

**BEFORE THE FITNESS TO PRACTISE COMMITTEE  
OF THE GENERAL OPTICAL COUNCIL**

**GENERAL OPTICAL COUNCIL**

**F(22)23**

**AND**

**HELEN LAMPKA (01-10388)**

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**DETERMINATION OF A SUBSTANTIVE HEARING  
13 MARCH 2023 – 20 MARCH 2023**

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| <b>Committee Members:</b>              | Ms Julia Wortley (Chair/Lay)<br>Mr Kevin Connolly (Lay)<br>Mr Ben Summerskill (Lay)<br>Ms Caroline Clark (Optometrist)<br>Ms Philippa Shaw (Optometrist)   |
| <b>Clinical adviser:</b>               | N/A  |
| <b>Legal adviser:</b>                  | Ms Helen Gower   |
| <b>GOC Presenting Officer:</b>         | Ms Wafa Shah   |
| <b>Registrant present/represented:</b> | No and not represented   |
| <b>Registrant representative:</b>      | N/A  |
| <b>Hearings Officer:</b>               | Mr Lee Wood  |
| <b>Facts found proved:</b>             | 1(a) [partly proved], 1(b), 1(c), 2(a), 2(b), 2(c), 3(a), 3(b), 4(a), 4(b) [partly proved] 4(c), 5(a), 5(b), 5(c), 6(a) [partly proved], 6(b), 7(a), 7(b), 7(d), 9(a), 9(c) [partly proved], 10(a), 10(b) [partly proved], 11(a), 11(b), 11(d), 12(a), 12(b) [partly proved], 12(c), 12(e), 13(a), 13(b), 13(c), 13(e), 16(a), 18(a), 18(d), 18(e), 19(a), 19(b), 20(a), |

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|--------------------------------|--|
|                                | 20(b), 20(c), 21(b) [partly proved], 21(c), 22(a), 23(a), 23(b), 24(a) [partly proved], 24(b) [partly proved], 25(b) [partly proved], 25(c), 26(a), 26(b), 27          |
| <b>Facts not found proved:</b> | 1(d), 2(d), 2(e), 3(c), 4(d), 6(c), 7(c), 8, 9(b), 11(c), 13(d), 14, 15(a)-(e), 16(b), 16(c), 17(a),(b), 18(b), 18(c), 19(c), 19(d), 20(d), 21(a), 21(d), 22(b), 25(a) |
| <b>Misconduct:</b>             | Found  |
| <b>Impairment:</b>             | Impaired   |
| <b>Sanction:</b>               | Suspension from the register for a period of twelve months – (With Review)   |
| <b>Immediate order:</b>        | Yes  |

**Proof of service**

1. The Committee heard an application from Ms Shah for the Council for the matter to proceed in the Registrant’s absence. First, the Council was required to satisfy the Committee that the documents had been served in accordance with Section 23A of the Act and Rule 61 of the Fitness to Practise Rules 2013. The Committee accepted the advice of the Legal Adviser.
2. The Committee was satisfied that all reasonable efforts have been made to notify the Registrant of the hearing. Notice of the hearing dated 31 January 2023 was sent to the Registrant’s registered address and to her e-mail address.

**Proceeding in the absence of the Registrant**

3. The Committee then went on to consider whether it would be in the public interest to proceed in the Registrant’s absence in accordance with Rule 22. The Committee accepted the advice of the Legal Adviser and was mindful of the guidance in *Adeogba v GMC* [2016] EWCA 162.
4. The Committee noted that the Registrant had not responded to any correspondence from the GOC relating to the hearing. This included an invitation to take part in a case management meeting. An unsuccessful attempt was also made to contact the Registrant by telephone on 3 February 2023.
5. The Committee inferred from the absence of any response to communication from the Council that the Registrant has voluntarily waived her right to attend the hearing. The Registrant has not requested an adjournment of the hearing and the Committee was of the view that an adjournment would serve no purpose. The

Committee acknowledged that the Registrant might be disadvantaged by not attending the hearing, but decided that her interests were outweighed by the public interest. There is a public interest in the expeditious disposal of the allegations which have been outstanding for almost five years.

6. In the circumstances, the Committee decided that it was fair and appropriate for the hearing to proceed in the Registrant's absence.

### **ALLEGATION**

The Council alleges that you, Helen Lampka (01-10388), a registered Optometrist:

1. In respect of Patient A on or around 22 May 2018, did not assess and/or accurately record the details of:
  - a) Corrected distance visual acuity achieved with the new spectacle prescription for distance;
  - b) The reason for visit and/or symptoms;
  - c) An adequate internal examination of the eye;
  - d) Advice given to Patient A;
  
2. In respect of Patient C on or around 28 May 2016, did not assess and/or accurately record the details of:
  - a) The reason for visit and/or detailed investigation of symptoms;
  - b) An adequate internal examination of the eyes;
  - c) A retinal abnormality which may have been related to the retinal vessels;
  - d) Advice given to Patient C; and
  
- e) You failed to refer patient C for a further examination in 24 months, which was inappropriate based on the symptoms Patient C presented and/or family history of glaucoma;

3. In respect of Patient D on or around 22 May 2018, did not assess and/or accurately record the details of:
  - a) The reason for visit and/or symptoms;
  - b) An adequate internal examination of the eyes;
  - c) Advice given to Patient D;
  
4. In respect of Patient E on or around 28 July 2017, did not assess and/or accurately record the details of:
  - a) An adequate internal examination of the eyes;
  - b) Previous ocular history;
  - c) The intraocular pressure;
  - d) Advice given to Patient E; and
  
5. In respect of Patient E on or around 28 July 2017, did not refer Patient E for further investigation:
  - a) To determine the cause of reduced vision;
  - b) To rehabilitation services; and/or
  - c) To a low vision clinic;
  
6. In respect of Patient F on or around 4 November 2017, did not assess and/or accurately record the details of:
  - a) Corrected distance visual acuity achieved with the new spectacle prescription for distance;
  - b) An adequate internal examination of the eyes;
  - c) Advice given to Patient F;
  
7. In respect of Patient G on or around 6 September 2017, did not assess and/or accurately record the details of:
  - a) The reason for visit and/or symptoms;
  - b) An adequate internal examination of the eyes;

- c) Advice given to Patient G; and
  - d) did not fully investigate and/or refer Patient G for further investigation of reduced visual acuity of the right eye;
8. In respect of Patient H on or around 19 April 2016 and/or 28 April 2016 did not accurately record whether a dilated eye examination was performed;
9. In respect of Patient H on or around 19 April 2016 and/or 28 April 2016, did not assess and/or accurately record the details of;
- a) An adequate internal examination of the eyes;
  - b) Advice given to Patient H;
  - c) A repeat intraocular pressure;
10. In respect of Patient H on or around 19 April 2016 and/or 28 April 2016, did not refer Patient H and/or arrange further management in respect of;
- a) Reduced vision in the right eye;
  - b) Raised intraocular pressure of the left eye;
11. In respect of Patient I on or around 18 February 2018, did not assess and/or accurately record the details of:
- a) The reason for visit and/or symptoms;
  - b) An adequate internal examination of the eyes;
  - c) Advice given to Patient I; and
  - d) Did not refer Patient I and/or arrange further management in respect of reduced vision in the left eye and/or visual field defect in the right eye;

12. In respect of Patient J on or around 28 November 2017, did not assess and/or accurately record the details of:
  - a) The reason for visit and/or symptoms;
  - b) Corrected distance visual acuity achieved with the new spectacle prescription for distance;
  - c) An adequate internal examination of the eyes;
  - d) Advice given to Patient J; and
  - e) Did not refer Patient J and/or arrange further assessment and/or management in respect of potentially reduced vision in the left eye;
  
13. In respect of Patient L on or around 15 March 2017, did not assess and/or accurately record the details of:
  - a) The reason for visit and/or symptoms;
  - b) An external examination of the eyes;
  - c) An adequate internal examination of the eyes;
  - d) Advice given to Patient L; and
  - e) Did not refer Patient L and/or arrange further management in respect of visual field defect in the right eye;
  
14. In respect of Patient M on 14 December 2016, did not accurately record whether a dilated eye examination was performed;
  
15. In respect of Patient M on 4 January 2017, did not assess and/or accurately record the details of:
  - a) The reason for visit and/or symptoms;
  - b) An adequate internal examination of the eyes;
  - c) Advice given to Patient M;
  - d) Corrected distance visual acuity of the left eye achieved with the new spectacle prescription for distance; and

- e) Did not refer Patient M and/or arrange further management in respect of abnormalities in both eyes;
16. In respect of Patient N on or around 20 March 2018, did not assess and/or accurately record the details of:
- a) Any, or any adequate, internal examination of the eyes;
  - b) Retinal photographs;
  - c) Advice given to Patient N;
17. In respect of Patient O:
- a) Did not date the records; and/or
  - b) Did not check and/or record whether the patient had had an eye examination within the past two years as part of the contact lens fitting;
18. In respect of Patient P, on or around 15 March 2017, did not assess and/or accurately record the details of:
- a) The reason for visit and/or symptoms;
  - b) An adequate internal examination of the eyes;
  - c) Advice given to Patient P; and
  - d) Did not verify the intraocular pressure with contact tonometry; and/or
  - e) Did not refer and/or maintain an adequate record of referral for further assessment of intraocular pressure;
19. In respect of Patient Q, on an unknown date, did not assess and/or accurately record the details of:
- a) Any, or any adequate, examination of the eyes;
  - b) The patient's vision with contact lenses and/or if the correct contact lens prescription was issued;
  - c) Whether it was appropriate for the patient to continue with contact lenses;

- d) Advice given to Patient Q;
20. In respect of Patient Q, on or around 6 March 2017, did not assess and/or accurately record the details of:
- a) Any, or any adequate examination of the eyes;
  - b) The patient's vision with contact lenses and/or if the correct contact lens prescription was issued;
  - c) Whether it was appropriate for the patient to continue with contact lenses;
  - d) Advice given to Patient Q;
21. In respect of Patient Q, on or around 31 March 2018, did not assess and/or accurately record the details of:
- a) Any, or any adequate examination of the eyes;
  - b) The patient's vision with contact lenses and/or if the correct contact lens prescription was issued;
  - c) Whether it was appropriate for the patient to continue with contact lenses;
  - d) Advice given to Patient Q;
22. In respect of Patient S, on or around 16 April 2016, did not assess and/or accurately record the details of:
- a) Intraocular pressure;
  - b) The timeframe for recall and/or further examination;
23. In respect of Patient U, on or around 14 March 2017, did not:
- a) Accurately record issuing Patient U with advice;
  - b) Undertake and/or refer Patient U for further management of the intraocular pressures;



24. In respect of Patient U, on or around 1 May 2018, did not assess and/or record details of:
  - a) Issuing Patient U with advice;
  - b) Recommending further assessment of the intraocular pressure;
  
25. In respect of Patient V, on or around 14 October 2017, did not adequately assess and/or accurately record details of:
  - a) Advice given to Patient V;
  - b) Ascertaining when the last and/or next review for glaucoma was scheduled;
  - c) The intraocular pressure on the left eye
  
26. In respect of Patient W, on or around 18 October 2017, did not assess and/or accurately record details of:
  - a) Any, or any adequate assessment of Patient W's eyes;
  - b) Retinal vein occlusion in the left eye;
  
27. Did not refer Patient W for further assessment and/or management in respect of the retinal vein occlusion on or around 18 October 2017.

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

## **DETERMINATION**

### **Background to the allegations**

7. The Registrant is a registered optometrist and over the time period covered by the allegations (April 2016 to March 2018), she was employed by REDACTED. Her line manager was Colleague B, the Managing Director for four REDACTED. The

Registrant was responsible for completing eye examinations and contact lens appointments.

8. While on annual leave in June 2018 the Registrant sent an e-mail to Colleague B dated 8 June 2018 in which she resigned. Her e-mail included allegations against Colleague B that he was encouraging staff to sell unnecessary products. These allegations were subsequently reported to and investigated by the Council and were closed by the GOC case examiners with no further action.
9. . During her period of annual leave Colleague A, who had recently qualified as an optometrist, provided cover for the Registrant at the REDACTED. He identified concerns about a number of the Registrant's patient records and raised the issue with Colleague B. The Registrant subsequently withdrew her resignation and returned to work.
10. The Registrant attended an investigatory meeting with Colleague B on 23 June 2018 and answered questions relating to some of her patient records. She was then invited to attend a disciplinary meeting, but resigned on 26 June 2023 before that meeting had taken place.
11. The Registrant provided a brief summary of her position in a letter dated 3 January 2019 to REDACTED in response to a notice of investigation by the Council. She stated that she thought that Colleague B had reviewed her records to find "anything he could use against me" after she had raised issues in her first resignation letter. She stated that since the issues were raised by Colleague B about her practice, she had endeavoured to make sure that her record keeping was "flawless". She added that she has been a practising optometrist for 39 years and had never had any complaints from patients or employers.

### **Findings in relation to the facts**

12. The Committee considered the Council's bundle of 486 pages. The bundle included the witness statements of Colleague A, Colleague B, the expert witness report of Dr Chaggar, the Registrant's resignation letters and documents relating to Colleague B's investigation, and patient records. The Committee heard evidence from Colleague A, Colleague B and Dr Chaggar.
13. The Committee heard submissions from Ms Shah on the facts.

14. The Committee accepted the advice of the Legal Adviser. She reminded the Committee that the burden of proof is on the Council in respect of the facts and that the standard of proof is the balance of probabilities.
15. The Committee accepted Colleague A's evidence that he had independently identified issues with the Registrant's patient notes and that his concern relating to Patient W had prompted him to raise the issue with Colleague B. He stated he had not been instructed to review the notes by Colleague B or any other individual.
16. In considering the allegations the Committee gave greater weight to the opinion of Dr Chaggar, the independent expert, and gave limited weight to comments about the Registrant's records made by Colleague A and Colleague B.
17. Dr Chaggar confirmed the content of his expert report. In relation to the examination of the internal eye he outlined the minimum information he would expect to see recorded in the patient notes following an assessment by an optometrist. It would include assessment of the media, optic nerve, blood vessels, central retina, and the peripheral retina. Dr Chaggar would expect to see some comment on the internal eye examination even if no abnormality was noted. In respect of visual acuity Dr Chaggar would expect the patient notes to include a measurement following the determination of the patient's prescription. This would be for various reasons and would be especially important to determine if the patient was safe to drive. These examinations would also be relevant for considering any pathology in the eye which might require a referral to another health practitioner, and they would also assist in future eye examinations.
18. In relation to measurement of intraocular pressure, Dr Chaggar explained that this would be particularly expected for patients over the age of forty because of the risk of development of glaucoma, which rarely causes symptoms in the early stages. The most common method of measuring intraocular pressure is non-contact tonometry which involves directing a small jet of air into the eye. This method produces a less accurate measurement compared to contact tonometry. Dr Chaggar would expect that if a high reading was obtained using non-contact tonometry it would be reasonable for the optometrist to invite the patient to return for repeat measurements. If the measurements were consistently high Dr Chaggar would expect contact tonometry to be undertaken, or the patient should be referred to a glaucoma specialist. Dr Chaggar explained that there were a range of factors that would inform the assessment of whether an individual patient should be referred.
19. In relation to the patient's history and reason for visit Dr Chaggar explained that the reason for the visit would inform the content of the eye examination. If the patient had symptoms he would expect this to be recorded in detail. He would

expect any record of previous eye problems, the patient's history, information on their general health, and any family history of eye disease to be recorded.

20. In relation to advice to the patient, Dr Chaggar stated that this would depend on the context for each patient. It would usually include whether spectacles were indicated and if so for which tasks, whether the patient required spectacles for driving, any treatment or management relating to their symptoms, such as referrals, and when the patient should return for their next eye examination.
21. Dr Chaggar supplemented the evidence in his expert report with further evidence relating to each patient.
22. In its deliberations the Committee considered whether or not it was appropriate to draw an inference that the Registrant had not made an assessment from the absence of any record that she had done so. The Committee took into account the requirements on optometrists in Standard 8 of the Council's Standards of Practice and the College of Optometrists guidance as set out in Dr Chaggar's expert report. In the absence of any evidence from the Registrant describing the examinations she had conducted for each patient, the Committee decided that it was generally appropriate to draw an inference that she had not made the relevant assessments. This was subject to a number of exceptions, where there was evidence suggesting that an assessment had been made and it would be inappropriate to draw this inference.
23. In its deliberations the Committee noted that it had not been provided with the relevant Patient record for Patient M in respect of Particular 15. In addition, the Committee was of the view that the Allegation, as drafted, could not encompass Dr Chaggar's assessment of the adequacy of the advice given to patients. The Committee was invited by Ms Shah to consider Dr Chaggar's evidence on the adequacy of evidence under the allegation that the Registrant did not "assess" the advice that she had given to various patients. The Committee decided that this allegation made no reference to the adequacy of the advice, and could not be read to incorporate such criticisms. Therefore, the Committee found the allegation that the Registrant had not assessed her advice not proved for each of the patients. In respect of both these matters the Committee had in mind the overriding objective and its responsibilities to protect the public. It decided that it was not necessary or proportionate to take further steps, taking into account the breadth and the nature of the allegations as a whole.

1. *In respect of Patient A on or around 22 May 2018, did not assess and/or accurately record the details of:*

- a) *Corrected distance visual acuity achieved with the new spectacle prescription for distance;*
- b) *The reason for visit and/or symptoms;*
- c) *An adequate internal examination of the eye;*
- d) *Advice given to Patient A;*

24. The Committee found Particular 1(a) partly proved by the documentary evidence and the evidence of Dr Chaggar. The Committee accepted Dr Chaggar's evidence that it is likely that the Registrant assessed Patient A's distance visual acuity because this would be required when assessing the prescription and because she had recorded the patient's near visual acuity. The Committee found that the Registrant had made an assessment, but had erroneously omitted her measurement of Patient A's distance visual acuity from Patient A's record. Particular 1(a) was therefore partly proved in respect of accurately recording distance visual acuity, but not in respect of assessing the distance visual acuity.

25. The Committee found Particular 1(b) proved by the documentary evidence and the evidence of Dr Chaggar in relation to assessing and accurately recording Patient A's reason for visit and symptoms.

26. The Committee found Particular 1(c) proved by the documentary evidence and the evidence of Dr Chaggar. For Patient A the Registrant had not made any written note in the section of the record which details the internal examination. Although there were retinal photographs the Registrant had not commented on them or signed the section of the record which confirmed that she had reviewed and assessed them.

27. The Committee found Particular 1(d) not proved. The Committee determined that the Council had not proved that the Registrant gave advice to Patient A which the Registrant had not then accurately recorded. For the reasons considered above, Dr Chaggar's assessment of the adequacy of the advice given to Patient A do not fall within the remit of Particular 1(d).

2. *In respect of Patient C on or around 28 May 2016, did not assess and/or accurately record the details of:*

- a) *The reason for visit and/or detailed investigation of symptoms;*

- b) An adequate internal examination of the eyes;*
- c) A retinal abnormality which may have been related to the retinal vessels;*
- d) Advice given to Patient C; and*
- e) You failed to refer patient C for a further examination in 24 months, which was inappropriate based on the symptoms Patient C presented and/or family history of glaucoma;*

28. The Committee found Particular 2(a) proved in respect of recording and assessing the reason for visit and symptoms. Although symptoms of “floaters” were noted in Patient C’s patient record, there was insufficient assessment or record of these symptoms. For example, there was no record of the onset or duration of floaters which is relevant because an acute onset can be associated with sight-threatening conditions.
29. The Committee found Particular 2(b) proved in respect of the Registrant’s assessment and recording of an examination of the internal eye. The Committee noted the limited record of an examination of the internal eye which records only details of the right eye and is restricted to the media, C/D ratio, and blood vessels. Patient C was recorded to be blind in the left eye, but an examination of that eye may nevertheless have been possible and relevant. The Committee also noted that the Registrant had not signed the record to confirm that she had reviewed and assessed the results of tests including retinal photographs.
30. The Committee found Particular 2(c) proved. The Registrant did not assess or record the abnormality identified by Dr Chaggar on the retinal photograph of the right eye. Dr Chaggar was unable to identify from the photograph whether the abnormality was an artefact or a true abnormality.
31. The Committee found Particular 2(d) not proved. The record for Patient C included limited advice given to Patient C in respect of a change of prescription and a timescale for recall. The Committee determined that the Council had not proved that the Registrant gave advice to Patient C which the Registrant had not then accurately recorded.
32. The Committee found Particular 2(e) not proved. The particular, as drafted, does not address Dr Chaggar’s assessment of the Registrant. It refers to a failure to refer the patient for a recall in 24 months. The Registrant

recommended a recall for Patient C of 24 months as stated in Patient C's record.

3. *In respect of Patient D on or around 22 May 2018, did not assess and/or accurately record the details of:*

a) *The reason for visit and/or symptoms;*

b) *An adequate internal examination of the eyes;*

c) *Advice given to Patient D;*

33. The Committee found Particular 3(a) proved by the documentary evidence and the evidence of Dr Chaggar.

34. The Committee found Particular 3(b) proved by the documentary evidence and the evidence of Dr Chaggar in relation to assessing and accurately recording an adequate internal examination of Patient D's eyes.

35. The Committee found Particular 3(c) not proved. The Committee determined that the Council had not proved that the Registrant gave advice to Patient D which the Registrant had not then accurately recorded.

4. *In respect of Patient E on or around 28 July 2017, did not assess and/or accurately record the details of:*

a) *An adequate internal examination of the eyes;*

b) *ocular history;*

c) *The intraocular pressure;*

d) *Advice given to Patient E;*

36. The Committee found Particular 4(a) proved in respect of both assessing and recording the internal eye examination. The internal eye examination section of the patient record was not completed, and the Registrant did not

sign patient E's record to confirm that she had assessed and reviewed the retinal photographs.

37. The Committee found Particular 4(b) partially proved in respect of assessing the previous ocular history. Although the Registrant noted that the Patient E had keratopathy treatment in 2014 there was no record of an assessment about the underlying cause for Patient E's significantly impaired vision, how long the Patient had the impairment, and whether there had been any change.

38. The Committee found Particular 4(c) proved in respect of assessing and recording Patient E's intraocular pressure. The intraocular pressure of only the right eye was recorded and the Registrant had not signed Patient E's record to confirm that she had assessed and reviewed the intraocular pressure.

39. The Committee found Particular 4(d) not proved. The Committee determined that the Council had not proved that the Registrant gave advice to Patient E which the Registrant had not then accurately recorded.

5. *In respect of Patient E on or around 28 July 2017, did not refer Patient E for further investigation:*

a) *To determine the cause of reduced vision;*

b) *To rehabilitation services; and/or*

c) *To a low vision clinic;*

40. The Committee found Particulars 5(a), (b) and (c) proved by the documentary evidence and the evidence of Dr Chaggar. Patient E was found to have reduced vision and therefore would require assessment to determine the cause of visual loss and whether any intervention was appropriate. It would also require management. Dr Chaggar described a range of advice and assistance and that may have been appropriate for Patient E to assist in managing with reduced vision.

6. *In respect of Patient F on or around 4 November 2017, did not assess and/or accurately record the details of:*

a) *Corrected distance visual acuity achieved with the new spectacle prescription for distance;*



*b) An adequate internal examination of the eyes;*

*c) Advice given to Patient F;*

41. The Committee found Particular 6(a) partly proved in that the Registrant assessed but did not accurately record Patient F's distance visual acuity. The Committee accepted Dr Chaggar's evidence that it is likely that the Registrant assessed Patient F's distance visual acuity because this would be required as part of the prescription and because she had recorded the patient's near visual acuity.

42. In relation to an internal examination of the eyes the Committee noted that dilating drops were instilled in Patient F's eyes as part of the examination. Nevertheless, the Registrant did not make any record of the internal eye examination and she did not sign the form to confirm that she had assessed the retinal photographs. The Committee therefore determined that she had not assessed or accurately recorded an adequate internal eye examination.

43. The Committee found Particular 6(c) not proved. The Committee determined that the Council had not proved that the Registrant gave advice to Patient A which the Registrant had not then accurately recorded.

7. *In respect of Patient G on or around 6 September 2017, did not assess and/or accurately record the details of:*

*a) The reason for visit and/or symptoms;*

*b) An adequate internal examination of the eyes;*

*c) Advice given to Patient G; and*

*d) Did not fully investigate and/or refer Patient G for further investigation of reduced visual acuity of the right eye;*

44. The Committee found Particular 7(a) proved in relation to assessing and recording the reason for visit and symptoms. Although the Registrant noted

some symptoms they were not described in any detail and there was no detail relating to Patient G's diabetes.

45. The Committee found Particular 7(b) proved in relation to both assessing and accurately recording an adequate internal eye examination for Patient G. The Committee noted that the Registrant had signed the form to confirm that she had assessed the retinal photographs. However, she made no comment on the photographs and no record of any findings of an internal eye examination. Dr Chaggar in his report noted that Patient G was found to have subnormal vision in the right eye and a dramatic change in the spectacle prescription of the right eye. This would suggest that Patient G had developed an abnormality and diabetic eye disease could not be excluded.
46. The Committee found Particular 7(c) not proved. The Committee determined that the Council had not proved that the Registrant gave advice to Patient G which the Registrant had not then accurately recorded.
47. The Committee found Particular 7(d) proved. The record for Patient G demonstrates that the Registrant did not fully investigate or refer Patient G in respect of reduced visual acuity in the right eye.
8. *In respect of Patient H on or around 19 April 2016 and/or 28 April 2016 did not accurately record whether a dilated eye examination was performed;*
48. The Committee found Particular 8 not proved. It noted that the record for Patient H included references to the dilating drops used by the Registrant for a dilated eye examination.
9. *In respect of Patient H on or around 19 April 2016 and/or 28 April 2016, did not assess and/or accurately record the details of;*
  - a) *An adequate internal examination of the eyes;*
  - b) *Advice given to Patient H;*
  - c) *A repeat intraocular pressure;*
49. The Committee found Particular 9(a) proved in that the Registrant did not assess or accurately record an adequate internal eye examination for Patient H. The Committee noted that the Registrant had signed Patient H's record to confirm that she had assessed the retinal photographs. However,

she made no comment on the photographs and no record of any internal eye examination. Although the Registrant recorded the use of drops for dilation of the eye the Committee did not infer that she had carried out an adequate internal eye examination. In particular, there was no record demonstrating that the Registrant had assessed the elements that might have caused a reduction in vision such as the lens or a peripheral fundus check.

50. The Committee found Particular 9(b) not proved. The Committee determined that the Council had not proved that the Registrant gave advice to Patient A which the Registrant had not then accurately recorded.

51. The Committee found Particular 9(c) proved to the extent that the Registrant did not record a repeat intraocular pressure. The record for Patient H includes a request for a repeat intraocular pressure assessment. The Committee therefore found that the Registrant had made some assessment of the need to repeat the measurement. Although it was not clear why the intraocular pressure measurement could not have been repeated on 28 April 2016 the Committee did not draw the inference that the Registrant had not made an assessment.

10. *In respect of Patient H on or around 19 April 2016 and/or 28 April 2016, did not refer Patient H and/or arrange further management in respect of;*

*a) Reduced vision in the right eye;*

*b) Raised intraocular pressure of the left eye;*

52. The Committee found Particular 10(a) proved in respect of referring Patient H and arranging further management. The record for Patient H includes a measurement of reduced vision in Patient H's right eye, but no record of any further management or referral by the Registrant.

53. The Committee found Particular 10(b) partly proved in that the Registrant did not refer Patient H. The record for Patient H includes measurement of the raised intraocular pressure and the Registrant's request for repeat measurement of intraocular pressures. Repeat measurement could form part of further management of Patient H. Therefore, the Council has not proved that the Registrant did not arrange further management for Patient H. The record for Patient H and the evidence of Dr Chaggar proved that the

Registrant did not refer Patient H in respect of raised intraocular pressure of the left eye.

*11. In respect of Patient I on or around 18 February 2018, did not assess and/or accurately record the details of:*

- a) The reason for visit and/or symptoms;*
- b) An adequate internal examination of the eyes;*
- c) Advice given to Patient I; and*
- d) Did not refer Patient I and/or arrange further management in respect of reduced vision in the left eye and/or visual field defect in the right eye;*

54. The Committee found Particular 11(a) proved by the documentary evidence and the evidence of Dr Chaggar.

55. The Committee found Particular 11(b) proved in relation to both assessing and accurately recording an adequate internal eye examination for Patient I. The Registrant did not sign Patient I's record to confirm that she had assessed the retinal photographs and she did not record an internal eye examination. She did not make an assessment or record the pale lesion on the retinal photograph, as described by Dr Chaggar. Dr Chaggar explained that this pale lesion could be an age-related change, a longstanding defect, or it could be a new finding indicating active pathology.

56. The Committee found Particular 11(c) not proved. The Committee determined that the Council had not proved that the Registrant gave advice to Patient I which the Registrant had not then accurately recorded.

57. The Committee found Particular 11(d) proved by the record for Patient I. The Registrant did not refer Patient I and she did not arrange further management in respect of the reduced vision or the visual field defect.

*12. In respect of Patient J on or around 28 November 2017, did not assess and/or accurately record the details of:*

- a) The reason for visit and/or symptoms;*
- b) Corrected distance visual acuity achieved with the new spectacle prescription for distance;*

- c) *An adequate internal examination of the eyes;*
  - d) *Advice given to Patient J; and*
  - e) *Did not refer Patient J and/or arrange further assessment and/or management in respect of potentially reduced vision in the left eye;*
58. The Panel found Particular 12(a) proved by the documentary evidence and the evidence of Dr Chaggar.
59. The Committee found Particular 12(b) partly proved in that the Registrant assessed but did not record Patient J's corrected distance visual acuity. The Committee accepted Dr Chaggar's evidence that it is likely that the Registrant made an assessment of the distance visual acuity because this would be required as part of the prescription and because she had recorded the patient's near visual acuity.
60. The Committee found Particular 12(c) proved in that the Registrant did not assess or accurately record an internal eye examination for Patient J. In the patient record the Registrant noted minimal details in the internal eye examination section of the form, but she did not include details of the examination including the macula, peripheral fundus, or blood vessels. The Registrant did not sign the form to confirm that she had assessed the retinal photographs. The Committee therefore inferred that the Registrant had not completed an adequate assessment of the internal eye.
61. The Committee found Particular 12(d) not proved. The Committee determined that the Council had not proved that the Registrant gave advice to Patient A which the Registrant had not then accurately recorded.
62. The Committee found Particular 12(e) proved by the documentary evidence and the evidence of Dr Chaggar. Dr Chaggar explained that he was unable to make an assessment from the retinal photographs of whether there was active pathology in the left eye. The left eye might have changes in the retina, or cataract related changes, or there might be artefacts on the photograph.
13. *In respect of Patient L on or around 15 March 2017, did not assess and/or accurately record the details of:*

- a) *The reason for visit and/or symptoms;*
- b) *An external examination of the eyes;*
- c) *An adequate internal examination of the eyes;*
- d) *Advice given to Patient L; and*
- e) *Did not refer Patient L and/or arrange further management in respect of visual field defect in the right eye;*

63. The Committee found Particular 13(a) proved by the documentary evidence and the evidence of Dr Chaggar.

64. The Committee found Particular 13(b) proved in relation to both assessing and accurately recording an adequate external eye examination for Patient L. It was the Registrant's practice to record details of an external eye examination, but she did not do so for Patient L. The Committee inferred that she had not made an assessment of the external eye on this occasion.

65. The Committee found Particular 13(c) proved in relation to both assessing and accurately recording an adequate internal eye examination for Patient L. The Registrant did not sign the record to confirm that she had assessed the retinal photographs and she did not record detail of an internal eye examination.

66. The Committee found Particular 13(d) not proved. The Committee determined that the Council had not proved that the Registrant gave advice to Patient L which the Registrant had not then accurately recorded.

67. The Committee found Particular 13(e) proved. The Registrant did not refer Patient L or make arrangements for further management, such as a repeat visual field test.

14. *In respect of Patient M on 14 December 2016, did not accurately record whether a dilated eye examination was performed;*

68. The Committee found Particular 14 not proved. The Committee reviewed the record for Patient M on 14 December 2016. It includes a note that the Registrant wished the patient to have an appointment for a dilated eye examination. The Committee determined that this note was a sufficient record that a dilated eye examination was not performed on this occasion.

15. *In respect of Patient M on 4 January 2017, did not assess and/or accurately record the details of;*

- a) The reason for visit and/or symptoms;*
- b) An adequate internal examination of the eyes;*
- c) Advice given to Patient M;*
- d) Corrected distance visual acuity of the left eye achieved with the new spectacle prescription for distance; and*
- e) Did not refer Patient M and/or arrange further management in respect of abnormalities in both eyes;*

69. The Committee found the entirety of Particular 15 not proved because it was not provided with Patient M's record for an appointment on 4 January 2017.

16. *In respect of Patient N on or around 20 March 2018, did not assess and/or accurately record the details of:*

- a) Any, or any adequate, internal examination of the eyes;*
- b) Retinal photographs;*
- c) Advice given to Patient N;*

70. The Committee found Particular 16(a) proved in relation to both assessing and accurately recording an adequate internal eye examination for Patient N. The Registrant did not sign the record to confirm that she had assessed the retinal photographs and she did not complete details of an internal examination of the eyes.

71. The Committee found Particular 16(b) not proved. Dr Chaggar explained in his evidence that he made enquiries but there were no retinal photographs for Patient N. The Committee did not infer that photographs were provided to the Registrant at the time of her examination of Patient N.

72. The Committee found Particular 16(c) not proved. The Committee determined that the Council had not proved that the Registrant gave advice to Patient N which the Registrant had not then accurately recorded.

*17. In respect of Patient O:*

*a) Did not date the records; and/or*

*b) Did not check and/or record whether the patient had had an eye examination within the past two years as part of the contact lens fitting;*

73. The Committee found Particulars 17(a) and (b) not proved. In her submissions Ms Shah acknowledged that there was uncertainty whether the record for Patient O was of an eye examination or of an order for contact lenses. The Committee decided that the evidence was insufficient for the Council to prove Particular 17.

*18. In respect of Patient P, on or around 15 March 2017, did not assess and/or accurately record the details of:*

*a) The reason for visit and/or symptoms;*

*b) An adequate internal examination of the eyes;*

*c) Advice given to Patient P; and*

*d) Did not verify the intraocular pressure with contact tonometry; and/or*

*e) Did not refer and/or maintain an adequate record of referral for further assessment of intraocular pressure;*

74. The Committee found Particular 18(a) proved by the documentary evidence and the evidence of Dr Chaggar.



75. The Committee found Particular 18(b) not proved. In respect of 15 March 2017 Dr Chaggar described the Registrant's recording of her internal examination of Patient P eyes as "borderline" in respect of its adequacy. The Registrant signed the record to confirm that she had assessed the retinal photographs.
76. The Committee found Particular 18(c) not proved. The Committee determined that the Council had not proved that the Registrant gave advice to Patient P which the Registrant had not then accurately recorded.
77. The Committee found Particular 18(d) proved in that the Registrant did not measure Patient P's intraocular pressure with contact tonometry. The Committee noted that there is no evidence as to whether the Registrant was trained to conduct such measurements. Dr Chaggar explained in his evidence that not all optometrists are trained to conduct measurements using contact tonometry. If an optometrist did not have the requisite training or relevant equipment available, they could refer the patient to another optometrist or to a specialist health professional.
78. The Committee found Particular 18(e) proved by the documentary evidence. The Registrant did not refer Patient P or record that she had referred P for further assessment of intraocular pressure. The Committee noted that this issue was not picked up until a further eye examination fifteen months later when another optometrist referred Patient P for further assessment.
19. *In respect of Patient Q, on an unknown date, did not assess and/or accurately record the details of:*
- a) Any, or any adequate, examination of the eyes;*
  - b) The patient's vision with contact lenses and/or if the correct contact lens prescription was issued;*
  - c) Whether it was appropriate for the patient to continue with contact lenses;*
  - d) Advice given to Patient Q;*
79. The Committee found Particular 19(a) proved in relation to both assessing and accurately recording an adequate examination of Patient Q's eyes. Patient Q was seen by the Registrant for a contact lens consultation or check-up. Dr Chaggar explained that the external examination of the eye should be assessed

with use of a diagnostic dye to detect any adverse effects of contact lens wear. There were limited notes of the slit-lamp investigation and no note of fluorescein use. The Registrant made no record of the date of the assessment. There was also no record of the contact lens fitting including whether the contact lens covered the cornea fully and the condition of the lens. The Committee inferred that the Registrant had not carried out an adequate assessment of these matters.

80. The Committee found Particular 19(b) proved in relation to assessing and accurately recording Patient Q's vision with contact lenses and whether the correct prescription was issued. In his expert report Dr Chaggar calculated that the contact lens power was correct for the right eye, but over-powered for the left eye to correct distance vision. Dr Chaggar acknowledged the possibility that the left eye had been over-powered to provide some focusing ability for Patient Q's near vision, but there was no record that the Registrant had made an assessment of Patient Q's vision or recorded visual acuity.

81. The Committee found Particular 19(c) not proved. In Patient Q's record the Registrant had recorded her assessment that Patient Q could wear contact lenses by ticking a box. The Committee inferred from this record that she had therefore made an assessment of whether, in her opinion, Patient Q could continue to wear contact lenses.

82. The Committee found Particular 19(d) not proved. The Committee determined that the Council had not proved that the Registrant gave advice to Patient Q which the Registrant had not then accurately recorded.

*20. In respect of Patient Q, on or around 6 March 2017, did not assess and/or accurately record the details of:*

- a) Any, or any adequate examination of the eyes;*
- b) The patient's vision with contact lenses and/or if the correct contact lens prescription was issued;*
- c) Whether it was appropriate for the patient to continue with contact lenses;*
- d) Advice given to Patient Q;*

83. The Committee found Particular 20(a) proved in relation to both assessing and accurately recording an examination of Patient Q's eyes. The Registrant's record did not include an assessment of the external eye or use of a diagnostic dye, and incomplete notes of the contact lens fit.
84. The Committee found Particular 20(b) proved by the documentary evidence and the evidence of Dr Chaggar. Patient Q's record did not include assessment of contact lens powers or measurement of visual acuity with contact lenses, and the Committee inferred that the Registrant had not assessed Patient Q's visual acuity.
85. The Committee found particular 20(c) proved in respect of assessing and recording the appropriateness of Patient Q continuing to wear contact lenses. The Registrant had not made any written record or ticked the box on the form relating to continued use, and the Committee inferred that the Registrant had not made the assessment.
86. The Committee found particular 20(d) not proved. The Committee determined that the Council had not proved that the Registrant gave advice to Patient Q which the Registrant had not then accurately recorded.
21. *In respect of Patient Q, on or around 31 March 2018, did not assess and/or accurately record the details of:*
- a) Any, or any adequate examination of the eyes;*
  - b) The patient's vision with contact lenses and/or if the correct contact lens prescription was issued;*
  - c) Whether it was appropriate for the patient to continue with contact lenses;*
  - d) Advice given to Patient Q;*
87. The Committee found Particular 21(a) not proved. Dr Chaggar described the Registrant's record as indicating an overall adequate exam. On this occasion the Registrant included the use of diagnostic dye in her assessment and recorded that there was "no staining" with diagnostic dye.

88. The Committee found Particular 21(b) partly proved. It accepted the evidence of Dr Chaggar. The record did not include details of the lenses worn, or the assessment of the power of contact lenses, and the Committee inferred that she had not assessed the contact lens prescription.

89. The Committee found Particular 21(c) proved in respect of assessing and recording whether it was appropriate for Patient Q to continue with contact lenses. The Registrant did not record any advice to Patient Q and she did not tick the box confirming whether the patient could continue with contact lenses.

90. The Committee found Particular 21(d) not proved. The Committee determined that the Council had not proved that the Registrant gave advice to Patient Q which the Registrant had not then accurately recorded.

22. *In respect of Patient S, on or around 16 April 2016, did not assess and/or accurately record the details of:*

*a) Intraocular pressure;*

*b) The timeframe for recall and/or further examination;*

91. The Committee found Particular 22(a) proved. Patient S was over the age of forty and therefore intraocular pressure should have been measured as part of the eye examination. There was no record of intraocular pressure in Patient S's record. The Committee inferred that the Registrant had not made an assessment of intraocular pressure.

92. The Committee found Particular 22(b) not proved. The Committee reviewed the record for Patient S which showed that an amendment had been made to the timeframe for recall of the patient. The Committee was satisfied that the Registrant had made an assessment of what she considered to be the appropriate time scale for Patient S's next eye test. Although the Registrant's amendment was not as clear as it might have been, the Committee decided that the Council had not discharged the burden of proof in respect of the recording of the timeframe for recall.

23. *In respect of Patient U, on or around 14 March 2017, did not:*

*a) Accurately record issuing Patient U with advice;*

*b) Undertake and/or refer Patient U for further management of the intraocular pressures;*

93. The Committee found Particular 23(a) proved. The Committee noted that particular 23(a) was drafted in a distinctly different way from other particulars relating to “advice”. The Committee accepted Dr Chaggar’s evidence that due to the raised intraocular pressure Patient U’s pressure measurements needed to be repeated, and if the Registrant was not able to do this she should have referred Patient U to a glaucoma specialist. There was no evidence of this advice being given on the records.

94. The Committee found Particular 23(b) proved. Patient U was recorded to have raised intraocular pressure. As explained in Dr Chaggar’s report the raised pressure required further management by repeating measurement with contact tonometry. Alternatively Patient U should have been referred to a glaucoma specialist, if the Registrant was not able to do this.

*24. In respect of Patient U, on or around 1 May 2018, did not assess and/or record details of:*

*a) Issuing Patient U with advice;*

*b) Recommending further assessment of the intraocular pressure;*

95. The Committee found Particular 24(a) proved in that the Registrant did not accurately record her advice to Patient U. The Committee noted that Particular 23(a) was drafted in a distinctly different way from other particulars relating to “advice”. Patient U returned to the practice for a further eye examination on 16 June 2018. Dr Chaggar described in his expert report that there is uncertainty about the information conveyed to Patient U by the Registrant that led to this further appointment where further measurements of intraocular pressure were obtained. Despite uncertainty about the content of the advice, the Committee inferred that the Registrant gave some advice to Patient U which resulted in the 16 June 2018 appointment. This advice is not recorded in the record for the appointment dated 1 May 2018.

96. The Committee found Particular 24(b) partly proved in that the Registrant did not record that she had recommended further assessment of the intraocular pressure. In respect of assessment, the Committee found Particular 24(b) not proved. It inferred that the Registrant had decided that further measurement of the intraocular pressure would be appropriate because she gave some advice to Patient U which resulted in the subsequent 16 June 2018 appointment.

*25. In respect of Patient V, on or around 14 October 2017, did not adequately assess and/or accurately record details of:*

- a) Advice given to Patient V;*
- b) Ascertaining when the last and/or next review for glaucoma was scheduled;*
- c) The intraocular pressure on the left eye*

97. The Committee found Particular 25(a) not proved. The Committee determined that the Council had not proved that the Registrant gave advice to Patient V which the Registrant had not then accurately recorded.

98. The Committee found Particular 25(b) partly proved. The Registrant recorded that Patient V attended a specialist glaucoma clinic at six monthly review intervals, but she did not record the date of Patient V's last visit to the clinic. The Committee inferred that there had been a conversation with Patient V and the Registrant relating to the glaucoma clinic. She had noted that Patient V was subject to regular specialist review in respect of glaucoma and was taking prescribed medication. The Committee found particular 25(b) not proved in respect of assessment.

99. The Committee found Particular 25(c) proved. The Registrant had not recorded the intraocular pressure on the left eye and the Committee inferred that she had not made an assessment.

*26. In respect of Patient W, on or around 18 October 2017, did not assess and/or accurately record details of:*

- a) Any, or any adequate assessment of Patient W's eyes;*
- b) Retinal vein occlusion in the left eye;*

100. The Committee found Particular 26(a) proved. Although the Registrant recorded information as part of her examination of Patient W's eyes her assessment and her record were flawed because they were inaccurate. The Registrant recorded a normal appearance for Patient W's left eye, but this was incorrect. There was a clear anomaly of a retinal vein occlusion as described by Colleague A, and confirmed by Dr Chaggar. Dr Chaggar explained in his evidence that this was a very clear and large anomaly which would have been plainly apparent to an optometrist when carrying out an internal eye examination and it was also apparent from the retinal photographs. The Committee inferred that the Registrant had not carried out an adequate assessment of Patient W's left eye, despite the fact that her records indicated that she had done so.

101. The Committee found Particular 26(b) proved. The Registrant did not assess or record the retinal vein occlusion in Patient W's left eye.

*27. Did not refer Patient W for further assessment and/or management in respect of the retinal vein occlusion on or around 18 October 2017.*

102. The Committee found Particular 27 proved. The Registrant had not identified or recorded the retinal vein occlusion and did not refer Patient W for further assessment or management.

### **Misconduct**

103. Having found some of the facts alleged proved, the Committee moved on to consider whether the proved facts amounted to misconduct.

104. The Committee heard submissions on misconduct from Ms Shah and she provided the Committee with written submissions. She referred the Committee to a number of provisions in the GOC's 2016 Standards of Practice for Optometrists and Dispensing Opticians. She submitted that the facts found proved were sufficiently serious to amount to misconduct, considered both individually and collectively.

105. The Committee received and accepted advice from the Legal Adviser. This included reference to a number of relevant authorities including the following guidance on misconduct from the judgment in the case of *Roylance v GMC* [2000] 1 AC 311:

*"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..."*

106. The Legal Adviser reminded the Committee that the conduct must be "serious" in that it falls well below the expected standards.

107. The Legal Adviser also advised the Committee on case law guidance regarding the limits to which Committees may consider its findings cumulatively when assessing whether conduct crosses the threshold of seriousness to amount to misconduct. She referred to the cases of

*Schodlock v GMC [2015] EWCA 769 and Ahmedsowida v GMC [2021] EWCA 3466*. The guidance given in *Ahmedsowida* was:

“The cumulation exercise, if permissible at all, is supposed to involve the cumulation of non-serious with other non-serious findings; not of one non-serious finding with two findings of misconduct that is serious in its own right. In the latter context there is no good reason to cumulate; the quality of the conduct is already correctly expressed without the need for any cumulation”.

108. The Committee was satisfied that the facts found proved involved multiple failures on the part of the Registrant to follow the GOC’s 2016 Standards of Practice for Optometrists, as follows:

**Standard 6. Recognise, and work within your limits of competence**

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

**Standard 7. Conduct appropriate assessments, examinations, treatments and referrals**

7.2 Provide or arrange any further examinations, advice, investigations or treatment if required for your patient. This should be done in a timescale that does not compromise patient safety and care.

7.5 Provide effective patient care and treatments based on current good practice.

**Standard 8. Maintain adequate patient records**

8.1 Maintain clear, legible and contemporaneous patient records which are accessible for all those involved in the patient’s care.

109. In its deliberations the Committee took into account the context that the Registrant is a competent optometrist and at the time of the events she had over thirty years’ experience. The Committee took into account, as part of its deliberations, Dr Chaggar’s opinion in respect of aspects of the Registrant’s conduct which fell far below the standard of a reasonably competent optometrist. The Committee considered that a number of the factual particulars crossed the threshold of seriousness because of their impact or potential impact on patient safety and their nature.



110. In the Committee's judgment the failure to refer Patient W (particular 27) was particularly serious because there was evidence of actual patient harm which is attributable to the Registrant's misconduct. Dr Chaggar explained that the vein occlusion had caused sight loss for Patient W which took place between the appointment with the Registrant on 6 October 2017 and Patient W's subsequent eye examination on 6 December 2017. Dr Chaggar told the Committee that treatment was available for the vein occlusion and this could have prevented Patient W losing as much of their sight if there had not been a delay in their referral. Dr Chaggar was of the opinion that Patient W had suffered some permanent sight loss as a result of the Registrant's omissions.

111. In addition, the Registrant did not refer Patient W to their GP for further evaluation of systemic conditions such as high blood pressure. This conduct exposed Patient W to the risk of serious harm resulting from such systemic conditions, including the risk of stroke or heart attack.

112. The Committee was also of the view that the Registrant's conduct in particular 26 (Patient W) fell far below the expected standards for optometrists. Although the Registrant's record for Patient W appeared to demonstrate that she had completed an assessment and adequate record, she could not have done so because there is no reference to the easily detectable visible vein occlusion. This was not merely an inadequate record, but an inaccurate one, and it contributed to the actual patient harm described by Dr Chaggar. This also evidenced misconduct in failing to view and accurately interpret fundus images. In the Committee's view particular 26 illustrates the importance of accurate record keeping and its relevance to patient safety.

113. The Committee also considered that each of the Registrant's failures to refer patients to investigate potentially sight threatening conditions fell far below the standards for optometrists. The context to these failures is relevant in that the Registrant had not made an adequate assessment or sufficient records of her examination of the patient's eyes. For some of the patients Dr Chaggar was uncertain about the extent of the risk of harm because of the Registrant's limited record-keeping. The Committee individually assessed each of the failures to refer as follows:

- Particular 5(a), (b) and (c). Dr Chaggar explained that Patient E required assessment and management of their significantly reduced vision. The Registrant missed an opportunity to refer Patient E. In the

Committee's judgment the failure to refer in respect of the cause of the reduced vision and for support were serious failures because of the potential risk of harm to the patient and the potential impact on their quality of life.

- Particular 7(d). Patient G had been diagnosed as a diet-controlled diabetic patient. In the Registrant's eye examination Patient G was found to have subnormal vision in the right eye together with a dramatic change in the spectacle prescription of the right eye. Dr Chaggar considered that on the basis of the information recorded, it would suggest that Patient G had developed an abnormality, but that it was not possible to determine its nature. It is possible that Patient G had diabetic eye disease. The Registrant had advised that Patient G should have a visual field assessment when collecting spectacles, but recommended no other management. In particular the reduced visual acuity in Patient G's right eye had not been investigated appropriately. The Registrant's failure to investigate and refer exposed Patient G to the risk of harm.
- Particular 10(c). The context is that the assessment and investigation as shown in Patient H's records was limited. Dr Chaggar was unable to exclude the presence of glaucoma given the raised and asymmetric intraocular pressure. There were also opportunities to refer Patient H on 19 April 2016 or 28 April 2016 on the basis of reduced vision in the right eye. The Registrant's failure to refer exposed Patient H to the risk of harm.
- Particular 11(d). Dr Chaggar described in his expert report that the pale lesion in Patient I's left eye might be a longstanding defect, or that it could represent a new pathological process. In addition, due to Patient I's condition of diabetes it would have been appropriate to investigate whether the subnormal vision in Patient I's left eye related to diabetes. Dr Chaggar would also expect a competent optometrist to investigate the visual field loss in the right eye. The Registrant's failure to refer exposed Patient I to the risk of harm, including the risk of permanent visual loss.
- Particular 12(e). On the basis of the limited records kept by the Registrant and the poor quality of the retinal photographs, Dr Chaggar was not able to exclude the presence of a sight-threatening condition for Patient J. There was potentially reduced vision in the

left eye which may have been amenable to therapy. Therefore, the Registrant's misconduct exposed Patient J to the risk of harm.

- Particular 13(e). The Registrant's records were limited for Patient L and Dr Chaggar was unable to reliably exclude the presence of a sight-threatening condition. He identified the possibility of an abnormality because of the visual field defect in Patient L's right eye. This failure, in the context of other omissions such as the failure to assess and record internal and external eye examination, exposed Patient L to the risk of harm.
- Particular 18(e). The gravity of the Registrant's conduct is in respect of her failure to refer Patient P for further investigation of the raised intraocular pressure. The Committee acknowledged that there are reasons why the Registrant may not have been able to conduct contact tonometry measurements herself. However, if she was unable to do so, the onus was on her to make the appropriate referral in accordance with the guidelines and referral criteria applicable at that time. There was a lengthy delay of fifteen months before Patient P was seen by a different optometrist and referred for investigation. Therefore, the Registrant's failure to refer exposed Patient P to the risk of harm.

114. The Committee was also of the view that the Registrant's misconduct in respect of management of patient's intraocular pressures fell far below the standard for optometrists. The Committee considered that the following failures were sufficiently serious to constitute misconduct.

- Particular 9(c). A repeat intraocular pressure assessment was requested for Patient H, but there is no documentation to suggest if this was actually undertaken. In circumstances where it was not possible to exclude the presence of glaucoma this failure in record keeping exposed Patient H to the risk of harm.
- Particulars 23(a) and (b). The Registrant's failures to record the advice she gave to Patient U on the management of intraocular pressure were serious. The management of intraocular pressure is important for patient safety and the Registrant missed an opportunity to refer Patient U.

115. In the Committee's judgment each of the proven failures in particulars 19, 20 and 21 were serious, falling far below the standards of a competent optometrist for the reasons described in Dr Chaggar's expert report. It is not possible to ascertain from the records if the correct prescription of contact lenses was prescribed for Patient Q. Dr Chaggar was also unable to reliably exclude the presence of a sight-threatening condition due to the lack of external eye examination and visual assessment. It was not possible from the patient record to ascertain if it was appropriate for Patient Q to continue to wear contact lenses.

116. The Committee applied the guidance in *Ahmedsowida* and determined that its findings above were sufficient to describe the quality of the Registrant's conduct. The Committee therefore determined that the Registrant's conduct in particulars 5(a), 5(b), 5(c), 7(d), 9(c), 10(c), 11(d), 12(e), 13(e), 18(e), 23(a) and (b), 19(a), 19(b), 20(a), 20(b), 20(c), 21(b) , 21(c), 26(a) 26(b), and 27, considered individually, were sufficiently serious to amount to misconduct.

### **Findings regarding impairment**

117. Having found that misconduct was established the Committee heard submissions from Ms Shah on behalf of the Council. Ms Shah submitted that the Registrant's fitness to practise is currently impaired because of the absence of evidence that the Registrant has addressed any of the deficiencies. In the absence of the Registrant she drew the Committee's attention to the following:

- the Registrant's hitherto unblemished record with the absence of any regulatory findings prior to the events in question and no subsequent referrals;
- the Registrant's statements about her own practice involving thirty nine years with no patient complaints;
- the Registrant's letter stating that she is now taking more care with respect to record-keeping.

118. The Committee accepted the advice of the Legal Adviser. Her advice included reference to the cases of *Cohen v GMC [2009] EWHC 645* and *CHRE v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927*.

119. In its consideration of whether the Registrant has remedied the deficiencies in her practice, the Committee took into account the three questions identified in Cohen, namely ‘Is the conduct easily remediable? Has it been remedied? Is it highly unlikely to be repeated?’
120. The Committee was provided with no information about the Registrant’s current circumstances, including whether she is currently working as an optometrist or has done so since the events in question.
121. The Committee considered the Registrant’s fitness to practise in context of her long and hitherto unblemished career history. While the Committee noted the Registrant’s statement that she had not received any patient complaints, it gave limited weight to this information when considering the current risks. The Committee gave greater weight to the pattern of failures to refer patients and to undertake other necessary actions in respect of potentially sight-threatening conditions. These failures occurred in a context where the Registrant had not assessed or recorded adequate eye examinations for each of the patients. As an experienced optometrist the Registrant had the ability to make, assess and record eye examinations, and to make the necessary referrals.
122. The Registrant’s misconduct involves clinical failures, and the Committee was of the view that such failures are potentially remediable. However, there was no evidence before the Committee that the Registrant has remedied the misconduct to any extent.
123. The available information for the Committee to assess the Registrant’s level of insight is limited. In her investigation interview with Colleague B the Registrant was asked about some of her patient records, but the interview was limited in its scope and did not include the wide-ranging matters covered in Dr Chaggar’s expert report. In the interview the Registrant did not appear to recognise the seriousness of the concerns that were raised with her. The Registrant’s response and attitude towards the GOC allegations is not known. The Committee acknowledged that in January 2019 the Registrant demonstrated some insight with regard to record-keeping failures. She stated in her letter to NHS England that she now strives to ensure that her record keeping is “flawless”. However, the Committee had before it no evidence that this ambition had been put into practice or of any level of insight in relation to the other matters described in the Committee’s conclusion on misconduct, including the serious case of Patient W.

124. In the absence of evidence of remediation and very limited evidence of insight, the Committee determined that the risk of repetition is high. A repetition of similar conduct would expose patients to the risk of harm, including the sight-threatening conditions described by Dr Chaggar in his expert report. Therefore, a finding of current impairment on the grounds that this was necessary for the purpose of protecting the public was required.
125. The Committee next considered whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the circumstances of this case.
126. The Committee has concluded that there is an ongoing risk to patients, and, consequently, fair-minded and informed members of the public would expect the Committee to make a finding of current impairment. Members of the public would be particularly concerned by the evidence that actual harm was caused to Patient W, albeit that the ultimate harm caused (after treatment) was limited. The case of Patient W clearly illustrates the harm to patients that might ensue if the Registrant were to repeat similar misconduct. The Committee therefore determined that a finding of current impairment is required on public interest grounds to uphold proper professional standards and maintain public confidence in the profession.

### **Sanction**

127. The Committee considered written submissions and heard oral submissions from Ms Shah on behalf of the Council. Ms Shah referred to paragraphs from the Indicative Sanctions Guidance (ISG) and submitted that the Council invited the Committee to impose either an interim conditions of practice order or a suspension order.
128. It has accepted the advice of the Legal Adviser. She referred the Committee to the GOC Indicative Sanctions Guidance (ISG) and reminded the Committee that it was required to act proportionately and start with consideration of the least severe sanction.

129. In reaching its decision on sanction the Committee took into account all relevant evidence before it and its prior decisions in this hearing.

130. The Committee identified a mitigating feature that the Registrant had a long and hitherto unblemished previous career of thirty-nine years and that there had been no subsequent complaints since these matters came to light.

131. The Committee identified the following aggravating features:

- actual harm to Patient W and potential risk of harm to a number of other patients;
- a pattern of repetition of similar failures over a prolonged period of time;
- increasing risk over time with the most significant concern arising at the end of the two year period covered by the allegations;
- the Registrant's apparent lack of insight as to the potential risk to patients when she was questioned by Colleague B.

132. The Committee first considered whether to take no action but concluded that this would be inappropriate in view of the risk of repetition and the seriousness of the case. The Committee decided that it would be neither proportionate nor in the public interest to take no action.

133. The Committee then considered whether to impose a financial penalty. However, this sanction would not be sufficient to protect the public against the risk of repetition and it would not adequately reflect the public interest.

134. The Committee next considered the imposition of a Conditional Registration Order. It noted the terms of paragraph 21.5 of the ISG which states:

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

1. *No evidence of harmful deep seated personality or attitudinal problems.*
2. *Identifiable areas of registrant's practise in need of assessment or retraining.*

3. *Evidence that registrant has insight into any health problems and is prepared to abide by conditions regarding medical condition, treatment and supervision.*
4. *Potential and willingness to respond positively to retraining.*
5. *Patients will not be put in danger either directly or indirectly as a result of conditional registration itself.*
6. *The conditions will protect patients during the period they are in force.*
7. *It is possible to formulate appropriate and practical conditions to impose on registration and make provision as to how conditions will be monitored.*

135. The Committee noted Dr Chaggar's evidence that the deficiencies in the Registrant's practice could be addressed by conditions of practice through a range of measures including training and supervision. However, the Committee did not have sufficient confidence that the Registrant would comply with conditions and it was of the view that conditions of practice are not currently workable. The Registrant is not currently engaging with the Council to any extent and her non-engagement is long standing for reasons that are unknown. As explained in the Committee's decision on impairment the Registrant has not demonstrated to the Committee that she has a sufficient level of insight. The Committee has no information about whether the Registrant has practised as an optometrist since 2018. In these circumstances the Committee was not satisfied that appropriate conditions could be formulated which would sufficiently protect the public. The Committee therefore decided that an order for conditional registration was not appropriate or sufficient.

136. The Committee then went on to consider whether a suspension order would be an appropriate sanction. The Committee noted the terms of the ISG dealing with when suspension may be appropriate sanction.

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

1. *A serious instance of misconduct where a lesser sanction is not sufficient.*
2. *No evidence of harmful deep-seated personality or attitudinal problems.*
3. *No evidence of repetition of behaviour since incident.*
4. *The Committee is satisfied the registrant has insight and does not pose a significant risk of repeating behaviour.*
5. *In cases where the only issue relates to the registrant's health, there is a risk to patient safety if the registrant continued to practise, even under conditions.*

137. The Committee considered that some of the factors were apparent. It did not consider that there was evidence of harmful deep-seated personality or



attitudinal problems and there was no evidence of repetition of behaviour since 2018. A suspension order would adequately protect the public against the risk of repetition. It is also a serious sanction which marks the seriousness of the Registrant's departure from professional standards.

138. The Committee was minded to impose a sanction of suspension, but before it confirmed this option, it considered the more restrictive option of erasure. The Committee was not of the view that the Registrant's misconduct was fundamentally incompatible with being a registered professional. It had in mind the Registrant's long and hitherto unblemished career history and Dr Chaggar's opinion that the clinical matters are capable of remediation. The reasons for the Registrant's non engagement are not known and the Committee was of the view that it would be proportionate to give her an opportunity to reflect on the Committee's reasons and consider whether she wished to engage with the process and take steps to remediate the deficiencies in her practice. The Committee was of the view that there is a public interest in the rehabilitation of a skilled and experienced optometrist to safe practice.

139. Having decided that erasure would be disproportionate, the Committee decided that the appropriate and proportionate sanction is a suspension order.

140. The Committee next considered the length of the suspension order. The Committee decided that the order should be for the maximum period of twelve months. This period was appropriate to mark the serious aspects of the case, particularly the actual harm to Patient W. The Committee was also of the view that a period of twelve months would enable the Registrant to reflect on the Committee's reasons and prepare evidence for a reviewing Committee.

141. The Committee decided that the suspension order should be reviewed before it expires. It considered that a reviewing committee may be assisted by the following:

- The Registrant's engagement and attendance at the review hearing;
- A statement from the Registrant with her reflections on the Committee's decision;
- Any training or CPD undertaken relating to the Committee's findings;
- Information from the Registrant about her current professional circumstances and any steps she has taken to keep her knowledge and skills up to date.

142. The Committee therefore determined that the Registrant should be suspended from the register for a period of twelve months with a review.

### **Immediate order**

143. The Committee has heard submissions from Ms Shah on behalf of the Council. Ms Shah invited the Committee to impose an immediate order to reflect the Committee's prior decisions.

144. The Committee accepted the advice of the Legal Adviser. She referred to section 13I of the Opticians Act and confirmed the Committee's power to impose an immediate order on the ground that it is necessary for the protection of the public, was otherwise in the public interest, or in the interests of the Registrant.

145. The Committee was satisfied that an immediate suspension order is necessary for the protection of the public and is otherwise in the public interest. The Committee had regard to the risk of repetition and the reasons set out in its decision on impairment in reaching its decision to impose an immediate order. To do otherwise would be incompatible with its earlier findings and fail to meet public protection and public interest.

146. If no appeal is made, then the immediate order will be replaced by the substantive order 28 days after the Registrant is sent the decision of this hearing in writing.

### **Costs**

147. Ms Shah informed the Committee that the Council made no application for costs.

**Chair of the Committee: Julia Wortley**



**Signature**

**Date: 20 March 2023**

**Registrant: Helen Lampka**

**Signature** ..... **Date:**

**NOTICE TO REGISTRANT:**

- The GOC will enter these conditions against your name in the register save for any conditions that disclose information about your health.
- In accordance with Section 13C(3) of the Opticians Act 1989, the GOC may disclose to any person any information relating to your fitness to practise in the public interest.
- In accordance with Section 13B(1) of the Opticians Act 1989, the GOC may require any person, including your learning/workplace supervisor or professional colleague, to supply any information or document relevant to its statutory functions.

| <b>FURTHER INFORMATION</b>              |  |
|---|--|
| <b>Transcript</b>                       |  |
|   | A full transcript of the hearing will be made available for purchase in due course.  |
| <b>Appeal</b>                           |  |
|   | 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). |
| <b>Professional Standards Authority</b> |  |

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](http://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.