not get the chance to look at any area of the fundus*' using the ophthalmoscope.

23. The expert report of Mr Booth exhibited The Sight Testing (Examination and Prescription) (No2) Regulations 1989 ('the Regulations). Section 3(1)(a)(ii) of these statutory regulations state that:

'*…it shall be [the optometrists] duty–*

(a) to perform, for the purpose of detecting signs of injury, disease or abnormality in the eye or elsewhere–

(i) …

(ii) an intra-ocular examination, either by means of an ophthalmoscope or by such other means as the…optician considers appropriate, …'

24. Mr Booth and Professor Evans agreed that:

- A fundus camera provides a limited field of view of approximately 30 - 45 degrees from the centre of the back of the eye;
- The fundus camera images in this case did not capture the mid-periphery;
- It is not uncommon for children to become visually inattentive;
- An optometrist should not replace an internal eye examination with fundus photography except in exceptional circumstances.

25. Professor Evans stated that although it may be acceptable, in exceptional circumstances, to rely on fundus photographs this is subject to three caveats ('the caveats'):

(i) An optometrist who relies on imaging should take reasonable steps to ensure that the correct images are being viewed. The steps that are reasonable depend on the system used, the clinician's information technology skills, their familiarity with the system, and their confidence in any supporting staff on whom they rely.

(ii) The reliance on retinal photographs should be recorded on the patient's records.

(iii) An early recall should be arranged.

26. Witness A, the technology innovations manager at REDACTED, gave evidence in relation to the IT system used by REDACTED Opticians. He produced a log of calls that were made to the helpdesk on 15 February 2012. Incidents were logged at 10.55am and 10.56am indicating that there was a problem with the EPOS (Electronic Point of Sale) system. At 11.03am the following was recorded, '*going into a patient record, entered the ref and got the error come straight up believed they had a power cut and have multiple record locks and error screens*.' At 11.05am the following was recorded, '*branch had power surge this morning and now getting error screen when looking at patient details*.' These calls were resolved at 11.05am and 11.06am respectively. Witness A informed the Committee that the EPOS system is separate from the retinal camera system and there is no link between the two. Witness A also stated that no other systems were affected and if a power cut had taken place there would have been many other issues reported. Witness C, the practice manager at the time, stated during her oral evidence that she could not recall the Registrant asking for help. Witness I, the Professional Services Officer for REDACTED Opticians, said in his original witness statement, dated 11 August 2015, which was read to the Committee that '*the retinal camera and associated equipment was fully operational at the time of the examination on 15-Feb-2012*'. He was asked to comment on the suggestion that the computer and/or screen in the consulting room was not working properly i.e. that the images from the fundus camera were not accessible from the consulting room. He said in his later witness statement, dated 24 April 2020, which was also read to the Committee '*I am unable to comment on this what I can say that in the event of images not being available on the consulting room computer, these would still have been available for review on the computer equipment associated with the retinal camera in the pre-examination area of the practice*.'

27. The Registrant stated that on 15 February 2012, the computer in her testing room was working, but she said she was unable to access the retinal images from it. She therefore viewed the retinal images in the pre-screening area instead. The Committee accepted the Registrant's evidence that she viewed the retinal images of Patient A and B in the pre-screening area prior to inviting the family into the testing room because, for whatever reason, she was unable to access the images on the computer screen in her testing room. Evidence from the optical consultants on duty that day, other than Witness J, was not adduced to challenge this aspect of her account. In accepting the Registrant's evidence

the Committee took into account that it was consistent with the evidence of Witness X who had no recollection of the Registrant leaving the testing room at any time or of her bringing up the images on the screen in the testing room.

28. The Committee noted that Witness C provided witness statements to the police on 22 November 2012, 20 December 2012 and 23 August 2015. Based on the content of Witness C's witness statements it would appear that she was not asked by the police whether the Registrant asked for help and it is unsurprising, due to the passage of time, that she had no recollection of this when asked during her oral evidence in these proceedings. The Committee noted that the Registrant had worked in the REDACTED branch on two Sundays in January 2012. On both occasions, she saw patients in the ground floor testing room which did not have a computer and viewed retinal images in the pre-screening area on the first floor. The Committee took the view that it was likely, based on the Registrant's experience the month before, that she was content to rely on the optical consultant to bring up the images on the computer in the pre-screening area.

29. The Committee was satisfied that the Registrant commenced an internal examination of Patient A's eye. This is supported by the evidence of Witness X and the contemporaneous records. However, it found that ophthalmoscopy was discontinued prior to completion. The Committee noted that there was no dispute that the Registrant had a duty to perform an internal eye examination using an ophthalmoscope '*or by such other means as the…optician considers appropriate'*. Both experts agreed that an alternative means may have been a Volk lens and Slit Lamp. However, according to the Registrant this option was not available to her because she did not have access to a Volk Lens. The Committee accepted the evidence of the expert witnesses that only in exceptional circumstances would it be appropriate for an optometrist to use a fundus photograph in place of direct ophthalmoscopy.

30. The Registrant's case appeared to be that Patient A's poor fixation amounted to exceptional circumstances. The Committee did not accept this. The Committee considered that it was not uncommon for primary school-age children to present particular challenges due to a combination of being easily distracted, the invasion of personal space, and the use of a uncomfortably bright light which can lead them to become visually inattentive. However, the Committee also considered that it would be unusual for an optometrist not

to be able to obtain a satisfactory view by gently persuading the child or by enlisting the assistance of a parent. By the Registrant's own admission, this was the first time that she had discontinued an internal examination. As this was a unique and exceptional event the Registrant should have made a note of it in Patient A's record card. The Registrant conceded that she did not say anything to Witness X. She said this was because in the past when she had had conversations with a parent about a child, the parents had been displeased and '*as a locum you have to please everyone'*. The Committee acknowledged that speaking to a parent about their child's visual attentiveness would require a degree of tact and diplomacy, but it was not satisfied that previous bad experiences justified abandoning an internal eye examination, without speaking to the parent first.

31. Whilst the Committee fully accepted the evidence of Witness X that Patient A was well-behaved throughout his examination, he may nonetheless have demonstrated a degree of poor fixation. It is unlikely that the Registrant, having started the internal eye examination, would have discontinued it for no reason. In reaching this conclusion the Committee did not accept the submission made on behalf of the GOC that the examination of Patient A was rushed as there was no evidence to support this. It did not consider the lack of a signature on Patient A's record card to be significant. The Committee accepted the Registrant's evidence that this is likely to be simply because she forgot.

32. The Committee noted that the eyes of young children are usually healthy. The Registrant had access to Patient A's previous records and had viewed the retinal image of a healthy eye in the pre-screening area. These factors may have given her false confidence that there was no cause for concern and as a consequence, although she commenced the internal eye examination, the Committee considered that she gave up prematurely. The Committee concluded that any efforts the Registrant made to address the poor fixation issue were not sufficient. For example, they did not include enlisting the assistance of Witness X.

33. The Committee found that a degree of poor fixation would not amount to exceptional circumstances justifying discontinuation of ophthalmoscopy and reliance instead on retinal photographs. However, even if exceptional circumstances had existed, the Committee accepted the evidence of Professor Evans that discontinuing an internal eye examination would only be acceptable if the caveats were met.

34. The first caveat is that the optometrist should take reasonable steps to ensure that they are viewing the correct patient image. The Registrant accepted that she must have viewed the retinal image of another patient because, otherwise, she would have detected the bilateral papilloedema. She recognised the papilloedema when she was shown the retinal images in her police interview and agreed that if she had seen the image of Patient A's eyes, she would have made an urgent referral to an ophthalmic hospital. Both experts agreed that the papilloedema would have been obvious to any reasonably competent optometrist. However, the Registrant recorded a cup-to-disc ratio of 0.5, which meant that the central disc took up approximately 50% of the rim area. Both experts agreed 0.5 was unusual for a child and that Patient A had no discernible cup-to-disc ratio in the 2012 retinal image. It was clear from the evidence of both experts that the Registrant was competent at assessing the cup-to-disc ratio from ophthalmoscopy based on the other records that she completed that same day. In these circumstances, the Registrant was either shown the wrong image for Patient A or she saw no image at all and made up her observations of the internal eye.

35. The Committee was provided with a considerable amount of evidence with regard to how the retinal image software could be used. The evidence demonstrated that there are a myriad number of ways in which a fundus image could be uploaded to the wrong patient record. The Committee noted that there was no evidence that this had happened in the case of Patient A. Alternatively, the fundus image could be correctly allocated to the patient record, but the optometrist could inadvertently be looking at the wrong image if more than one tab is visible on the screen. The Committee noted that the patient name is always visible when the fundus image is displayed. It also heard evidence that one method of bringing up an image was to click on 'images that had been taken today'. The operator would look down the list and then select the patient. The Committee noted that the other optometrist on duty that day had a patient (Patient 61385) at 10.00am, in respect of whom a retinal photograph was also taken. That patient had a cup-to-disc ratio of 0.5 as agreed by both experts. The Committee concluded that it is unlikely that the Registrant would make up the cup-to-disc ratio of 0.5, particularly as the Committee did not accept the submission that the examination of Patient A was rushed and 0.5 was unusual for a child. It therefore found it implausible that she invented the observations of the internal eye and

concluded that it was more likely that Patient 61385's image was viewed by the Registrant in error.

36. The Committee found that the Registrant did not take reasonable steps to ensure that she was viewing the correct image because she did not take the basic step of checking the name of the patient that was brought up on screen. She accepted that she did not check the names on any of the retinal images she viewed on 14 and 15 February 2012. The Committee found that it was the Registrant's duty to ensure that she was viewing the correct image and that she failed in that duty.

37. In respect of second caveat the Registrant failed to make a note in Patient A's records that she was relying on fundus photography having taken the highly unusual decision to discontinue the internal eye examination. In respect of the third caveat she did not advise an early recall.

38. Therefore, Particular 1(a) was found proved.

Particular 1(g) **– Found Proved**

'failed adequately to assess the cup-to-disc ratio in each eye [Patient A]*;'*

Particular 1(h) – **Found Proved**

'failed properly to assess the optic nerve head [Patient A];*'*

Particular 1(i) – **Found Proved**

'failed to detect the signs and/or presence of bilateral papilloedema [Patient A];*'*

39. The Registrant had a duty, in accordance with section 3(1)(a)(ii) of the Regulations, to assess the cup-to-disc ratio, assess the optic nerve and detect signs of disease or abnormality as part of her internal examination of Patient A's eyes.

40. As set out above, in relation to Particular 1(a), the internal eye examination for Patient A was not completed and the Registrant's decision to discontinue the examination was not appropriate. As a direct consequence of failing to carry out an adequate internal eye examination, the Registrant also failed to assess the cup-to-disc ratio in each eye, failed

to assess the optic nerve head and failed to detect the signs and presence of bilateral papilloedema. Furthermore, the Registrant did not place herself in a position where she could properly assess the cup-to-disc ratio and optic nerve by another means because she did not take sufficient steps to ensure that she was viewing the correct retinal images. The same applies to the failure to detect papilloedema.

41. Therefore, Particulars 1(g), 1(h) and 1(i) were found proved.

Particular 2(a) **– Found Proved**

'purported to record an internal examination of both eyes when you had not performed such an examination;'

42. The Registrant stated in her witness statement that *'[w]hilst [she] was unable to perform an internal examination of Patient A's eyes using ophthalmoscopy, [she] was able to assess the optic discs, vessels and macula using the fundus photographs*.' The Committee accepted the evidence of Professor Evans that it is reasonable for an optometrist, in exceptional circumstances, to use fundus photographs to view and describe internal structures. However, the Committee concluded that as a prerequisite, the optometrist must take reasonable steps to ensure that they are viewing the image which relates to the correct patient. The Registrant failed to take any steps to verify that the image she was shown was taken from Patient A and therefore she did not complete an internal examination of his eyes. A partial internal examination discontinued prematurely without a good and sufficient reason does not constitute an internal examination.

43. The Committee noted that there is no section or box on the record card to indicate the method used to perform the internal examination. However, as partial reliance on a retinal image is the exception rather than the norm, the Committee was satisfied that the Registrant should have made an appropriate note on the patient's record card. The note should have made it clear that ophthalmoscopy had been discontinued, and that she had relied on the fundus photograph. This was particularly important because the Registrant was a locum and it was unlikely that she would undertake the next eye examination for this patient. It is essential that a subsequent optometrist is able to understand from the

notes what parts of the examination had or had not been undertaken on the previous occasion.

44. Therefore, Particular 2(a) was found proved.

Particular 2(c) **– Found Proved**

'purported to record the cup-to-disc ratio of each eye as 0.5 when in fact it was significantly less than that.'

45. The Registrant stated in her witness statement and confirmed during her oral evidence that the '*fundus photographs shown to [her] in the pre-screening area were those of healthy eyes, with a cup-to-disc ratio of 0.5 in each eye.'* She made a record of this.

46. The Committee accepted this. However, it was the Registrant's responsibility to ensure that she was viewing the correct image. The Committee did not accept that the Registrant had taken reasonable steps to ensure that she did so and as a result she assessed and recorded the cup-to-disc ratio of the wrong patient's eyes. The correct image clearly showed that there was significant swelling of the optic nerve in Patient A's eyes and as a consequence there was no discernible cup-to-disc ratio.

47. In these circumstances, the Committee concluded that the evidence adduced in relation to variability between practitioners in assessing cup-to-disc ratios which included the Harper et al study, did not assist the Committee in its determination of this factual particular.

48. Therefore, Particular 2(c) was found proved.

Particular 1(b) – **Found Not Proved** (measurements); **Found Proved** (recording)

'failed properly to measure and/or properly record unaided vision, separately of each eye [Patient A];

Particular 4(c) – **Found Not Proved** (measurements); **Found Proved** (recording)

failed properly to measure and/or properly record unaided vision for each eye separately [Patient B]

49. The Registrant recorded the unaided vision of Patients A and B on the patient record cards under the heading 'Objective'. Mr Booth informed the Committee that this is shorthand for objective refraction which is a measurement of the refractive error of the eyes. He stated that it is usually measured with an autorefractor or a retinoscope. The Committee noted that the Registrant had recorded Patient A's unaided vision by writing 6/5 between the boxes for the left eye and the right eye. On Patient B's record card she had recorded 6/6 between the boxes for the left eye and the right eye. Mr Booth, in his expert report, stated, '*This would indicate to any reasonably competent optometrist that this was the measurement of both eyes together*.' He maintained this opinion during his oral evidence in chief and during cross examination by Mr Stern. He informed the Committee that if the patient's vision was measured monocularly (separately for each eye) the objective vision should be recorded separately for each eye. The Committee noted that for Patient A the Registrant had separately recorded +0.50 under 'Sph' for both the left eye and the right eye. For Patient B she had separately recorded +0.25 for both eyes.

50. The Registrant stated in her witness statement and during her oral evidence that she assessed Patient A and Patient B's unaided vision monocularly. The Registrant explained that recording the measurements between the left and right boxes is a form of shorthand to indicate that she had measured both and that the results were the same. She stated that she had '*adopted*' this shorthand method of recording from other optometrists.

51. Professor Evans stated that the sample record cards for Patients 103998, 100380, 113040 and 110113 supported the Registrant's evidence that she routinely measured monocularly, even though in the sample records she recorded the measurements in different ways.

52. The Committee accepted this aspect of the Registrant's evidence and accepted the evidence of Professor Evans that the sample records indicate that it was her normal practice to test monocularly.

53. Therefore, the Committee found Particulars 1(b) and 4(c) <u>not proved</u> in relation to the measurements of the unaided vision.

54. The Committee noted that both experts were critical of the Registrant's method of recording the unaided vision of Patient A and Patient B. The Committee accepted their evidence that the record is ambiguous. Although another optometrist may be able to understand the Registrant's notes, without referring to her other records to decipher her shorthand, the key issue is whether a responsible body of competent optometrists would make a note to a similar standard. The Committee concluded that in making an ambiguous note the Registrant failed to act in accordance with a responsible body of competent optometrists.

55. Therefore, the Committee found Particular 1(b) and 4(c) proved in relation to the recording of the unaided vision.

Particular 1(c) - **Found Not Proved** (measurements); **Found Proved** (recording)

'failed properly to measure and/or properly record best corrected visual acuities of each eye individually [Patient A];*'*

Particular 4(f) – **Found Not Proved** (measurements); **Found Proved** (recording)

'failed properly to measure and/or properly record best corrected visual acuity for each eye separately' [Patient B];

56. The Registrant recorded the best corrected visual acuities of Patients A and B on the patient record cards under the heading 'Subjective'. Mr Booth informed the Committee that the heading 'Subjective' is shorthand for subjective refraction. He stated that this is a measurement of the refractive error of the eyes based on the patient's responses. Mr Booth told the Committee that near visual acuity should have been recorded in the box labelled 'NVA' and not in the 'Near Prism' box. Under the heading 'Final' the Registrant had entered the sign for infinity in relation to both the left eye and the right eye, which indicates zero power. The Registrant recorded the best corrected visual acuity for distance as 6/5 and for near 'N5' between the boxes for left and right. For Patient B the corrected visual acuity was recorded as 6/6 in the same manner. Mr Booth stated, in his expert report, that these entries '…*would indicate to any reasonably competent optometrist that these were the measurements of both eyes together. It would not identify if there was reduced vision in one eye*.' He confirmed this opinion during his oral evidence in chief and during cross examination by Mr Stern.

57. The Registrant stated in her witness statement and during her oral evidence that the refractive error was 'plano' meaning zero in each eye and that the best corrected visual acuities would have been the same as the unaided vision i.e. 6/5 for Patient A and 6/6 for Patient A in each eye.

58. Professor Evans stated in his expert report that when there is no refractive error, '*the best corrected visual acuities are expected to be the same as the unaided vision*.' Therefore, his opinion in relation to the measurement of the corrected visual acuities was the same as his opinion in relation to unaided vision.

59. The Committee accepted this aspect of the Registrant's evidence. The Committee also accepted the evidence of Professor Evans that the sample records indicate that it was the Registrant's normal practice to test monocularly.

60. Therefore, the Committee found Particulars 1(c) and 4(f) <u>not proved</u> in relation to the measurement of the corrected visual acuities.

61. The Committee noted that both experts were critical of the Registrant's method of recording the corrected visual acuities of Patient A and Patient B. The Committee accepted their evidence that the record is ambiguous. Although another optometrist may be able to understand the Registrant's notes, without referring to her other records to decipher her shorthand, the key issue is whether a responsible body of competent optometrists would make a note to a similar standard. The Committee concluded that in making an ambiguous note and in recording her findings in the wrong box the Registrant failed to act in accordance with a responsible body of competent optometrists.

62. Therefore, the Committee found Particulars 1(c) and 4(f) <u>proved</u> in relation to the recording of the corrected visual acuities.

<u>Particular 1(d) – **Found Not Proved** (measurements); **Found Proved** (recording)</u>

'*failed properly to measure and/or properly record the oculomotor balance* [Patient A];*'*

<u>Particular 4(a) – **Found Not Proved** (measurements); **Found Proved** (recording)</u>

'failed properly to measure and/or properly record the oculomotor balance; [Patient B]'

63. The Registrant recorded oculomotor balance for Patients A and B under the heading 'Presenting OMB'. There are 4 boxes beneath the heading. Mr Booth informed the Committee that the top left hand box is for recording the distance oculomotor balance with prescription and the top right hand box is for recording the distance oculomotor balance, without prescription. Below these are the corresponding boxes for measuring the near oculomotor balance. The Registrant recorded a circle bisected by a vertical and horizontal line in the middle where the corners of the 4 boxes meet. Mr Booth informed the Committee that this indicates '*no movement*.' He stated, in his expert report, that the Registrant '…*did not distinguish whether it applied to distance vision or near vision, or with or without prescription*.' During his oral evidence, Mr Booth conceded that there would be no need for the Registrant to measure with correction, as Patients A and B did not have a prescription. However, he maintained that the Registrant was required to distinguish between distance and near measurements.

64. The Registrant stated in her witness statement and during her oral evidence that the symbol drawn at the intersection of all 4 boxes indicates a normal ocular motor balance test result for distance and near in relation to both the right and left eye. She stated that she had '*adopted*' this method of recording from other optometrists.

65. Professor Evans stated in his expert report that the position of the Registrant's symbol indicates a normal ocular balance and that this applies to distance and near vision and to with and without refractive correction. He stated that *'[t]his is concordant with the fact that there were no spectacles and there was no refractive error, so the result would be the same with and without refractive correction*.' Professor Evans expressed the opinion that '*there is a large body of reasonably competent optometrists who would make this interpretation*.' Although Professor Evans was not critical of the Registrant's recording of the ocular motor balance, during his oral evidence he stated that he would advise students to record distance and near vision separately and acknowledged that '*there would be experts who would be critical'*.

66. The Committee accepted the Registrant's evidence that she measured Patient A and B's distance and near vision.

67. Therefore, the Committee found Particulars 1(d) and 4(a) not proved in relation to the measurement of the ocular motor balance.

68. The Committee acknowledged that another optometrist may be able to understand the Registrant's notes, without referring to her other records to decipher her shorthand, but the key issue is whether a responsible body of competent optometrists would make a note to a similar standard. The Committee concluded that in making an ambiguous note the Registrant failed to act in accordance with a responsible body of competent optometrists.

69. Therefore, the Committee found Particulars 1(d) and 4(a) proved in relation to the recording of the ocular motor balance.

Particular 1(e) – **Found Not Proved**

'*failed to properly record pupil reactions'*

Particular 4(b) – **Found Not Proved**

'failed to properly record pupil reactions'

70. The Registrant made markings in the boxes on the patient record cards which record pupil reactions. Mr Booth told the Committee that 'R' is an abbreviation for right; 'L' is an abbreviation for left; 'D' is an abbreviation for direct; 'C' is an abbreviation for consensual; 'N' is an abbreviation for near and 'RAPD' is an abbreviation for relative afferent pupil defect. The Registrant made 3 diagonal markings through the dividing line between the right and left under 'D', 'C' and 'N'. Mr Booth stated that '…*this would indicate to any reasonably competent optometrist that the pupil reactions were not checked*.' This was based on his interpretation that the markings were dashes and not ticks. Beneath the 'RAPD' heading, the Registrant had circled 'N', indicating there was no relative afferent pupil defect on examination. In Mr Booth's opinion, if the pupil reactions were in fact checked and the markings indicate that the pupil reactions were normal, the Registrant's record keeping fell below the standard required as there were only 3 markings; not 6 (3 each for left and right).

71. The Registrant stated in her witness statement that the '*3 oblique marks*' indicate that she had tested the pupil reactions of the right eye and the left eye separately. She stated that she had '*adopted*' this shorthand method of recording from other optometrists. During her oral evidence she stated that if she had not completed the tests, she would have left that part of the record card blank.

72. Professor Evans was not critical of this aspect of the Registrant's record keeping. He interpreted the 3 markings as '*incomplete ticks'*.

73. The Committee concluded that by themselves the marks are ambiguous. They could be interpreted as *'incomplete ticks'* indicating that the Registrant tested the pupil reactions separately. Alternatively, they could be interpreted as the equivalent of 'not applicable'. However, as stated above, the circled 'N' beneath the RAPD heading indicates that the Registrant found no pupil relative pupil afferent defect. When read in conjunction with the markings, the Committee concluded that the ambiguity is removed.

74. Therefore, Particulars 1(e) and 4(b) were found not proved.

Particular 1(f) – **Found Not Proved**

'failed to differentiate between the right and left eye in recording the clinical picture [Patient A];

Particular 4(g) – **Found Not Proved**

'failed to differentiate between the right and left eye in recording the clinical picture [Patient B];

75. The Committee concluded during its consideration of the Rule 46(8) application (see Annex A, para 33) that the 'clinical picture' in this particular is limited to the external examination.

76. There is a box in the patient records of Patients A and B headed 'External Examination'. The Registrant had bracketed the sub-headings together (Lids/Lashes, Conjunctiva, Cornea, Anterior Chamber and Tears) and had recorded '*clear and ok'*. Mr Booth stated in his expert report that '…*the failure to assess and record these elements individually and differentiate between the right and left eyes is below the standard expected from a*

reasonably competent optometrist.' He stated, in oral evidence, that he would conclude that all five elements were examined but he could not tell if it was just the right eye, or the left eye, or both.

77. The Registrant stated in her witness statement that rather than write two sets of identical notes, she developed a form of shorthand to indicate that the same results applied to both eyes. She stated that she adopted this form of shorthand from other optometrists.

78. Professor Evans was not critical of the Registrant's recording of the clinical picture. He stated in his expert report that during an examination the findings are '*very often the same or very similar for each eye*' and therefore '*optometrists typically develop a shorthand to avoid writing identical records twice*.' He also stated that the two most common approaches are (i) to write the results for the right eye and then for the left eye write '*As R*' or (ii) to write findings that apply to each eye in the centre of the record.

79. The Committee noted that the record card headed 'External Examination' contains two diagrams at each end of a rectangular box with 'R' for right and 'L' for left in the top corners. Between the diagrams is a large gap. In this space the Registrant had drawn a bracket and to the left of the bracket had written '*clear and ok'*. Professor Evans stated in his expert report that, where the records have a large gap in the centre of the relevant section, writing clinical results in the centre is the most appropriate method.

80. The Committee accepted this aspect of the Registrant's evidence. The Committee also accepted the evidence of Professor Evans in relation to the appropriateness of the Registrant's recording of her clinical findings in the centre of the relevant part of the record. The Committee acknowledged that the Registrant had a duty to differentiate the left and right eye in recording the external clinical picture where different findings apply in respect of each eye. The Committee was satisfied that the Registrant's recording is not ambiguous. A natural reading of the entries she made is that the brackets relate to the 5 external structures and '*clear and ok*' is a reference to both the right and left eye. As the findings were the same for both eyes, the Committee concluded that in this scenario, it amounted to a good and sufficient reason for not differentiating between the right and left eye.

81. Therefore Particulars 1(f) and 4 (g) were found not proved.

Particular 3 (in relation to Particular 2(a):

3(a) *'inaccurate'* - **Found Proved;**

3(b) *'misleading'* - **Found Proved;**

3(c) *'dishonest'* - **Found Not Proved**

'purported to record an internal examination of both eyes when you had not performed such an examination [Patient A]*;'*

82. There is no indication in the Registrant's notes that she discontinued Patient A's internal eye examination and relied on the fundus photograph.

83. In the absence of an appropriate note, it would be reasonable for a future optometrist to assume, based on the entries made on the record card, that the Registrant had undertaken direct ophthalmoscopy to examine the internal structures of Patient A's eyes using an ophthalmoscope or indirect ophthalmoscopy using, for example, a Slit Lamp and Volk Lens. As reliance on a fundus photograph is unusual and only appropriate in exceptional circumstances, a future optometrist would have no way of knowing that the Registrant had discontinued the internal eye examination and relied on retinal images.

84. In these circumstances, the Committee concluded that the Registrant's record card is inaccurate as significant information, which should have been recorded, has been omitted. It is also misleading because the note had the potential to lead a future optometrist to believe that an internal eye examination of Patient A had been completed, when it had not.

85. The Registrant's note indicates that she performed an internal examination of Patient A's eyes. The Committee has already determined that a partial internal examination discontinued prematurely without a good and sufficient reason, does not constitute an internal examination. However, the Committee accepted that at the time the entry was made it is likely that the Registrant believed that she had performed an internal eye examination because, although she had discontinued ophthalmoscopy, she had viewed a fundus image. Although the Registrant viewed the wrong image, she did not know this at the time she made the entries on Patient A's record card, and for that reason she was not acting dishonestly.

86. Therefore, Particular 2(a) in relation to being inaccurate and misleading was found proved.

87. In relation to dishonesty Particular 2(a) was found not proved.

Particular 3 (in relation to Particular 2(b)

Particular 3(c) *'dishonest'* – **Found Proved**

'noted that the periphery of both eyes was 'normal' when you had not examined the internal aspects of the eyes sufficiently to make such a note [Patient A]*;'*

88. The Registrant made a note on Patient A's record card that the periphery was '*normal*'. There was no dispute that this was a reference to both eyes. The Registrant admitted at the outset of these proceedings that her entry was inaccurate and misleading as she had not seen the periphery. However, she denied that this was dishonest. She informed the Committee that she assumed the periphery was normal because of the lack of symptoms, the absence of any concerns based on Patient A's previous records and the rest of the test was normal. She stated that she was not deliberately trying to mislead anyone.

89. During cross examination the Registrant admitted that by recording 'normal' against periphery she was giving the impression that she had examined it, and that had the potential to mislead future optometrists. She also accepted that she made the entry knowing that it was untrue. The relevant parts of the exchange with Mr Kark were as follows:

'Q But you must have realised misleading as you wrote it, because you knew

you had not examined it

A Yes

….

Q I appreciate that, but that's what's understood from this note, that you did

as much as you can from ophthalmoscopy and the periphery you examined

was normal. That's what this note means.

A Yes

Q And that's simply untrue isn't it
A Yes
Q And when you wrote it you knew it was untrue didn't you?

A Yeah'

90. The Committee took the entirety of the Registrant's evidence on this issue into account in determining her state of her knowledge at the time including her attempt during re-examination to resile from her admission that she knew the note was untrue when she wrote it. The Committee did not accept her explanation for recording the periphery as 'normal'. Her assumption that the periphery was most likely to be normal based on her clinical judgment does not explain why she made a note to the effect that the periphery had been *examined* and was normal when that was not the case. The Committee concluded that the Registrant knew then that: (i) she had not seen Patient A's periphery using an ophthalmoscope or any other means; (ii) recording '*normal*' gave the impression that she had seen the periphery when she had not; and (iii) she knew that it was misleading at the time that she made the entry. In these circumstances, the Committee concluded that the note in relation to the periphery was dishonest by the ordinary standards of reasonable and honest people.

91. Accordingly, the Committee concluded that the Registrant's actions were intentionally misleading and as a consequence were dishonest.

92. Therefore, Particular 2(b) in relation to dishonesty was found proved.

Particular 3 (in relation to Particular 2(c):

3(a) *'inaccurate'* - **Found Proved;**

3(b) *'misleading'* - **Found Proved;**

3(c) *'dishonest'* – **Found Not Proved**

'purported to record the cup-to-disc ratio of each eye as 0.5 when in fact it was significantly less than that [Patient A];*'*

93. The Registrant recorded the cup-to-disc ratio of Patient A's eye as 0.5. This is inaccurate because Patient A had no discernible cup-to-disc ratio due to the swelling of his optic nerve. As the Committee has already determined, it is likely that the Registrant viewed the retinal image of Patient 61385, which showed a healthy eye with a cup-to-disc ratio of 0.5. The Registrant's recording of the cup-to-disc ratio is also misleading because it would lead a future optometrist to believe that Patient A had a cup-to-disc ratio of 0.5, when in fact his cup-to-disc ratio was not discernible.

94. Although the Registrant viewed the wrong image, she did not know this at the time she recorded the cup-to-disc ratio on Patient A's record card, and for that reason she was not acting dishonestly.

95. Therefore, Particular 2(c) in relation to being inaccurate and misleading was found proved. In relation to dishonesty Particular 2(c) was found not proved.

Findings in relation to misconduct

Submissions

96. Mr Kark, on behalf of the GOC, submitted that the Registrant's acts and omissions, as found proved, should be considered cumulatively. He further submitted that each factual allegation found proved, whether said by the expert witnesses to fall below or far below the relevant standard, cumulatively supported a finding of serious misconduct. Mr Kark reminded the Committee of The College of Optometrists Guidelines and referred the Committee to the '*Code of Conduct for Individual Registrants'* ('Code of Conduct') issued by the GOC in 2010. He submitted that the Registrant had breached a number of the standards expected of registered practitioners. He invited the Committee to conclude that the Registrant's failure to carry out an adequate internal eye examination and her substandard, inadequate and dishonest record keeping are sufficiently serious to cumulatively amount to misconduct.

97. Mr Stern, on behalf of the Registrant, invited the Committee to determine as a preliminary issue whether the facts found proved are individually capable of amounting to misconduct. He queried whether factual findings which fell below the expected standards, but not far below, are capable of amounting to misconduct, either individually or collectively. He reminded the Committee that the GOC's case as put in opening, cross-examination and closing was that in relation to Patients A and B, the Registrant did not view any retinal images and rushed the eye examinations. However, the Committee found the facts proved on a different basis which is consistent with the account that the Registrant gave when she was interviewed by the police. Mr Stern reminded the Committee of the evidence and submitted that on analysis the facts found proved do not, either individually or cumulatively, support a finding of misconduct.

Committee's Approach

98. The Committee took into account the submissions from both parties and the GOC guidance on misconduct as set out within the '*Hearing and Indicative Sanctions Guidance.*' The Committee heard and accepted the advice of the Legal Adviser.

99. The Committee was aware that determining the issue of misconduct is a matter for its independent judgement; there is no burden or standard of proof.

100. In considering the issue of misconduct, the Committee bore in mind the explanation of that term provided by the Privy Council in *Roylance v GMC (No.2) [2000] 1 AC 311* where it was stated that:

> *"Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a … practitioner in the particular circumstances. The misconduct is qualified in two respects. First, it is qualified by the word 'professional' which links the misconduct to the profession ... Secondly, the misconduct is qualified by the word 'serious'. It is not any professional misconduct which will qualify. The professional misconduct must be serious."*

101. The Committee was aware that departures from the GOC Code of Conduct alone do not necessarily constitute misconduct. The Committee also noted that dishonesty does not automatically result in a finding of misconduct as each case turns on its own facts and the conduct and behaviour must be assessed in context.

102. The Committee noted that the facts found proved relate to the acts and omissions of the Registrant during a period of less than two hours on 15 February 2012. Although the appointments with Witness X and Patients A and B were scheduled as three separate appointments, and the Registrant assessed each patient separately, this was within the context that they attended as a family unit. Witness X was present throughout the routine eye examinations of her children. Patient A was present when Patient B was being examined and vice versa. Furthermore, when the Registrant attended the pre-screening room to view the retinal images of Patient A and Patient B, she viewed both images one after the other and subsequently noted them separately on the patient record cards. In these circumstances, the Committee concluded that overall, the Registrant's acts and omissions should be assessed as a course of conduct, made up of a number of elements which are inextricably linked. Therefore, the Committee did not accept Mr Stern's submission that it had to consider as a preliminary issue whether each fact found proved is, in itself, capable of amounting to misconduct.

103. The Committee took the view that, in essence, it was required to determine the nature and seriousness of the Registrant's failings. The Committee concluded that, based on its factual findings, the key features of the Registrant's course of conduct are as follows:

(i) she failed to carry out an adequate internal eye examination of Patient A; and
(ii) aspects of her record keeping were substandard, inadequate and dishonest.

104. In considering these features, the Committee asked itself, whether the facts found proved, either individually or collectively, are sufficiently serious to amount to misconduct.

Decision on Misconduct

105. The Registrant failed to carry out an adequate internal eye examination. The Committee concluded that this failure encompassed a chain of events including premature curtailment

of the examination and viewing the wrong retinal image. The failures to assess properly the optic nerve head, to assess and accurately record the cup to disc ratio and to detect the presence of bilateral papilloedema were inevitable consequences of the Registrant's fundamental failure to perform her basic statutory duty.

106. The Committee took the view that the inadequate internal eye examination is the most serious and significant aspect of the Registrant's failings. A statutory eye test requires an intra-ocular examination either by means of an ophthalmoscope '*or by such other means as the…optician considers appropriate'.* The Committee found that the Registrant commenced an internal examination of Patient A's eyes but discontinued it prematurely without sufficient justification. There are a number of measures the Registrant could have taken, including but not limited to enlisting the assistance and cooperation of Witness X, before taking the unusual step of discontinuing the internal eye examination. The likelihood of identifying clinical pathology in a primary school-age child may have been low, but this was a significant failing because it exposed Patient A to an unwarranted risk of harm. Had the Registrant complied with her duty she would have detected the bilateral papilloedema and urgently referred Patient A for treatment. The Committee acknowledged that the Registrant may have been falsely reassured by the retinal image of the healthy eye that she was shown in the pre-screening area. However, the Registrant viewed the wrong retinal image. The Committee noted that obtaining retinal photographs is not a mandatory requirement and that the Registrant did not know, at the time that she viewed the retinal images, that she would not complete ophthalmoscopy for Patient A. Nonetheless, having viewed the images, the Registrant should have taken reasonable steps to satisfy herself that she was viewing the correct retinal image, but failed to do so.

107. Furthermore, the Registrant, having curtailed the internal eye examination and having read Patient A's previous records, did not go back to review the retinal images. The Registrant had, at this time, an unusual clinical picture. She had discontinued the internal eye examination which was a unique event for her. The historical records indicated that on previous occasions Patient A's cup to disc ratio was 0.2 and then 0.3, and she had seen a retinal image with a cup to disc ratio of 0.5. Although clinical pathology may have been unlikely, the Registrant should not have made any assumptions. Based on the information the Registrant had at the time she should have made further efforts to complete the internal eye examination particularly as she did not review the retinal image for a second time.

108. As a consequence of the above, the Committee concluded that the Registrant breached the following Codes of Conduct:

- **1.** *Make the care of the patient your first and continuing concern;*

- **5.** *Give patients information in a way they can understand and make them aware of the options available…*

- **7.** *Respect the patients right to be involved in decisions about their care;*

109. The Committee concluded that the Registrant's failure to undertake an adequate internal eye examination and the inevitable consequential failures, as set out in paragraph 105 above, are so serious that they amount to misconduct.

110. The Committee took the view that the failure to carry out an adequate internal eye examination is inextricably linked to the record keeping failures in two interrelated respects. First, the Registrant, having discontinued Patient A's internal eye examination failed to make an appropriate record of that fact. Secondly, the inaccurate, misleading and dishonest record keeping demonstrates an attitudinal failing.

111. The College of Optometrists Guidelines emphasise the importance of accurate records. Not only did the Registrant fail to record that she had discontinued ophthalmoscopy, she also recorded that she had examined the periphery. This created the false impression that a complete internal eye examination had taken place when it had not. Although no direct harm was caused to Patient A as a consequence of the misleading record, there was a risk of harm because incomplete and inaccurate clinical records have the potential to adversely impact patient care. The Registrant as a registered optometrist had a professional obligation to safeguard and protect the well-being of Patient A which includes maintaining accurate records based on appropriate assessments and sound clinical reasoning but failed to do so.

112. As a consequence, the Committee concluded that the Registrant breached the following Code of Conduct:

- **6.** *Maintain adequate patients' records.*

113. The Committee concluded that the Registrant's failure to record that she had discontinued ophthalmoscopy was sufficiently serious to amount to misconduct.

114. The Registrant recorded that the periphery of both of Patient A's eyes were normal. The Committee found that this was inaccurate, misleading and dishonest as she had not seen the periphery. The Registrant's dishonest entry in relation to the periphery is serious. It had the potential to mislead future optometrists and other health professionals and undermine trust and confidence amongst her colleagues, the wider profession and the public who are entitled to expect that a registered optometrist will maintain high standards of honesty and integrity at all times. The Committee concluded that the dishonest record was sufficiently serious to amount to misconduct.

115. In addition, the Registrant made record keeping errors in relation to the unaided vision, best corrected visual acuity and oculomotor balance of Patient A and Patient B. The Committee took the view that, on their own, these record keeping failings would not amount to misconduct. However, the Committee concluded that the record keeping failures in the context of a failure to record that the eye examination of Patient A had been curtailed and a dishonest record with regard to the periphery demonstrates a casual attitude to record keeping. Although these failings relate to a limited period on a single occasion, they involve two patient records.

116. As a consequence, the Committee concluded that the Registrant breached the following Codes of Conduct:

- **6.** *Maintain adequate patients' records.*
- **10.** *Be honest and trustworthy;*
- **19.** *Ensure your conduct…does not damage public confidence in you or your profession.*

117. The Committee concluded that cumulatively the record keeping failures are sufficiently serious to amount to misconduct.

118. Overall, the Committee concluded that the Registrant's acts and omissions, as found proved, fell far below the standards expected of a registered optometrist and amount to misconduct.

Decision on Impairment

Impairment decision quashed on grounds of appeal, see Impairment decision dated 26 July 2022

Decision on Sanction

Sanction decision quashed on grounds of appeal, see sanction decision dated 26 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.