BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(24)11

AND

ELIZABETH WILLIAMS (01-36542)

DETERMINATION OF A SUBSTANTIVE HEARING
16 -18 SEPTEMBER 2024 and 12 – 16 MAY 2025

Committee Members:	Ian Crookall (Chair/Lay) (16-18 September 2024 only) Paul Curtis (Chair/Lay)(Chair from 12-16 May 2025) Nigel Pilkington (Lay) Kalpana Theophilus (Optometrist) Ewen MacMillan (Optometrist)
Legal Adviser:	Aaminah Khan
GOC Presenting Officer:	Nutan Fatania
Registrant present/represented:	No and not represented
Registrant representative:	N/A
Hearings Officer:	Arjeta Shabani 16-18 September 2024 Latanya Gordon 12-16 May 2025
Facts found proved:	Particulars 1(a)(c)(d), 2, 3(a)(c), 4, 5, 6(a)(b), 7, 8(a)(c), 9, 10, 11(a)(c)(e)
Facts not found proved:	Particulars 1(b)(e), 3(b), 6(c), 8(b)(d), 11(b)(d)
Misconduct:	Found
Impairment:	Impaired
Sanction:	Suspension 12 months – (With Review)
Immediate order:	Imposed

Proof of service

1. As the Registrant did not attend the hearing, nor was she represented, the Committee heard an application from Ms Fatania, on behalf of the Council, for the matter to proceed in the Registrant's absence.

2. First, the Council was required to satisfy the Committee that the documents had been served in accordance with Section 23A of the Opticians Act 1989 and Rule 61 of the General Optical Council (Fitness to Practise) Rules 2013 ('the Rules'). The Committee had before it a service bundle, containing documentation relating to the service of the Notice of Hearing. It also received a 'non-engagement bundle', which contained further correspondence relating to the preparation for the substantive hearing.

3. Ms Fatania took the Committee through the service bundle and referred the Committee to the Notice of Hearing, dated 10 June 2024, which contained the details of the hearing. Ms Fatania highlighted that the correspondence had been emailed to the Registrant's registered email address, which she had previously consented to being used for correspondence with the Council. Further, the Registrant had been sent the relevant information relating to the hearing bundle and the hearing links, as required by the Rules.

4. Ms Fatania invited the Committee to find from the correspondence with the Registrant that there had been good service in accordance with the Rules.

5. The Committee accepted the advice of the Legal adviser, who referred the Committee to the Rules on service of the Notice of Hearing, the requirement that at least 28 days notice should be given for a substantive hearing and acceptable methods of service.

6. The Committee had regard to the documentation before it regarding service contained within the service bundle. The Committee noted that the Registrant had been served with the Notice of Hearing over 28 days ago, on 10 June 2024, which was sent to an email address that the Registrant had registered with the Council. The Committee further noted that the Registrant had previously confirmed in an email to the Council on 28 February 2023 that she was content to receive notices from the Council via that email.

7. The Committee was satisfied, in the circumstances, that there had been effective service of the Notice of Hearing and that all reasonable efforts had been made to notify the Registrant of the hearing, in accordance with the Rules.

Proceeding in the absence of the Registrant

8. The Committee then went on to consider whether it would be in the public interest to proceed in the Registrant's absence in accordance with Rule 22, which states that:

> **"*Proceeding in the absence etc. of the registrant***
>
> *22. Where the registrant is neither present nor represented at a hearing, the Fitness to Practise Committee may nevertheless proceed if—*
> *(a) it is satisfied that all reasonable efforts have been made to notify the registrant of the hearing in accordance with section 23A(a) and rule 61; and*
> *(b) having regard to any reasons for absence which have been provided by the registrant, it is satisfied that it is in the public interest to proceed."*

9. Ms Fatania, on behalf of the Council, submitted that it was in the public interest to proceed in the absence of the Registrant, as the Registrant had not engaged with these proceedings since 7 March 2024. Ms Fatania highlighted the most recent correspondence received from the Registrant, which was dated 7 March 2024, in which she stated that, "*I have nothing more to add to the statement I provided previously re my investigation*." Ms Fatania submitted that it was significant that the Registrant went on to state in this email that she was no longer a Registrant and had no desire to re-register. Furthermore, she had not responded to any other correspondence regarding the preparations for this hearing.

10. Ms Fatania submitted that there was no application to adjourn, or any other submissions received from the Registrant. Therefore, it was reasonable to conclude that her position is as set out in the email of 7 March 2024 and that she had chosen not to engage further. Ms Fatania submitted that in the circumstances there was no prejudice or injustice to the Registrant in proceeding with the hearing and she invited the Committee to determine that it was in the public interest to proceed in the Registrant's absence.

11. The Committee accepted the advice of the Legal adviser, who referred the Committee to the guidance on proceeding in a Registrant's absence in the Council's '*Hearings and Indicative Sanctions Guidance*' (updated November 2021)('the Guidance'). She referred the Committee to the cases of *R v Jones* [2002] UKHL and *General Medical Council v Adeogba* [2016] EWCA Civ 162, which outlined the principles to apply when considering an application to proceed in absence.

12. The Legal Adviser advised that the Committee had a discretion as to whether to proceed in absence, and if so this should be exercised with great care. The Committee should have regard to any reasons for absence which have been provided by the Registrant, and consider, whether in the circumstances, it is in the public interest to proceed. The Legal Adviser advised the Committee that it should take into account the public interest in the hearing of cases in a timely and fair manner and if a decision was made to proceed in absence, this did not need to be reviewed at future stages of the hearing.

13. The Committee was satisfied that the Registrant was fully aware of today's hearing. It took the view from the Registrant's email dated 7 March 2024, that she had voluntarily absented herself and had waived her right to attend. There was no application to adjourn by the Registrant. In the circumstances, the Committee could not see any basis for not proceeding today and there would be no purpose served by adjourning the hearing, as it was unlikely that the Registrant would attend a future hearing.

14. The Committee considered that the risk of reaching an incorrect conclusion, in the absence of the Registrant, was low, given that she had made some concessions in her workplace interview regarding her recordkeeping. The Committee noted that the Registrant had raised some issues regarding her workload and what accommodations had been made for her, which could be put to the witnesses by the Committee. Further, the Council had its witnesses available to give evidence and they would be inconvenienced if the hearing did not proceed. These were serious allegations and it was in the public interest to determine them without undue delay.

15. Accordingly, the Committee determined that it would be in the public interest for the hearing to proceed in the Registrant's absence.

Preliminary Issue – Application to amend the Allegation

16. Ms Fatania, on behalf of the Council, made an application to amend the Allegation. Ms Fatania explained that, in essence, the application was to withdraw certain parts of the original Allegation, in order to streamline what was alleged and to focus upon the more serious parts of what had been alleged, based upon the expert evidence of Dr Anna Kwartz.

17. Ms Fatania referred the Committee to her skeleton argument, which set out the amendment application being made and in particular, to Rule 46(20), which is in the following terms:

> *"(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 or those grounds in appropriate terms."

18. Ms Fatania submitted that there was no injustice to the Registrant in making the proposed amendments, as they were all supported by the evidence. The Registrant had received the hearing bundles and the original Allegation. Ms Fatania submitted that if parts of the Allegation were no longer pursued by the Council, then this would not cause injustice to the Registrant and it would be fair and appropriate to proceed with the proposed amended Allegation.

19. The Chair of the Committee raised that as there were several amendments being sought, rather than having to cross-refer the original and proposed Allegations, it would assist if these were set out in a single document for the Committee to consider. The Council were given time in order to draft a version of the Allegation that showed the proposed amendments more clearly.

20. In relation to the amendment application, the Legal Adviser advised that the Committee had a discretion under Rule 46(20) to make amendments, at any stage of the hearing, either on an application by a party or of its own motion, if satisfied that the amendment can be made without injustice and that issues of prejudice and fairness had to be considered from both parties' perspectives.

21. The Committee went on to consider the Council's application to amend the Allegation and considered carefully whether the amendments could be made without injustice. Each of the individual proposed amendments were considered separately and in turn.

22. The Committee noted that the amendments proposed were in the Registrant's interests, as they withdrew parts of what was originally alleged and narrowed the issues. The Committee was satisfied that the proposed amendments could be made without unfairness or prejudice to either party. Accordingly, the Committee allowed the Council's application to amend the Allegation in full.

The following Allegation was agreed as the basis for proceeding:-

ALLEGATION (AS AMENDED)

The Council alleges that you, Mrs Elizabeth Williams (01-36542), a registered Optometrist:

Patient 2

1. On or around 20 July 2022 you examined Patient 2, and you:

a) Failed to perform a dilated examination; and/or
b) Failed to record a dilated examination; and/or
c) Failed to obtain adequate information in relation to Patient 2's diabetes including:

i. Whether Patient 2 attended a diabetic screening programme; and/or

ii. When Patient 2 had last been examined at a diabetic screening programme; and/or

iii. The outcome of any examination carried out as part of a diabetic screening programme.

d) Failed to perform an anterior examination of Patient 2's eyes; and/or

e) Failed to record an anterior examination of Patient 2's eyes.

2. In relation to the referral of Patient 2 for cataract surgery made on or around 3 September 2022, you failed to make the referral within a reasonable timeframe.

Patient 3

3. On or around 4 August 2022 you examined Patient 3, and you:

a) Failed to perform a visual fields test; and/or

b) Failed to record a visual fields test; and/or

c) Failed to provide safety-netting advice.

4. On or around 14 September 2022 you failed to record adequate information in your letter of referral in that you did not include information relating to:

a) Macula pathology; and/or

b) Intraocular pressures; and/or

c) Cup:disc ratios; and/or

d) Epi-retinal membrane.

5. *In relation to the referral of Patient 3 for cataract surgery made on or around 14 September 2022, you failed to make the referral within a reasonable timeframe.*

Patient 4

6. *On or around 22 August 2022 you examined Patient 4, and you:*

   a) Failed to record the cause of Patient 4's amblyopic left eye; and/or

   b) Failed to perform a visual fields test; and/or

   c) Failed to record the visual fields test.

7. *In relation to the referral of Patient 4 made on or around 14 September 2022, you failed to record adequate information in that you did not include information relating to Patient 4's cup:disc ratio.*

Patient 5

8. *On or around 17 November 2022 you examined Patient 5, and you:*

   a) Failed to test Patient 5's intraocular pressures; and/or

   b) Failed to record Patient 5's intraocular pressures; and/or

   c) Failed to obtain clinical information including:

      i) Patient 5's general health: and/or

      ii) Medications Patient 5 was taking; and/or

      iii) A detailed history relating to Patient 5's visual loss; and/or

iv) Patient 5's visual acuity; and/or

d) Failed to make an adequate record in that you did not record:

i) Patient 5's general health: and/or

ii) Medications Patient 5 was taking; and/or

iii) A detailed history relating Patient 5's visual loss; and/or

iv) Patient 5's visual acuity; and/or

9. On or around 17 November 2022 you failed to urgently refer Patient 5.

Patient 6

10. On or around 10 November 2022 failed to refer Patient 6.

Patient 7

11. On or around 15 July 2022 you examined Patient 7, and you:

a) Failed to examine the anterior vitreous for pigment cells; and/or

b) Failed to record any examination of the anterior vitreous for pigment cells; and/or

c) Failed to perform a dilated examination; and/or

d) Failed to record a dilated examination; and/or

e) Failed to provide safety-netting advice.

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

DETERMINATION

Admissions in relation to the particulars of the allegation

23. As the Registrant was not present, nor represented, there were no admissions made to the Allegation. The Allegation (as amended) was deemed read into the record.

Background to the allegations

24. The Registrant is an Optometrist who first registered with the Council on 21 January 1994. The Registrant was removed from the register on 22 June 2017 for a failure to apply. She was restored on the register on 4 January 2019 but was subsequently removed on 9 April 2019 again for a failure to apply to the register. The Registrant was restored to the register on 23 October 2020 but was again removed on 20 May 2022 for failing to meet her CET requirements. The Registrant restored again on 22 June 2022 and remains artificially retained on the GOC's register pending full conclusion of these proceedings. The Registrant has no fitness to practise history.

25. The Registrant began full time employment with [redacted] ('the practice') on 3 January 2022 and remained employed by the practice until 21 December 2022. Witness A, who has provided evidence in these proceedings, was her Line Manager.

26. Witness A details in his witness statement that following enquiries made with different clients after their eye examination appointments with the Registrant, he became concerned that referrals were not progressing as expected. A number of clients had contacted the practice to enquire about their referrals following an appointment with the Registrant. As a result, this issue was monitored by Witness A over the course of 8 weeks where the Registrant's cases were reviewed.

27. Following further clinical concerns being raised, an investigation was carried out by [redacted] within the practice. The Registrant engaged with the investigation and was interviewed in an investigation meeting on 29 September 2022 regarding allegations of failing to refer clients within an appropriate timeframe, which potentially could have led to Patient harm. In relation to Patient 2's referral for cataract surgery, which was delayed for approximately six weeks, the Registrant stated that she had '*no time to write it'* and that she was so busy in her clinic that there was no time to do anything other than testing. The Registrant raised concerns that her working day did not provide sufficient time to complete referrals and that her colleagues would stay late or come in early to complete administrative tasks, but that she was not in a position to do so.

28. At the investigation meeting on 29 September 2022 the Registrant was also asked about Patient 3's referral, which was requested by the Patient on 4 August 2022 and written on 14 September 2022. Patient 3 had also contacted the practice as they had not heard anything further regarding the private cataract referral requested following the appointment with the Registrant. The Registrant again stated that this had not been done sooner

due to a lack of time and she did not consider it to be a sight threatening issue, as it would join the list of cataract referrals.

29. Following the first investigation meeting on 29 September 2022, the Registrant sent an email to Person A from the practice, on 2 October 2022, in which she outlined her difficult personal circumstances. She also explained that there had been an increase in Patient s since the Covid-19 pandemic and her lunch break had reduced to 30 minutes, which reduced the time that she had to deal with administration.

30. A further meeting with the Registrant took place on 14 October 2022, at which the Registrant acknowledged that her standards were below what was expected for the role. However, this was as a result of a lack of time in the clinic to complete the work that was required. The meeting discussed what further support the Registrant required to cope with the demands of the role and the personal matters and [redacted] issues that the Registrant had raised. The outcome of the disciplinary hearing at this stage was for the Registrant to be issued with a final written warning by the practice.

31. The Registrant continued to remain at the practice and examine Patient s following the initial investigation meeting, although she appeared to be suspended for a period of time. An expectation setting meeting took place on 3 November 2022, at which support for the Registrant was discussed.

32. The Registrant saw Patient 5 at an appointment on 17 November 2022, at which it is alleged the Patient exhibited symptoms which indicated that an urgent referral was necessary. It is alleged that the Registrant did not urgently refer, as she ought to have done and Patient 5 subsequently attended the Accident and Emergency department on 23 November 2022, due to suffering a posterior vitreous detachment in the right eye causing a portion of the vision to go black.

33. A second investigation meeting with the Registrant took place on 2 December 2022, to discuss additional concerns. At this stage Witness A informed the Registrant that he had found four cases where he was concerned that Patient referrals had not been completed. The Registrant again raised issues regarding not having sufficient time to complete her clinic and administrative tasks. She had made handwritten notes as she could not keep up with the Optix electronic Patient record system and acknowledged that she had a '*lack of IT skills and speed.*'

34. The Registrant accepted that she had not made a referral for Patient 5 and that this was due to a lack of time and she also thought that whilst urgent, it was not an immediate referral because it was a long standing condition and their vision was still very good.

35. A further alleged failure to refer in relation to Patient 6, who showed signs of suspected glaucoma, was also discussed at the 2 December 2022 meeting and the Registrant confirmed that she had not completed it as she did not have time to do so.

36. The Practice wrote to the Registrant on 8 December 2022 confirming that there was a disciplinary case to answer and a disciplinary hearing took place on 19 December 2022, at which the practice raised its concerns regarding the Registrant, including that she did not consider Patient 5 to be an immediate referral. The Registrant acknowledged that this referral was her responsibility but that she considered that the working model at the practice did not work for her. The Registrant ceased employment on 21 December 2022.

37. The Registrant, in her written representations to the Case Examiners dated 18 August 2023, highlighted that she had an unblemished record for thirty years. She explained that during appointments she had made handwritten notes intending to input these into the system later, but this became unmanageable.

38. The Council had instructed an expert witness, Dr Anna Kwartz. She reviewed the Patient records of six Patient s the subject of the Allegation and gave an opinion on the standards to be expected of a reasonably competent Optometrist. Dr Kwartz's opinion is set out in an expert report dated 27 October 2023.

The hearing

39. The Committee had before it a 249 page bundle of documentary evidence, which included but was not limited to, a witness statement of Witness A (Practice Manager) and his exhibits relating to the local investigation, meeting notes, internal emails, the Registrant's referrals tracker, correspondence between the practice and the Registrant, the expert report of Dr Anna Kwartz, dated 27 October 2023 and the Registrant's representations to the Case Examiners. Also included within the bundle were the clinical records of Patient s 2,3,4,5,6,7, taken from screenshots of the Optix system, which was an electronic Patient record system used by the practice.

40. On the first day of the hearing, the Committee dealt with the preliminary issues, set out above. On the second day, after opening the Council's case, Ms Fatania called Dr Kwartz as the Council's first witness. Dr Kwartz was called out of the anticipated witness order, as Witness A was not available that day.

41. During the course of Dr Kwartz's evidence, when giving her opinion in relation to Patient 2, Dr Kwartz confirmed that she had not been given access to the Optix system when preparing her report but was given the screenshots of the system that were in the bundle. Dr Kwartz highlighted that sometimes in the Patient records a text box appeared to be truncated and the text could not always be fully read, which she had highlighted in her report.

42. The Committee asked Dr Kwartz questions regarding this issue in relation to Patient 2, where it is alleged that the Registrant failed to obtain adequate information in relation to Patient 2's diabetes. When the Committee asked Dr Kwartz whether it was possible that there had been something written in

Patient 2's Optix record under family history, which could not be seen on the screenshot, Dr Kwartz replied that was possible.

43. Similarly, when asked if it was possible that there was more information recorded under the sections for medication, general health, family health or allergies, which had drop down boxes, Dr Kwartz replied that she did not know if they contained any information and if they did, it had not been forwarded to her. Dr Kwartz stated that some records provided to her showed two very similar pages, where it appeared that scrolling had been done to show the text recorded on the system. However, she accepted that where the box was truncated there could be additional information recorded which was not visible on the screenshot.

44. Ms Fatania referred the Committee to an email within the bundle from Person B, Commercial Director of [redacted], dated 2 March 2023, in which she replies to enquiry from the Council regarding the records in question and states "*there is nothing missing from the records that we have sent.*" It further states that the Registrant's record keeping was very poor and there was nothing else that could be provided.

45. Ms Fatania submitted that the Council's position was that this email speaks to all matters regarding the records, but if the Committee remained concerned about this issue the Council would consider its position further. The Committee considered the email from Person B and was of the view that it did not answer its concerns as, it appeared to be in response to a specific enquiry regarding Patient 5's records. However, the Committee did not have the preceding email to Person B to confirm precisely what she was responding to.

46. The Chair of the Committee gave the indication that notwithstanding the email of Person B, it was the view of the Committee that there remained matters that needed to be clarified regarding the Patient records. It was the view of the Committee that the email of Person B did not cover the specific concerns raised and it was not appropriate to continue with the evidence of Dr Kwartz without giving the Council time to consider what further enquiries could be made. The case finished early on the second day to allow the Council time to consider its position and make further enquiries.

47. At the start of the third sitting day, Ms Fatania, on behalf of the Council, made an application to adjourn the hearing part-heard. Ms Fatania gave the Committee the updated Council's position that in light of the issues raised by the Committee the previous day and their view that the email of Person B did not answer the specific queries raised, there was a gap in the evidence that needed to be addressed.

48. The Council's view was that Witness A was not a witness that could assist with this issue, as he was not the relevant witness who had checked the records that were provided to the expert witness Dr Kwartz. If the Council were to make enquiries with Person B, who would be the appropriate witness to speak to these issues, this would involve the taking of new evidence, which the Registrant would not have the opportunity to consider before hand. Ms

Fatania submitted that this raised an issue of fairness. Whilst an application had been made to proceed in the Registrant's absence, this was on the basis that she had been provided with the evidence upon which the Council rely.

49. Ms Fatania stated that the Council had carefully considered whether Witness A could assist, but had concluded that this would essentially be taking new evidence from him, which would also not be appropriate mid-hearing, for the same reasons. Ms Fatania submitted that the issue that had arisen was a significant one, as it went to the basis of the expert's evidence and the Committee had indicated that it was concerned about it.

50. Ms Fatania submitted that it would be appropriate and fair to adjourn the hearing part-heard, so that the Council could clarify the position either way regarding the technical issues and to serve any additional evidence it wished to rely upon, on the Registrant, so that she had notice of it. Ms Fatania submitted that to proceed with the hearing without clarification would have a bearing on later stages, as the answer may make a difference to the issues for the Committee to consider. Ms Fatania highlighted that as a result of the enquiries it may be that the Council will seek to amend the Allegation, if that was considered appropriate and/or the expert Dr Kwartz may need to revise her report.

51. The Committee accepted the advice of the Legal Adviser who referred the Committee to the relevant parts of the Rules. This included the usual timetable for the service of evidence 10 days prior to the hearing, set out in the standard procedural directions in Rule 29, which states at direction (9) that,

"*Any document which has not been served on the Fitness to Practise Committee in accordance with the provisions of directions 2 to 8 is only to be admitted into the evidence at the hearing with the permission of the Fitness to Practise Committee*."

52. The Legal Adviser advised that the Rules allowed for the admission of late evidence, as long as it was fair and relevant to admit it. Fairness was likely to be the key consideration here, as generally a party should not be taken by surprise by new evidence they have not had an opportunity to consider (with reference to the case of *In re S (A Barrister)* [1970] 1 QB 160).

53. The Legal Adviser referred to the discretion that the Committee had to adjourn the hearing set out in Rules 35 and 36 and reminded the Committee that on an application for adjournment the onus is on the applicant to show the need for an adjournment. The overall test for granting or refusing an adjournment was one of procedural fairness and this had to be considered in relation to both parties. The Committee would need to consider what was in the interests of justice balancing fairness, the public interest, the significance of the issue that had been raised and the fact that the Registrant was not in attendance.

The Committee's decision on the adjournment

54. The Committee was of the view that the issue that had been raised was a very significant one, going to the integrity and completeness of the Patient

records, which were provided to the expert Dr Kwartz. If there was missing information not provided to the expert, this may affect the expert's opinion.

55. Given the evidence before the Committee, there was uncertainty as to whether Dr Kwartz had been given the complete records, as it was clear from the screenshots in the bundle that parts of the Optix text boxes were truncated and therefore it appeared that there may be information recorded on the system which had not been provided to the expert.

56. The Committee noted that this issue was not isolated to Patient 2 and would appear to be a potential issue across the whole of the Patient records and therefore across the whole Allegation.

57. The Committee was of the view that proceeding with the hearing today, in the current circumstances, would be potentially unfair towards the Registrant, the Council and the expert witness Dr Kwartz. Clarification of the position would also assist the Committee in making the determinations that it is required to make in these proceedings.

58. This was an issue which had only become apparent during the live evidence of the expert witness Dr Kwartz and the Committee did not consider that it could have been reasonably foreseen by the Council before the hearing, noting that it had not been specifically raised by the Registrant in correspondence. The Committee noted that adjourning would mean that there would be delay to the conclusion of the proceedings. However, this was considered by the Committee to be the fairest outcome to all parties in the circumstances.

59. The Committee agreed with the Council's position that it would not be fair to the Registrant for the Council to obtain and adduce further material evidence during this hearing, without the Registrant having had sight of it and the opportunity to consider it, notwithstanding the fact that the hearing was proceeding in her absence. It also would not be fair to the Council to proceed further with the hearing without giving them the opportunity to clarify the issue with the Patient records and obtain any further evidence they see fit to obtain.

60. Accordingly, the Committee determined that it was in the interests of justice for the hearing to be adjourned part-heard to enable the Council to clarify the position regarding the accuracy and completeness of the Patient records and for the most accurate and complete records to be available to both the expert and the Committee.

61. The Committee would want to resume the hearing as expeditiously as possible. However, it is mindful that any further evidence obtained would need to be served upon the Registrant with sufficient time for her to consider it and further, that Dr Kwartz may need to revisit her report.

62. The Committee directs that any additional evidence upon which the Council intends to rely to be served by the Council relating to the adequacy and/or completeness of the Patient records and any other material documents within 42 days of todays date and the hearing to be relisted as soon as practicable thereafter.

The resumed hearing – 12 May 2025

63. At the resumed hearing, the original Committee chair was not part of the panel. Prior to the hearing commencing, the remaining four members of the Committee voted for Mr Paul Curtis to be the replacement lay chair and he was duly appointed. The Legal Adviser advised, and Ms Fatania confirmed, on behalf of the Council, that this was acceptable and that the Committee was quorate, in accordance with the Rules.

Proof of service

64. As the Registrant did not attend the resumed hearing, nor was she represented, the Committee heard an application from Ms Fatania, on behalf of the Council, for the matter to proceed in the Registrant's absence.

65. First, the Council was required to satisfy the Committee that the documents, notifying the Registrant of the resumed hearing, had been served in accordance with Section 23A of the Opticians Act 1989 and Rule 61 of the General Optical Council (Fitness to Practise) Rules 2013 ('the Rules'). The Committee had before it, within the updated bundle, a notice of hearing that had been sent to the Registrant in respect of this hearing.

66. As the email address that this notice of hearing was sent to was redacted, Ms Fatania provided the Committee with an unredacted version, so that the Committee could check that the notice had been sent to the Registrant's correct email address. The Committee was also provided with the original service bundle, containing documentation relating to the registration details of the Registrant, including the email address that the Registrant had provided the Council with.

67. Ms Fatania took the Committee through the documentation relevant to the issue of service and referred the Committee to the Notice of Hearing for the resumed hearing, dated 3 April 2025, which contained the details of the hearing. Ms Fatania highlighted that the correspondence had been emailed to the Registrant's registered email address, which she had previously consented to being used for correspondence with the Council. Ms Fatania submitted that the documents for the hearing had been sent to the Registrant and that she had been given sufficient notice of the hearing. Therefore, she invited the Committee to find that there had been good service in accordance with the Rules.

68. The Committee accepted the advice of the Legal adviser, who referred the Committee to the Rules on service of the Notice of Hearing, the requirement that at least 28 days notice should be given for a substantive hearing and acceptable methods of service.

69. The Committee had regard to the documentation before it regarding service. The Committee noted that the Registrant had been served with the Notice of

Hearing over 28 days ago, on 3 April 2025, which was sent to an email address that the Registrant had registered with the Council. The Committee further noted that the Registrant had previously confirmed in an email to the Council on 28 February 2023 that she was content to receive notices from the Council via that email.

70. The Committee was satisfied, in the circumstances, that there had been effective service of the Notice of Hearing and that all reasonable efforts had been made to notify the Registrant of the hearing, in accordance with the Rules.

Proceeding in the absence of the Registrant

71. The Committee then went on to consider whether it would be in the public interest to proceed in the Registrant's absence in accordance with Rule 22 (set out in paragraph 17 above).

72. Ms Fatania, on behalf of the Council, submitted that it was in the public interest to proceed in the absence of the Registrant, as the Registrant had not engaged with these proceedings since 7 March 2024. Ms Fatania highlighted the most recent correspondence received from the Registrant, which was dated 7 March 2024, in which she stated that she would respect whatever the Committee decided and that, "I have nothing more to add to the statement I provided previously re my investigation." The Registrant went on to state in this email that she was no longer a Registrant and had no desire to re-register.

73. Ms Fatania reminded the Committee that the Registrant had not attended the original hearing and had not engaged with the Council since. The Registrant had not responded to the latest Notice of Hearing, which was sent to her on 3 April 2025, therefore Ms Fatania submitted that it remained the case that the Registrant was willingly absenting herself from these proceedings.

74. Ms Fatania submitted that in the circumstances it was fair and reasonable to proceed with the case in the Registrant's absence and that there was no prejudice or injustice to the Registrant due to the position that she had taken.

75. The Committee accepted the advice of the Legal adviser, who referred the Committee to Rule 22 and the guidance on proceeding in a Registrant's absence in the Council's 'Hearings and Indicative Sanctions Guidance' (updated November 2021)('the Guidance'). She referred the Committee to the principles to apply when considering an application to proceed in absence, including having regard to any reasons for the absence which have been provided by the Registrant, and whether an adjournment has been sought by either party or would secure the Registrant's attendance.

76. The Committee was satisfied that the Registrant had been given notice of today's hearing and, as with the original hearing, that she had voluntarily absented herself and had waived her right to attend. The Registrant had

made it clear that she did not wish to engage in her earlier correspondence. She had an opportunity to re-engage since the last hearing and has not done so. There was no application to adjourn by the Registrant. In the circumstances, the Committee could not see any basis for not proceeding today and there would be no purpose served by adjourning the hearing, as it was unlikely that the Registrant would attend in future. These were serious allegations and it was in the public interest to determine them without undue delay.

77. Accordingly, the Committee determined that it would be in the public interest for the hearing to proceed in the Registrant's absence.

The resumed hearing

78. At the resumed hearing the Committee had before it an updated bundle of documentary evidence of 522 pages, which included an additional witness statement of Witness B (Optometrist and former Clinical Development Coach for [redacted]), dated 24 October 2024, and exhibits produced by her, including further Patient records printed from the Optix computerised Patient records system ('Optix'). This evidence related to the concern raised by the Committee at the original hearing regarding the incomplete Patient records from the Optix system that had been provided to Dr Kwartz.

79. The bundle also contained an addendum report of Dr Kwartz, dated 10 November 2024, following her review of the witness statement of Witness B and the additional material produced. In that report, Dr Kwartz confirmed that, having carried out a review of the additional material, there was no change to any of the opinions that she had expressed in her original report.

80. The Committee heard oral evidence from the Council's witnesses, Witness A (Dispensing Optician and Practice Manager of [redacted] and the Registrant's Line Manager), Witness B and Dr Kwartz, who were all questioned by Ms Fatania, on behalf of the Council, and the Committee.

81. In closing submissions, Ms Fatania submitted that all of the Allegation could be found proved on the basis of the evidence that the Council had relied upon, namely the evidence of Witness A and Witness B for the factual basis underpinning the Allegation. Ms Fatania submitted that this position was assisted by the Registrant's own accounts given in her internal investigation interviews, in which she for the most part accepted responsibility for the factual issues in the Allegation.

82. Ms Fatania reminded the Committee that it had heard evidence of Dr Kwartz, who gave expert opinion on matters such as the adequacy of the patient referrals and reasonableness of the timeframes. Ms Fatania made submissions in respect of three particulars of the Allegation which alleged a failure of the Registrant to record matters (particulars 8(b), 11(b) and 11(d)). Ms Fatania acknowledged that in respect of all three particulars, Dr Kwartz provided an opinion, in her live witness evidence, regarding the standards to

be expected on a hypothetical basis. Ms Fatania submitted that the Council's position was that, factually, all of the Allegation could be found proved, including the failures to record. There was a distinction to be made between the evidence on the facts and the standards to be expected, the latter of which was for a later stage of the proceedings.

83. Ms Fatania submitted that the Council had discharged its burden of proving the case and invited the Committee to find the entirety of the facts proven as alleged.

84. The Committee accepted the advice of the Legal Adviser that the burden of proving a disputed allegation was on the Council, to the civil standard of the balance of probabilities. In particular, the Legal Adviser gave advice regarding considering each particular of the Allegation separately, but that findings in respect of one particular of the allegation could be taken into account in respect of other particulars, if relevant to do so. The Legal Adviser reminded the Committee that where a failure is alleged, the Committee has to firstly be satisfied that there was a duty upon the Registrant to so act. The Legal Adviser advised the Committee in relation to the Registrant's good character, and its relevance in respect of credibility and propensity, as she had no previous regulatory findings against her.

Findings in relation to the facts

85. The Committee considered all of the evidence in this case, including the documentary evidence, the oral evidence of the witnesses Witness A and Witness B, and the expert evidence of Dr Kwartz (both oral and her reports). The Committee also considered the oral and written submissions from Ms Fatania, on behalf of the Council. The key parts of the evidence are summarised below, with the Committee's conclusions.

86. The Committee considered the denied particulars of the Allegations in turn.

Patient 2

1. On or around 20 July 2022 you examined Patient 2, and you:

a) Failed to perform a dilated examination; and/or
b) Failed to record a dilated examination; and/or

c) Failed to obtain adequate information in relation to Patient 2's diabetes including:

i. Whether Patient 2 attended a diabetic screening programme; and/or

ii. When Patient 2 had last been examined at a diabetic screening programme; and/or

iii. The outcome of any examination carried out as part of a diabetic screening programme.

d) Failed to perform an anterior examination of Patient 2's eyes; and/or

e) Failed to record an anterior examination of Patient 2's eyes.

2. In relation to the referral of Patient 2 for cataract surgery made on or around 3 September 2022, you failed to make the referral within a reasonable timeframe.

87. In considering all of the particulars of the Allegation, the Committee had regard to the Patient records, including the relevant referral letters completed by the Registrant. At the resumed hearing the Committee was satisfied that it now had before it the complete clinical records from the Optix system and the concerns that had been raised during the initial hearing had been addressed by the evidence of Witness B. Further, the Committee noted that the additional records had not led to Dr Kwartz altering her opinion, as although some additional information had been provided, this was not material to the issues in the case.

88. In relation to particular 1, the Committee noted that the Registrant did not appear to dispute that she had examined Patient 2 on 20 July 2022, nor that she referred the Patient on 3 September 2022 for assessment regarding cataract surgery. When interviewed in the internal investigation, she appeared to broadly take responsibility for the factual matters raised in the allegations, albeit the focus of those discussions was on the Patient referrals rather than the specifics of any particular eye examination. When asked in the investigation interview regarding the date of the referral (being 6 weeks after the examination), the Registrant stated that there was no time for her to write it and that she had little time to do anything apart from testing due to the number of patients seen.

89. The Committee considered particulars 1(a)-(c) together as it considered that they were interlinked. The Committee was mindful that where an allegation pleads a failure to act, the Committee needs to first be satisfied that there was a duty upon the Registrant to so act. In relation to Patient 2, who had diabetes, the Committee was satisfied, on the evidence before it, that there was an obligation upon the Registrant to establish information regarding whether they were attending a diabetic screening programme. If not, the Registrant ought to have performed a dilated examination to check the status of the peripheral retina, given the Patient 's risk of diabetic eye disease.

90. The Committee had regard to the opinion of Dr Kwartz, set out in her expert report dated 27 October 2023 (as supplemented by her addendum report dated 10 November 2024 and oral evidence). Dr Kwartz was of the opinion that a reasonably competent Optometrist would be expected to establish whether a diabetic Patient was attending a diabetic screening programme, with reference to 'Performance Criterion 1.1.1 of the prevailing General Optical Council's Optometry Stage 2 Core

Competencies (2011)', which states that an Optometrist should obtain '*relevant history and information relating to general health, medication, family history, work, lifestyle and personal requirements*.'

91. The Committee accepted the expert evidence of Dr Kwartz and was satisfied that there was an obligation upon the Registrant in the circumstances to have obtained adequate information regarding Patient 2's diabetes, as alleged, and perform a dilated eye examination and additionally, there was no record of Patient 2 attending a diabetic screening programme.

92. Having been satisfied that there was a duty upon the Registrant to have carried out a dilated examination, the Committee went on to consider whether she failed to do so. The Committee noted that the relevant sections of the Patient record on the Optix system, which would have been completed if a dilated examination was performed, were blank. The Committee considered that as a dilated examination was not recorded in the clinical records for Patient 2, and in the absence of any other evidence that one was performed, it was reasonable to infer that the Registrant failed to perform a dilated examination. The Committee was therefore satisfied, on the balance of probabilities, that the Registrant failed to perform a dilated examination on Patient 2. The Committee found particular 1(a) proved.

93. In relation to particular 1(b), which alleged that the Registrant failed to record a dilated examination, the Committee took the view that as it had found that the dilated examination had not been performed, it was not possible in the circumstances for the Registrant to make a record of an event that did not occur. It therefore found 1(b) not proved.

94. In relation to particular 1(c) the Committee was satisfied that this information was not recorded in Patient 2's records and therefore the Committee inferred that the Registrant had not obtained adequate information from Patient 2 regarding their diabetic history.

95. Turning to particular 1(d), whether the Registrant failed to perform an anterior examination of Patient 2's eyes, the Committee firstly considered whether there was a duty upon the Registrant to have done so. Dr Kwartz's evidence was that this was required by Statutory Instrument 1230 the Sight Testing (Examination and Prescription) (No 2) Regulations (Appendix 1) (1989), which sets out what a sight test is required to include for all Patient s. The Committee was satisfied based upon the expert evidence of Dr Kwartz that there was a requirement for the Registrant to perform an anterior examination of Patient 2's eyes and further, there was no evidence in the records that it had been performed. The Committee noted that the section in Patient 2's records, where findings relating to the anterior eye would be recorded, was blank. In the absence of the Registrant having made a record, or any other positive evidence that it had been conducted, the Committee was satisfied that it was reasonable to infer that the Registrant had not conducted an anterior

examination of Patient 2's eyes. Particular 1(d) of the Allegation is therefore found proved.

96. However, in relation to particular 1(e) of the Allegation, that the Registrant failed to record an anterior eye examination, as the Registrant would be unable to record details of a test that was not performed, this was found not proved.

97. In relation to particular 2 and the referral of Patient 2 for cataract surgery made on or around 3 September 2022, and the allegation that the Registrant failed to make the referral within a reasonable timeframe. The Committee noted that the referral was made approximately 6.5 weeks after the appointment with Patient 2. Dr Kwartz had given evidence that in relation to this referral, it would have been reasonable to have referred Patient 2 between a few days up to a week after the appointment, however the 6 week period was '*too long, as the Patient would have been struggling with their visual function*.' The Committee accepted the opinion of Dr Kwartz that 6.5 weeks was not a reasonable timeframe for a referral to be initiated for Patient 2 and accordingly found particular 2 proved.

Patient 3

3. On or around 4 August 2022 you examined Patient 3, and you:

a) Failed to perform a visual fields test; and/or

b) Failed to record a visual fields test; and/or

c) Failed to provide safety-netting advice.

4. On or around 14 September 2022 you failed to record adequate information in your letter of referral in that you did not include information relating to:

a) Macula pathology; and/or
b) Intraocular pressures; and/or

c) Cup:disc ratios; and/or

d) Epi-retinal membrane.

5. In relation to the referral of Patient 3 for cataract surgery made on or around 14 September 2022, you failed to make the referral within a reasonable timeframe.

98. In relation to particular 3(a) and (c), the Committee firstly considered was the Registrant was under a duty to perform a visual fields test on Patient 3. The Committee had regard to the expert evidence of Dr Kwartz, which was that as Patient 3 had asymmetric cup:disc ratios, which could be a feature of glaucoma, having made that finding, a reasonably competent Optometrist would have gone on to perform a visual fields test, as part of the three component tests used to detect open angle glaucoma. Dr Kwartz gave evidence that the difference in cup ratio identified by the Registrant

was 0.2, which was clinically significant. The Committee was satisfied on the evidence before it that the Registrant had found some asymmetry in cupping indicating a risk of glaucoma development, and therefore she was under a duty to then carry out a visual fields test, which she did not perform. The Committee was satisfied that, as above, as there was no record in the Patient records of the Registrant having carried out a visual fields test, that on the balance of probabilities, considering the evidence as a whole, it was reasonable to infer that this test had not been performed by the Registrant. The Committee therefore found particular 3(a) proved.

99. In relation to particular 3(b), as above, as the Registrant would be unable to record details of a test not performed, the Committee took the view that this part of the Allegation falls away and is not proved.

100. In relation to particular 3(c), the Committee considered whether the Registrant was under a duty to provide safety-netting advice to Patient 3 regarding the epiretinal membrane detected in one eye. The evidence of Dr Kwartz was that a reasonably competent Optometrist would have provided safety-netting advice to Patient 3, to contact them if they noticed a distortion in their vision. Dr Kwartz's evidence was that it was common to give Patient s an Amsler chart to assist with checking their visual function. There was no evidence of safety-netting advice having been given by the Registrant, as there was no entry on the Patient records to that effect. The Committee accepted the expert evidence of Dr Kwartz that the Registrant was under a duty to give Patient 3 safety-netting advice in these circumstances and that furthermore, on the balance of probabilities and considering the Patient records of Patient 3, that the Registrant failed to do so. Accordingly, the Committee found particular 3(c) proved.

101. In relation to particular 4, which alleged that the Registrant failed to include adequate information in her referral letter for Patient 3, the Committee considered whether the Registrant was required to include the information particularised in the Allegation. The Committee had regard to the evidence of Dr Kwartz, which was that all relevant clinical information, such as any pathology found during the sight test, ought to be included in the referral letter for the benefit of the recipient, so that their attention is drawn to relevant findings. Dr Kwartz explained why the clinical information was relevant to include in the referral letter. The Committee was satisfied on the evidence of Dr Kwartz that the Registrant ought to have included all of the information set out in particular 4 within her referral letter for Patient 3 and she failed to do so. Accordingly, the Committee found particular 4 proved.

102. In relation to particular 5 and the allegation that the Registrant did not refer Patient 3 for cataract surgery within a reasonable time frame, the Committee noted that in this instance the time frame was approximately 5.5 weeks after the appointment with Patient 3. Dr Kwartz's evidence was, as with Patient 2, that it ought to have been completed within a few days to a week. Whilst no harm would have been suffered by the Patient due to the delay, as the cataracts would not have significantly worsened in that

time, the Patient may have been able to have them operated upon sooner if the referral had been prompt. The Committee accepted the evidence of Dr Kwartz and considered that the referral was not made within a reasonable time frame. Accordingly, the Committee found particular 5 proved.

Patient 4

6. On or around 22 August 2022 you examined Patient 4, and you:

a) Failed to record the cause of Patient 4's amblyopic left eye; and/or

b) Failed to perform a visual fields test; and/or

c) Failed to record the visual fields test.

7. In relation to the referral of Patient 4 made on or around 14 September 2022, you failed to record adequate information in that you did not include information relating to Patient 4's cup:disc ratio.

103. The Patient records for the examination of Patient 4 on 22 August 2022 show that the Registrant examined Patient 4 and made reference to the Patient having an amblyopic left eye, but no cause is recorded. Dr Kwartz's evidence on this issue is that it is not clear from the record why the Patient has an amblyopic left eye and that in not detailing the causative factor '*the Registrant has shown a significant deviation from the expected standard and the record has poor narrative power*'. In her live evidence, Dr Kwartz explained that the typical causes of an amblyopic eye are a squint or a very high prescription in one eye and whilst the record stated that the Patient had said they had always had it (a lazy eye), Dr Kwartz took the view that a Patient 's recall is not always reliable. It was the opinion of Dr Kwartz that a reasonably competent Optometrist would have wanted to establish the clinical reason for it, by checking for a squint or a significant refractive error. On the basis of the evidence before it, namely the expert opinion of Dr Kwartz, the Committee was satisfied on the balance of probabilities that the Registrant was required to record the cause of Patient 4's amblyopic left eye and she failed to do so. Accordingly, the Committee found particular 6(a) proved.

104. In relation to particular 6(b), the alleged failure of the Registrant to perform a visual fields test on Patient 4, the Committee firstly considered whether there was a duty on the Registrant to have done so. The Committee had regard to the evidence of Dr Kwartz, which was that the Registrant was required to have conducted a visual fields test on Patient 4, as they only had one good eye, which the Patient relied upon and so greater care was needed when examining such a Patient . Dr Kwartz considered that a visual fields test should have been conducted to rule out glaucoma, as

there seemed to be asymmetry of the cup:disc ratios from the disc images. Dr Kwartz, when questioned by the Committee, confirmed her view that a body of reasonably competent Optometrists, would have conducted a visual fields test on this Patient , having seen the images. The Committee accepted the expert evidence of Dr Kwartz and was satisfied that the Registrant was under a duty to have performed a visual fields test and further, based upon the fact that no information was recorded in the Patient records, she had failed to do so.

105. In relation to particular 6(c), the Committee considered that this falls away, having found that the Registrant had not performed the test.

106. In relation to particular 7, the Committee considered whether in the referral letter written by the Registrant regarding Patient 4, the Registrant was required to have included the information relating to Patient 4's cup:disc ratio. The Committee noted that the Registrant had made an estimate of the cup:disc ratio, which Dr Kwartz considered was an appropriate estimate. Dr Kwartz when giving evidence stated that all relevant information ought to be included in referral letters, to make the recipient aware of relevant information and findings. The Committee was satisfied on the basis of the evidence before it, that the information relating to Patient 4's cup:disc ratio was relevant information that ought to have been included by the Registrant in the referral letter and it was not included by her. Accordingly, the Committee found particular 7 proved.

Patient 5

8. On or around 17 November 2022 you examined Patient 5, and you:

a) Failed to test Patient 5's intraocular pressures; and/or

b) Failed to record Patient 5's intraocular pressures; and/or

c) Failed to obtain clinical information including:

i) Patient 5's general health: and/or

ii) Medications Patient 5 was taking; and/or

iii) A detailed history relating to Patient 5's visual loss; and/or

iv) Patient 5's visual acuity; and/or

d) Failed to make an adequate record in that you did not record:

i. Patient 5's general health: and/or

ii. Medications Patient 5 was taking; and/or

iii. A detailed history relating Patient 5's visual loss; and/or

iv. Patient 5's visual acuity; and/or

9. On or around 17 November 2022 you failed to urgently refer Patient 5.

107. The Committee considered whether there was a duty upon the Registrant to have tested Patient 5's intraocular pressures as part of the examination that took place on 17 November 2022. The Committee heard evidence from Dr Kwartz that Patient 5 had presented with a branch retinal vein occlusion (BRVO) in their right eye, which could be seen on the fundus and OCT images. Dr Kwartz explained the significance of such a finding, and that this required an 'immediate systemic work-up' to include measurements of the Patient 's intraocular pressures, which should have been performed by the Registrant. This would have provided the Registrant with further information about the potential causes of the BRVO, one of which is significantly raised intraocular pressure. The Committee was satisfied on the basis of the evidence of Dr Kwartz, that in these circumstances, there was a duty upon the Registrant to have tested the intraocular pressures of Patient 5 to check whether they were raised. Furthermore, the Committee found that the Registrant failed to conduct the test on the basis that it had not been recorded in Patient 5's notes, either on the Optix system, which contained no clinical entry for this Patient , nor in the handwritten notes that the Registrant made regarding the examination, which were included in the documentary evidence before the Committee. Accordingly, the Committee found particular 8(a) proved.

108. In relation to particular 8(b), the Committee considered that this falls away, having found that the Registrant had not performed the test.

109. In relation to particular 8(c), and the alleged failure of the Registrant to obtain clinical information regarding Patient 5's general health and medications, a detailed history of visual loss and visual acuity, the Committee accepted the evidence of Dr Kwartz regarding the significance of this information in relation to a Patient who presents with BRVO. As this condition can be related to systemic health issues, such as raised blood pressure, cholesterol or leukaemia, such a finding would need to be acted upon with an urgent referral for further investigations. Dr Kwartz gave evidence that the information should have been obtained as it was relevant to the referral. The Committee was satisfied on the evidence before that in the circumstances the Registrant was under a duty to have obtained the clinical information set out in particular 8(c) and further found, given that this was not recorded in the Patient notes, that she failed to obtain it. Therefore, the Committee found particular 8(c) proved.

110. In relation to particular 8(d), the Committee considered that this falls away, as the Registrant could not record information that was not obtained.

111. In relation to particular 9, it is alleged that the Registrant failed to refer Patient 5, when she ought to have done. The Committee was satisfied on the evidence before it and the expert opinion of Dr Kwartz that given that the Registrant had detected BRVO on the OCT scan, given the significance of this finding on the Patient 's systemic and eye health, there ought to have been an urgent referral, due to the potentially significant ocular consequences and significant risk to the Patient 's health.

112. The Committee noted that it appears from the notes taken by the Registrant of Patient 5's GP surgery, that the Registrant had a conversation with Patient 5 regarding a referral to their GP. However, no such referral was actually made and on 23 November 2022 Patient 5 experienced visual loss and attended A&E for emergency treatment. When the Registrant was interviewed about this matter, she recognised that it was urgent but did not think it was immediate, because it was a long standing condition and the Patient 's vision was still very good. In her live evidence Dr Kwartz made reference to the College of Optometrists Guidance for this condition which states that in an urgent referral a Patient should be seen the same day or the next day and that the Optometrist should ring the hospital to triage the Patient . The Committee was satisfied that the Registrant did not urgently refer the Patient , when she ought to have done and therefore particular 9 was found proved.

Patient 6

10. On or around 10 November 2022 failed to refer Patient 6.

113. In relation to Patient 6, the Registrant made a decision that referral of Patient was 6 was necessary for suspected glaucoma but she did not go on to initiate a referral. In her investigation interview, the Registrant accepted that she had not completed a referral for Patient 6 because she did not have time to do it.

114. When giving evidence regarding this matter, Dr Kwartz was of the view that a referral for Patient 6 was somewhere between acceptable and cautious, however having once made a decision to refer, Dr Kwartz was of the view that an Optometrist is obliged to complete a referral. Dr Kwartz explained that although she considered that a referral in this instance for Patient 6 may have been cautious, the Registrant would have been in a better position to assess the Patient and decide whether a referral was required, as her view of the optic nerve features in person would have been more accurate than a review of the images. The Committee considered that the duty to refer arises from the findings made in the sight test and if an abnormality is detected or a condition suspected, then this needs to be acted upon. The Committee was satisfied that in this case the Registrant had detected an abnormality and made a decision to refer, but by not doing so, she failed in her duty to refer Patient 6.

Patient 7

11. On or around 15 July 2022 you examined Patient 7, and you:
a) Failed to examine the anterior vitreous for pigment cells; and/or

b) Failed to record any examination of the anterior vitreous for pigment cells; and/or

c) Failed to perform a dilated examination; and/or

d) Failed to record a dilated examination; and/or

e) Failed to provide safety-netting advice.

115. The Committee considered whether the Registrant was required to examine the anterior vitreous for pigment cells, perform a dilated examination and give-safety netting advice to Patient 7. This Patient had presented with an increase of floaters in the right eye, which Dr Kwartz explained was a 'red flag', as it could indicate a retinal detachment. Dr Kwartz referred the Committee to Paragraph A259 of the College of Optometrists' prevailing Guidance for Professional Practices, which details the examination of Patient s who present with flashes and floaters, which states*: "If you suspect a retinal break or tear, you should, as a minimum: a. take a detailed history and symptoms, looking for particular risk factors, b. examine the anterior vitreous to look for pigment cells, c. perform a dilated fundal examination, using an indirect viewing technique, d. give appropriate advice to the Patient , which you back up with written information."*

116. The Committee was satisfied that in the circumstances the Registrant was under a duty to perform a dilated examination, examine the anterior vitreous for pigment cells and give appropriate safety-netting advice, based upon the above guidance and evidence of Dr Kwartz. Further, having regard to the Patient record, which did not record that such examinations had been performed, or advice given, the Committee was satisfied that it was reasonable to infer that it had not been performed or given and accordingly found particular 11(a),(c) and (e) proved. In relation to particulars (b) and (d), the Committee found that these fell away, as the tests were not performed.

Misconduct

117. The Committee proceeded to consider whether the facts found proved amounted to misconduct which was serious.

118. The Committee heard submissions from Ms Fatania, on behalf of the Council. No further material was put before the Committee at this stage.

119. Ms Fatania referred the Committee to the Council's written submissions, which included an outline of the caselaw on misconduct.

120. Ms Fatania stated that the Council relied upon the evidence of Dr Kwartz on the issue of misconduct and Dr Kwartz's opinion of the conduct that fell far below the standards required of a reasonably competent Optometrist. Ms Fatania submitted that Dr Kwartz's opinion assists greatly and where Dr Kwartz considered conduct had fallen far below the standards, this falls within the category of misconduct which was serious.

121. Ms Fatania submitted that whilst Dr Kwartz did not consider that Patients 2, 3 and 4 would have any long term effects from the Registrant's conduct, with Patient 5 the delayed referral could have had serious consequences. Ms Fatania highlighted the email correspondence sent by Patient 5 in which they stated that several days after the appointment with the Registrant, Patient 5 experienced a posterior vitreous detachment in the right eye and had to attend A&E, where an injection was administered to defer any further deterioration. Ms Fatania stated that it could not be said that the delayed referral had contributed to that, but it supported that an urgent referral was needed and should have been actioned by the Registrant.

122. Ms Fatania referred the Committee to the "*Council's Standards of Practice for Optometrists and Dispensing Opticians*", effective from April 2016 ('the Standards of Practice'). She invited the Committee to find that the Registrant has departed from the following standards by virtue of her conduct:

- ***5. Keep your knowledge and skills up to date***
- *5.1 Be competent in all aspects of your work including clinical practice, supervision, teaching, research and management roles, and do not perform any roles in which you are not competent.*
- *5.3 Be aware of current good practice, taking into account relevant developments in clinical research, and apply this to the care you provide.*
- *5.4 Reflect on your practice and seek to improve the quality of your work through activities such as reviews, audits, appraisals or risk assessments.*
- *Implement any actions arising from these.*
- ***6. Recognise, and work within, your limits of competence***
- *6.1 Recognise and work within the limits of your scope of prac□ce, taking into account your knowledge, skills and experience.*
- *6.2 Be able to identify when you need to refer a patient in the interests of the patient's health and safety, and make appropriate referrals.*
- ***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. This should be done in a timescale that does not compromise patient safety and care.*
- *7.5 Provide effective patient care and treatments based on current good practice.*
- *7.7 When in doubt, consult with professional colleagues appropriately for advice on assessment, examination, treatment and other aspects of patient care, bearing in mind the need for patient confidentiality.*
- ***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;*
- *8.2 As a minimum, record the following information*
- *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.*
- *8.2.5 Details of any treatment, referral or advice you provided, including any drugs or optical device prescribed or a copy of a referral letter*
- ***10. Work collaboratively with colleagues in the interests of patients***
- *10.1 Work collaboratively with colleagues within the optical professions and other healthcare practitioners in the best interests of your patients, ensuring that your communication is clear and effective;*
- *10.4 Ensure that patient information is shared appropriately with others, and clinical records are accessible to all involved in the patient's care;*
- ***11. Protect and safeguard patients, colleagues and others from harm***
- *11.4 If you have concerns about your own fitness to practise whether due to issues with health, character, behaviour, judgement or any other matter that may damage the reputation of your profession, stop practising immediately and seek advice.*
- ***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;*
- ***19. Be candid when things have gone wrong***
- *19.3 Ensure that when things go wrong, you take account of your obligations to reflect and improve your practice as outlined in standard 5.*

123. Ms Fatania submitted that the Registrant's behaviour amounts to misconduct in that her conduct fell far below the standards expected due to the potential risk of harm to patients. She invited the Committee to consider Dr Kwartz's evidence in respect of each patient, which she submitted was helpful as it set out what could have been the risk of harm to them.

124. The Committee heard and accepted the advice of the Legal adviser, who referred the Committee to the section on misconduct in the Guidance. In particular, the Legal adviser referred to the case of *Roylance v General Medical Council (no2)* [2000] 1 AC 311, regarding the two principal kinds of

misconduct, either conduct linked to professional practice or conduct that otherwise brings the profession into disrepute. The Committee was reminded that misconduct was a matter for its own independent judgement and no burden or standard of proof applied at this stage. Further, that the Committee needed to consider whether the conduct was sufficiently serious to amount to professional misconduct.

The Committee's findings on misconduct

125. The Committee noted that it had been referred to the Council's Stage 2 Optometry Core Competencies (2011) by both Ms Fatania in her written submissions and Dr Kwartz, in her evidence. However, the Committee considered the most appropriate standards to have regard to when considering the matter of misconduct were the Council's Standards of Practice for Optometrists and Dispensing Opticians, effective April 2016.

126. The Committee was mindful that not every falling short of the standards was sufficient to amount to misconduct, as it must be serious. The Committee considered which of the Standards were engaged and whether the Registrant's conduct had fallen far below the expected standards of what was proper in the circumstances, in relation to each patient in the Allegation.

127. Throughout its deliberations the Committee had regard to the expert evidence of Dr Kwartz, who in both her oral and written evidence had given her expert opinion on whether the failings fell below or far below the standards expected of a reasonably competent Optometrist. The Committee had regard to this evidence but was mindful that the decision as to whether failings amounted to misconduct was a matter for the independent judgment of the Committee.

128. The Committee considered the definitions of 'conduct falling below' and 'conduct falling far below' used by Dr Kwartz in her evidence were helpful, which are as follows:

> '*5.2 In my opinion, conduct falling below the standard expected of a reasonably competent optometrist is a failure or minor error that does not cause a risk of significant harm to a patient or is a minor deviation from the expected standard.*
>
> *5.3 Conduct falling far below the standard of a reasonably competent optometrist is a failure that causes an increased risk of harm to a patient, including a small risk of serious harm and/or there is significant departure from the expected standard and/or there are numerous minor failures over a single patient episode and/or actual harm occurred to the patient*.'

Patient 2

129. The Committee considered that the Registrant's conduct in failing to conduct a dilated examination, failing to take adequate history regarding Patient 2's diabetes and failing to initiate a referral for cataracts in a timely manner, were clear breaches of Standards 7.1 and 7.2 (Conduct appropriate assessments, examinations, treatments and referrals). Whilst Ms Fatania, in her submissions, made reference to a wider range of Standards (as set out above), the Committee considered that Standards 7.1 and 7.2 were the most relevant.

130. As to whether the Registrant's conduct in relation to Patient 2 fell below or far below these standards, the Committee had regard to the evidence of Dr Kwartz, who in her report stated that,

> '*8.2.1 A reasonably competent optometrist would also ascertain if the patient was attending a diabetic screening programme, when they had last been examined and the outcome of such an examination. In not doing so, I consider that Elizabeth Williams' standard fell far below that of a reasonably competent optometrist as there was a significant risk to Patient 2 of her omissions and, as she had not dilated their pupils, she had no way of knowing about the status of their peripheral retina.*
>
> *8.2.3 …there is no evidence that she undertook an examination of the external surface of the eye and its immediate vicinity. In failing to do so, I consider that her standard fell far below that of a reasonably competent optometrist, as it is a significant departure from the normal standard of practice…*
>
> *8.2.4 …I consider that in not dilating Patient 2's pupils, the Registrant's standard fell far below that of a reasonably competent optometrist as there was an increased risk of harm to the patient.*'

131. In addition, in relation to the delayed referral, Dr Kwartz considered that a period of over 6 weeks was too long, as the patient will have been struggling with their visual function, and in her opinion, the Registrant's conduct fell far below the standard, as a 6 week delay of a referral is a significant departure from the expected standard.

132. The Committee accepted the evidence of Dr Kwartz that the Registrant's conduct in respect of Patient 2 was a significant departure from the standards to be expected of a reasonably competent Optometrist. The Committee considered that the Registrant's conduct was serious, as there was an increased risk of harm to Patient 2, particularly in respect of the Registrant's failure to carry out a dilated eye examination. Therefore, the Committee found that the Registrant's conduct in relation to Patient 2 amounted to misconduct.

Patient 3

133. In relation to Patient 3, the Committee considered that Standards 7.1, and 7.2 applied, as there was a failure to adequately assess the patient and carry out a clinically necessary visual fields test. Additionally, 8.2.4 and 8.2.5 were relevant to the Registrant's failures to include relevant clinical information in the referral letter.

134. Dr Kwartz's opinion was that the Registrant's failure to carry out a visual fields test fell far below the required standard, as there was an increased risk to the patient, as glaucoma causes asymptomatic and irreversible visual loss. Furthermore, Dr Kwartz considered that in failing to put relevant information into the referral letter and give the safety netting advice to Patient 3 regarding the epi-retinal membrane, the conduct fell far below the standards expected as there were multiple failures within the same patient episode.

135. The Committee accepted the evidence of Dr Kwartz that the Registrant's conduct in respect of Patient 3 was a significant departure from the standards to be expected of a reasonably competent Optometrist. The Committee considered that the Registrant's conduct was serious, as there was an increased risk of potential harm to Patient 3, by not being given a visual field test that was indicated and the appropriate safety netting advice in respect of the epi-retinal membrane. Therefore, the Committee found that the Registrant's conduct in relation to Patient 3 amounted to misconduct.

Patient 4

136. In relation to Patient 4, the Committee considered that Standards 7 and 8 were engaged, as the Registrant failed to carry out a visual fields test which was clinically indicated and failed to record relevant matters in both the patient record and a referral letter.

137. The Committee had regard to the evidence of Dr Kwartz, who was of the opinion that the record made by the Registrant falls far below the standard of a reasonably competent Optometrist, as it was not clear why Patient 4 had an amblyopic left eye. Further, that by not conducting a visual fields test on this patient, the Registrant fell far below expected standards as the patient was at risk of developing glaucoma, which could have significant visual consequences and this was a patient who was significantly reliant upon their right eye. The Committee accepted the evidence of Dr Kwartz and agreed that this conduct was more serious due to that fact and there would be a higher duty of care in the circumstances. Therefore, the Committee found that the Registrant's conduct in relation to Patient 4 amounted to misconduct.

Patient 5

138. The Committee considered that in relation to Patient 5 the Standards that were engaged were 5.1, 7.1, 7.2, 8.1, 12.4 (In an emergency take appropriate action to provide care, taking into account your competence and other available options). In this case, the Patient had a BRVO in their right eye and on the OCT images there were signs of macular oedema (where fluid accumulates at the macula). Dr Kwartz's evidence was that this condition should be referred to an Opthalmologist as an urgent/priority case and that the College of Optometrist Guidance recommends that the Optometrist should telephone the eye emergency department for triage.

139. It appeared to the Committee from the internal investigation interview that the Registrant did not appreciate the urgency of the situation for Patient 5 and she accepted that no referral letter was initiated. In addition, the Registrant's assessment of Patient 5 was inadequate as no clinical record was completed, as the Optix record did not contain an input of a clinical record of the examination (apart from a previous prescription and OCT results) and whilst the Registrant made handwritten notes, these were not adequate.

140. Dr Kwartz's evidence sets out how in her opinion the Registrant's conduct in respect of Patient 5 fell far below the standards to be expected of a reasonably competent Optometrist in several respects. There was a risk of harm to Patient 5, because of the nature of the condition which could be sight threatening. Dr Kwartz stated in her report that visual acuity and intra-ocular pressure are profoundly important in patients with a vein occlusion. Dr Kwartz stated that,

> *'8.5.2 Omission of all these facts from the record constitutes a standard far below the required level because vital information that can have a consequence for the patient's health and/or vision were not documented, significantly increasing the risk of harm to the patient.'*

141. Additionally, Dr Kwartz considered that in not actioning a referral for this patient, the Registrant's conduct fell far below the standards expected.

142. The Committee accepted the evidence of Dr Kwartz that the Registrant's conduct in relation to Patient 5 fell far below the standards expected. The Committee considered that this was the most serious aspect of the facts found proved, given the sight threatening nature of the condition, which required urgent management and the fact that the Patient had to attend A&E within a week of the appointment with the Registrant for treatment. Therefore, the Committee found that the Registrant's conduct in relation to Patient 5 amounted to misconduct.

Patient 6

143. The Committee considered that the relevant Standard in respect of the Registrant's failure to refer Patient 6, was 7.2. The Registrant had departed from this Standard by not referring Patient 6 for suspected glaucoma after she had detected clinically signs suggestive of glaucoma. Having detected these clinical signs, she had a duty to refer the patient for further assessment.

144. Dr Kwartz's opinion was that in not making a referral, the Registrant's conduct fell far below the standards to be expected, as glaucoma causes painless irreversible visual loss. The Committee accepted the evidence of Dr Kwartz and considered that the Registrant's departure from the standards expected in not referring Patient 6 was serious because of the potential risk of harm, due to the permanent sight loss that can be suffered by a patient if glaucoma is not diagnosed. Therefore, the Committee found that the Registrant's conduct in relation to Patient 6 amounted to misconduct.

Patient 7

145. The Committee considered that the relevant Standard in respect of Patient 7 was 7.1, as the Registrant failed to carry out an adequate assessment of Patient 7. Whilst the Registrant dealt with Patient 7's macular problem (and made an appropriate referral in respect of it), she did not adequately deal with the increase in floaters, which Dr Kwartz referred to as a 'red flag', given that an increase in floaters suggests posterior vitreous detachment or retinal detachment. This should have led to the Registrant carrying out a dilated assessment, which was not performed.

146. Dr Kwartz's opinion in relation to Patient 7 was that the Registrant's conduct fell far below that of a reasonably competent Optometrist, as she had not carried out the required assessments which are set out 'as a minimum' in the College of Optometrists' Guidance for patients who present with floaters (paragraph A259). Nor had she given the appropriate safety netting advice to Patient 7 so that they could take appropriate action if symptoms worsened. The Committee accepted the evidence of Dr Kwartz that these were significant departures from the standards to be expected of a reasonably competent Optometrist. Accordingly, the Committee found that the Registrant's conduct in relation to Patient 7 was serious and amounted to misconduct.

147. Additionally, the Committee considered that in relation to all of the facts found proved, across all patients, Standard 17 (Do not damage the reputation of your profession through your conduct) applied throughout, as the Registrant's conduct was sufficiently serious, particularly when taken together, to damage the reputation of the profession.

148. In relation to all of the particulars that were found proved, in respect of all patients, the Committee was satisfied that the Registrant's conduct fell far below the standards expected of a reasonably competent Optometrist to amount individually to misconduct, which was serious, in each instance.

149. Accordingly, the Committee found that the facts found proved do amount to misconduct.

Impairment

150. The Committee went on to consider whether the Registrant's fitness to practise is currently impaired by reason of her misconduct. The Committee heard submissions from Ms Fatania on behalf of the Council, who invited the Committee to find that the Registrant's fitness to practise is currently impaired.

151. Ms Fatania referred the Committee to her written submissions and highlighted the case of *CHRE v (1) NMC and (2) Grant* [2011] EWHC 927 (admin). Ms Fatania outlined the test that was formulated by Dame Janet Smith in the report to the Fifth Shipman Inquiry, which was approved in the case of *Grant* as an appropriate approach to considering impairment (framed in respect of doctors but applicable to Optometrists):

> *"Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:*
>
> *a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> *c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession;*
>
> *and/or d. has in the past acted dishonestly and/or is liable to act dishonestly in the future."*

152. Ms Fatania submitted that limbs (a), (b) and (c) of the above test all applied in this case (with (d) not being applicable), in light of the facts found proved and the Committee's findings regarding misconduct

153. Ms Fatania acknowledged that the Registrant had shown remorse in her internal investigation interviews and that [redacted], her line manager, thought that she had taken responsibility for her conduct. Ms Fatania referred to the Registrant's comments in her email dated 18 August 2023, written in response to these proceedings, in which the Registrant agreed that her conduct was unacceptable. Ms Fatania also highlighted that the Registrant, in

the same email, realised her '*struggles and limitations*' in adjusting to more modern practises. Additionally, the Registrant previously had an unblemished record.

154. Ms Fatania submitted that whilst the Registrant had taken a level of responsibility, she had also outlined in her email that the conduct occurred due to '*time restraints, and a lack of flexibility/personal approach to staff needs by the employer*'. Ms Fatania submitted that when the Registrant raised time restraint issues at work, she was given support and more breaks and yet the concerns continued.

155. In relation to remediation, Ms Fatania highlighted that the Registrant has stated that if she '*ever wished to return to practice I would have to seriously revisit my clinical record keeping and standards of practice*'. However, there is no evidence of any remediation, such as training, being undertaken by the Registrant to improve on these issues and do the work required. Ms Fantania submitted that in the circumstances there was a risk of repetition. Ms Fatania submitted that the Registrant has stated that she has lost her confidence in being able to practise safely and that she has not worked as an Optometrist since 2022, based on the most recent evidence from the Registrant.

156. Ms Fatania referred to the public interest and stated that the need to uphold professional standards and maintain public confidence in the profession would be undermined if no finding of impairment was made. She submitted this case due to the Committee's earlier findings at the facts and misconduct stages and as the Registrant has not taken any steps to remediate or address the concerns in this case. Therefore, she submitted the public interest requires a finding of current impairment in this case to declare and uphold standards and maintain public confidence in the profession.

157. The Committee accepted the advice of the Legal Adviser who advised the Committee that the question of impairment was a matter for its independent judgement She reminded the Committee that a finding of impairment does not automatically follow a finding of misconduct and outlined the relevant principles set out in the cases of *CHRE v (1) NMC and (2) Grant* [2011] EWHC 927 (admin) and *Cohen v GMC* [2008] EWHC 581 (Admin). The Committee considered whether the Registrant's conduct was capable of being remediated, whether it had been remediated and whether there is a risk of repetition of the conduct in future.

The Committee's findings on Impairment

158. The Committee considered whether the Registrant's conduct was capable of being remediated, whether it had been remediated and whether there is a risk of repetition of the conduct in future.

159. The Committee was of the view that the nature of the conduct in this case, namely clinical failings, was in principle capable of being remediated (with insight and remediation).

160. However, when considering whether the misconduct had been remediated by the Registrant, the Committee concluded that the Registrant had only shown limited insight into her conduct. The Committee acknowledged that the Registrant had shown remorse and apologised during the internal investigation, as outlined in the evidence of her line manager [redacted]. Further, in her email response to these proceedings, dated 18 August 2023, the Registrant had recognised that her conduct was not acceptable.

161. However, the Committee considered that this insight was limited, as the Registrant in her email correspondence did not appear to accept full responsibility. For example, she provided excuses as to why she believed the misconduct occurred, including time restraints, despite more breaks for administration having been provided. In addition, the Registrant was referring to her recordkeeping and referral time being unacceptable, whereas the findings made by the Committee in these proceedings have been wider in scope, including significant clinical failings. The Committee did not consider that the Registrant fully appreciated the seriousness of the clinical concerns and the potential risk of harm to the patients concerned.

162. In relation to remediation, there is no evidence that the Registrant has taken any specific steps to remediate her misconduct. The Committee concluded that the Registrant's insight into her misconduct was limited, and she still has significant work to do in this respect in order for the Committee to be reassured that she has remediated her misconduct. However, there was no indication that the Registrant was willing to complete the work required, as she has disengaged from these proceedings and indicated that she currently does not wish to practise.

163. The Committee was of the view that the Registrant's conduct had put patients at risk of harm in the past and the Committee was concerned that without reflection, the further development of insight and adequate remediation, she would do so again in future if she were to return to unrestricted practice. Given the lack of evidence of insight and remediation by the Registrant to address the failings, the Committee was of the view that there was a significant risk of repetition.

164. Considering all of the above, the Committee was satisfied that the Registrant's fitness to practise is currently impaired on public protection grounds.

165. The Committee considered the public interest and had regard to the case of *CHRE v (1) NMC and (2) Grant* [2011] EWHC 927 (admin). The Committee agreed with the submission of Ms Fatania that limbs (a), (b) and (c) were all applicable in this case, both in respect of the Registrant's past conduct and also in relation to the Registrant being '*liable in the future*', to put patients at unwarranted risk of harm, bring the profession into disrepute, and breach a fundamental tenet of the profession.

166. The Committee considered whether a finding of impairment was necessary on the basis of the wider public interest in order to uphold proper professional standards and public confidence in the profession. Given the serious nature

of the misconduct, which concerned significant clinical failings, resulting in potential harm to several patients, the Committee concluded that the public would be concerned if no finding of impairment was made, and this would undermine the public confidence. The Committee determined that it was also necessary to make a finding of impairment in this case in order to maintain confidence in the profession, and the Regulator and in order to uphold proper professional standards.

167. Accordingly, the Committee found that the fitness of the Registrant Ms Elizabeth Williams to practise as an Optometrist is currently impaired.

Sanction

168. The Committee went on to consider what would be the appropriate and proportionate sanction, if any, to impose in this case. The Committee received no new material at this stage.

169. The Committee heard oral submissions from Ms Fatania, on behalf of the Council, supplementing her written submissions on sanction. Ms Fatania stated that the Council's position was that a suspension was the appropriate sanction in this case. Whilst in the Council's written submissions on sanction it had been suggested that a sanction of conditions may be appropriate, that was if the Registrant was engaging with these proceedings and intended to continue practising. Ms Fatania submitted that conditions could address the misconduct in this case. However, the Registrant had not engaged and there was no evidence of remediation. Nor was there any evidence that the Registrant wished to return to practice at this stage.

170. Ms Fatania referred the Committee to paragraph 21.18 of the Hearings and Indicative Sanctions Guidance ('the Guidance'), which states that, if imposing conditions, the Committee should satisfy itself that the Registrant would respond positively to the imposition of conditions, including considering any objective evidence about the Registrant's practice. In this case, Ms Fatania submitted that objective evidence is not present and it appears that the Registrant has not worked as an Optometrist since November 2022.

171. Ms Fatania further referred to paragraph 21.20 of the Guidance, which states that conditions should be appropriate, proportionate, workable and measurable. Ms Fatania submitted that the key word in this case is 'workable' and that it could not be said that conditions would be workable in this case when the Registrant is not engaging; therefore this sanction was not an option for the Committee.

172. Ms Fatania submitted that in these circumstances, where the Registrant is not working and currently has no intention to, the appropriate sanction would be

one of suspension. Ms Fatania invited the Committee to impose a suspension, with a Review hearing and to give the Registrant guidance on what remediation would be required, if the Registrant wished to return to practice.

173. Additionally, Ms Fatania invited the Committee to make an immediate order. She submitted that whilst there had been no repetition since the incident, given the Committee's earlier findings, an immediate order would be appropriate.

174. The Committee accepted the advice of the Legal Adviser, which was for the Committee to take into account the factors on sanction as set out in the Guidance; to assess the seriousness of the misconduct; consider any aggravating and mitigating factors; and to consider the range of available sanctions in ascending order of seriousness. Further, the Committee is required to act proportionately by weighing the interests of the Registrant against the public interest. The Legal Adviser advised that a Review hearing should be considered if conditions or a suspension were to be imposed and that at a Review hearing all options regarding sanction are available, including erasure.

The Committee's findings on sanction

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

i) The number of incidents of misconduct, in that there was a range of serious clinical failures, of the same or similar nature, in respect of six patients, over a period of approximately 4 months;

ii) In respect of all of the patients, the misconduct either put the patients at some harm or potential risk of harm;

iii) The Registrant has not demonstrated the timely development of insight and the insight documented remains limited.

176. The Committee considered the following to be mitigating factors:

i) There was evidence that the Registrant had apologised and shown some remorse for her misconduct;

ii) There was evidence that the Registrant was aware of her limitations and her obligations to her patients;

iii) There was some evidence that the Registrant had personal difficulties at around the time of the misconduct, which may have had an impact upon her conduct;

iv) The Registrant has no fitness to practise history.

177. The Committee considered the range of sanctions available to it from the least to the most restrictive, starting with no further action.

178. The Committee considered taking no further action as set out in paragraphs 21.3 to 21.8 of the Guidance. It was of the view that there were no exceptional circumstances to justify taking no action in this case. It further considered that taking no further action would not protect the public, was not proportionate, nor sufficient, given the seriousness of the misconduct and would not meet the public interest concerns.

179. The Committee considered the issue of a financial penalty order. However, it was of the view that such an order was not appropriate, as the case did not involve financial motivation or gain. In addition, a financial penalty order would not protect the public nor meet the public interest concerns.

180. The Committee considered the Guidance in relation to the imposition of conditions. It was of the view that conditional registration would not be appropriate, as conditions would not be workable in this case. The Committee noted that the misconduct was of a type where conditions could be appropriate, as it involved identifiable clinical areas of practice in need of assessment or retraining, which conditions often seek to address. However, as the Registrant had not engaged with these proceedings and there was no indication that she wished to improve her practice at this time, the Committee could not be reassured that the Registrant would respond positively to any conditions imposed. Therefore, the Committee concluded that conditions could not be devised in this case that would be workable.

181. Additionally, given that there was no evidence to suggest that the Registrant would respond positively to any conditions imposed, the Committee considered that conditions would not be an adequate sanction to protect the public.

182. The Committee next considered the sanction of suspension and had regard to paragraphs 21.29 to 21.31 of the Guidance. In particular, the Committee considered the list of factors contained within paragraph 21.29 that indicate that a suspension may be appropriate, which are as follows:

Suspension (maximum 12 months)

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. In cases where the only issue relates to the registrant's health, there is a risk to patient safety if the registrant continued to practise, even under conditions.

183. The Committee considered that several of the factors listed in paragraph 21.29 of the Guidance were applicable and relevant to this case, including a), b) and c). In relation to d), the Committee had found at the impairment stage, that the Registrant had shown some insight, albeit it was limited. Factor e) was not applicable. The Committee further noted that not all of the factors in paragraph 21.29 are required to be present for a suspension to be appropriate, noting that the guidance states that a suspension may be appropriate when '*some, or all'*, of the factors were present and that the list was not exhaustive.

184. The Committee was satisfied that there were several factors present that indicated that a suspension would be an appropriate sanction. The Committee considered that although the Registrant had not engaged in these proceedings and had indicated that she had no current intention to return to practice, the misconduct that had been found in this case was capable of being remediated, should the Registrant wish to address the concerns. The Committee considered that the Registrant ought to have the opportunity to engage and carry out the remediation required, which she would be able to do during a period of suspension.

185. Considering the misconduct and balancing the mitigating and aggravating factors present, the Committee was satisfied that a period of suspension would be a sanction that would be proportionate and protect the public. A suspension would mark the seriousness of the misconduct, maintain confidence in the profession and uphold proper standards of professional conduct and behaviour.

186. Additionally, the Committee was of the view that erasure was not warranted in this case. The Committee considered the list of factors where erasure is likely

to be appropriate set out in paragraph 21.35 of the Guidance and considered that most of them did not apply. Whilst there had been serious departures by the Registrant from the Standards of Practice, the Committee did not consider that the misconduct was fundamentally incompatible with being a registered professional. The Committee considered that erasure was not the only sanction that would sufficiently protect the public and meet the public interest and therefore erasure would be disproportionate.

187. The Committee therefore determined to impose a sanction of suspension. In relation to the length of the order, the Committee determined that, having considered the nature and seriousness of the misconduct, and balanced the aggravating and mitigating factors, it would be appropriate and proportionate to suspend the Registrant for the maximum period of 12 months. The Committee considered that this period would reflect the seriousness of the misconduct and also allow the Registrant sufficient time to reflect, develop her insight further and carry out the necessary remediation required to address the concerns arising in this case, if she wishes to do so.

188. The Committee considered whether to direct that a Review hearing should take place before the order expired. The Committee noted that at paragraph 21.32 of the Guidance, it states that a review should normally be directed before the end of the order, because the Committee will need to be reassured that the Registrant is fit to resume unrestricted practice.

189. The Committee bore in mind that it had found that there remained a significant risk of repetition of the conduct, as the Registrant had limited insight and had not yet remediated. The Committee considered that in the circumstances, and given the length of the suspension imposed, a Review hearing was appropriate and should take place before the period of suspension expires. This will enable a future Review Committee to consider whether the Registrant has engaged and carried out the work required to return to practice safely. A future Review Committee would also be able to consider all of the options available to it, should the Registrant not engage.

190. The Review Committee will need to be satisfied that the Registrant:

(i) has fully appreciated the gravity of the misconduct,
(ii) has maintained her skills and knowledge and
(iii) that the Registrant's patients will not be placed at risk by the resumption of unrestricted practice.

191. In addition, the Committee considers that it would assist the Review Committee if the Registrant was able to provide the following:

(i) A detailed reflective statement;
(ii) Evidence that the Registrant has addressed the failings in the Standards of Practice that are identified in this determination;
(iii) Any testimonials and/or other evidence that the Registrant considers may assist.

Immediate order

192. The Committee heard submissions from Ms Fatania, on behalf of the Council, who invited the imposition of an immediate order.

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

194. The Committee had regard to the section of the Guidance regarding immediate orders and considered the statutory test. The Committee bore in mind that it had found that the misconduct was serious and there was a significant risk of repetition. The Committee was therefore concerned that if no immediate order was made, the Registrant could, despite indicating that she did not wish to practice, return to practise and repeat the conduct during any appeal period. The Committee therefore concluded that an immediate order was necessary to protect members of the public in this case.

195. Additionally, given the serious nature of the misconduct, the Committee decided that it was also otherwise in the wider public interest that an immediate order be imposed. Accordingly, the Committee imposed an immediate order of suspension.

Revocation of interim order

196. There was no interim order to revoke.

Chair of the Committee: Paul Curtis

Signature **Date:** 16 May 2025

Registrant: Elizabeth Williams

Signature …Not Present **Date:** 16 May 2025

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.