BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(23)41

AND

YAQUT KHAN (01-26586)

DETERMINATION OF A SUBSTANTIVE HEARING
22 APRIL 2024 – 3 MAY 2024

Committee Members:	Rachel O'Connell (Chair) Carolyn Tetlow (Lay) Ian Hanson (Lay) Gemma O'Rourke (Optometrist) Amit Jinabhai (Optometrist)
Legal adviser:	Alice Moller
GOC Presenting Officer:	Christopher Geering (Counsel)
Registrant present/represented:	Yes, represented.
Registrant representative:	Trevor Archer (Counsel) Instructed by Nan Mousley (AOP)
Hearings Officer:	Terence Yates
Facts admitted and found proved:	Particulars 1, 2, 3 and 4 Sub-particulars 5 a, 5 b (i) (v) and 5 c Particular 6 Sub-particulars 7 a (ii) (iv) (v) and 7 c Particulars 8 and 9 Sub-particulars 10 a, b, c (ii) d, e, f and g.
Facts found not proved:	Sub-particulars 5 b (vi) 7 a (iii) and 10 c (i)
Misconduct:	Found
Impairment:	Impaired
Sanction:	Erasure
Immediate order:	Immediate order imposed.

ALLEGATION (As amended)

The Council alleges that in relation to you, Yaqut Khan (01-26586), a registered Optometrist, whilst you were working at Specsavers A and Specsavers B, as a Locum Optometrist:

1. *On or around 28 July 2013, failed to provide an adequate standard of care to Patient 1 in that you:*
   a. *failed to identify the patient was suffering from macular-off retinal detachment in his left eye,*
   b. *wrongly referred for wet AMD despite the patient presenting with signs of retinal detachment.*
2. *On or around 30 July 2013, failed to provide an adequate standard of care to Patient 2 in that you:*
   a. *failed to identify the patient potentially was suffering from papilloedema or failed to appreciate the seriousness of the patient potentially suffering from papilloedema,*
   b. *failed to make an emergency and / or urgent referral.*
3. *On or around 9 October 2013, amended Patient 2's record of the sight test conducted on 30 July 2013 as set out in Schedule A.*
4. *Your conduct as set out at paragraph 3 above was dishonest in that you:*
   a. *did not make clear these comments were made retrospectively,*
   b. *knew such amendments should be identified as having been made retrospectively,*
   c. *intended these amendments to look like they were part of the original entry made on 30 July 2013,*
   d. *claimed to have completed an Amsler test, when you had not.*
5. *On or around 20 July 2019, failed to provide an adequate standard of care to Patient 3 in that you:*
   a. *completed the eye examination in around 6 minutes which was either incomplete and/or performed to an inadequate standard,*
   b. *failed to perform the following tests or ensure that they were performed:*
      i. *a cover test,*
      ~~*ii. an ocular mobility check,*~~
      ~~*iii. pupil checks,*~~
      iv. ~~*a check of the health of the back of the eye*~~*,*
      v. *an adequate peripheral retinal check,*
      vi. *an adequate intraocular or eye pressure check,*
   c. *recorded completing one or more tests set out at paragraph 5(b) (i) and (v) when you had not done so.*
6. *Your conduct as set out at paragraph 5(c) above was dishonest in that you knew you had not performed one or more of the tests recorded in the records.*
7. *On or around 2 April 2019, you failed to provide an adequate standard of care to Patient 106 in that you:*
   a. *failed adequately to:*
      ~~*i. assess the patient's binocular vision,*~~

ii. *conduct an adequate internal eye examination.*

iii. *conduct an adequate external eye examination,*

iv. *conduct a basic cover test,*

v. *explore and / or assess his report that his vision was "worse" at distance,*

~~*b. issued a prescription and / or issued new spectacles without adequate justification,*~~

c. failed adequately to document:

i. *the general health of the patient in that the Registrant inaccurately recorded "no health issues" in one part of the notes when this was not the case,*

ii. *an assessment of the patient's binocular vision,*

iii. *the results of a basic cover test,*

iv. *one or more results of the internal eye examination,*

v. *one or more results of the external eye examination,*

vi. *sufficient exploration of his vision being reported as "worse" at distance,*

vii. *why the prescription and / or new spectacles were appropriate.*

8. *On or around 15 June 2019, inappropriately amended Patient 106's record of the sight test conducted on 2 April 2019 as set out in Schedule B.*

9. *Your conduct as set out at paragraph 8 above was dishonest in that you:*

a. did not make clear these comments were made retrospectively,

b. knew such amendments should be identified as having been made retrospectively,

c. intended these amendments to look like they were part of the original entry made on 2 April 2019,

d. recorded clinical findings when you:

i. *knew you had not observed one or more of these findings on 2 April 2019,*

ii. *were reckless as to whether the observations / results you entered into the notes represented the actual clinical findings / results observed on 2 April 2019 or not.*

10. *Between 1 August 2018 and 1 August 2019, you failed to provide an adequate standard of care in that you:*

a. in respect of one or more patients in Schedule C, you failed adequately to:

i. *explore / assess vision symptoms where the patient reported a decline in distance or near vision,*

ii. *record having explored / assessed vision symptoms where the patient reported a decline in distance or near vision.*

b. in respect of one or more of those patients listed in Schedule D, you failed:

i. *to explore patient(s') employment adequately,*

ii. *adequately to record sufficient detail relating to patients' employment.*

c. in respect of one or more patients listed in Schedule E, you failed:

i. *to conduct an adequate external examination of the eye,*

ii. *adequately to record the external examination of the eye,*

d. in respect of one or more patients listed in Schedule F, you failed adequately to:

i. conduct an adequate internal examination of the eye,

ii. record the internal examination of the eye,

e. in respect of one or more patients listed in Schedule G, you failed:

i. to conduct a cover test either adequately or at all,

ii. adequately to record the outcome of a cover test,

f. in respect of Patient 048, you failed adequately to:

i. investigate or explore the headache symptom being experienced,

ii. record having investigated or explored the headache symptom,

g. in respect of Patient 087 and /or 099, you failed to:

i. complete a visual field test,

ii. record adequately having completed a visual field test.

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

Schedules A-G

Refer to Annex A

DETERMINATION

Preliminary issues and applications

Membership of Committee

1. On 16 April 2024, Dr Amit Jinabhai, an Optometrist member of the Committee, sent a detailed email to the Council, outlining a tenuous connection to one of the witnesses for the Council, Professor Robert Harper. Both Dr Jinabhai and Professor Harper had professional connections with Manchester University. This information was notified to representatives for the Registrant and the Council last week.

2. Mr Geering, on behalf of the Council and Mr Archer, on behalf of the Registrant, said that having considered the matter, they had no objection to Dr Jinabhai being a member of the Committee and hearing this case. Both counsels indicated that they were content to proceed on the basis that the case could be heard fairly and objectively by the Committee as currently constituted.

3. The Legal Adviser said that the Committee should take account of relevant principles in the authorities, including *Porter v Magill [2002] 2 AC 357*, which set out the test of apparent bias as being '*whether a fair minded and informed observer, having considered the facts, would conclude that there is a real possibility that the tribunal was biased*', as well as *Helow v Home Secretary [2008] 1 WLR 2416*, which described a fair-minded observer as '*the sort of person who always reserves judgment on every point until she has seen and fully understood both sides of the argument. She is not unduly sensitive or suspicious, nor complacent*'. There was no comment on this legal advice.

4. The Committee took account of submissions from counsel and legal advice. There was no suggestion that Dr Jinabhai had any financial or other interest in the outcome of these proceedings, or any other reason to doubt his neutrality. His link to Professor Harper was remote. Mr Archer did not object to his presence on the Committee. The Committee considered that it may proceed on the basis that the case could be heard fairly, in an unbiased way, by the Committee as constituted today.

5. The Committee considered that a fair-minded and informed observer, having considered the facts, would conclude that there was no real possibility that the Committee was biased by reason of Dr Jinabhai being involved. The Committee determined to proceed.

Application to adduce further evidence by the Council

6. On behalf of the Council, Mr Geering made an application to present further evidence, not provided in advance of the hearing. After discussion with Mr Archer, he no longer sought to rely on disputed documents 4, 5, 6 in Exhibit C5. Instead, he applied to adduce documents collated in Exhibits C6 and C7.

7. The Committee had been provided earlier with a bundle of extra documents in Exhibit C5 but the Council no longer sought to rely on the draft Table of Admissions and other items challenged by Mr Archer. Mr Geering offered to provide a new bundle Exhibit C7 without any disputed pages.

8. Mr Archer had no objection to Exhibits C6 and C7 being adduced by the Council and said that he was content that the Committee would be able to ignore any documents contained in Exhibit C5 that had been seen prior to discussions between counsel. Each Committee member agreed that this was so.

9. The Legal Adviser gave advice to the Committee on Rule 40 of the General Optical Council (Fitness to Practise) Rules 2013 (the Rules). The decision whether to grant or refuse the application is for the Committee alone, taking account of submissions from both counsel, Rules and legal advice. There was no objection to this advice by counsel.

10. The Committee accepted that it should first consider whether each piece of evidence in Exhibits C6 and C7 appeared to be relevant to any particular in the Allegation, or not. If deemed relevant, the Committee should consider whether it would be fair to the Registrant for the Council to rely on the additional evidence, taking account of its late production.

11. The Committee took account of Rule 40 which provides:

Admissibility of evidence

Rule 40.

(1) The Fitness to Practise Committee may admit any evidence it considers fair and relevant to the case before it, whether or not such evidence would be admissible in a court of law.

12. Mr Geering sought to rely on an earlier test record for Patient 106, emails between the Council's expert, the Association of Optometrists (AOP) and other relevant documents in Exhibits C6 and C7. These all related to issues raised by the Allegation.

13. The Committee considered all documents contained in Exhibits C6 and C7 to be relevant to the Allegation. Mr Archer had no objection to this information being presented by the Council and the Committee concluded that it would not be unfair to the Registrant to accede to Mr Geering's application.

14. The Registrant had been provided with enough notice of the additional information to be able to consider and discuss it with legal representatives. It would not be unfair to allow the Council to rely on it. The Committee determined to allow Mr Geering to adduce all documents in Exhibits C6 and C7.

Applications to amend Allegation

15. On the first and second days of the hearing, Mr Geering made four successive applications to delete or amend some parts of the Allegation as notified to the Registrant under Rule 28 of the Rules. Each application was uncontested by Mr Archer, counsel for the Registrant.

16. The Council's aim was to render the Allegation more accurate, taking account of documents relied on, the opinions of its expert and to correct typographical errors. Where the Council no longer considered any fact alleged to be amenable to proof (on a balance of probabilities) Mr Geering requested that particular or sub-particular to be deleted.

17. Mr Geering alluded to his Skeleton argument, as well as to correspondence between the Council, Professor Harper and the AOP.

18. Mr Geering submitted that the proposed amendments were uncontentious and may be made without injustice. Some reflected points made by emails from the AOP on behalf of the Registrant.

19. The Council considered that the following particulars should be deleted: 5(b)(ii) (iii) (iv) 7(a)(i) and 7(b). This is because the Council no longer considered that it could prove those elements of the Allegation to the civil standard. In other words, there was no realistic

prospect of the Committee finding that what had been alleged at paragraphs 5(b) (ii) (iii) (iv) 7(a) (i) and 7(b) could be shown to have occurred on a balance of probabilities.

20. In relation to 5(b)(vi), Mr Geering applied to amend the sub-stem of 5(b) '*failed to perform*' by adding the words '*the following tests or ensure that they were performed'*. He submitted that the Registrant had a duty to ensure that an adequate eye pressure check was performed, if he did not do it himself. The stem may fairly be amended to reflect the fact that Professor Harper accepted that the Registrant did not have a duty to perform this check personally.

21. Although this part of the Allegation may be easier for the Council to prove after the amendment, no injustice would be caused to the Registrant as he would have had sufficient notice of the change to be able to prepare his case. He would have enough time to discuss the revised stem of Particular 5(b)(vi) with his lawyers and to present his response to the revised allegation.

22. Mr Archer did not object to Mr Geering's application to amend the sub-stem of Particular 5(b). He did not dispute the reason given for doing so.

23. Other amendments involved deleting particulars or correcting typographical or other errors. In those circumstances, Mr Archer did not object to any of the amendments proposed by Mr Geering.

24. The Committee drew Mr Geering's attention to three drafting issues. First, it observed that Particular 4(d) should say 'a**n A**msler' test (not 'a amsler' test). Both counsel agreed.

25. Next, if the deletions proposed at Particular 5(b) were to be made, it would make sense to amend Particular 5(c) to refer to particular 5(b)(i) and (v) rather than (i)-(v). This would reflect the deletion of sub-particulars 5(b)(ii) (iii) and (iv). Both counsel accepted this.

26. Lastly, on reviewing documents in the bundle, the Committee noted that Schedule A should reflect the precise words in records. The original record said 'DV worse NV OK **No** headaches No diplopia No other problem reported'. Counsel both agreed that insertion of the word 'No' before 'headaches' in the middle column in Schedule A would make the Allegation consistent with the Council's case and documents, of which the Registrant was fully aware.

27. Mr Archer, on behalf of the Registrant, did not oppose the application to amend the Allegation. He agreed that the proposed amendments would allow the Allegation to better reflect the totality of the evidence.

28. The Legal Adviser said that the Committee should consider each amendment proposed separately. If an amendment could be made to the Allegation without injustice to the Registrant, Council or public interest, then it may be made.

29. The Committee should take account of Rule 46(20) of the Rules:

> *'46(20) Where it appears to the Fitness to Practise Committee at any time during the hearing, either upon the application of a party or of its own volition, that—*
>
> *(a) the particulars of the allegation or the grounds upon which it is based and which have been notified under rule 28, should be amended; and*
>
> *(b) the amendment can be made without injustice, it may, after hearing the parties and consulting with the legal adviser, amend those particulars...'*

30. The Committee retired in private to consider the Council's application to amend the Allegation. The Committee considered carefully whether the amendments could be made without injustice. Each proposed change was discussed separately. The Committee noted

that many of the proposed amendments were to ensure that the Allegation reflected evidence relied on. The Committee took account of the lack of objection to any of the proposed amendments.

31. The Committee took account of the background to the applications to amend the Allegation. The Council had considered representations by AOP made on behalf of the Registrant and asked for their expert to comment on them. Professor Harper had accepted some of the Registrant's explanations for his actions. The Council had then proposed that certain particulars be deleted, to reflect the current opinions of its own expert.

32. The Committee heard and accepted the advice of the Legal Adviser in relation to the preliminary issue of amending the Allegation. The Committee was aware that it had a discretion under Rule 46(20) to make amendments, at any stage of the hearing, either on an application by counsel or of its own motion, if satisfied that the amendment may be made without injustice.

33. The Committee was concerned to be fair to the Registrant as well as to the Council. It was in the interests of justice for the Allegation to be clear and readily understood. The Committee accepted that the proposed amendments more accurately reflected the evidence, including clinical records and expert's view.

34. There was nothing in the proposed amendments which would surprise the Registrant or place him at a disadvantage. Some proposed changes were prompted by representations made on his behalf. The deletions were in the Registrant's interests, as they addressed points raised by the AOP and also narrowed the issues.

35. After hearing submissions and advice from the Legal Adviser the Committee decided to amend a typographical error at Particular 4(d) so that it would now read: '*an Amsler test'*. It substituted the word 'and' for the dash at Particular 5(c). Also, the Committee added '*No*' to the middle column of Schedule A to reflect the contents of documents provided and facts alleged.

36. The Committee accepted that removal of particulars not considered amenable to proof was in the Registrant's interests, and those of the Council representing the public interest. This would allow attention and resources to be focused on those particulars considered to have a realistic prospect of being found proved.

37. The Committee was satisfied that the proposed amendments could be made without injustice or unfairness to the Registrant or the Council/public. Therefore, the Committee allowed the Council's applications to amend the Allegation.

Admissions to specific particulars of the Allegation

38. On the first day of the hearing, the Registrant admitted the following paragraphs of the Allegation, through his representative Mr Archer:

- Particulars 1, 2, 3 and 4
- Sub-particulars 5 a, 5 b (i) (v) and 5 c
- Particular 6
- Sub-particulars 7 a (ii) (iv) (v) and 7 c
- Particulars 8 and 9
- Sub-particulars 10 a, b, c (ii) d, e, f and g.

39. After hearing these admissions, the Chair announced that all had been found proved by the Committee. The Committee proceeded to hear evidence in relation to the remaining particulars of the Allegation that remained in dispute:

    - Particular 5 b (vi)
    - Particular 7 a (iii)
    - Particular 10 c (i).

Background

40. After completing his pre-registration training at Specsavers in [redacted] from November 2010 to January 2012, the Registrant qualified as an optometrist in 2012. He was employed as a resident optometrist in [redacted] from January 2012 until he relocated to [redacted] in October 2012. Shortly after this, he obtained work as a full-time locum in the Specsavers C and Specsavers A practices.

41. The Registrant described this post as '*a fast-paced job'* with '*tests scheduled as 20-minute clinics including pre-tests*'. His statement said he believed that: '*when we ran behind on a clinic there was pressure from management to speed up*.' These details were given to explain the context, but not to justify his actions.

42. In his witness statement, the Registrant said that, in October 2018 the store relocated from Specsavers C to larger premises at Specsavers B in [redacted] and time pressures increased through the addition of '*ghost clinics'*. According to the Registrant, this meant that an additional clinic was booked and '*optometrists were expected to cover all the patients who attended*' to ensure that no '*optometrist time'* was wasted if there were '*no show'* patients.

43. The Registrant has not sought to deny that he had rushed some examinations and that there were issues with his record-keeping. His evidence was that he first became aware of allegations against him in 2019 when he received a GOC fitness to practise notification of investigation.

Response to the Allegation by the Registrant

44. At the relevant time, the Registrant worked as a locum Optometrist for Specsavers in two branches known as Specsavers A and Specsavers B. A complaint in July 2019 and subsequent audits identified concerns about his practice.

45. The Registrant made admissions in a witness statement to deficiencies in his record-keeping and other matters. As set out above, he indicated that he would accept that he had done as alleged in most particulars of the Allegation.

Patient 1

46. After an examination of Patient 1 on 28 July 2013 the Registrant made a referral for left eye wet Age-Related Macular Degeneration (AMD) through the wet-AMD rapid access pathway. Patient 1 was subsequently diagnosed with a left eye retinal detachment. Particular 1(a)-(b) alleges that the Registrant failed to identify signs of this retinal detachment and this was admitted, through counsel, at the outset of this hearing.

Patient 2

47. On 30 July 2013, the Registrant examined Patient 2 and then wrote to their GP requesting a routine referral to the Eye Department for unexplained headaches and slightly raised

optic disc margins. On 16 September 2013, a Consultant Ophthalmic Surgeon diagnosed papilloedema, noting that Patient 2 had had headaches for the previous three years.

48. The Registrant admitted Allegation 2a on the basis that he had failed to appreciate the seriousness of Patient 2 potentially suffering from papilloedema.

49. The Registrant also admitted that he had later altered the clinical record for Patient 2 on 9 October 2013 and presented the revisions as part of the original record: Allegation 3. For example, the Registrant incorrectly claimed to have conducted an Amsler test when he had not done so. He accepted that this was dishonest and admitted Allegation 4.

Patient 3

50. On 20 July 2019, the Registrant saw Patient 3 who was accompanied by her daughter, Ms A, a pre-registration optometrist. Ms A complained to Specsavers that the Registrant had not conducted a full examination. The Council alleged that the Registrant had falsified the clinical record to indicate that he had conducted tests which had not been undertaken.

51. The Registrant accepted that he had failed to perform a cover test and an adequate peripheral retinal check. On the first day of the hearing, he admitted deficiencies in relation to Patient 3 set out in Particulars 5(a) and 5(b)(i) and (v) as well as inaccuracies in record-keeping in Particular 5(c) of the Allegation.

52. By recording he had performed these tests when he had not, the Registrant accepted that he had acted dishonestly: Allegation 6.

53. The Registrant disputed the allegation that he had failed to check the intraocular eye pressure (IOP) as alleged at Particular 5(b)(vi).

Patient 106

54. On 2 April 2019, the Registrant saw Patient 106. The Registrant accepted that his eye examination was inadequate as alleged at Particulars 7(a) (ii) (iv) and (v). This is because the Registrant failed to conduct an adequate internal eye examination, a basic cover test or to explore Patient 106's report of '*worse*' distance vision.

55. However, the Registrant denied that he failed to conduct an adequate external eye examination. He disputed Particular 7(a)(iii) of the Allegation.

56. The Registrant accepted deficits in his record-keeping and admitted Particular 7(c) too. He admitted making retrospective amendments to the record to include clinical findings not made: Allegation 8.

57. The Registrant accepted that his later amendments, without annotation to show that any was done retrospectively, was dishonest. He admitted Particular 9.

Audit

58. An audit by Specsavers identified shortcomings by the Registrant in other examinations conducted between 1 August 2018 and 1 August 2019. Failings identified are reflected in Particulars 10(a)-(g).

59. Except for Particular 10 (c)(i) the Registrant accepted all elements of Particular 10 of the Allegation. He contended that he 'always' examined the external eye, even if he had failed to record it; the Registrant admitted failing to record the external examination. He also admitted that he failed to explore and record patients' symptoms, history and employment; also that he did not conduct appropriate internal eye examinations or cover tests.

Disputed Facts at Particulars 5 (b) (vi) 7 a (iii) and 10 (c) (i)

60. The Committee considered all evidence adduced by the Registrant and the Council, including statements from Mr A, an Ophthalmic Director and Professional Services Consultant for Specsavers and Ms B, General Manager for the Specsavers A and B Practices. The Committee then heard evidence from Ms A daughter of Patient 3, Mr B, an Optometry Director at Specsavers, expert witness Professor Harper and the Registrant who was cross-examined by Mr Geering and questioned by Committee members. The Committee heard submissions on behalf of the Council and the Registrant.

Submissions on behalf of the Council

61. Mr Geering submitted that the Registrant had demonstrated an unreliability in his recollection, but did not argue that he had been dishonest in his evidence. Mr Geering invited the Committee to find that his evidence had shifted on detailed points and that his account on disputed issues was not coherent or compelling.

62. In relation to Particular 5(b)(vi), Mr Geering submitted that the intraocular or eye pressure check (IOP) had not been recorded because it had probably not been conducted or checked by the Registrant. Mr Geering suggested that it was inherently unlikely that the Registrant would record tests not performed but also omit to record those tests conducted.

63. Mr Geering submitted that it was more likely than not that the IOP was not done on 20 July 2019. The IOP was not recorded because the Registrant did not conduct it or note that someone else had provided him with IOP test results for Patient 3.

64. In relation to Particulars 7 (a) (iii) and 10 (c) (i) Mr Geering submitted that no external eye examination had been recorded. As the Registrant had no recollection of these tests, he gave unreliable evidence based on what he described as his usual practice. The Registrant admits that, on occasions he did not adequately examine eyes or do cover tests. Mr Geering submitted that the Committee may infer that the Registrant's practice was often '*rushed'* and *'slapdash'*. Tests not being done indicates sub-standard practice. On that basis Mr Geering invited the Committee to find that tests were not performed as set out in Particulars 7 (a) (iii) and 10 (c) (i) of the Allegation.

Submissions of behalf of the Registrant

65. Mr Archer reminded the Committee that the Registrant had accepted some particulars without recalling events as he accepted they were probably correct. He had admitted being dishonest in the past in his own interests. There would have been plenty of scope in these proceedings to minimise or dispute allegations not otherwise amenable to proof by the Council.

66. The Registrant could have said that he asked patients questions about employment history or that he did cover tests but failed only in record-keeping; that would have been less serious than not conducting tests. The Registrant may have succeeded in such an attempt to minimise his failings, but instead he admitted those elements of the Allegation he knew to be correct, regardless of whether the Council could prove them without his admissions.

67. However, Mr Archer argued that the Registrant cannot, in good conscience, admit to those disputed particulars he knows to be wrong in terms of what occurred. Admitting the three outstanding facts in dispute would be highly unlikely to make any difference to the outcome, in terms of the overall seriousness of his conduct.

68. Mr Archer submitted that, if Particulars 7 (a) (iii) and 10 (c) (i) were true, the Registrant would have nothing to gain by disputing them and potentially a lot to lose. By disputing

part of the Allegation he has opened himself up to being tested by questions from Mr Geering and the Committee. The Registrant is aware that, later on, he will be expected to be able to demonstrate insight.

69. In relation to Particular 5(b)(vi). Mr Archer asked the Committee to accept that Patient 3's IOP was measured by another member of staff in a pre-test. Ms A acknowledged that a pre-test took place and Professor Harper indicated that this would have been standard practice at Specsavers, with IOP test results being placed in a rack for the optometrist to pick up. There is no reason to find that standard procedure was not followed; this process was entirely routine.

70. Mr Archer submitted that it would be difficult sensibly to conceive how Patient 3's appointment could have proceeded in any other way but that described by the Registrant and Ms A. The Registrant said the start of his appointment with Patient 3 was delayed as her pre-test took longer than anticipated. His evidence was that he reviewed the IOP test results but failed to record them.

71. The Registrant did not measure IOPs himself but Professor Harper confirmed that he would not have been required to do so. Mr Archer submitted that the Registrant cannot be said to have failed to ensure that the test was carried out, because he saw the results.

72. In relation to Particulars 7 (a) (iii) and 10 (c) (i), Mr Archer submitted that the Committee should accept the Registrant's evidence that he had always conducted adequate external eye examinations, although he had omitted some other steps when under pressure of time. In the context of his wide-ranging admissions to most of the Allegation the Committee is invited to accept the Registrant's reluctance to admit disputed particulars as reflective of the true position. If he had omitted them, his lowest risk option would have been to admit all, but the Registrant properly chose not to admit failing to conduct tests which he had performed.

Legal Advice

73. The Legal Adviser said that, at this stage the Committee is required to determine whether any of the outstanding facts alleged at Particulars 5 b (vi) 7 a (iii) and 10 c (i) have been proved. The burden of proving disputed facts is on the Council. The Registrant does not need to disprove anything in the Allegation. The standard of proof required is the civil standard, that is the balance of probabilities.

74. The Committee should consider the entirety of oral evidence heard, in the context of documentary evidence. The Committee should analyse the evidence fairly and impartially, taking account of any gaps or apparent contradictions.

75. Although it does not provide a defence, previous good character is an important factor capable of assisting the Registrant in two ways: in relation to credibility as well as propensity. This good character direction is modified by the fact that the Registrant has admitted some dishonest behaviour.

76. The Committee must reach a conclusion on each particular separately, but it is entitled, in determining whether or not each particular is proved, to have regard to relevant evidence in relation to any other particular. It may consider the evidence in the round. The Committee must be satisfied that each element of an allegation has been made out before finding a specific allegation proved.

77. There was no comment on the legal advice after it had been given in open session. The Committee accepted it.

Findings in relation to outstanding facts in dispute

78. The Committee first considered Particular 5(b)(vi) of the Allegation. This allegation is that, on or around 20 July 2019, the Registrant failed to provide an adequate standard of care to Patient 3 in that he failed to perform an adequate intraocular or eye pressure check or to ensure it was performed.

79. The Committee accepted the veracity and accuracy of evidence from Ms A, who was a pre-registration optometrist. As such Ms A may be expected to be in a better position than many others to understand and/or to recall what she saw when she accompanied her mother to Specsavers.

80. Ms A told the Committee that her mother was taken into pre-test screening. Due to her training as an optometrist, Ms A would have a good idea of what should be done, and the Committee considered that Ms A was likely to have picked up obvious omissions.

81. In his evidence, the Registrant was consistent in his account that a pre-screen test was conducted for Patient 3, referring to the delay this had caused. The Registrant gave consistent evidence that he did not write the IOP test results down, but maintained that he did ensure that they were done, when he picked up the results for Patient 3 from the rack.

82. Another witness Mr B gave evidence that IOPs would routinely be conducted for patients over 40 years old, as Patient 3 was. This supported the Registrant's account that Patient 3 would have undergone this test.

83. Professor Harper testified that optometrists need not measure the IOPs personally. He also said that Specsavers' usual practice (to the best of his knowledge) was for someone else to measure the IOPs. Professor Harper thus partially confirmed the Registrant's account of usual practice.

84. Ms A's oral evidence partially supported the account of the Registrant, as did that of two professional witnesses, one an expert. All three were independent witnesses and had no reason to seek to confirm the Registrant's evidence.

85. The Council invited the Committee to infer that the Registrant did not do the IOP or check that this test was done because there was no record of it. However, it was common ground that he had omitted to record important information on other occasions.

86. The Council did not provide any eyewitness or other evidence to undermine Ms A's account that her mother went into a clinical area for a pre-test before seeing the Registrant. The Committee gave weight to Ms A's description of events.

87. The Registrant gave a good reason for him to recall Patient 3: there had been an immediate complaint by Ms A. The Committee accepted the Registrant's evidence in relation to Patient 3.

88. Taking account of all evidence, submissions and legal advice, the Committee concluded that the Council had not discharged the burden on it to demonstrate that it was more likely than not that the Registrant had failed to perform an adequate intraocular or eye pressure check or to ensure it was performed. The Committee determined to find Particular **5(b)(vi)** of the Allegation **not proved**.

89. In relation to Particulars 7 a (iii) and 10 c (i) the Committee recognised that the Council had to establish to the civil standard that the Registrant had failed to conduct an adequate external eye examination in relation to each.

90. Although the Registrant had admitted numerous clinical failings and dishonesty in relation to amending records, he denied failing to conduct adequate external eye examinations. He

did not claim to recall exactly what had occurred, but he consistently and strongly maintained that he had '*always*' conducted an adequate external eye examination on all his patients.

91. In answer to questions, the Registrant gave a plausible explanation for failing to record the results of external eye examinations. He said that the screens / pages on the computer system he used at Specsavers were in a different order from the steps he took in his appointments with patients. In evidence he explained that he had sometimes forgotten to scroll back to an earlier screen to add test results. The Committee accepted the account of the Registrant on this point as plausible and consistent with other evidence.

92. It is for the Council to prove the Allegation, not for the Registrant to prove that he did not do as alleged. Tables of entries show that he failed to record some information, but do not prove that he did not perform adequate external eye examinations.

93. Professor Harper gave evidence that: '*Everyone in practice will occasionally omit aspects [of an examination]… the [patient] record is not a precise record of an eye examination.'* The Committee accepted this and considered that most healthcare professionals will, on occasion, fail to record a detail which would have been noted in ideal circumstances.

94. Taking account of all evidence, submissions and legal advice, the Committee concluded that the Council had not discharged the burden on it to demonstrate that it was more likely than not that the Registrant had failed to conduct an adequate external eye examination as alleged at Particulars 7 a (iii) and 10 c (i). Had he done so, the Committee considered it likely that the Registrant would have made the appropriate admissions, in line with his early acceptance of other, more serious, particulars. The Committee thus determined to find Particulars **7 a (iii) and 10 c (i)** of the Allegation **not proved**.

95. In conclusion, all three disputed elements, Particular **5 (b)(vi)** Particular **7 a (iii) and Particular 10 c (i)** of the Allegation were found **not proved**.

Misconduct

Submissions on behalf of the Council

96. Mr Geering submitted that an optometrist should identify any retinal detachments. Particular 1 amounts to a serious failing, far below the standard expected of a reasonably competent optometrist.

97. By not recognising the urgency of the situation, the Registrant put Patient 2 at risk of harm. There was a serious failing in relation to Particular 2.

98. Particulars 3 and 4 relate to the Registrant amending records with a dishonest intention. Amending records ten weeks later must be a concern and it is inevitably serious if dishonest. The Registrant claimed to have carried out an Amsler test, but he had not done so (Particular 4d).

99. Mr Geering submitted that Particulars 5 a and b should be considered together in relation to Patient 3 as there is a significant degree of overlap. Two important tests were not conducted and this is a serious omission. The Registrant accepted in evidence that serious pathology could have been missed.

100. Particulars 5c and 6 dealt with the way in which clinical examinations were recorded. The Registrant admitted a dishonest intention, a serious matter in relation to clinical interactions. Mr Geering submitted that the Registrant put his own interests ahead of those

of his patients; the consequence was that he created inaccurate records which could mislead future clinicians and put the patient at risk.

101. Particular 7a relates to the inadequacy of the Registrant's examination of Patient 106, another serious matter. Failure to conduct an assessment to the appropriate standard of care is seriously below what patients are entitled to expect.

102. Mr Geering submitted that Particulars 8 and 9 related to serious matters as the Registrant invented the results of tests. He referred to a peripheral retinal check where none was done. This reaches the threshold of misconduct.

103. In relation to Particular 10 a b c (ii) d e g, Professor Harper testified that these acts or omissions fell far below the proper standard; this amounts to misconduct.

104. Professor Harper did not consider Particular 10f (i) or (ii) to be far below the standard expected, so the Council does not submit that these failings amount to misconduct. Failings have to be sufficiently serious to be described as deplorable or to go to fitness to practise.

105. Mr Geering submitted that the Committee must exercise its professional judgment in considering whether the facts, admitted and found proved, constitute misconduct. It is accepted that not every breach of proper professional standards will constitute misconduct. It must be serious. It may assist to ask whether a fellow practitioner would consider the conduct in question to be "*deplorable*". The Committee needs to ask whether the conduct is sufficiently serious to go to the Registrant's fitness to practise.

106. In the Council's submission, the allegations in this case amply satisfy this threshold. Most of the clinical findings are serious in their own right.

107. Mr Geering's Skeleton argument referred to Particular 10. He argued that, whilst a single failure to explore or record certain symptoms may not be serious, in itself, Particular 10 encompasses numerous such failings over the course of a year. That is more than sufficient to demonstrate misconduct.

108. Mr Geering further submitted that the most serious aspect of this case was the dishonesty. The Registrant acted in a dishonest manner on three occasions, once in 2013 and twice in 2019. Each time, he put his own interests above those of the patient. His concern had been to "improve" on his records to protect himself. In doing so he invented tests which were not in fact carried out. There is a clear public protection issue if clinical records cannot be trusted.

Submissions on behalf of the Registrant

109. On behalf of the Registrant, Mr Archer accepted that misconduct was made out. However, he submitted that the context is relevant and that there are degrees of misconduct.

Patient 1

110. In relation to Patient 1, Mr Archer submitted that the Registrant conducted the eye examination correctly, but he ought to have diagnosed a retinal detachment; he now finds it hard to understand how he did not do so.

111. Professor Harper said retinal detachment is fairly rare. Mr Archer submitted that the Registrant's relative inexperience amounted to a mitigating factor in this context. The Registrant did not find out until 2019 that he had failed to identify this and has had no similar incidents in the intervening six years.

112. Mr Archer submitted that the Registrant's inexperience in July 2013 was a primary factor in misdiagnosing Patient 1. The Registrant used the correct referral pathway for wet age-

related macular degeneration (AMD), but this was wrong for the condition that Patient 1 had. Particular 1b alleges the same failure as 1a but puts it in a different way. The mis-referral was a logical consequence of the misdiagnosis, but Patient 1 had a relatively good outcome.

Patient 2

113. Particulars 2-4 relate to Patient 2, who had another rare condition: papilloedema. However, the Registrant accepts that he failed to identify the seriousness of the presentation. Mr Archer submitted that the Registrant should be given credit for acknowledging that he had seen papilloedema previously, although this was in a more extreme presentation. Mr Archer added that Professor Harper's evidence was that the swelling of an optic disc can range from borderline to full blown and other symptoms may be relevant.

114. In his evidence Professor Harper said that a patient with '*blurred margins and no symptoms'* should be referred urgently. However, Mr Archer said that, in his recent training, the Registrant was told that a grade 1 case with no symptoms may be monitored with advice. Either way, the Registrant accepts that blurring and headaches (a reported symptom) made an urgent referral necessary.

115. Mr Archer submitted that the Registrant correctly identified *potential* papilloedema. Although he did well to ask follow-up questions about symptoms after noting signs of concern, the Registrant accepts that it was a serious failing to make a routine referral, as opposed to an urgent or emergency referral.

116. The Registrant asked Patient 2 about any recent headaches. The subsequent letter from a consultant noted that Patient 2 had had headaches for three years, so Mr Archer submitted that the patient would probably not have considered them to be '*recent*'.

117. The Registrant initially recorded '*no headache*s'. However, Mr Archer said that, when probed, the patient described long-standing headaches; the Registrant should have gone back into the system to add this, but did not do so. He submitted that, although the clinical record was therefore inaccurate, the letter drafted by the Registrant was correct. When the consultant confirmed papilloedema, the Registrant noted that the clinical record was wrong, and inconsistent with his referral letter.

118. An optometrist colleague then told the Registrant that he had wrongly referred Patient 2 for a routine referral. The Registrant decided to correct details in the clinical record to make it look '*better*' by adding reference to an Amsler test. This test was inappropriate, and Mr Archer submitted that this showed the Registrant had acted on impulse; he was not thinking clearly as he was anxious and defensive.

119. Mr Archer submitted that, although he found it hard to recall his state of mind at the time, the Registrant accepts that his actions were dishonest. He accepts that his approach would be considered dishonest by the standards of ordinary people. Applying the test, the Registrant was dishonest as he did not stop to give it thought and accepts that he tried to make the changes look like his original record.

Patient 3

120. Particulars 5 and 6 relate to events six years later. There were no allegations in the interim. Mr Archer submitted that Specsavers B was a busier practice than other practices he had worked in. To save time, the Registrant had changed the order of his eye examination to avoid dazzling patients [with early use of bright light]. Using default IT settings increased the chance of the Registrant making an error. The Registrant recalled that his examination of Patient 3 probably took a bit longer than six minutes but he accepts that it was '*around*' that time.

121. Mr Archer submitted that the complaint made the Registrant stop and reflect. He was friendly at work and tried to pick up slack when clinics were running late, to meet the expectations of management. It was not in his nature to complain but his solution was to find work elsewhere. In private practice the Registrant realised that Specsavers' way was not the only way.

Clinical failings

122. Professor Harper said that some level of error is inevitable in record-keeping. In themselves the errors in relation to Particulars 10 f i ii would not amount to serious misconduct as these related to Patient 48 alone. In a high-pressure environment the Registrant accepts that he did not conduct all tests required and that his error rate was too high. In relation to Particular 10c, the Registrant did conduct examinations but did not always record the results.

Legal Advice

123. The Committee has made findings of fact, so must next consider misconduct and then, if misconduct is found, go on to consider impairment of current fitness to practise. Not every case of misconduct results in a finding of impairment: *Cohen v GMC 2008 EWHC 581*.

124. The word misconduct connotes a serious breach indicating that fitness to practise may be impaired. It is important to set the matters complained of in the context of the Registrant's whole practice: *Calhaem v GMC 2007 EWHC 2606*. Misconduct was described as a wrongful or inadequate mode of performance of professional duty in *Mallon v GMC 2007 CSIH 17*.

125. In *Remedy UK v GMC 2010 EWHC 1245* the High Court said that misconduct is of two principal kinds. First, misconduct in the exercise of professional practice. Second, morally culpable or otherwise disgraceful conduct, outside or within practice. Conduct falls into the second category if it attracts some kind of opprobrium – that may be sufficient to bring the profession into disrepute.

126. The Committee need not go on to consider the issue of impairment, if it determined that the facts found proved did not amount to serious misconduct. Misconduct that the Committee might otherwise consider to be serious may be held not to be in the special circumstances of the case *Campbell v GMC [2005] 2 All ER 970*.

127. The Court of Appeal said in *Schodlok v GMC [2015] EWCA Civ 769*:

'*If the Panel decides that the facts do not amount to serious misconduct that would automatically mean that the doctor's fitness to practise is not impaired. However, if the Panel decide that the facts do amount to serious misconduct it has to decide whether that misconduct has the consequence that the doctor's fitness to practise is impaired … A finding of misconduct should not inevitably lead to a finding of impairment of fitness to practise.*'

128. There was no comment on the Legal Advice from Counsel.

Analysis and conclusion of the Committee

129. The Committee took account of all evidence adduced, including testimonials, submissions by both counsel, legal advice and guidance. This included the Council's *Code of Practice* published in April 2010 and *Standards of Practice for Optometrists,* published in April 2016. The 2010 Code applied to Particulars 1-4 and the current 2016 guidance applied to Particulars 5-10 of the Allegation.

130. In its analysis, the Committee excluded Particulars 10 f (i) and (ii) as Professor Harper did not consider those failings to be 'far below' the requisite standard. In other words, the Committee did not consider that the facts in these sub-particulars amounted to misconduct.

131. The Committee then considered misconduct in relation to the remaining clinical failings and the three instances of dishonesty, admitted and found proved. The Committee took account of the context of relevant events.

132. The Committee considered that Patients 1 and 2 were potentially at risk from the Registrant's clinical failings. The Committee took account of the relative inexperience of the Registrant but noted that he had been qualified for approximately 18 months.

133. Professor Harper accepted that Patient 1 did not present with classic symptoms of flashes or floaters as the retinal detachment was more chronic. He agreed that the incorrect referral stemmed from incorrect diagnosis, which could reflect the Registrant's inexperience, but Professor Harper added that even an '*entry level optometrist should detect retinal detachment*'.

134. Professor Harper said that a knowledge gap, leading to errors, may be remedied through further training. He added that optometrists benefit from exposure to a mixture of patients as this enables abnormalities to be detected.

135. The Registrant had not appreciated the seriousness of Patient 2's condition. Professor Harper considered this to be far below the standard expected, as Patient 2 should have been referred as an urgent or emergency case.

136. The Committee accepted Professor Harper's evidence and considered the facts at Particulars 1-4 to amount to serious failings.

137. The Registrant saw Patient 106 on 2 April 2019. The recording errors were picked up by an NHS Audit in May 2019 and the Registrant amended the record on 15 June 2019. Patient 106 had various health issues and was on medication. Yet, the Registrant copied previous test results from December 2017 into Patient 106's April 2019 records. Future clinicians could be misled and therefore Patient 106 was at risk of avoidable harm in consequence of the Registrant's actions.

138. The Registrant then dishonestly amended the record for Patient 3 in July 2019 by entering results for tests he knew that he had not performed.

139. The Registrant admitted three instances of dishonesty. The Committee considered that he had put his own concerns above the safety and well-being of patients, as he acknowledged in evidence.

140. Particular 10 was very serious due to the high number of patients involved, as Professor Harper indicated:

'*The 222 eye examinations within the bundle with missing examination details are comprised of 118 cases from* [Specsavers B] *and 84 cases from* [Specsavers A]*. These samples are stated to have been drawn from an audit of 1893 cases from* [Specsavers B] *and 873 cases from* [Specsavers A]*, with, respectively, ~7.2% and 9.6% of the Registrant's cases being deemed from this audit to have lacked clinical entries for external and/or internal eye examinations. This proportions of examinations of between ~7and 10% lacking such key documentation reflects a serious failing and occurring quite so regularly across many records from a large sampling base, the finding would reflect a very serious failing, one falling far below the standard expected of a reasonably competent optometrist*.'

141. The Committee considered that not conducting examinations properly, failing to record test results, making retrospective amendments to clinical records and being dishonest were all very serious. The Registrant's dishonesty, in the exercise of his professional practice, was morally culpable and would be considered deplorable.

The Code 2010 – Particulars 1-4

142. The Committee considered that the Registrant had breached particulars 1, 6, 10 and 19 of the Council's *Code of Practice* published in April 2010.

143. The Code required optometrists to:

> '*1: Make the care of the patient your first and continuing concern,*
>
> *6: Maintain adequate patients' records,*
>
> *10: Be honest and trustworthy*
>
> *19: Ensure your conduct, whether or not connected to your professional practice, does not damage public confidence in you or your profession.*'

Standards 2016 – Particulars 5-10

144. The Committee took account of the preamble to the current *Standards of Practice for Optometrists,* published in April 2016:

> *'As an optometrist you must make the care of your patients your first and overriding concern: the care, well-being of and safety of patients must always be your first concern. This is at the heart of being a health care professional*.'

145. The Registrant had not ensured that patients were at the heart of his decisions in relation to their care. The Registrant had failed to conduct appropriate assessments and examinations. He had not maintained adequate patient records and had retrospectively amended them. He had been dishonest in a way that would attract opprobrium.

146. The Committee concluded that the Registrant's conduct had breached relevant parts of Standards 7, 8, 16 and 17 of the 2016 Standards:

> ***7 Conduct appropriate assessments, examinations, treatments and referrals***
>
> *7.1 Conduct an adequate assessment for the purposes of the optical consultation, including where necessary any relevant medical, family and social history of the patient. This may include current symptoms, personal beliefs or cultural factors.*
>
> *7.2 Provide or arrange any further examinations, advice, investigations or treatment if required for your patient.*
>
> ***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.*
>
> *As a minimum, record the following information:*
>
> *8.2.2 Your patient's personal details.*
>
> *8.2.3 The reason for the consultation and any presenting condition.*
>
> *8.2.4 The details and findings of any assessment or examination conducted.*
>
> ***16 Be honest and trustworthy***
>
> *16.1 Act with honesty and integrity to maintain public trust and confidence in your profession.*
>
> ***17 Do not damage the reputation of your profession through your conduct***

17.1 Ensure your conduct, whether or not connected to your professional practice, does not damage public confidence in you or your profession.

147. The Registrant had retrospectively amended patients' records. He had put patients at risk and acted dishonestly to protect himself from scrutiny. His clinical failings were considered to amount to misconduct. The Registrant's dishonesty was serious and clearly amounted to misconduct.

148. The Committee concluded that the facts admitted and found proved amounted to misconduct.

Impairment

149. The Committee was provided with further relevant documents, including two NHS Audits, evidence of continuing professional development (CPD) and testimonials. It also heard evidence from the Registrant who answered questions from both Counsel and the Committee.

Submissions on behalf of the Council

150. On behalf of the Council, Mr Geering invited the Committee to find that the Registrant's fitness to practise is currently impaired. He referred to principles in *Grant [2011] EWHC 927* and said that the Committee should determine whether the Registrant '*was liable in the future*' to act as he had in 2013 and 2019. Mr Geering submitted that the Registrant had put patients at risk, brought the profession into disrepute, breached a fundamental tenet of his profession (in that he had put his own interests first) and acted dishonestly. Mr Geering submitted that there is a clear risk of repetition.

151. Clinical concerns arose in 2013 when two serious conditions were missed or misunderstood by the Registrant. To his credit, the specific concerns from 2013 were subject to targeted remediation. Nonetheless, clinical concerns again arose in 2019. Mr Geering referred to '*dozens of patients'* not being properly examined, or not having relevant tests performed, or not being asked appropriate questions.

152. Mr Geering submitted that these failings were widespread and significant. There were 30 patients in Schedule C who reported a decline in vision; the Registrant had failed to explore this adequately. There were 74 patients in Schedule D whose employment was not explored adequately. Schedule F lists dozens of patients who had no adequate internal eye examination. Schedule G identifies patients who had no cover test. Mr Geering submitted that all these patients were put at risk of harm.

153. Mr Geering argued that these schedules tie in with the evidence relating to Patient 106 and Patient 3, who were not examined properly by the Registrant. Neither of these examples represents an isolated incident or episode. Mr Geering submitted that there was a clear pattern.

154. The Registrant has provided the Committee with a reference from his manager postdating the events in question and two audits, relating to a total of 20 patients. Mr Geering submitted that this constitutes a limited evidential basis on which to find that the Registrant has fully remediated such long-standing and widespread concerns.

155. Mr Geering submitted that the Registrant's insight and remediation is still limited and that there is a real risk of repetition of dishonesty, which should be a concern, as there is a clear pattern of dishonesty. In 2013 the Registrant altered records and claimed to have conducted a test that he had not conducted. In 2019 the Registrant altered Patient 106's records and recorded fictitious tests in relation Patient 3. Mr Geering argued that the

Registrant had repeatedly acted in a dishonest manner and exposed patients to risk of harm.

156. Mr Geering submitted that the Registrant's anxiety in relation to work pressure do not provide an adequate explanation for dishonesty or clinical shortcomings in 2013 and 2019. Mr Geering did not accept that the Registrant had amended records in 2013 (solely) to make them more accurate, in view of his decision (on another occasion) to include a test that he had never performed.

157. The Registrant did not seek advice from his union, whistle-blow or make a complaint about work pressure in 2019. Mr Geering said there was no real evidence that the Registrant had raised concerns informally at the time, or expressed anxiety (regarding work pressures) to colleagues or anyone else.

158. Mr Geering submitted that the Registrant displayed no insight at the time of his interview by Mr B. Although it is to his credit that the Registrant has cooperated with his regulator and admitted the allegations, Mr Geering submitted that the Registrant cannot properly claim credit for being remorseful '*immediately*' as his actions did not demonstrate any immediate remorse.

159. Mr Geering submitted that the Registrant had not adequately reflected on the full extent of his dishonesty and the danger it posed to patients, until he was cross examined in this hearing and given an example of the risk of melanoma not being identified.

160. Mr Geering acknowledged that the Registrant's admissions provide some evidence of insight, but argued that it is still developing. Mr Geering submitted that there is a risk of the Registrant again putting his own interests above those of patients, as he did many times in 2013 and 2019.

161. Mr Geering acknowledged that not every instance of misconduct (even involving dishonesty) indicates impairment. However, he submitted that the Registrant's dishonesty was not minor or insignificant, as it undermined the integrity of clinical records for the patients concerned.

162. In addition, Mr Geering submitted that the Registrant's clinical failings were widespread and serious. He submitted that the wider public interest requires a finding of impairment in this case, even if the Committee finds no risk of repetition.

163. Mr Geering submitted that the Registrant's actions had caused alarm to Ms A and had exposed Patient 3 and Patient 106 to a risk of harm. Mr Geering said that the Registrant's dishonesty was repeated in relation to Patient 3 and Patient 106 and argued that his actions required a degree of planning: logging on, accessing records and addressing the failings.

164. Mr Geering submitted that the public interest is strongly engaged and that a finding of impairment is required to protect patients, uphold standards and maintain public confidence in the profession of optometry.

Submissions on behalf of the Registrant

165. On behalf of the Registrant, Mr Archer submitted that the purpose of fitness to practise proceedings is not to punish the Registrant for past misdoings. Rather, the purpose is to protect the public against the acts and omissions of those who are not fit to practise. The task, therefore, of the Committee is to look forward, not back: *Meadow v GMC* [2006] EWCA Civ 1390.

166. The Registrant's misconduct was in 2013 and 2018-2019. Mr Archer said that the question now is ***not*** whether the Registrant's fitness to practise was impaired then, it clearly was. The key question is whether his fitness to practise is still impaired today.

167. Mr Archer submitted that the gaps in the Registrant's clinical knowledge have been remediated. The failure to diagnose retinal detachment, and the inappropriate referral for Patient 2 both happened years ago, with no repetition of those mistakes in 11 years of further practice. To the contrary, the Registrant has properly diagnosed and handled every case of retinal detachment that he has been presented with since then. Mr Archer drew the Committee's attention to letters from patients describing their satisfaction with treatment by the Registrant.

168. Mr Archer submitted that the Registrant has undertaken training so that he has the ability to assess swollen discs, and to deal with those cases appropriately.

169. Another patient was referred immediately by the Registrant, found to have intracranial hypertension and given a lumbar puncture the following day. Mr Archer drew attention to supporting written evidence of this too.

170. Mr Archer said that the Registrant has undertaken work to fill the gaps in his knowledge and demonstrated over 11 years of regular practice that the Registrant will never repeat the mistakes that he made very early in his career.

171. Mr Archer submitted that record-keeping concerns had also been fully remediated by the Registrant, as he explained in his evidence: he gives himself more time during appointments, enters test results and checks records at the end.

172. Mr Archer acknowledged that it is much harder for a Registrant to show that probity concerns had been remediated. Mr Archer submitted that the Registrant's major change in approach began when he was confronted by Ms A (daughter of Patient 3) and that he had undertaken extensive learning on professional ethics and probity since then.

173. The Registrant admitted dishonesty at the outset of the hearing. If any dishonesty had been denied (and found proved) that would have been of much greater concern. Mr Archer submitted that a registrant who acts dishonestly by the standards of a reasonable person, and then disputes that they had done so, would be a real concern. But a registrant who realises their error, admits it, and then goes on to demonstrate that they have completely changed their approach and worked hard to ensure they will never repeat the same mistakes is in an entirely different category.

174. Mr Archer submitted that, before that point, the Registrant: '*did not consider himself to be dishonest. He viewed himself as a good person, a team-player, trying to meet the expectation of his managers, trying to pick up the slack when clinics were not running on schedule, trying to get through appointments quickly so that patients were not inconvenienced*…

175. Mr Archer added that, a month later, when [the Registrant] was under pressure at Specsavers in [redacted], he had resisted that pressure:

    'He refused to rush his appointments. He told the manager that he could not test any faster.'

176. Mr Archer summarised the Registrant's further training on probity and ethics and submitted that this further learning had equipped the Registrant with the knowledge and confidence to give effect to his desire to do the right thing. He is now able to recognise when ethical issues may arise in the workplace, and has the tools to rationalise and to articulate what the appropriate response is. He now has the confidence he needs to be the optometrist he has always wanted to be.

177. Mr Archer submitted that it was very difficult for the Registrant to face up to the reality that he had acted *dishonestly* because he considers himself to be honest in a fundamental sense. Mr Archer submitted that the Registrant had focused much effort on remediation to ensure that there is no risk of repetition.

178. Mr Archer submitted that the Registrant had made full admissions and admitted allegations that he could have very easily denied or minimised if he had wanted to. Instead, Mr Archer argued that the Registrant's approach has been to be totally honest and to admit everything, except those things that he *knew* were wrong.

179. Mr Archer said that the Registrant is '*a very different person now'* from the person who acted as described in the Allegation in 2013 and 2018-2019. The Registrant now has the knowledge, training and resolve to always act honestly irrespective of the consequences.

180. On behalf of the Registrant, Mr Archer submitted that his fitness to practise is not currently impaired, adding that a finding of impairment is not required or *necessary* in the public interest. Although every finding of misconduct will, to some degree, affect public confidence in the profession, that does not mean that every case requires a finding of impairment to be made to maintain public interest in the profession.

181. Mr Archer submitted that fair-minded members of the public are not entirely unsympathetic to human frailty. He argued that no GOC witness had demonstrated any animosity towards him or mentioned any reason to doubt that the Registrant is a fundamentally decent person. The Committee should take account of the lapse of time since the relevant time/s.

182. Mr Archer submitted that the allegations are now '*very old'* so a fair-minded member of the public might struggle to understand why it is necessary to take action now given that it was not considered necessary to impose any interim order, and in circumstances where the Registrant has proved over the last five years that he is an honest and competent optometrist… who now refuses to succumb to pressure from managers to test patients quickly.

183. In conclusion, Mr Archer submitted that a finding of current impairment of the Registrant's fitness to practise is not required to protect patients or the wider public interest. A finding of impairment is not necessary in this case.

Legal Advice

184. The Legal Adviser reminded the Committee that, at the impairment stage, there is no burden or standard of proof. It is a question of judgment for the Committee. Impairment may be based on historical matters or a continuing state of affairs, but it is to be decided at the time of the hearing. To do this the Committee must look forward, taking account of any reparation, changes in behaviour, conduct or attitude since the relevant time.

185. In determining impairment, the Committee must consider whether or not the Registrant's misconduct indicates any future risk of harm, breach of a fundamental tenet of his profession, bringing optometrists into disrepute or dishonesty: *Grant [2011] EWHC 927*.

186. The need to maintain public confidence in the health professions or declare standards of behaviour may mean that a clinician's fitness to practise is impaired by reason of misconduct. This is because the public simply would not have confidence in him, or in the profession's standards, if the Committee regarded this sort of misconduct as leaving fitness to practise unimpaired.

187. A finding of impairment may be necessary (even in the absence of ongoing risk) to reaffirm to the public and optometrists the standard of conduct expected: *Yeong v GMC [2009] EWHC 1923*.

Analysis and decision of the Committee

188. The Committee accepted the unchallenged advice of the Legal Adviser. It took account of all evidence and submissions presented by the Council and the Registrant. The Committee understood that it had to determine whether the Registrant's ***current*** fitness to practise is impaired, or not.

189. The Committee also took account of the Council's *Indicative Sanctions Guidance* (ISG) in relation to impairment and dishonesty:

'17.1 The GOC's Code of Conduct for individual registrants and Standards document both state that the registrant must "*be honest and trustworthy*". Dishonesty is particularly serious as it may undermine confidence in the profession. Examples of dishonesty may include:

a) …

b) …

c) Improperly amending or changing the detail on patient records…

17.8 The Committee should be mindful of the guidance given in *Lusinga v NMC [2017] EWHC 1458 (Admin)* about the scale of dishonesty: '*...dishonest conduct can take various forms; some criminal, some not; some destroying trust instantly, others merely undermining it to a lesser or greater extent.*'

190. The Committee took account of positive factors raised by Mr Archer including the positive NHS audit findings, letters from patients and CPD certificates in the context of the Registrant's written reflections and oral evidence.

191. No concerns in relation to the Registrant's practice had arisen during two NHS record audits in 2021 and 2022. The Committee accepted the conclusions of the NHS independent clinical adviser who had reviewed a random sample of records. He informed the Registrant:

'Your records I've viewed today are certainly to the expected standard. […] I hope this feedback is helpful and you are reassured by me reviewing and being happy with your record keeping.'

192. The Committee also accepted the written evidence of Professor Harper:

'…*the Registrant's remedial steps seem very detailed and appropriately focussed on the clinical and ethical matters at the heart of the allegations against him.'*

193. In oral evidence Professor Harper confirmed his view:

'Taken in the round and alongside CPD, it seemed to me that [the Registrant] had made an appropriately focused effort to address both the clinical and ethical concerns.'

194. However, the Committee was concerned about the scale of the Registrant's failings and the high number of patients involved. The Committee was also concerned by the Registrant's repetition of dishonest actions.

195. The Committee considered principles in *Grant* which set out the appropriate test for panels considering impairment of fitness to practise. The Committee found that the Registrant's misconduct had repeatedly put patients at risk of harm, placed his own interests above those of patients (a breach of a fundamental tenet of good health care), brought the profession of optometry into disrepute and been dishonest. The Registrant acknowledged all these issues in his evidence, thus demonstrating a degree of insight.

196. The Registrant provided reflective statements to the Committee dated 8 April 2024 and 27 April 2024. He gave oral evidence of positive changes in his practice. These included reducing the number of eye examinations conducted each day and increasing his test time to 25-30 minutes, to allow for time to review clinical records at the end of each appointment. He also customised the order of electronic screens to reflect the order of his examinations, rather than using default settings.

197. The Committee took account of the Registrant's engagement with CPD to address concerns arising from interactions with Patient 1 and Patient 2, involving retinal detachment (2019) and swollen discs (2021). He had provided evidence of reflection on what he had learned in relation to swollen discs and other matters.

198. The Registrant had also undertaken further training on record-keeping. This included a course in 2023: '*Master Your Record-keeping'*. Results of two audits of ten random patient records in 2021 and 2022 disclosed no concerns about records made by the Registrant in those years. He provided two reflections on record- keeping in 2023.

199. Positive NHS audit findings were relevant to record-keeping, but the Committee considered that the Registrant's failings were more extensive and wide-ranging than record-keeping errors alone. His failings included falsifying records and failing to conduct tests and/or record results of tests conducted. The Committee was aware that record cards show what test results were recorded, but do not necessarily reflect what tests were conducted.

200. The Registrant provided reflections on maintaining standards in practice, detailing six occasions between July 2022 and June 2023 when he had dealt with clinical pressures. Testimonials from four patients indicated that the Registrant had correctly identified retinal detachment or swollen optic nerve/s.

201. In view of his clinical remediation and uneventful years of practice since the relevant time, the Committee found that there was little or no risk of the Registrant making similar errors to those admitted in relation to Patient 1 and Patient 2. This is because he had demonstrated an ability to diagnose retinal detachment and make appropriate referrals in relation to suspected papilloedema.

202. The Committee was concerned that, due to the Registrant's frequently cavalier approach to clinical care, a total of 222 patients had to be retested. This was reflected in the Allegation and Schedules of numerous patients affected in one year. The Committee identified an ongoing risk that the Registrant may put his own perceived interests ahead of those of future patients. Another clinician may be misled by inaccurate records and there could be serious health or other consequences for patients.

203. The Committee also took account of the Registrant's CPD on probity and ethics. This included ongoing reflections and the following:

- October 2019 - Peer discussion '*GOC Complaints – be safe, not sorry*'.
- July 2021 - In-person interactive event '*Always be on your best behaviour*'.
- 14-17 July 2022 - Three day in-person course on *Ethics and Probity*.
- July 2022 - Webinar by Prof Ariely '*The truth and dishonesty'*.
- June 2023 - Webinar '*Navigating challenging situations at work*'.
- September 2023 - Webinar '*Dishonesty in Practice'*.

204. The Committee considered dishonesty to be inherently difficult to remediate, particularly when it has been repeated or sustained over time. Although ethics and probity courses are useful and may trigger or enhance the development of insight, CPD is not sufficient, *in itself*, to demonstrate a change in attitude and behaviour.

205. The Committee took account of a positive testimonial from the General Manager (aware of the allegations) at one of the two independent practices where the Registrant practises one day a week. It gave less weight to a character reference from an optometrist who was a student optometrist at the same time as the Registrant.

206. The Registrant sought to explain how he applies his learning in relation to ethics and probity in his current practice. In the Committee's view he demonstrated partial insight into potential consequences of errors or omissions for patients, future clinicians (relying on his records) and public confidence in the profession of optometry.

207. The Registrant acknowledged, when prompted in cross-examination, the risk of melanoma being missed in clinic, should an optometrist not conduct or record the results of an internal eye examination. In answer to a Committee question about the most useful part of his remediation, the Registrant focused on his need to reduce his anxiety about '*running behind'* instead of considering his patients' interests directly.

208. The Committee recognised that lowering anxiety may reduce his risk of cutting corners or dishonesty, but the Committee considered that such behaviour is never justifiable, or readily explicable, however busy the practice. The Registrant's relative lack of experience does not explain his dishonest insertion of an Amsler test result in Patient 2's records, which he knew he had not conducted.

209. Many optometrists work under pressure and clinics sometimes run late. This is not a good explanation for cutting corners, omitting important tests, or making retrospective amendments to cover up previous errors or omissions.

210. The fact that the Registrant did not mention his dishonesty in relation to Patient 106 when he was alerted to probity issues in relation to Patient 3 (a few weeks later) casts doubt on his ability or inclination to be open when things go wrong in practice, in the view of the Committee. If Ms A had not observed the Registrant making inaccurate entries in the record, it is uncertain when (or if) his corner-cutting and false records would have come to light.

211. The Registrant could have admitted previous falsification of records when questioned at work in 2019 but, as he acknowledged, he became defensive and tried to 'be clever' with his answers to Mr B. The Committee took account of Mr B's record of interview. This said that the Registrant claimed to have '*checked everything relevant in the eye examination and knew he hadn't overlooked anything*.'

212. The Committee considered that the Registrant's misconduct was motivated by wanting to '*look good'* to colleagues and to avoid further criticism. If an optometrist records that they have examined the back of an eye without having done so, as happened with Patient 106 and the 68 patients in Schedule F, this poses a real risk to patients. It was unclear to the Committee how aware the Registrant was (at the time) of potential consequences for patients, who trusted him to act professionally.

213. Development of insight may be an ongoing process. As the Registrant's insight and remediation are not yet sufficient, the Committee identified an ongoing risk of repetition, taking account of the history of dishonesty over time in a clinical context.

214. The Committee considered that the Registrant has partial insight into some (if not all) of the catalysts for his misconduct and its potential consequences for patients, colleagues, the profession and public confidence. However, the Registrant has not demonstrated sufficient awareness of why he acted as he did, or why he lacked probity in relation to his practice.

Conclusions

215. The Committee is satisfied that sufficient remediation has been undertaken in relation to Particulars 1 and 2. However, the Committee concluded that, although his remediation demonstrates that the Registrant has made efforts to improve his clinical practice, the CPD and reflection undertaken were not sufficiently targeted towards his understanding the importance of conducting all elements of a sight test.

216. The Committee was not provided with sufficient evidence of the implementation of relevant changes in practice. The Registrant had not yet adequately addressed the misconduct found in relation to Particulars 5-10.

217. In the Committee's view the Registrant's clinical failings were the result of his '*slapdash'* and cavalier approach to eye examinations, rather than to a lack of knowledge or training. He took shortcuts in his clinical examinations and added tests that had not been undertaken, in his own interests, to meet deadlines and avoid criticism, rather than prioritising the needs of his patients. In the Committee's view this is an attitudinal issue and not simply a record-keeping issue.

218. In all the circumstances, the Committee concluded that there is a risk of repetition. The Registrant may put future patients at risk of harm; place his own interests above theirs, thereby breaching a fundamental tenet of the profession; bring the profession of optometry into disrepute or be dishonest in future.

219. The Committee considered that the large number of patients affected by the Registrant's failings, 222 of whom had to be re-examined, and most of whom are likely to have lived locally, together with the repetition of dishonesty, would cause great concern to members of the public. Trust in the profession of optometry is likely to have been damaged and public confidence in the profession would therefore be undermined if a finding of impairment were not made.

220. A finding of impairment is required to protect the public and in the wider public interest, including to uphold standards and maintain confidence in the profession.

221. The Committee determined that the Registrant's fitness to practise is impaired by reason of misconduct.

Sanction

222. Having determined that the Registrant's fitness to practise is currently impaired by reason of misconduct, the Committee went on to consider whether it was impaired to a degree which required action to be taken in relation to his registration.

Submissions on behalf of the Council

223. On behalf of the Council, Mr Geering submitted that the appropriate and proportionate sanction was erasure in view of the Registrant's calculated and repeated dishonesty. He said that the Registrant had put his own interests above those of his patients. Mr Geering submitted that the Registrant's misconduct had the potential to cause harm to patients and to undermine public confidence in optometrists.

224. Although he had engaged with his regulator, demonstrated partial insight and made admissions to all particulars found proved, erasure is the only sanction which is sufficient to protect the public and wider public interest.

Submissions on behalf of the Registrant

225. On behalf of the Registrant, Mr Archer submitted that the Committee should consider a Conditional Order or a Suspension Order as erasure would be unnecessary and disproportionate. The Registrant's CPD in relation to probity and other topics had enabled him to identify and deal with potential clinical or ethical issues in the future.

226. Mr Archer submitted that the Committee should take account of the Registrant's admissions to the allegations. In this context he referred to various judgments on dishonesty including *Moseka v NMC* [2014] EWHC 946 which said:

'*The consequences of proceedings such as these can potentially be more severe than the sentence imposed in many criminal cases. When somebody's livelihood is hanging in the balance, that is a real test of a registrant. Not everybody is prepared to stick to their principles in the face of potentially losing their career and the ability to support their family*.'

227. *Hassan v GOC* [2013] EWHC 1887 provides a reminder that dishonesty encompasses a wide range of circumstances. Mr Archer submitted that there is no default sanction of erasure for dishonesty. In *Hassan,* a student optometrist had received a caution for an offence of fraud but failed to declare this. The High Court quashed the sanction of erasure on the basis that the (registrant) appellant should have been given credit for admitting his wrongdoing to the police; although he did fail to declare the caution on two separate occasions, he had ultimately come forward to refer himself to the GOC.

228. Mr Archer also relied on *Lusinga v NMC [2017]* EWHC 1458 to support his submission that there are two ways to assess the scale of dishonesty. First, to look at whether a registrant's misconduct amounted to a criminal offence; Mr Archer said that it does not in this case. Second, the Committee should determine whether the Registrant's dishonesty undermined or destroyed public trust instantly, or not. Mr Archer said that there was no evidence that trust had *instantly* been destroyed. However, he acknowledged that members of the public would be concerned about the Registrant's (dishonest) retrospective amendments of clinical records.

229. Mr Archer reiterated that the Registrant is '*a very different person now'* from the person he was at the relevant times. Mr Archer submitted that the Registrant's behaviour in 2013 and 2018-2019 may be dealt with by way of a Conditional Order or a Suspension Order; his misconduct does not require the most serious sanction. Erasure would have a devastating impact on the Registrant, who has a young family to support, and would be disproportionate in all the circumstances.

230. Mr Archer reminded the Committee to adopt a proportionate approach, balancing aggravating with mitigating factors. With reference to paragraph 14 of the *Hearings and Indicative Sanctions Guidance* (ISG) Mr Archer submitted that there is no evidence of harm to any member of the public. However, the Registrant accepts that copying details from previous clinical records into current records would pose a risk to patients.

231. The evidence of remorse is far stronger than a mere assertion and should be given weight. Ms A gave evidence that the Registrant appeared to be '*ashamed'* as soon as he was confronted. In late 2019, he refused to succumb to pressure from managers at Specsavers in [redacted] to test patients quickly, indicating good judgement and probity. He refused to continue working there, recognising that he needed over 20 minutes to examine each patient. This change in his practice was very early.

232. Mr B told the Committee that he had found the Registrant to be remorseful. The Registrant had understood Ms A's comments and was happy to accept further training. Mr Archer submitted that this provides strong evidence of remorse and insight; also that the Registrant had proved over the last five years that he is now a competent and honest optometrist. He has completed extensive CPD.

233. Mr Archer submitted that the Committee should take account, as a mitigating factor, of the lapse of time since these events and the fact that the Registrant was at an early stage in his career in 2013. The allegations are based on events going back a long time and the Registrant has been aware of (and affected by) these proceedings for the past five years.

234. Mr Archer reminded the Committee that the Council had not deemed it necessary at any point during that period to impose an Interim Order, so the Registrant has continued to practise without any restriction since 2019. Mr Archer submitted that the Registrant has

used his time well in the past five years to progress and reflect on how to ensure that there was no repetition of his misconduct.

235. If the Committee determined to impose conditions, the Registrant would present no ongoing risk to the public. Supervision would ensure his further remediation. The Committee should not underestimate the impact of these proceedings, which have been hanging over the Registrant for five years.

236. The criteria for a suspension order, set out in the ISG, indicate that this would be adequate to deal with the concerns raised by these proceedings. There should be no need for the Committee seriously to consider erasure, which is not required to protect the public or in the wider public interest. It would be over-punitive in the context of the Registrant's responsibilities and disproportionate in light of all the mitigating factors.

Legal Advice

237. At the Sanction stage of proceedings there is no burden or standard of proof and the decision on sanction is a matter for the Committee's judgment alone.

238. *Raschid v GMC* [2007] 1 WLR 1915 indicates that the Committee is mainly concerned with the reputation of the profession, despite the fact that sanctions may have a punitive (even a devastating) effect. *Bijl v GMC [2001]* UKPC 42 said that a Committee should not be obliged to erase an otherwise competent and useful healthcare professional who presents no danger to the public, in order to satisfy public demand for blame or punishment.

239. The ISG is intended to be flexible and is not comprehensive in describing all circumstances. Although a Committee need not adhere to the ISG, it should have proper regard to it: *Bramhall [2021]* EWHC 2109.

240. Mitigation can affect the type of sanction, as well as the length of a relevant order. In *Wisniewska v NMC* [2016] EWHC 2672 it was said that, where there are only two options for sanction such as striking off or suspension, it is critical that the available mitigation is applied when evaluating the proportionality of each alternative. Although mitigation can reduce the length of suspension, it could also pull a case back from the brink of strike-off and mean that a suspension is proportionate. Mitigation must be assessed by the Committee in this context. While there might be a public interest in enabling a practitioner's return to safe practice, protection of patients and the wider public interest remain a primary concern.

241. The impact on public confidence in cases involving dishonesty, in particular of a regulatory regime, is not diminished just because the practitioner in question is unlikely to repeat their dishonesty, if that is the case: *GMC v Armstrong* [2021] EWHC 1658.

242. In deciding what sanction, if any, to impose the Committee should consider the available options starting with the least restrictive. It should also take account of the principle of proportionality and the need to weigh the interests of the public against those of the Registrant.

243. The Committee should consider all evidence of remorse, insight and remediation, including CPD certificates and relevant testimonials. Account should be taken of submissions from both Counsel.

The Committee's Decision on Sanction

244. The Committee accepted the unchallenged advice of the Legal Adviser and took account of the ISG which confirms that sanctions are to be considered in ascending order of severity. The Committee accepted that the purpose of a sanction was not to be punitive, but to protect members of the public; also that the wider public interest includes declaring and

upholding professional standards and maintaining public confidence in both the profession and the regulatory process.

245. In reaching a decision on sanction, the Committee has taken account of all the evidence and submissions from counsel in light of principles in the ISG, the statutory overarching objective and relevant law.

Aggravating and Mitigating Factors

246. The Committee took account of its decisions at earlier stages of this hearing, in its deliberations on sanction. The Committee considered and balanced the aggravating and mitigating factors identified in this case.

247. The Committee considered paragraph 14.3 of the ISG and identified the following aggravating factors:

Dishonesty

- On three occasions, two of which occurred close together in 2019
- Two incidents involved a degree of planning in relation to amendment of records.

Scale of wrongdoing

- A large number of patients were affected by the Registrant's misconduct,
- All were placed at potential risk of harm.

2. Both aggravating factors were identified as serious.

3. The Committee considered relevant parts of paragraph 14 of the ISG and identified the following mitigating factors:

- Admissions to all particulars found proved
- Partial insight
  - Reflected by CPD and other steps to remediate
- Lapse of time since 2019
  - Five years of practice, without evidence of repetition
- Testimonials, including one from a current manager, and several from patients.

4. The Committee gave most weight to the first three mitigating factors.

5. The Committee also took account of the fact that the Registrant has expressed remorse and apologised for his behaviour, and that he had no previous regulatory findings. The Committee had no evidence of actual harm to any patient.

6. After weighing the aggravating and mitigating factors discussed above, the Committee considered each option / sanction in ascending order of severity, starting with the least restrictive. A financial penalty was not deemed relevant to this case as the Allegation did not relate to financial issues.

7. The Committee considered whether a sanction was necessary.

No further action

8. The Committee had to consider whether to conclude the case by taking no action. Taking no action after a finding of impaired fitness to practise is appropriate only in exceptional circumstances. The Committee determined that there are no exceptional circumstances in this case that would justify taking no action. To take no action would not be proportionate or in the public interest, given the serious nature of the Registrant's misconduct.

9. No further action would not protect patients, uphold standards or maintain public confidence in the profession. Accordingly, the Committee concluded that a sanction was required.

Conditional Order

10. The Committee next considered whether to impose conditions of practice for up to three years on the Registrant. It took account of his readiness to comply with supervision, as implied by Mr Archer.

11. The Committee took account of paragraph 21.25 of the ISG:

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

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

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

12. In the Committee's view the clinical failings of the Registrant indicate fundamental attitudinal problems. The Registrant's clinical failings stemmed from a cavalier approach to his professional practice. Although the Registrant has now changed his practice, conditions are not workable to address this attitudinal problem.

13. Similarly, the Committee was not satisfied that any conditions would be appropriate to address the Registrant's dishonesty.

14. The Committee concluded that imposing a Conditional Order on the Registrant would not be sufficient or appropriate to protect future patients, uphold standards or maintain public confidence in the profession of optometry.

Suspension Order

15. The Committee next considered whether to suspend the Registrant from practice for up to twelve months. Suspension can have a deterrent effect and it would send a signal to the Registrant, the profession, and the public as to the standards expected of registered optometrists.

16. Suspension may be appropriate where there is an acknowledgement of fault and the Committee is satisfied that the misconduct is unlikely to be repeated. It would protect the public for the period of the suspension, and give the Registrant further time to develop insight and remediate.

17. The Committee took account of relevant criteria in paragraph 21.29 of the ISG:

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

a. A serious instance of misconduct 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

e. …

18. The Registrant's misconduct breached important professional standards. These allegations stemmed from the Registrant's cavalier approach to conducting eye examinations in 2013 and 2018-2019. The misconduct was uncovered by chance, when a student optometrist happened to observe the Registrant dishonestly recording an eye examination. This led to an audit of the Registrant's eye examinations over the previous year, a high proportion of which were found to have been inadequate, with important aspects of many examinations not undertaken. His clinical failings had placed numerous patients at risk of harm.

19. The Registrant's dishonesty in retrospectively amending records was considered by the Committee to have been an attempt to cover up his previous failings. He failed, when caught, to declare the previous incident only a few weeks earlier. The seriousness of the Registrant's dishonesty was compounded by his reluctance to be fully candid at his investigation interview in 2019.

20. The Registrant repeatedly placed his own interests above the interests of patients through his dishonest actions and inadequate standard of care. The Committee considered that the period of time over which the misconduct took place, its scale impacting over 200 patients, the range of his clinical failings, and a cavalier approach to patient care are all indicative of attitudinal problems. In the Committee's view, his previous attitude was ingrained.

21. Attitudinal issues are difficult to remediate. Despite the Registrant's CPD and changes to his practice, his insight into the seriousness of his behaviour and their potential adverse consequences remains partial. The Committee considers that there is a significant risk of repetition.

22. The Committee did not give weight to his relative inexperience as all optometrists, even those who are newly qualified, should know not to amend any clinical record without a clear indication that a change was made. There was no proper justification for inserting false results for the Amsler test.

23. The Committee considered that none of the mitigating factor/s presented by Mr Archer significantly reduced the seriousness of the Registrant's misconduct. His actions amounted to a pattern of serious misconduct that had put numerous patients at risk of harm.

24. The Committee determined that a Suspension Order, even for 12 months, would not adequately satisfy the need to protect patients and maintain public confidence in optometrists.

25. **Erasure**

26. In considering erasure, the Committee took account of relevant sections of paragraphs 14.5, 21.35 and 21.37 of the ISG:

    14.5 …*If a registrant's conduct shows they are fundamentally unsuited for registration as a healthcare professional, no amount of remorse or apology, or indeed positive personal qualities in other respects, can mitigate the seriousness of that conclusion and its impact on registration*.

21.35 – 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):

a. Serious departure from the relevant professional standards as set out in the Standards of Practice for 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……

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

21.37 Erasure from the register is appropriate if it is the only means of protecting patients and/or maintaining public confidence in the optical profession.'

27. The Committee considered that the Registrant's behaviour was so serious that his misconduct is fundamentally incompatible with continued registration.

28. Although there is merit in facilitating the safe return to practice of an otherwise competent practitioner, the Committee considered that it would be difficult for (informed) colleagues to place their trust in the Registrant or his records. In addition, members of the public are likely to be concerned about the reliability of his eye examinations or clinical records. Public confidence would be adversely impacted by the fact that over 200 people had had to be recalled to have their eyes re-examined.

29. The Committee took account of the grave financial and reputational consequences of erasure for the Registrant. However, the Committee was very concerned about the need to protect the public and the impact of the Registrant's misconduct on public confidence in the profession. It took account of paragraph 21.38 and relevant principles in *Bolton* [1994] 1WLR 512:

'The reputation of the profession is more important than the fortunes of any individual member. Membership of a profession brings many benefits but that is part of the price.'

30. The Committee concluded that a sanction of erasure is required to protect patients, promote and maintain public confidence in the profession of optometry, and to uphold proper professional standards and conduct for members of the profession.

31. The Committee therefore determined to erase the Registrant's name from the register of optometrists.

Decision on the Council's Application for an Immediate Order

32. Having determined to erase the Registrant's name from the register of optometrists, the Committee has considered if his registration should be subject to an immediate order, in accordance with section 13I of the Opticians Act 1989 and paragraph 23 of the ISG.

Submissions

33. Mr Geering applied for an immediate order of suspension in light of the risk of repetition and to be consistent with the Committee's substantive determination.

34. On behalf of the Registrant, Mr Archer opposed the application. He submitted that an immediate order was not necessary. It is the Registrant's right to appeal and he has been practising for the last five years without incident. Therefore, allowing him to continue for another 28 days would not pose a risk.

Legal Advice

35. The Committee may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the Registrant; the standard is necessity. An immediate order might be particularly appropriate in cases where the Registrant poses a risk to patient safety.

36. Immediate action may also be taken to protect public confidence in the profession. In relation to the wider public interest, the bar is high, close to necessity.

Decision of the Committee

37. The Committee took account of relevant paragraphs of the ISG. In particular, it considered paragraph 23:

'*23.3 If the Committee has made a direction for (suspension or) erasure, it should consider whether there are reasons for ordering immediate suspension. Before doing so, the Committee must be satisfied that to do so is necessary for the protection of members of the public, otherwise in the public interest or in the best interests of the Registrant.*

23.4 If the Committee thinks there may be grounds for immediate conditions or suspension, it must inform the Registrant of these concerns and invite representations on this issue from both the Presenting Officer and the Registrant's representative. The Committee must then decide whether to impose an Immediate Order and give reasons.

23.5 The Committee must always make clear in its determination that it has considered whether to make an Immediate Order and explain the factors considered, even if it decides that an Immediate Order is not necessary.'

38. The Committee, having heard and accepted the advice of the Legal Adviser, decided to impose an immediate order. In view of its findings that there was an ongoing risk to the public, the Committee considered that such an order was necessary to protect the public and otherwise in the wider public interest.

39. The direction to erase the Registrant's name from the register of optometrists will take effect 28 days from when notice is deemed to have been served on him, unless he lodges an appeal in the interim. A notice explaining his right of appeal will be sent to him. If the Registrant lodges an appeal, the immediate order of suspension will remain in place until such time as the outcome of any appeal is determined.

40. That concludes this case.

Chair of the Committee: Rachel O'Connell

Signature  **Date: 3 May 2024**

Registrant: Yaqut Khan

Signature *present and received via email* **Date: 3 May 2024**

Annex A

Schedule A

Record section	***Original record***	***Amended record***
Reason for visit	*'DV worse NV OK **No** headaches No diplopia No other problem reported'*	*'DV worse NV OK headaches longstanding No diplopia No other problem reported'*
Optic disc	*'Healthy Colour Margins NRR intact'*	*'Healthy Colour Margins discs slightly raised no haems'*
Macula	*'Normal Reflex'*	*'Normal Reflex no distortion on amsler'*

Schedule B

Record Section	***Amended Record***
Anterior Chamber Left and Right	*'Clear & Quiet'*
External Eye Right and Left	*'Lids/Lashes Bulbar Conjunctiva Sclera Cornea Normal as seen'*
Lens Right and Left	*'Clear Lens'*
Optic Disc Right and Left	*'Healthy Colour Margins'*
CD Ratio Right and Left	*'0.25'*
Vessels Right and Left	*'Normal'*
AV Ratio Right and Left	*'2/3'*
Macula Right and Let	*'Normal Reflex'*
Peripheral Retina Right and Left	*'All Quadrants Checked Flat/ Even Pigmentation'*

Schedule C

Patient
Patient 012
Patient 015
Patient 021
Patient 024
Patient 030
Patient 033
Patient 036
Patient 057
Patient 069
Patient 072
Patient 075
Patient 084
Patient 087
Patient 090
Patient 099
Patient 102
Patient 108
Patient 111
Patient 126
Patient 129
Patient 132
Patient 135
Patient 141
Patient 150
Patient 171
Patient 177
Patient 180
Patient 183
Patient 201
Patient 210

Schedule D

Patient
Patient 003
Patient 006
Patient 009
Patient 012
Patient 015
Patient 018
Patient 021
Patient 024
Patient 027
Patient 030
Patient 033
Patient 036
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Patient 042
Patient 045
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Patient 198
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Patient 204
Patient 207
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Patient 216
Patient 219
Patient 222

Schedule E

Patient
Patient 003

Patient 006
Patient 009
Patient 012
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Patient 042
Patient 048
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Patient 216
Patient 219
Patient 222

Schedule F

Patient
Patient 003
Patient 006
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Patient 039
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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.