BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(24)33

AND

MOHAMMED UL HAQ (01-31900)

DETERMINATION OF A SUBSTANTIVE HEARING
30 JUNE – 8 JULY 2025

Committee Members:	Andy Brennan (Chair/Lay) Kevin Connolly (Lay) Vivienne Geary (Lay) Kalpana Theophilus (Optometrist) Gaynor Kirk (Optometrist)
Legal adviser:	Kelly Thomas
GOC Presenting Officer:	Chuba Nwokedi
Registrant present/represented:	Yes and represented
Registrant representative:	Eleanor Curzon (Counsel)
Hearings Officer:	Arjeta Shabani
Facts found proved:	All allegations 1-12 admitted and found proved.
Misconduct:	- 2a, 2b, 2c, 4b, 4c, 5a, 7b, 7c, 8a, 10a, 10b and 12, which individually each amounted to serious professional misconduct; - 1a, 3a, 7a, 9a and 11a taken cumulatively amount to serious professional misconduct.
Impairment:	Impaired
Sanction:	Suspension for 3 months – with Review

Immediate order:	Immediate order

ALLEGATION

The Council alleges that you, Mr Mohammed Ul-Haq (01-31900), a registered optometrist:

1. *On or around 15 August 2022, you carried out a sight test on Patient A and:*

    a. *You failed to make a timely referral for cataract in the left eye; and/or*
    b. *You added further details on the record after the sight test for binocular visual acuity and the near spectacle prescription and did not annotate to show it was an addition or amendment.*

2. *On or around 18 July 2022, you carried out a sight test on Patient B and you failed to maintain adequate record in that you:*

    a. *You failed to record adequate information on record card to determine if a referral was necessary; and/or*
    b. *You added further details on record after the sight test on delegated health checks, history and symptoms, external and internal eye examination, refraction, vision/visual acuity and advice section after the sight test and did not annotate to show it was an addition or amendment; and/or*
    c. *You failed to assess and/or record the intraocular pressure of the left eye*

3. *On or around 29 June 2022, you carried out a sight test on Patient C and:*

    a. *You failed to make a timely referral for cataract to Hospital Eye Service (HES) for cataract investigation.*

4. *On or around 30 July 2022, you carried out a sight test on Patient D and:*

    a. *You failed to adequately and/or appropriately record clinical data in that the paper notes recorded an add of 2.50 whilst the computer records has an add of 2.00; and/or*

b. *You failed to adequately and/or appropriately record the recall interval in that the paper notes recorded a recall of 2 years whilst the computer records has a recall of 12 months; and/or*

c. *You added further details on record after the sight test on refraction, vision/visual acuity and advice section after the sight test and did not annotate to show it was an addition or amendment.*

5. *On or around 3 July 2022, you carried out a sight test on Patient E and:*

   a. *You did not annotate the record to show it was a duplicate of the original.*

6. *On or around 22 June 2022, you carried out a sight test on Patient F and failed to adequately and/or appropriately record clinical data in that:*

   a. *You later changed the sight test results 'consider referral for GAT although all tests are normal → gat better for measuring IOPs' but this was later replaced on the record card with '[dis]charged for high IOPs previously. On repeat → wnl. 12/12 RSIAP' Where RSIAP means 'return sooner if any problems' and did not annotate to show it was an addition or amendment.*

7. *On or around 11 July 2022, you carried out a sight test on Patient G and:*

   a. *You failed to make a timely referral for a YAG- Laser Capsulotomy; and/or*
   b. *You failed to assess and/or record the intraocular pressure and/or a visual field assessment of the right eye; and/or*
   c. *You added further details on record after the sight test relating to family history, external examination, internal examination, visual fields, intraocular pressure and did not annotate to show it was an addition or amendment*

8. *On or around 6 August 2022, you carried out a sight test on Patient H and you failed to:*

   a. *Annotate the record to show it was a duplicate or amendment of the; and/or*
   b. *You failed to assess and/or record the intraocular pressure*

9. *On or around 29 June 2022, you carried out a sight test on Patient I and:*

a. *You failed to make a timely referral for cataract; and/or*
b. *You added further details on record after the sight test relating to history and symptoms, and did not annotate to show it was an addition or amendment*

10. *On or around 13 June 2022, you carried out a sight test on Patient J and:*

a. *You failed to make a timely referral for cataract in the left eye.*
b. *You added further details on record after the sight test relating to history, external examination and internal examination, and did not annotate to show it was an addition or amendment*

11. *On or around 27 July 2022, you carried out a sight test on Patient K and:*

a. *You suspected glaucoma and failed to make a timely referral to Hospital Eye Service (HES) and potentially delayed Patient K's treatment; and/or*
b. *You added further details on record after the sight test relating to visual fields, motility, pupils, visual acuity and near spectacle prescription and did not annotate to show it was an addition or amendment*

12. *You failed to ensure clinical records could be accessed easily by other staff in that you kept patient records stored with another colleague without other staff being aware of this*

13. *On or around 20 September 2022, you were asked to review records for Patient A to K and complete outstanding actions and referrals. You made additions and or amendments to the patient records and did not annotate that they were additions and or amendments as set out in 2b, 6a, 1b, 2b, 4c, 7c, 9b and 10b above.*

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

Application to amend allegation

1. Mr Nwokedi, on behalf of the General Optical Council (GOC) made an application to amend the allegations. He submitted that particular 13 duplicated the allegations 1-12 and applied to withdraw allegation 13.
2. Ms Curzon on behalf of the Registrant raised no objections.

3. The Legal Adviser advised that the Committee had the power to amend the allegation if it consider, under *Rule 46(20) of the Fitness to Practice Rules* 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.

4. The Committee determined that it would be appropriate to amend allegation 13 to avoid duplication, and in fairness to the Registrant. Allegation 13 was withdrawn.

DETERMINATION

Admissions in relation to the particulars of the allegation

5. The Registrant admitted all of the particulars of the allegations 1-12.

6. The Committee therefore found all of the particulars of allegations 1-12 proved.

Background to the allegations

7. The Registrant is a registered Optometrist who was first registered with the GOC as a student optometrist on 13 October 2015 and registered as a fully qualified optometrist on 20 August 2019.

8. The matter concerns alleged record keeping failures including ensuring the safe custody of records, making appropriate referrals and amendment of records.

9. A whistle blower raised concerns that the Registrant had provided patient records to another colleague instead of placing the records in the appropriate place while the Registrant was on leave from 24 August 2022 – 19 September 2022. During the Registrant's leave, several of the patients he served contacted the store to enquire about their referrals. Other colleagues could not locate the patient records and were unaware they had been passed to another colleague while the Registrant was on leave. It transpired that the Registrant did not send the referrals.

10. An internal investigation was carried out by Ms A, Clinical governance Optometrist at Boots Opticians. Ms A requested that these records be sent to her for investigation and these were shared on 13 September 2022. In her report, having viewed the records she found the following:

    (a) "Six were missing referral letters:

    - Four for cataracts

    - One for YAG-laser Capsulotomy

    - One suspect Glaucoma due to nerve appearance

(b) *Two indicated that referral for Ocular Hypertension/suspect Glaucoma was being considered but no evidence of follow up. Records state that the patient was known to previously have 'high IOPs'*

(c) *Due to lack of details recorded, it was not possible to determine whether referral was required/being considered for three of the records."*

11. On his return, the Registrant was asked to review the 11 patient records and complete the referral. After this review, the records were returned to Ms A. All records had been amended in one way or the other in the following ways:

"Sections of the records which had been added to:

1. *Front of record (3)*
2. *Delegated Health Checks (2)*
3. *History and symptoms (2)*
4. *External eye examination (5)*
5. *Internal eye examination (4)*
6. *Refraction (4)*
7. *Advice (4)*

12. The findings were detailed:

1. *The six records identified as "missing" referral letter on 13 September 2022 now have referral letters included. Delay in writing the referral ranged from 21 days to 92 days [subsequently amended to 22–99 days].*
2. *Both records where referral for Ocular Hypertension/suspect Glaucoma was being considered have been annotated to suggest that the Ishan(sic) decided to monitor the IOPS referral was not necessary.*
3. *Extra details have been added to the remaining three records – two of the records have been completely re-written. There is evidence that Ishan(sic) has confused two patients and therefore one of the records is not factually correct."*

13. Mr. Ul-Haq was then contacted for comment via email on 9 December 2022. His response was received on 19 December 2022.

14. With regards to the delayed referrals, the Registrant made the following comments:

'I generally try to complete referrals whilst the patient is still in the practice, but this isn't always possible due to time constraints. I was aware that in this case, it

was a routine referral so I believe I kept the record to one side within my room with the intention of completing the records and referral later that day…'

15. With regards to the record keeping. The Registrant states:

'I received a record keeping audit from Ms A. Some areas for improvement were noted, but overall I was pleased that I had passed the audit and received generally positive comments. This was the first time I'd been audited as a locum and I welcomed the feedback. I would like to say at the time, I kept a good standard of record keeping and the store had good staffing levels and experienced staff.

After this period, the store became short-staffed, and extra patients were often booked in for eye tests or contact lens checks into the collection clinic. Given that I was predominately the only qualified practitioner on the premises this effectively meant that I was frequently double-booked, and as these patients were not turned away I was left in a difficult position. This increased pressure led me to develop bad habits such as writing down notes in my notebook, and transferring them onto the record later, rather than recording everything immediately within the main clinical notes.'

12. The matter was referred to the GOC in an email referral from Boots Opticians on 23 February 2023.

Findings on the facts

13. The Registrant admitted all of the particulars of allegations 1-12.

14. The Committee therefore found the particulars of allegations 1-12 proved.

Submissions on misconduct

15. Mr Nwokedi outlined the case of *Roylance v GMC [1999] Lloyd's Rep Med 139,* where misconduct was described as:

"A falling short by omission or commission of the standards to be expected among [medical practitioners] and such falling short must be serious… It is of course possible for negligent conduct to amount to serious professional conduct, but the negligence must be to a high degree".

16. Mr Nwokedi submitted that the Registrant's actions were not just mere misconduct but serious misconduct. He submitted that the facts span a range of failings including:

a. Repeated failures to make timely referrals (Allegations 1a, 3a, 7a, 9a, 10a)

b. Repeated retrospective alterations to clinical records without annotation, across at least different patients (Allegations 1b, 2b, 4c, 6a, 7c, 8a, 9b, 10b, 11b, 12)

c. Multiple failures to assess or record intraocular pressures or other basic tests (Allegations 2c, 7b, 8b)

d. Significant discrepancies between digital and paper records

e. Failures to ensure clinical records were accessible (Allegation 12)

17. Mr Nwokedi submitted that the acts and omissions of the Registrant represent serious, sustained departures from the Registrant breached *Standards of Practice for Optometrists and Dispensing Opticians ("the Standards"),* namely:

- *Standard 7.2:Provide or arrange further investigations within a timescale that does not compromise patient care;*
- *Standard 8: Maintain adequate patient records;*
- *Standard 10.4: Ensure patient records are accessible to others involved in care;*

18. Mr Nwokedi submitted that the legal test for misconduct is not contingent solely on an expert's grading, but a matter for the Committee, having regard to *all* the circumstances, including whether public confidence would be undermined by a failure to make a finding of misconduct. Mr Nwokedi stated that the Registrant's misconduct is not minor or technical in nature. It directly undermines patient safety, integrity and clinical records which are fundamental to continuity of care and upholding trust in the profession.

21. Mr Nwokedi submitted that each individual action is serious enough to constitute misconduct. However, even if some record-keeping lapses, lack of assessments or lack of referrals appear minor in isolation, taken together with repeated failures in referrals and core clinical assessments, they cross the *Roylance* threshold. They form a pattern of perhaps of an attitudinal issue or a fundamental issue with adhering to what is expected of a professional in that area, and therefore the cumulative effect of the misconduct is plainly serious professional misconduct because they pose a clear risk of harm and compromise to patient safety.

22. Ms Curzon, on behalf of the Registrant, submitted that the case of *Roylance* is the leading case in this area and the description for misconduct in that case is qualified in two respects. Firstly, it is qualified by the word "professional" which links the misconduct to the profession [of optometry]. Secondly, the misconduct is qualified by the word "serious". It is not any professional misconduct which would qualify. The professional misconduct must be serious.

23. Ms Curzon submitted that the Committee is required to consider each specific part of the allegation individually and consider whether it crosses the threshold of

'misconduct', and when 'misconduct' is alleged, you must consider the *seriousness* of the act or omission. This was reiterated in *Meadow v General Medical Council* [2007], the Court of Appeal made clear that "misconduct" should not be viewed as anything less than "serious professional misconduct."

24. Ms Curzon submitted that not every falling short of acceptable practise amounts to professional misconduct of a gravity that crosses the threshold at which a Registrant's fitness to practise may be subject to scrutiny. Falling short of the expected standard only crosses that threshold it if can be properly described as '*serious' as per the case of Roylance.*

25. Ms Curzon submitted that it is not appropriate to consider the allegations cumulatively. Each allegation must be considered in turn and an independent decision made in respect of whether it meets amounts to serious professional misconduct. The case of *Schodlok v GMC* [2015[EWCA Civ 769 confirmed that:

"In the normal case, I do not think that a few allegations of misconduct that are held individually not to be serious can or should be regarded collectively as serious misconduct."

26. Ms Curzon submitted that the Committee must consider each part of the allegation separately and ask itself whether that element crosses the threshold of seriousness that means it qualifies as serious professional misconduct. If the answer is 'no', the Committee should not then aggregate a number of lesser allegations to make a serious allegation. In other words, if no individual allegation amounts to serious professional misconduct, then there is no serious professional misconduct.

27. Furthermore, Ms Curzon submitted that the GOC's 'Hearings and Indicative Sanctions Guidance ("*the Guidance")* at paragraph 15.8, means that if the Committee finds itself in a position where it has dismissed most of the allegations as not falling below the required standard, and the Committee is left considering just one or two remaining allegations, the Committee would need to consider very carefully whether the remaining allegations are sufficiently serious to justify a finding of misconduct bearing in mind the guidance.

28. Ms Curzon went on to outline each individual allegation, and the findings of the expert in the case, Dr Chaggar. In respect of each allegation, Ms Curzon invited the Committee to find that none of the facts found proved amount to conduct that could cross the requisite threshold of seriousness to amount to serious professional misconduct.

29. Ms Curzon stated that the Registrant has not been charged with dishonesty, therefore the GOC submissions that the Registrant has acted in a way that suggests a 'lack of candour' should not be considered, as it is not a matter before the Committee.

30. In summary, Ms Curzon submitted that the Registrant's position is one in keeping with the GOC's expert, namely, that the record-keeping inaccuracies are

inconsequential in respect of ensuring patient care and safety is maintained, and that the only consequence of delayed referrals is one of inconvenience to the patients, rather than affecting patient care and safety. As such, it is submitted that the allegations cannot meet the required 'seriousness' threshold.

31. Ms Curzon submitted that there is no evidence to suggest that any patient care has been compromised contrary to *Standard 7.2* due to the actions of the Registrant, and this is confirmed across the entirety of the expert's report.

32. Ms Curzon stated that the expert does not, at any point, say that the Registrant's conduct falls *far below* that of a reasonably competent optometrist, therefore serious professional misconduct cannot be found on the evidence before the Committee.

33. The Legal Adviser outlined the *Guidance* at *Paragraphs 15.6-15.9,* and the case of *Roylance.*

34. The Legal Adviser further outlined the case of *Remedy UK Ltd v General Medical Council [2010] EWHC 1245 (Admin)*, that there were two principal kinds of misconduct, conduct which relates to professional practice and conduct that otherwise brings the profession into disrepute. The Committee were advised that only serious misconduct is taken into consideration at the impairment stage. The Committee should therefore consider each of the proven allegations in turn and first decide on whether each amount to serious misconduct.

35. The Legal Adviser then outlined the case of *Schodlok v General Medical Council [2015] EWCA Civ 769* to advise the Committee that only if it did find multiple instances of non-serious misconduct, it is in principle possible that these, taken together, can amount to serious misconduct. However there has been judicial criticism of this approach so the Committee would need to articulate its reasons if adopting that approach. It must consider both the volume and the similarity of the non-serious misconduct, as well as the way in which the case was put, before it could conclude that a series of non-serious misconduct amounts to a finding of serious misconduct. In the *Schodlok* case, Vos LJ declined to rule it out *"in a very unusual case on very unusual facts"* but went on, "*In the normal case, I do not think that a few allegations of misconduct that are held individually not to be serious can or should be regarded collectively as serious misconduct*."

36. The Legal Adviser also outlined the case of *Ahmedsowida v GMC [2021] EWHC 3466 (Admin)* where the tribunal was considering only three (proven) allegations, and found that the cumulative effect amounted to misconduct. However, this was criticised by the Court of Appeal in that the tribunal did not follow the principles in *Schodlok* and that they had not properly understood the case. The tribunal had made no comparison with the facts in *Schodlok*, or considered whether the facts were "*exceptional*," or considered whether the GMC had put its case on a cumulative basis (it had not) or whether there was a large number of incidents making up a series.

37. In the Registrant's case, the Legal Adviser outlined that the Committee is able to consider an accumulation of non-serious matters, however *Schodlok* has set a high bar for cumulation; unless the numbers are large and the case exceptional.

38. The Legal Adviser reminded the Committee that misconduct was a matter for its own independent judgement and no burden or standard of proof applied.

Findings on misconduct

39. The Committee heard and accepted the advice of the Legal Adviser and considered the written and oral submissions as well as the *Guidance* at Paragraph 15.5-15.9 and the definition of misconduct in the case law.

40. The Committee identified that the relevant *Standards* engaged in this case were *Standards 2, 7, 8, 9, and 10.*

41. The Committee considered carefully the evidence provided in the GOC bundle, including the opinion of Dr Chaggar, the GOC expert.

42. The Committee noted that Dr Chaggar's report dated 1 June 2024, explained the definitions applied for actions which fall below, and those which fell far below what is required for the reasonably competent optometrist, and then considered each of the allegations in turn. The Committee bore in mind its duty to form its own independent judgment for serious professional misconduct, and noted it was not necessary to accept every opinion in Dr Chaggar's report, but to consider all of the evidence before it when reaching a conclusion on misconduct.

43. The Committee then considered each allegation in turn.

1(a) On or around 15 August 2022, you carried out a sight test on Patient A and you failed to make a timely referral for cataract in the left eye

44. The Committee considered the relevant sections of the expert report and noted the following:

"4.2: However, the Registrant did not generate a referral on the day of the examination, but did this on the first day back on return from holiday. This was over one month later from the date of the examination. In this regard I consider the Registrant to fall below, but not far below the standard of a reasonably competent Optometrist. This is on the basis that although the delay incurred an inconvenience for Patient A, it is unlikely to have significantly compromised the care or safety of Patient A.

7.2: *A referral for cataract is typically a non-urgent/routine referral.*

7.3*The College of Optometrists guidance for urgency of referrals does not include referral of a cataract to be done on an urgent/priority basis.*

7.4 *I am not aware that there is a mandatory timescale for when a referral letter must be generated and sent by, however, in order to comply with the General Optical Council standards this would need to be done in a timescale that does not compromise patient care or safety.*

7.6 *In this case the cataract did not appear to be causing any secondary complications such as inflammation or raised intraocular pressure, or any immediate/imminent sight-threatening complications. Therefore, a routine referral would be appropriate and there was no indication for immediate/emergency referral."*

45. The Committee noted that the patient was over 65 years of age and had previously had a cataract removed from his right eye, affording him good vision in his right eye. The referral from the Registrant took over one month, which the Committee found in the circumstances to be unacceptable. The Registrant would have also been aware that he himself was due to go on holiday on 29 August 2022 for one month and failed to make the referral.

46. The Committee also considered the expert reference to the *College of Optometrists Guidance ("the College Guidance")*, which stated that urgency of referrals does not include referral of a cataract to be done on an urgent/priority basis and there is no mandatory time frame within which non-urgent cataract referrals are made, simply that patient care is not compromised.

47. The Committee considered the expert's conclusions at Paragraphs 7.9 and 8.2 that leaving the referral for a period of one month in this instance is behaviour that falls below, not far below the standard of a reasonably competent Optometrist, as '*although the delay incurred an inconvenience for Patient A, it is unlikely to have significantly compromised the care or safety of Patient A'*.

48. The Committee determined that the Registrant's actions fell below, but not far below the standards expected of a reasonably competent Optometrist. The Committee found that particular 1a did amount to misconduct but did not consider that this crossed the threshold into serious professional misconduct.

1(b) You added further details on the record after the sight test for binocular visual acuity and the near spectacle prescription and did not annotate to show it was an addition or amendment

49. The Committee considered the expert's findings for this allegation:

"3.3 …it would appear that the Registrant has produced an accurate record card of the examination on 15 August 2022 for Patient A. The additional comments as detailed in 3.1 above [that the Registrant between 13 and 20 September added the near spectacle prescription and visual acuity details and binocular distance visual acuity information to the record of Patient A] are essentially inconsequential and it would appear the Registrant documented the relevant

findings at the time of the examination. Although this is a failure in record-keeping to have not recorded this at the time of the examination, and to have not annotated when this was added, I consider this to be an inconsequential failure as it would not have compromised the care or safety of Patient A. Therefore, I consider the Registrant to fall below, but not far below the standard of a reasonably competent Optometrist for this element."

50. The Committee did not consider the Registrant's actions to reflect a contemporaneous note, which would be the expected standard for clinical records. The Committee noted that the amendments to the records were completed only once the Registrant had been told to update the records by Ms A, it was not initiated by the Registrant. The Committee considered that this would leave both Patient A, and the Registrant's colleagues in difficulties during the period the Registrant was on holiday because a contemporaneous note would have been unavailable, which causes a break in continuity of care and a potential risk to patient safety.

51. The GOC expert concluded that the addition of these details was an 'inconsequential failure,' which does not compromise patient care or safety of Patient A, and in this case, the Committee agreed.

52. The Committee determined that the Registrant's actions fell below, but not far below the standards expected of a reasonably competent Optometrist. The Committee found that particular 1b did amount to misconduct but did not consider that this crossed the threshold into serious professional misconduct.

(2)On or around 18 July 2022, you carried out a sight test on Patient B and you failed to maintain adequate record in that you:

53. *(a) failed to record adequate information on record card to determine if a referral was necessary*

54. In respect of this allegation, the Committee considered the expert's findings:

"1.6.6 It would appear Patient B was investigated for glaucoma (a condition of the eye in which the nerve connecting the eye to the brain [optic nerve] becomes damaged over time, usually cause by increased fluid pressure in the eye, leading to impaired vision) and subsequently discharged.

i. There is no further detail regarding this such as if Patient B had been diagnosed with glaucoma or when and/or why they were discharged.

1.6.7 Nevertheless, I believe there would be a body of reasonably competent Optometrists that would enquire about such information and only record the information it was possible to ascertain and/or the salient points of the discussion.

5.2 I am not able to confirm:
i. If the pale optic disc in the right eye required further assessment and/or management;
ii. If it was necessary to assess the intraocular pressure of the left eye
iii. If referral for the cataract in the left eye was necessary;
iv. If referral for certification as sight-impaired was necessary;
v. If referral to a Low Vision Clinic would be appropriate
Therefore, I am not able to ascertain if there is a failing in this regard."

55. The Committee noted that Patient B was born in 1936, and there was reference in the record to him having had glaucoma at some stage. There was also a reference to cataracts and there was no record of reason for the appointment. The Committee determined that there were a range of reasons including those listed by the expert why Patient B should have been referred, but the Registrant did not record an adequate assessment to ensure patient safety as per *Standard 7.1*.

56. Patient B was also noted to already have poor vision and as such any treating Optometrist would have needed to have regard to the *College Guidance* specifically dealing with patients with low vision. The Committee did not see any reference to this in the expert report.

57. The Committee considered that the Registrant had fallen far below *Standards 7.1 and 8* in not recording contemporaneous and crucial information which would be fundamental to a referral, particularly where there is a patient with a visual impairment as well as reference to a cataract.

58. The Committee determined that the Registrant's actions in this regard were a concern because an assessment for a referral could not have been determined until all of the above information had been recorded, the outcome was that no management was offered to the patient. The Committee did not consider that the GOC expert opinion assisted it on this issue. The Committee independently reached the view that the Registrant's actions fell far below *Standards 8 and 7.1.*

59. The Committee therefore found that particular 2a amounted to serious professional misconduct.

2(b) You added further details on record after the sight test on delegated health checks, history and symptoms, external and internal eye examination, refraction, vision/visual acuity and advice section after the sight test and did not annotate to show it was an addition or amendment

60. The Committee looked at the GOC expert findings for this matter:

"*1.9.4 However, in the 'Subjective' section of the record, directly beneath the*

'Objective' section, the Registrant has recorded the corrected vision of the left eye to be '6/LP'. This would suggest that Patient B had some degree of vision in the left eye; LP is an acronym for light perception. It appears that Patient B improved from NPL to LP with a lens having no ability to improve vision, which is anomalous and would suggest an error in documentation.

1.9.5 The Registrant has recorded the binocular vision of Patient B to be '6/LP'. This is unusual as typically the binocular vision is similar to that of the better seeing eye. In this case Patient B had markedly better vision in the right eye and therefore it would be expected that Patient B would have a level of binocular vision similar to the level of vision of the right eye. This would suggest there has been an error in the recording of binocular vision for Patient B.

3.3 The amended record card may be an accurate representation of the findings of the examination, and the amendments made do not appear to be inaccurate or irregular. However, the Registrant has not documented when the amendments were made which is therefore an inaccuracy in the detail of the record, albeit likely inconsequential. On this basis, I consider the Registrant to fall below, but not far below the standard of a reasonably competent Optometrist for this element."

61. The Committee were able to view patient B's records before and after the Registrant added further details. There was no annotation to denote the date of these additions. It also noted from the expert opinion that the Registrant made two errors in his documentation. It noted that the advice section of the original record was completely blank, with no advice on patient management. The eye examination was conducted on 18 July 2022 and the Boots internal investigation determined that the additions were made after 19 September 2022 at least nine weeks later.

62. The Committee noted that the Registrant admitted that the notes were not made contemporaneously, which would fall short of *Standard 8.1.* The Committee considered this to be an important failure which caused issues in patient safety, integrity of clinical records which are fundament to continuity of care. The Committee also determined that the failure to record contemporaneous notes would undermine trust in the profession.

63. The Committee noted that this was also a patient with reduced vision in his right eye and no light perception in his left eye. In addition, the Registrant has not recorded the reasons for the consultation, the findings or indeed the details of treatment, referrals or advice, all of which would fall far below the *Standards* at 7.1, 8.2, 8.24 and 8.25.

64. The Committee considered that even if other colleagues had found the notes, the record was not full and therefore the care of Patient B would have been at risk.

This falls far short of *Standard 10.4* as the Registrant is clearly not working collaboratively with colleagues in the interests of patients. The records were not accessible in a physical sense and nor, had they been found, would they have been useful to colleagues as they were incomplete. This would also fall short of *Standard 7.5* as it the actions cannot be said to be consistent with providing effective patient care.

65. The Committee considered the *College Guidance* and noted that having qualified in 2019, the Registrant would have been familiar with this. At *A18* the *College Guidance* states:

> *"A18: You must keep patient records to:*
>
> *a. retain clinical information, including the patient's history*
>
> *b. facilitate the clinical management of the patient and continuity of care*
>
> *c. enable another practitioner to take over the care of the patient, and*
>
> *d. protect yourself in case of complaints or for reference in a legal situation."*

66. The Committee determined that although this is only *College Guidance,* the Registrant's actions fell far short of this, as well as damaging public confidence in profession according to the *Standards* at *17.1.*

67. The expert, Dr Chaggar, concluded that these failings were 'inconsequential.' However, the Committee must reach its own judgment. The Committee did not consider the initial omissions to be inconsequential, particularly where the record failed to record the advice given to Patient B, which would have affected the management of the patient. The Committee noted that the sight test occurred on 18 July 2022 and there is no evidence as to when the amendments were made. Boots internal investigation noted that it was after the Registrant returned from his holiday in September 2022.

68. The Committee did not consider this to be a minor administrative oversight but a serious breach of professional standards which represents a significant failure to maintain records.

69. For those reasons, the Committee determined that the Registrant's actions fell far below the standards expected of a reasonably competent Optometrist. The Committee found that particular 2b did amount to serious professional misconduct.

2(c) You failed to assess and/or record the intraocular pressure of the left eye

70. The Committee noted the GOC submissions that given the clinical context of Patient B's presentation, it is submitted that this is a critical omission.

71. The Committee considered the expert report in relation to Patient B:

> *1.11.4 Typically, even if an eye has reduced vision, as the left eye of Patient B did, assessment of the intraocular pressure is usually still warranted to exclude the presence of any other pathology. Patient B was noted to have a dense cataract in the left eye. In certain situations, the components of the cataractous lens can leak outside of the natural sac of the eye which contains the cataract, this leads to inflammation and/or raised intraocular pressure which can cause pain. Similarly, as the cataract matures, this occupies more space in the eye and can obstruct the normal pathways by which intraocular fluid is drained from within the eye. This again can lead to raised intraocular pressure which can cause pain.*
>
> *1.11.5 At the time of writing, I have not been provided with any previous information for Patient B and therefore am not able to comment upon whether it was not necessary to assess the intraocular pressure of the left eye.*
>
> *1.14 However, if it is not possible to establish if:*
>
> *i. Patient B was registered as visually impaired, and/or did not require referral for this, and/or;*
>
> *ii. The finding of a pale optic disc in the right eye had been investigated previously and this had not altered from the previous examination(s) to indicate new pathology, and/or;*
>
> *iii. It was not necessary to assess the intraocular pressure of the left eye based upon a previous documentation, and/or;*
>
> *iv. Referral for left eye cataract surgery was not necessary and/or;*
>
> *v. Referral to a Low Vision Clinic was not necessary*
>
> *Then in my opinion the Registrant has not conducted an adequate examination and may fall below the standard or a reasonably competent. I am unable to comment further on this as I do not have the relevant information."*

72. The Committee considered Paragraph 1.11.4 to be important, as even if an eye has reduced vision, the assessment of the intraocular pressure is still warranted to exclude other pathology. In addition, in this case, the records show that the

last eye examination was unknown, and there was also no reason recorded as to why the pressure check was not completed. Even where the Optometrist delegated the measurement of the intraocular pressure, it would be the Optometrist's duty to record this, or why it was not undertaken. The Committee determined that the Registrant's actions would fall far below Standards 9.2 and 9.4.

73. The Committee considered that given that this patient had significantly impaired vision, it was a serious omission to fail to complete the intraocular pressure on both eyes. This could carry a risk of pain and/or further pathology affecting the limited remaining sight of the patient's other eye.

74. The Committee took into account the expert opinion but determined that a failure to assess and/or record intraocular pressure is a serious clinical failing.

75. The Committee determined that the Registrant's actions fell far below the standards expected of a reasonably competent Optometrist. The Committee found that particular 2c did amount to serious professional misconduct.

3(a) On or around 29 June 2022, you carried out a sight test on Patient C and you failed to make a timely referral for cataract to Hospital Eye Service (HES) for cataract investigation

76. The Committee considered paragraphs 7.2-7.4 in the expert's report in respect of Patient A to also be relevant to this allegation. Patient C was referred for cataract surgery on 20 September 2022, almost 3 months after their examination on 29 June 2022. It noted that Patient C was currently under the care of the Hospital Eye Service for glaucoma.

77. The Committee considered the relevant opinion from the expert's report with regard to this allegation:

"4.2 However, the Registrant did not generate a referral on the day of the examination, but did this on the first day back on return from holiday, which it would appear was when the Registrant was aware of this oversight. This was approximately three months later from the date of the examination. In this regard I consider the Registrant to fall below, but not far below the standard of a reasonably competent Optometrist. This is on the basis that although the delay incurred an inconvenience for Patient C, it is unlikely to have significantly compromised the care or safety of Patient C."

78. The Committee determined that the delay in making the referral fell below, but not far below the standard of a reasonably competent optometrist, and therefore this did not amount to serious professional misconduct.

4(a) On or around 30 July 2022, you carried out a sight test on Patient D you failed to adequately and/or appropriately record clinical data in that the paper notes recorded an add of 2.50 whilst the computer records has an add of 2.00; and/or

79. The Committee considered the expert's findings with regards to the discrepancies between the paper notes and the computer notes in respect of Patient D. The Committee considered the GOC expert in this regard:

"3.1 (vii) From the information available it is not evident when the electronic information was entered and/or amended. Nevertheless, there are discrepancies …

a. It may be that these are typographical errors, which can happen if more than one system of records is used.

3.1 (vii)(d) Overall, if these are typographical errors, then I consider the Registrant to fall below, but not far below, the standard of a reasonably competent Optometrist in relation to record keeping. This is on the basis that it is not evident why and when the amendments were made and therefore there are inaccuracies in the record, but are likely to be inconsequential errors."

80. The Committee considered Patient D was over 60 years old and required magnification for reading spectacles. The effect of an incorrect prescription would not pose a risk to the patient's vision through their reading spectacles, but merely the position where reading material would focus. The expert concluded that this was an 'inconsequential' typographical error. For this particular patient, for the above reasons, the Committee agreed and determined that the Registrant's actions fell below, but not far below the standards expected of a reasonably competent Optometrist. The Committee found that particular 4a did amount to misconduct but did not consider that this crossed the threshold into serious professional misconduct.

81. *4(b) You failed to adequately and/or appropriately record the recall interval in that the paper notes recorded a recall of 2 years whilst the computer records has a recall of 12 months*

82. The Committee considered the expert's report which deals with this discrepancy for Patient D:

"*3.1(vii)(b) Typically, with regard to non-clinical information, such as recall intervals, the electronic system is utilised to generate recalls and reminders. Therefore, in this case reducing the interval from 24 months to 12 months would not compromise the care or safety of Patient D. Therefore, I do not consider the*

Registrant to fall below the standard of a reasonably competent Optometrist for this element."

83. The Committee determined that use of a recall date on the electronic record of 12 months cannot be assumed. The Committee considered that the records showed that Patient D was over 60 with a risk of glaucoma. On that basis it would be expected for the Registrant to have assessed the pressures, cup to disc ratio and visual fields. The Committee noted that the Registrant had documented "fields down" in the box where a visual field test would be recorded and had taken no further steps to conduct this test on another day. In this regard, the Committee considered that the expert's report did not go far enough to address the fact that this was a patient with a history of high intraocular pressure at risk of glaucoma as outlined in the records.

84. The Committee considered that the ambiguity of having two different records, one saying 12 months and one saying 2 years is unhelpful to any patient. It would cause confusion and concern both to the patient and to colleagues if they were able to access the notes. The Committee were concerned at the risk of the patient not being able to gain access to a timely sight test when required, i.e. after 12 months. The Committee considered that the Registrant had a duty to work collaboratively with colleagues and to provide clear and effective communication to the patient, which has failed in this instance**.**

85. The Committee determined that this fell far short of the *Standards at 2.1, 8.1 and 10.1.* The Committee therefore found that particular 4b amounted to serious professional misconduct.

4(c) You added further details on record after the sight test on refraction, vision/visual acuity and advice section after the sight test and did not annotate to show it was an addition or amendment

86. The Committee considered the expert's report with regards to Patient D:

"3.3 Aside from the comments as detailed in 3.1 above it would appear that the Registrant has produced an accurate record card of the examination on 30 July 2022 for Patient D. The additional comments as detailed in 3.1 above are essentially inconsequential and it would appear the Registrant documented the relevant findings at the time of the examination.

3.5: The amended record card may be an accurate representation of the findings of the examination, and the amendments made do not appear to be inaccurate or irregular. However, the Registrant has not documented when the amendments were made. which is therefore an inaccuracy in the detail of the record, albeit likely inconsequential. On this basis, I consider the Registrant to fall below, but not far below the standard of a reasonably competent Optometrist for this element."

87. The Committee noted that the Registrant admitted that the notes were not made contemporaneously, which would fall short of *Standard 8.1.* The Committee were able to view the amendments made and considered this to be important information which caused issues in continuity of care and patient safety if the records could not be relied upon, even for a short period. The Committee noted that the amendment of "↑ *IOP's long standing"* made over six weeks later did not identify either the date or the source of this additional information. This was a patient at risk of harm to their vision and the Registrant did not manage him appropriately.

88. The Committee did not agree that these amendments were 'inconsequential.' They affected the management of the condition based on whether the condition was active or long standing. For this patient, the Committee determined that the Registrant's actions fell far below the standards expected of a reasonably competent Optometrist.

89. The Committee found that particular 4c did amount to serious professional misconduct.

90. *5(a) On or around 3 July 2022, you carried out a sight test on Patient E and You did not annotate the record to show it was a duplicate of the original*

91. The Committee considered the relevant paragraphs of the expert report:

"3.1 According to the information detailed in the Investigation report from Boots Opticians, Appendix 1, it would appear that the Registrant has produced a new record card for Patient E at some point between 13 September 2022 and 07 October 2022. If this record is an accurate representation of the examination, then I do not consider the Registrant to fall below the standard of a reasonably competent Optometrist for this element.

3.3 I note Patient E appears to have had a contact lens assessment on 25 August 2022. For this to have proceeded, details of a current eye examination (dated within two years) would have been required, including a spectacle prescription. It would appear likely that in the absence of a prescription documented on the computer system as suggested by the Investigation report from Boots Opticians, the second record for Patient E would have been available for the contact lens fitting process to proceed. This is on the basis that the first record card did not have details of a valid spectacle prescription.

3.4 The updated record card would appear to be an accurate representation of the examination of Patient E on 29 August 2022 and I do not consider the Registrant to fall below the standard of a reasonably competent Optometrist for this element. This is on the basis that the Registrant has only documented the assessments and findings that were done at the time of the examination."

92. The Committee determined that this was not a contemporaneous record, and it was apparent from the evidence that the originals were not kept. The Registrant has indicated that he did this for clarity but it is apparent that he made the new record two months after the original. The Committee consider that this alteration obscured the original clinical reasoning and timeline, impairing the record's integrity and reliability. The Committee also determined that a replacement record, unlabelled as such, undermines trust in the accuracy of the clinical history and creates risk for future practitioners.

93. The Committee considered these actions to fall far below *Standard 8.* Indeed, the Committee noted that there were several omissions which did not appear on the duplicate, for example the removal of the 'pre-screener name' which caused more concern as to the integrity of the record. The Committee considered that the lack of transparency of records leaves a risk to patients and practitioners with regards to continuity of care.

94. The Committee therefore found that particular 5a amounted to serious professional misconduct.

6(a) On or around 22 June 2022, you carried out a sight test on Patient F and failed to adequately and/or appropriately record clinical data in that you later changed the sight test results 'consider referral for GAT although all tests are normal → gat better for measuring IOPs' but this was later replaced on the record card with '[dis]charged for high IOPs previously. On repeat → wnl. 12/12 RSIAP' Where RSIAP means 'return sooner if any problems' and did not annotate to show it was an addition or amendment

95. The Committee considered the relevant paragraph of the expert report:

"3.2 According to the statement of the Registrant dated 18 December 2022, where record 6 would appear to refer to Patient F, the Registrant suggests that he reviewed the information on the day of the examination. If these amendments were made at the time of the examination, then I consider the record is an accurate representation of the examination, and I do not consider the Registrant to fall below the standard of a reasonably competent Optometrist for this element.

3.3 The amended record card may be an accurate representation of the findings of the examination, and the amendments made do not appear to be inaccurate or irregular. However, the Registrant has not documented when the amendments were made which is therefore an inaccuracy in the detail of the record, albeit likely inconsequential. On this basis, I consider the Registrant to fall below, but not far below the standard of a reasonably competent Optometrist for this element."

96. The Committee noted that the Registrant admitted that the notes were not made contemporaneously, which would fall short of *Standard 8.1.* The Committee

considered this to be important information which caused issues in continuity of care and patient safety if the records could not be relied upon, even for a short period. The Committee noted that this was also a patient with risk factors for glaucoma, for the reasons above.

97. The expert concluded that this was an 'inconsequential' amendment to a record. The Committee determined that the Registrant's actions fell below, but not far below the standards expected of a reasonably competent Optometrist.

98. The Committee found that particular 6a did amount to misconduct but did not consider that this crossed the threshold into serious professional misconduct.

7(a) On or around 11 July 2022, you carried out a sight test on Patient G and: You failed to make a timely referral for a YAG- Laser Capsulotomy

99. The Committee looked at the relevant paragraph of the expert report with regard to Patient G:

"7.6 The Registrant did not generate a referral on the day of the examination, but did this on the first day back on return from holiday, which it would appear was when the Registrant was aware of this oversight. This was approximately two months later from the date of the examination. In this regard I consider the Registrant to fall below, but not far below the standard of a reasonably competent Optometrist. This is on the basis that although the delay incurred an inconvenience for Patient G, it is unlikely to have significantly compromised the care or safety of Patient G."

100. The Committee noted that Patient G was 71 years old and visited for a routine eye test. There is a clear reference to a family history of glaucoma on the record ("F=glaucoma") and normally the Committee would expect to see intraocular pressure tests completed on both eyes. This has not been recorded. There is an undated referral letter.

101. The Committee considered that because Patient G's vision in his better eye was functional, the delay would have only caused inconvenience and not compromised the patient's care or safety, therefore would have fallen below but not far below the standard of a reasonably competent optometrist.

102. The Committee found that particular 7a did amount to misconduct but did not consider that this crossed the threshold into serious professional misconduct.

7(b) You failed to assess and/or record the intraocular pressure and/or a visual field assessment of the right eye

103. The Committee considered the expert report with respect to Patient G, which dealt with both the intraocular pressure and the visual field assessment:

"2.1 The Registrant did not assess and/or not document assessment of the intraocular pressure of the right eye in Patient G, being over the age of 60 and recognised to be at risk of glaucoma, I consider the Registrant to fall below, but not far below, the standard of a reasonably competent Optometrist. This is on the basis that aside from not assessing the intraocular pressure of the right eye, in my opinion the Registrant has conducted a reasonable examination of Patient G.

2.2 *In the context of a first degree relative of Patient G having glaucoma, a visual field assessment would have been appropriate. A visual field assessment may show features of glaucoma even if the intraocular pressure is in the normal range and the optic disc appears to be normal. Typically, if the optic disc appears normal and the intraocular pressure is in the normal range it is unlikely a visual field defect would be present.*

2.4 *As the Registrant did not assess and/or document assessment of the intraocular pressure of the right eye in Patient G and also did not conduct a visual field assessment of the right eye, I consider the Registrant to fall below the standard of a reasonably competent Optometrist. This is on the basis that although the optic disc may have appeared healthy, without an intraocular pressure assessment and/or visual field assessment of the right eye, the presence of glaucoma cannot reliably be excluded in the right eye. By not undertaking a visual field assessment and/or intraocular pressure of the right eye, the Registrant may have compromised the care or safety of Patient G. However, it is fortunate that the Registrant did refer Patient G for posterior capsular opacification in the left eye, and through this process it is likely that it would be identified if the intraocular pressure of the right eye was abnormal and managed accordingly. Overall, it is therefore likely that the care and safety of Patient G has not been compromised."*

104. The Committee noted that the intraocular pressure has not been recorded nor is there a comment to explain why. In addition, the visual fields box is blank on both the original and the amended record.

105. The expert does not appear to acknowledge that even though Patient G is a high risk of glaucoma, the pressure checks were not completed, which would form part of the *College Guidance.* The patient was only referred after two months, and only on the basis of PCO (posterior capsular opacification) and not glaucoma.

106. The Registrant's amended record does show amendments to the visual fields and pressure tests, but he has fallen far below *Standard 7.5,* and below the *College Guidance that* the optic nerve and intraocular pressures should have been completed.

107. The Committee determined that this fell far below standards expected of a reasonably competent Optometrist. The Committee found that particular 7b amounted to serious professional misconduct.

7(c) You added further details on record after the sight test relating to family history, external examination, internal examination, visual fields, intraocular pressure and did not annotate to show it was an addition or amendment

108. The Committee looked at the expert report:

"3.4 The additional documentation that would have altered the assessment and management of Patient G is that the father of Patient G had glaucoma. The relevance of this is detailed in section 2.0 relating to Patient G.

3.7 The amended record card may be an accurate representation of the findings of the examination, and the amendments made do not appear to be inaccurate or irregular. However, the Registrant has not documented when the amendments were made which is therefore an inaccuracy in the detail of the record, albeit likely inconsequential as detailed in section 2.0 relating to Patient G. On this basis, I consider the Registrant to fall below, but not far below the standard of a reasonably competent Optometrist for this element."

109. The Committee noted that the Registrant has admitted the facts and his own notes suggest that Patient G had a family history of glaucoma which is important.

110. The Committee considered the expert's report to be contradictory in this regard, as at 3.4 he concludes that the additional documentation *would have altered the assessment and management,* but at 3.7 he concludes that this would be *inconsequential.* The Committee bore in mind its duty to reach its own conclusion on misconduct.

111. The Committee considered that an addition that the patient had a family history of glaucoma considerably changes how this patient should have been investigated and managed and do not consider that this was inconsequential. The Committee determined that a colleague finding the original record, without the family history and without any pressure checks, would not have been aware of those risks and would amount to a potential risk to patient safety.

112. The Committee determined that this fell far below standards expected of a reasonably competent Optometrist. The Committee found that particular 7b amounted to serious professional misconduct.

8(a) On or around 6 August 2022, you carried out a sight test on Patient H and you failed to annotate the record to show it was a duplicate or amendment of the; and/or

113. The Committee noted in this particular that Patient H was born in 1976. His sight test was completed on 6 August 2022.

114. However, when entering the new additions upon his return from holiday, it appears that the Registrant has created a substitute record which relates to an entirely different patient. This person is referred to throughout as "[redacted] brother" and appears to be a colleague optical assistant's relative, also named "[redacted]." The Boots internal investigation clarified that Patient H was not [redacted] brother. The Committee considered therefore that this record is entirely unreliable as it is not only an amended and augmented record, but also the Registrant has inserted information for a completely different patient. The Registrant has also signed the document to confirm he had completed a pre-screening test when in fact it does not appear that any pre-screen was completed with regard to Patient H. Further, the Registrant has failed to annotate that it was a substitute clinical record.

115. In his own statement the Registrant states:

116. *"It appears that this record was rewritten completely, based on information in my notebook. Again this was not in an effort to mislead, but simply to ensure that for future reference the record was legible and accurately reflected the examinations conducted on the day. As you can see on the original record, all examinations were completed at the initial visit. Binocular refraction was added as I specifically completed this test for this patient (no other records include this). I was conscious the patient was a high myope, and on my notebook during volk I would have recorded PPA, clear retinas and anterior angle examinations. I noted no photos were available. Looking at the record now, I realise OMB was omitted from the final record. I fully understand the implications and consequences of this however I hope this reiterates that my intention was never to mislead and insinuate I carried out examinations that had not been completed."*

117. The Committee determined that the Registrant had not, even at the time he wrote his statement, realised that the patient results referred to in the record was not in fact Patient H. The Committee considered this to be a significant failing.

118. The Committee considered the expert's report:

"3.4 If the record is an accurate representation of the examination of Patient H on 06 August 2022, then I do not consider the Registrant to fall below the standard of a reasonably competent Optometrist for this element.

3.5 If the record is not an accurate representation of the examination of Patient H on 06 August 2022, then I consider the Registrant to fall below, but not far below, the standard of a reasonably competent Optometrist. This is on the basis

that the amendments to the record card would not have any significant clinical relevance and would not compromise the safety or care of Patient H."

119. The Committee concluded that the expert has not made the connection that the amended record relates to an entirely different patient. It is not only a substitute clinical record but also for the wrong patient.

120. The Committee considered that the failure to annotate the record to show it was a duplicate or amendment undermines the need to keep contemporaneous notes. This creates a potential risk to Patient H because the notes do not correspond with the information which would have been accurate to his appointment, but rather for an entirely different patient.

121. The Committee considered this to be a serious failing which falls far below the standard of a reasonably competent Optometrist. The Committee found that particular 8a amounted to serious professional misconduct.

8(b) You failed to assess and/or record the intraocular pressure

122. The Committee considered the opinion of the expert:

"2.1 There is no evidence to suggest that the intraocular pressure of Patient H was assessed and/or any arrangements were made to assess the intraocular pressure of Patient H.

2.2 Patient H was recognised to be over the age of 40 and this is considered to be a risk factor for glaucoma. Additionally, Patient H had a spectacle prescription of more than -6.00 in the right eye; a spectacle prescription of more than -6.00 is also considered to be a risk factor for the development of glaucoma. There did not appear to be any other risk factors, such as a family history of glaucoma, that may have been relevant to Patient H.

2.3 In an otherwise reasonably normal eye examination, it is unlikely that if the intraocular pressure was elevated, that it would be elevated to such a degree that it would have compromised the care or safety of Patient H significantly. However, it is not possible to determine if the intraocular pressure of Patient H was elevated or not. Therefore, I consider the Registrant to fall below, but not far below, the standard of a reasonably competent Optometrist.

4.1 In the circumstances of the examination of Patient H on 06 August 2022, which was a routine eye examination and Patient H was essentially asymptomatic, a reasonably competent Optometrist would be expected to conduct an examination consisting of the following:
i. History and symptoms
ii. Assessment of the spectacle prescription and corrected vision/visual acuity
iii. External and Internal examination of the eye
iv. Assessment of intraocular pressure

The Registrant has documented conducting the assessments detailed in i-iii above. However, the Registrant did not assess and/or not document assessment of the intraocular pressure of Patient H, even though Patient H was over the age of 40 and this is recognised to be a risk factor for glaucoma. Therefore, I consider the Registrant to fall below, but not far below, the standard of a reasonably competent Optometrist for this element. This is on the basis that aside from not assessing the intraocular pressure, in my opinion the Registrant has conducted an adequate examination and managed Patient H appropriately. Furthermore, in an otherwise reasonably normal eye examination, if the intraocular pressure was elevated, it is unlikely that it would be elevated to such a degree that it would have compromised the care or safety of Patient H significantly."

123. The sight test was completed on 6 August 2022 and the record was added sometime in September once the Registrant returned from holiday. The Committee considered this to be a failure to record any information. In this case, where the patient was over 40, which means a higher risk of glaucoma, and a high myope (as referenced in the expert's report at 2.2 and also the Registrant's statement) there were higher risk factors. The Committee considered Standard 7.5 to be relevant to this failing.

124. However, the Committee agreed with the expert that there were no other high risk factors and as such, agreed that the failure to assess and/or record the intraocular pressure would not fall far below the standards of a reasonably competent Optometrist.

125. The Committee found that particular 8b did amount to misconduct but did not consider that this crossed the threshold into serious professional misconduct.

9(a) On or around 29 June 2022, you carried out a sight test on Patient I and you failed to make a timely referral for cataract; and/or

126. The Committee noted that Patient I was born in 1963. The Committee noted that the sight test in this case took place on 23 August 2022 at 2.50pm on the day before the Registrant went on holiday for one month. The Committee noted that the patient's reason for visit was to renew their driving licence. They were referred routinely for cataract assessment. The Committee noted from the Boots investigation that the only addition the Registrant made was to add 'glare and blurred vision.' The Committee considered that this would impact the speed at which the patient might be dealt with for the cataract procedure.

127. The Committee considered the expert's opinion:

"4.2 The Registrant did not generate a referral on the day of the examination, but did this on the first day back on return from holiday, which it would appear was when the Registrant was aware of this oversight. This was around three to six

weeks later from the date of the examination. In this regard I consider the Registrant to fall below, but not far below the standard of a reasonably competent Optometrist. This is on the basis that although the delay incurred an inconvenience for Patient I, it is unlikely to have significantly compromised the care or safety of Patient I."

128. The Committee also noted the Registrant's comments in relation to Patient I:

"This patient was referred for cataract assessment. I recalled her complaining of blur and glare, but I did not note this down at the time of sight test. When I completed the referral, it appears that I recalled this detail and added it to the record for completeness. There appears to be a sticky note attached to the back of the record suggesting referring the patient for routine glaucoma investigation. There is no clinical concern regarding glaucoma and a referral for cataract was made. This sticky note is likely to be from a different episode and may have attached to the back somehow. I probably shredded this sticky note to avoid confusion and attached the referral letter instead. This is another example of not writing my routine referral on the day. In retrospect I would have done that immediately with the patient present and sent it there and then, time permitting."

129. The Committee were concerned that the Registrant appears to have left his clinical notes, returned from his holiday after one month and then retrospectively completed them. The Committee considered this to be a concern, especially where the Registrant acknowledges his pattern of his behaviour but states that his notes and referrals would only be completed contemporaneously, 'time permitting.' The Committee considered this to be an unprofessional approach which may indicate attitudinal concerns.

130. The Committee also noted in this case that Patient I's vision was reduced in both eyes which meant she was borderline for driving. Indeed, it is noted that the reason for the visit was for the patient to be assessed to renew her provisional driving licence. Given also that the patient had reported a 'glare or blur,' a timely referral was very important. This is an issue the expert has not covered in his report.

131. However, the Committee considered the expert's report to be accurate in that the three to six week delay fell below, but not far below the standards expected of an Optometrist.

132. The Committee found that particular 9a did amount to misconduct but did not consider that this crossed the threshold into serious professional misconduct.

<u>9(b) You added further details on record after the sight test relating to history and symptoms, and did not annotate to show it was an addition or amendment</u>

133. The Committee considered the relevant paragraph of the expert's report:

"3.3 Aside from the comments of 'Glare ↑ Blur ↑', it would appear that the Registrant has produced an accurate record card of the examination on 23 August 2022 for Patient I. The additional comments of 'Glare ↑ Blur ↑' are essentially inconsequential. Therefore, in this regard I do not consider the Registrant to fall below the standard of a reasonably competent Optometrist for this element."

134. The Committee considered that the addition of blur and glare should speed up the cataract referral, which was not 'inconsequential.' The Registrant appears to have added comments without any reference to new information. Again the Committee considered it to be unlikely that the Registrant remembered the assessment more accurately one month after the event. This is not a contemporaneous clinical record and would therefore fall below Standard 8.1.

135. However, the Committee agreed that the failure did not fall far below the standards of a reasonably competent Optometrist. The Committee found that particular 9b did amount to misconduct but did not consider that this crossed the threshold into serious professional misconduct.

10(a) On or around 13 June 2022, you carried out a sight test on Patient J and you failed to make a timely referral for cataract in the left eye

136. The Committee noted that Patient J was aged 58 and was 'blind' in his right eye. The Committee considered that the examination conducted by the Registrant was reasonable and it contained evidence that Patient J had been treated for glaucoma, a cataract and retinal detachment in his right eye.

137. The Committee viewed the further augmented external and internal eye assessment notes that the Registrant made in comparison to the original contemporaneous notes made pre-September 2022. The Registrant accepts that these were added retrospectively. The Committee determined that this would be contrary to Standards 8.1 and 8.2.4.

138. In addition, in terms of management, the Committee considered the fact that Patient J had only one functional eye which meant that a timely referral was crucial. The delay in referral between 13 June 2022 to 20 September 2022 was particularly inappropriate, and could cause a risk to the patient who only had one functional eye.

139. The Committee considered the expert's opinion in this regard:

"4.3 However, the Registrant did not generate a referral on the day of the examination, but did this on the first day back on return from holiday. This was around three months later from the date of the examination. In this regard I consider the Registrant to fall below, but not far below the standard of a reasonably competent Optometrist. This is on the basis that although the delay

incurred an inconvenience for Patient J, it is unlikely to have significantly compromised the care or safety of Patient J."

140. The Committee reminded itself of its duty to form its own judgement with regard to misconduct. The patient is irreversibly blind in right eye at age 58. In his left eye he has significant difficulties, has a cataract as well as evidence of glaucoma. The Registrant has taken three months to refer. The referral is inadequate because it should have been processed without delay.

141. The Committee noted that even in the Registrant's comments in the (undated) referral letter he stated "*I believe that IOL [Intraocular Lenses] would improve [Patient J's] overall vision and quality of life*." The Committee considered this to be significant to this patient.

142. The Committee did not consider this to be an oversight as per the expert's opinion. The Registrant had kept a log of outstanding actions as well as his own notebook, neither of which had been produced in evidence for the hearing. The Committee determined that this was a patient at an increased risk of significant visual loss since he had only one functional eye. He should have been treated as a priority and as such, the Registrant's actions fell far below the standards expected of a reasonably competent Optometrist.

143. The Committee considered this to be a serious failing which falls far below the standard of a reasonably competent Optometrist. The Committee found that particular 10a amounted to serious professional misconduct.

144. *10(b) You added further details on record after the sight test relating to history, external examination and internal examination, and did not annotate to show it was an addition or amendment*

145. The Committee noted that the Boots internal investigation indicated that the additions related to the external eye test. This patient had been previously treated for glaucoma. The additions suggest that a full assessment was completed and the external eye was fine. The Committee considered this to seriously undermine the integrity of the record, as any future colleague looking at the record would be reassured that a thorough examination was completed when it plainly was not recorded. This would have been a potential risk to the Patient J who was already blind in one eye.

The Committee looked at the expert report:

3.3 Aside from the comments as detailed in 3.1 above it would appear that the Registrant has produced an accurate record card of the examination on 13 June 2022 for Patient J. The additional comments as detailed in 3.1 above are essentially inconsequential and it would appear the Registrant documented the relevant findings at the time of the examination.

146. The Committee disagreed with the expert's findings. The external eye examination was central to a patient at risk of glaucoma, the internal eye examination central to a patient with retinal detachment. The original notes would have been misleading to other Optometrists and the fact that the Registrant had amended these after the event, and only indicated a routine referral was a serious concern.

147. The Committee also considered the expert's opinion at:

3.5 *The amended record card may be an accurate representation of the findings of the examination, and the amendments made do not appear to be inaccurate or irregular. However, the Registrant has not documented when the amendments were made which is therefore an inaccuracy in the detail of the record, albeit likely inconsequential. On this basis, I consider the Registrant to fall below, but not far below the standard of a reasonably competent Optometrist for this element.*

148. The Committee did not agree with the expert's findings as he appeared to have omitted to consider that this patient was already blind in one eye.

149. The Committee considered the Registrant's actions to be serious failings which falls far below the standard of a reasonably competent Optometrist. The Committee found that particular 10b amounted to serious professional misconduct.

11(a) On or around 27 July 2022, you carried out a sight test on Patient K and you suspected glaucoma and failed to make a timely referral to Hospital Eye Service (HES) and potentially delayed Patient K's treatment; and/or

150. The Committee noted that Patient K was 47 years old, had visited for a routine eye test on 29 July 2022 due to having dry eyes, and had signs of glaucoma and moderate cataracts. The records indicate that the Registrant did not see any previous photographs of the eyes so there was no reference point to determine deterioration. The Registrant made a routine referral.

151. The Committee noted the Registrant's comments in relation to this patient:

"I believe I recorded ocular motility and pupil reflexes on the day of the sight test within my notebook, and added this information to the clinical record when I completed the referral. I also crossed out the visual field boxes so it was clear this hadn't been done. I also noted that the full prescription had not been recorded and so I would have added in this information based on what I had previously recorded on the OPS. A copy of referral is present but I did not include date of referral. Whilst I might have written this by hand before the referral was sent to GP, I understand it is good practice to have included it when I typed up the letter."

152. The Committee also looked at the expert opinion:

5.1 *In the circumstances of the examination of Patient K on **29 August 2022**, which was essentially a routine examination, a reasonably competent Optometrist would be expected to identify that the family history of glaucoma and the enlarged C/D ratio were risk factors for Patient K developing glaucoma and arrange a non-urgent/routine referral for Patient K. The Registrant has identified both of these issues and referred Patient K on a non-urgent/routine basis. Therefore, I do not consider the Registrant to fall below the standard of a reasonably competent Optometrist for this element.*

7.6 The Registrant did not generate a referral on the day of the examination, and it would appear this was done at some point between 13 September 2022 and 25 November 2022. This was around 2 weeks to three months later from the date of the examination. In this regard I consider the Registrant to fall below, but not far below the standard of a reasonably competent Optometrist. This is on the basis that although the delay incurred an inconvenience for Patient K, it is unlikely to have significantly compromised the care or safety of Patient K."

153. The Committee noted that the expert has referred to the wrong date for the sight test, which was in fact on 29 July 2022. In any event, the Boots internal investigation confirmed that the referral was completed at a point between 13 September and 25 November 2022.

154. The Committee was concerned at the risk factors of having no previous eye photographs to compare to, a high asymmetric CD ratios and a family history of glaucoma. The referral was made at best 6 weeks, at worst 16 weeks after the sight test. The Committee considered the issue of whether this particular allegation fell below, or far below the standards expected of a reasonably competent Optometrist to be finely balanced. The Committee gave the benefit of the doubt to the Registrant that if it were 6 weeks it agreed it would be considered a timely referral and therefore agreed with the expert's findings that it fell below, but not far below the standards.

155. The Committee concluded that the Registrant's actions with regard to Patient K did not amount to serious professional misconduct.

11(b) You added further details on record after the sight test relating to visual fields, motility, pupils, visual acuity and near spectacle prescription and did not annotate to show it was an addition or amendment

156. The Committee noted that in his additions, the Registrant had noted that a visual field assessment was attempted but could not be completed due to language barriers, the Registrant recording 'poor communication' in the clinical record. There were also a number of other additions including those relating to motility tests and visual acuity. The Registrant had not recorded seeing any previous photographs of the eyes so there was no reference point to determine deterioration.

157. The Committee looked at the expert's report in relation to the records for Patient K:

"3.5 The amended record card may be an accurate representation of the findings of the examination, and the amendments made do not appear to be inaccurate or irregular. However, the Registrant has not documented when the amendments were made. which is therefore an inaccuracy in the detail of the record, albeit likely inconsequential. On this basis, I consider the Registrant to fall below, but not far below the standard of a reasonably competent Optometrist for this element.

158. Whilst it is clear the Registrant added visual fields, motility, pupils, and visual acuity tests, a motility test the Committee agreed with the expert that this fell below, but not far below the standards of a reasonably competent Optometrist.

159. Given these conclusions, the Committee did not consider the actions of the Registrant to amount to serious professional misconduct.

12) You failed to ensure clinical records could be accessed easily by other staff in that you kept patient records stored with another colleague without other staff being aware of this

160. The Committee considered the statement of Ms B who stated "*Around June/July 2022, prior to patient complaints, I found baskets of records in [the Registrant's] cupboards. I asked him what the records were for and why they were there, he stated that he hadn't had time yet to deal with them*."

161. In the present allegation, and during the Boots internal investigation, Ms B was asked the question regarding the September 2022 issues:

162. "*Q 3. As a Store Manager, do you or a team member check the consulting rooms for clinical records?*

It is not part of the normal store routine to check consulting rooms for clinical records. However, in June, when looking underneath sinks for cleaning materials I found a cardboard box full of patient record cards covered in paper towel, this was in the consulting room used by Ihsan on a daily basis.

Since this discovery, I have made it my practice to check the consulting rooms on an adhoc basis for patient records. Ihsan regularly had patient records in his room in a variety of locations; in desk drawers, storage cupboard, clinical equipment drawers and on the desk. I gathered all record cards together into two baskets to prevent loss of information and ensure secure storage. My Dispensing Optician/ASM checks the consulting rooms on a regular basis as part of her usual habits and practices. She has found record cards in the locations described above and always removed the cards or questioned the Optom as to why they were there."

163. The Committee noted that there were no comments from the expert in relation to allegation 12.

164. The Committee considered that failing to ensure clinical records could be accessed easily includes both access to the physical records and access to accurate information within the record itself. Even if colleagues had been able to access the patient records, the information contained within were plainly inadequate, as is evidenced from the multiple additions the Registrant admits to making on multiple patient records. The Committee determined this to be a clear breach of Standard 10.4.

165. Further, the Committee determined that keeping patient records '*underneath sinks for cleaning materials… [in] a cardboard box … covered in paper towels … in the consulting room'* was entirely inappropriate and breached *Standard 14.7* to securely store patient records. The Committee considered that the GDPR data controller at the store would not have been able to access these clinical records, which were incomplete in any event.

166. The Committee considered this to be a serious failing which falls far below the standard of a reasonably competent Optometrist. The Committee found that particular 12 amounted to serious professional misconduct.

167. **Findings on cumulation**

168. For clarity, the Committee had determined that particulars 2a, 2b, 2c, 4b, 4c, 5a, 7b, 7c, 8a, 10a, 10b and 12 amounted to serious professional misconduct.

169. The Committee determined that particulars 1a, 1b, 3a, 4a, 6a, 7a, 8b, 9a, 9b, 11a and 11b amounted to non-serious misconduct.

170. The Committee noted the parties' submissions and the legal advice in relation to the cumulation of matters involving non-serious misconduct and the cases of Schodlok and Ahmedsowida.

171. The Committee considered that matters 1a, 3a, 7a, 9a and 11a all related to the issues of timeliness of referrals relating to either glaucoma, cataracts or YAGs. All occurred under the same circumstances where the Registrant had left the referrals for varying periods of time whilst he went on leave, before the referrals were actioned when prompted upon his return. Whilst they were routine referrals, it was entirely unprofessional to have treated patients' referrals in this way, as the Registrant had disregarded the importance of timely referrals as per *Standard 7.2*. The Committee were concerned about the Registrant's attitude towards this, as he appears to justify these delays due to lack of time. The Committee do not consider this an acceptable reason to delay referrals, even those that are routine. The Committee concluded that this was a high number of matters which occurred over a short period, of a similar nature.

172. Further, with regards to the “timeliness” particulars, the Committee noted that the GOC, from the outset had made clear in its submissions that this was a pattern of behaviour and that it would be appropriate to cumulate these matters, if found to be non-serious. Indeed, the Committee had received the Registrant’s submissions from his representatives in relation to cumulation and therefore it concluded that the Registrant had been aware of the risk of cumulation from the outset and had the opportunity to address the Committee on this point. The Committee were satisfied that the GOC had put its case on a cumulative basis in relation to the particulars involving timeliness of referrals.

173. The Committee therefore decided that this was an exceptional case as per *Schodlok* and *Ahmedsowida* and cumulated the “timeliness” particulars 1a, 3a, 7a, 9a and 11a to reach the conclusion that, taken together, these matters amounted to serious professional misconduct.

174. The Committee also considered particulars 1b, 9b and 11b to be of a similar nature, namely that they related to “amendments” to patient records. The Committee noted that despite the fact that records should be made contemporaneously, these additions were only made after the Registrant was prompted by a colleague, the records having been located after patients had called to query their referrals.

175. Further, with regards to the “amendments” particulars, the Committee noted that the GOC, from the outset had made clear in its submissions that this was a pattern of behaviour and that it would be appropriate to cumulate these matters, if found to be non-serious. Indeed, the Committee had received the Registrant’s submissions from his representatives in relation to cumulation and therefore it concluded that the Registrant had been aware of the risk of cumulation from the outset and had the opportunity to address the Committee on this point. The Committee were satisfied that the GOC had put its case on a cumulative basis in relation to the particulars involving timeliness of referrals.

176. However, the whilst the Committee found that the “amendments” particulars were of a similar nature and the GOC had put its case on a cumulative basis, there being only three incidents, this was not sufficient to satisfy the volume referred to in *Schodlok*, therefore this part was not ‘exceptional.’ The Committee therefore determined that the “amendments” particulars 1b, 9b and 11b did not, cumulatively, amount to serious professional misconduct and therefore would not take them into account at impairment stage.

177. In conclusion, moving towards impairment, the Committee would take into account the following particulars:

- 2a, 2b, 2c, 4b, 4c, 5a, 7b, 7c, 8a, 10a, 10b and 12, which individually each amounted to serious professional misconduct;

- 1a, 3a, 7a, 9a and 11a which taken cumulatively to amount to serious professional misconduct.

Submissions on impairment

178. The Registrant provided a bundle including a reflective statement, CPD statements, six references and several reports from his interim order supervisors and customer reviews.

179. Mr Nwokedi submitted that when considering impairment of fitness to practise, the Committee must have regard to public interest considerations. In *PSA v Nursing and Midwifery Council (Grant) [2011] EWHC 927*, the High Court said that, in deciding whether fitness to practise is impaired, the Committee should ask themselves "*Not only whether the registrant continued to present a risk to members of the public, but whether the need to uphold proper professional standards and public confidence in the Registrant and in the profession would be undermined if a finding of impairment of fitness to practise were not made in the circumstances of this case."*

180. Dame Janet (Lady Justice) Smith in the *5th Report to the Shipman Inquiry* identified four matters for consideration when considering whether a doctor's fitness to practise is impaired:

    a. That the doctor presented a risk to patients,

    b. The doctor had brought the profession into disrepute

    c. That the doctor had breached one of the fundamental tenets of profession and

    d. That the doctor's integrity could not be relied upon

181. Mr Nwokedi submitted that delayed referrals, unclear timelines and inaccurate records all added to the risk that the patients would not get the attention or treatment required. The Registrant has brought the profession into disrepute because if a member of the public knew of the considerable mistakes and errors, this would damage public confidence to the profession. The Registrant has failed to adhere to the Standards of Practice for Optometrists as outlined in the Committee's findings. Further, Mr Nwokedi submitted that the integrity of the Registrant cannot be relied upon. The Registrant's apologies are limited to his lack of attention to record keeping, he shows no evidence of insight and the explanations offered seem somewhat inconsistent.

182. Mr Nwokedi submitted that having given no evidence, and provided a reflective statement only at this stage, the Registrant has not addressed the seriousness of the concerns. The Registrant's reflection lacks meaningful engagement with the gravity of his misconduct and appears primarily focused on external validation rather than internal reform. Mr Nwokedi submitted that the reflective statement does not reflect on past failings or show any insight beyond surface level. The tone of the reflection appears to be more self-validating rather than introspective. Without a true and reflective understanding of the danger of the

actions beyond knowing its bad to do something, Mr Nwokedi submitted that there is a real risk of repetition in this case.

183. Mr Nwokedi submitted that the Registrant has not demonstrated enough insight, and that the CPD courses completed by the Registrant are generic in nature and do not address the specific failures in relation to record keeping. This means that the same shortcuts could recur the next time clinical pressure arises, therefore the risk is clearly real and continuing. Mr Nwokedi submitted that a finding of impairment is necessary in order to protect the public, until it can be ensured that the Registrant has remedied the issue.

184. Mr Nwokedi also submitted that a finding of impairment is still necessary to uphold public confidence in the profession because the Registrant's actions would have serious reputational consequences undermining the reliability of optical records. Mr Nwokedi submitted that when Optometrists are perceived as completing clinical records inaccurately, the professions' credibility is irreparably harmed as referred to in *Nicholas-Pillai v GMC (2009) EWHC 1048 (Admin).* Whilst that is a case regarding dishonesty, which is not alleged in this case, Mr Nwokedi submitted that the case is still relevant because it involves inaccurate

185. Ms Curzon, on behalf of the Registrant, submitted that the Committee should not find impairment in this case. Ms Curzon submitted that the Registrant has no fitness to practise history and no further concerns or complaints have been raised either before the proved allegations or since. Ms Curzon indicated that the Registrant has been on an Interim Order with conditions for over two years (since 19 May 2023) and has provided regular positive progress reports during this time.

186. Ms Curzon submitted that the Registrant has completed successful remediation. She submitted that the conduct is remediable and the Registrant has demonstrated extensive commitment in continuing to practise under supervised conditions for over two years, in which he has received consistently positive feedback from both supervisors and patients, and because he has undertaken additional training and extensive, targeted and appropriate CPD courses. Further, Ms Curzon submitted that the Registrant's reflective statement demonstrates clear insight and his references are very positive.

187. Ms Curzon submitted that there is no ongoing risk to the public. The misconduct was an isolated period of time when the Registrant was under particular stresses and he has taken active steps to ensure these are not repeated. The Registrant has worked continually under conditions, demonstrating a high level of compliance and has engaged thoroughly with these proceedings, and the references and supervisor reports support this.

188. Mr Curzon submitted that public confidence in the profession can be satisfied because the rigorous assessment of the issues in the regulatory hearing itself as well as the conditional registration of the Registrant for the past two years

amounts to appropriate regulatory action having been taking in response to the allegations. Ms Curzon submitted that the reflective bundle demonstrates that the Registrant is now a safe practitioner and the public would be reassured by this. As professional regulation is a protective, not punitive regime, it encourages a degree of reflection and remediation in practitioners who have transgressed. Ms Curzon submitted that the public can understand how a repentant optometrist, who has thoroughly learnt from their mistakes is unlikely to repeat them, particularly having undergone and engaged with a rigorous disciplinary assessment of his fitness to practice. Ms Curzon submitted that the public interest includes facilitating an otherwise competent and caring practitioner such as the Registrant's unrestricted return to practice.

189. The Legal Adviser outlined *Paragraphs 16.1 to 16.7* of the *Guidance.* The Legal Adviser advised the Committee to consider the two separate elements of impairment namely the public component, which concerns the reputation of the profession and upholding professional standards, and the personal component which concerns the risk of repetition and insight displayed on the part of the Registrant as in *Cohen v GMC 2008 EWHC 581***.** The Legal Adviser also highlighted the four questions in the Grant case.

190. The Legal Adviser further advised the Committee that at the impairment stage, there is also no burden or standard of proof, but ultimately it is a question of judgement for the Committee alone.

Application to admit further evidence

191. Following submissions on impairment, and prior to completing deliberations, the Registrant made an application to admit five reports from his supervisor. Ms Curzon submitted that there had been an oversight and these should have been included in the original reflective bundle. Ms Curzon submitted that the GOC have already had these documents, having been submitted to the GOC in compliance with his interim conditions, and therefore it was fair and relevant to admit these.

192. Mr Nwokedi, on behalf of the GOC, objected to the admission of the five reports. Mr Nwokedi submitted that it would not be fair or relevant to admit the documents at this late stage, because submissions on impairment have already been completed, and there is no proper justification for such late service.

193. The Legal Adviser outlined *Rule 40(1)* of the *Fitness to Practice Rules 2013:* "*The Fitness to Practise Committee may admit any evidence it considers fair and relevant to the case before it, whether or not such evidence would be admissible in a court of law. This is subject to paragraphs (2) and (3).* The test for the Committee is whether it would be fair and relevant to admit the reports.

194. The Committee noted that although the submissions on impairment have concluded, it had not finished deliberations, and considered the supervisor

reports to be relevant to its decision making and fair to the Registrant to consider these documents. The Committee considered whether it would be unfair to the GOC to allow this information to be admitted at such a late stage. Whilst it is unsatisfactory for a Registrant to serve documents so late, the Committee determined that the unfairness to the GOC could be remedied by allowing the GOC time to respond to the reports provided.

195. The Committee determined that it would be both fair and relevant to admit the five supervisor reports.

196. The Committee offered Mr Nwokedi time to consider whether he had any further submissions. Having had the time, Mr Nwokedi confirmed that he had no further submissions to make.

Findings on impairment

197. The Committee heard and accepted the legal advice.

198. The Committee considered all of the written evidence, the submissions from both parties, and the Registrant's full bundle including the Registrant's reflective piece, CPD training, references and supervisor's reports supplied.

199. The Committee also considered the *Guidance* at *Paragraphs 16.1* to *16.7* and the *Cohen* case. The Committee also considered the four questions in the *Grant* case, namely:

a. *'Has [the Registrant] in the past acted and/or is [he] liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
b. *Has [the Registrant] in the past and/or is [he] liable in the future to bring the medical profession into disrepute; and/or*
c. *Has [the Registrant] in the past breached and/or is [he] liable in the future to breach one of the fundamental tenets of the medical profession;*
d. *has in the past acted dishonestly and/or is liable to act dishonestly in the future*

200. The Committee also considered the Council's overriding objective, and gave equal consideration to each of its limbs as set out below:

"To protect, promote and maintain the health, safety and well-being of the public, the protection of the public by promoting and maintaining public confidence in the profession and promoting and maintaining proper professional standards and conduct."

201. The Committee first considered the questions in the *Grant* case with regards to the Registrant's past behaviour.

202. The Committee determined that the facts found in this case did amount to the Registrant *in the past* acting so as to put patients at unwarranted risk of harm. The Registrant had admitted and the Committee had found significant and repeated failings in record keeping and repeated unwarranted and improper

delays in timely referrals. In particular the Committee was concerned in relation to Patient H, where the Registrant had shredded the original record and created a new 'duplicate' record which in fact contained information relating to a completely different patient. The Committee determined that patients have been placed at risk of harm due to the delays in making referrals, omissions, duplication and inaccessibility of clinical records to other colleagues as a result of the Registrant's actions. The Committee also noted that it was only when prompted to address these issues that the Registrant made any attempt to correct his patient management and rectify the omissions on the clinical records and refer patients. The Committee share the concerns from the GOC submissions and considered the Registrant's failings to amount to a serious breach of professional conduct which had, in the past, put patients at risk of harm.

203. The Committee determined that the Registrant had also *in the past* brought the profession in disrepute. The Committee considered that leaving records incomplete, and then altering records without annotating the alterations, for significant periods of time after the original appointment does bring the profession into disrepute. Again the Committee determined that the duplication allegation in relation to Patient H was a particular concern. The Committee did not consider that the Registrant had placed the patient front and centre of the process, which reflects badly on the reputation of the profession as a whole. The Committee considered that having had discussions with the patients in the proven allegations regarding their referrals, the Registrant's failure to complete contemporaneous records fully and accurately and more importantly, to fail to refer patients in a timely manner would have been shocking to those patients and their families.

204. The Committee noted that its findings at particular 12 included a previous occasion in June/July 2022, when clinical records could not be accessed by other staff, as referred to in the statement of Ms B, when the Registrant was spoken to regarding "*baskets of records"* which the Registrant had "*not had time*" to deal with. Whilst the Committee was careful to note that the Registrant had not faced further allegations in this regard, the Committee noted that the Registrant admitted the allegations and had not challenged this evidence. It did not consider it to be a short or isolated period of time that the Registrant had been exhibiting this concerning behaviour.

205. The Committee determined that failing to maintain adequate patient records, adding to the records and not annotating them to indicate the amendments, and failing to make timely referrals did bring the profession into disrepute. These are core clinical competencies of a reasonably competent Optometrist. The Registrant was in a trusted position to provide adequate care to all patients, particularly those with higher risk factors. These failures undermine the

reputation of the profession amongst members of the public, other colleagues in the profession and patients.

206. The Committee found that the Registrant had *in the past,* breached the fundamental tenets of the profession. In its findings the Committee had concluded that the Registrant had breached *Standards 2.1,7.1, 7.2, 7.5,8.1,8.2,8.24,8.25, 9.7, 10.1, 10.4, 14.7 & 17.1.* The Committee determined that the public must be able to place complete reliance on the timely referrals and adequate record keeping of optometrists, and the failure to do this affects the standards and reputation of the profession as a whole.

207. In relation to limb d) of the *Grant* criteria, the Committee considered the submissions of the GOC with regard to integrity. As the case was not put as an integrity or dishonesty case, the Committee did not consider it fair to introduce such a finding at this stage, and as such it has disregarded this limb in considering impairment.

208. The Committee therefore considered that limbs a), b) and c) of the *Grant* questions were engaged in relation to the Registrant's past conduct.

209. The Committee then went on to consider the issues in the case of Cohen as found at Paragraph 16.1 of the Guidance.

210. Firstly, the Committee considered whether the conduct which led to the allegation is remediable. The Committee considered that the failures to make timely referrals, failures to record adequate information and failures to annotate amendments made on clinical records were remediable with specific targeted training. The misconduct relates to a clinical concern and with good insight, completion of relevant training and access to useful support, is capable of being remediated. The Committee considered that to be remediable, any training support would need to be targeted to the specific failings demonstrating an understanding of good practice itself as well as understanding why the good practice exists. For these reasons, the Committee concluded that in this case, the conduct was capable of remediation.

211. Secondly, in considering *Cohen*, the Committee considered whether the conduct has been remedied. The Committee were, to an extent, reassured by the fact that the Registrant has worked under interim conditions for the past two years, with good supervisor reports and some exceptional feedback from patients who obviously felt valued. The Registrant had completed one cycle of CPD points, and is undertaking a second cycle, some of which was targeted to the specific concerns in this case, namely clinical issues regarding record keeping, referrals and accountability. Further, the testimonials largely supported the Registrant's assertions that his practice had changed and the Committee found these to be helpful. For example, the testimonial from Ms C stated *"I have seen [the Registrant] take the time after clinic hours to review records and referral notes to*

ensure completeness and accuracy." On the whole the Committee considered there were positive aspects to the Registrant's efforts to remediate.

212. However, due to comments in his reflective statement, the Committee had concerns in relation to whether the Registrant understood or had taken responsibility for the impact of his actions or whether in fact he recognised that his attitude and outlook at the time had led to his misconduct. The Registrant stated "*While my intention was never to mislead or compromise patient care, I acknowledge that these actions had the potential to undermine professional standards.*" The Committee determined that the *Standards* made very clear that this type of behaviour would breach professional standards and the Registrant should have been aware of this at all times.

213. The Registrant went on to state: "*This process has allowed me to gain a clearer understanding of how lapses in administrative diligence can have far-reaching consequences."* The Registrant also states "*At that time, I maintained a handwritten record of key clinical details throughout the day, intending to transfer these into patient records at a later stage. Although intended as a practical response to time constraints, It introduced unnecessary risk and I know complete all records on the main system. I haven't worked in a practice with paper records since leaving broadmead, this in itself had mitigated the risk of recurrence. Should I ever work in a practice with paper records in future, I will certainly ensure all notes are made directly into the main record in real time. The delays in referral were not clinically negligent, but were the result of workload-related time pressures and inefficient systems. While no direct harm occurred, I recognise that any delay in referral can compromise continuity of care*."

214. The Committee determined that the Registrant's reflective statement does not go far enough to demonstrate that the Registrant has a real understanding that patient care is at the heart of the best practice guidance in maintaining integrity of notes and timely referrals. The Registrant makes no reference to the potential impact to the patient in leaving records incomplete for an extensive period of time, nor the potential impact on the patient in the delays to timely referrals.

215. The Committee determined that the Registrant's reflections do not meet the Committee's specific concerns. The Registrant has not reassured the Committee that he understands *why* the good practice guidance exists and the values that they promote. The Committee are concerned that the Registrant has minimised his behaviour as 'administrative failings.' The Committee considered that the Registrant had relied on practical steps he has taken, rather than demonstrating an understanding of the reason why his poor record keeping and failure to make timely referrals has had a potentially significant negative impact on patient care and the reputation of the profession, as well as public confidence in the profession.

216. The Committee concluded that the Registrant has developing insight and has not yet fully remediated.

217. The Committee considered next whether the conduct is likely to be repeated. The Committee noted the five steps the Registrant refers to in his reflective statement in his submissions that the risk of repetition has been "*eliminated*":

> *"[ ] I no longer use handwritten notes. All records are completed in real time using digital systems.*
>
> *[ ] I do not agree to unsafe patient scheduling or rushed consultations.*
>
> *[ ] I only work within practices that utilise reliable digital record systems.*
>
> *[ ] All referrals are generated and shared with patients before they leave the consultation.*
>
> *[ ] I routinely self-audit referrals and outstanding clinical tasks."*

218. The Committee were assisted by these factors but again were left with concerns that the functional and practical safeguarding measures the Registrant has in place did not go far enough to reassure it that the Registrant's attitude towards his misconduct had changed. The Registrant does not go far enough to satisfy the Committee that he understands why these systems exist and how they ensure patient safety. The Registrant appears to blame external factors for his misconduct with no real reassurance that he understands the professional values that these safeguards promote. The Registrant does not appear to have demonstrated an understanding of the gravity of the potential risks where there are failures in the integrity of clinical records and timely referrals. The Committee were left concerned that if any of those safeguards failed, there was a material risk of repetition if the Registrant faced similar pressures again.

219. For the above reasons, the Committee concluded that there remains a risk of repetition.

220. The Committee then returned to the *Grant* questions with reference to the Registrant's *future* risk. The Committee determined that the Registrant does not recognise that his understanding towards his misconduct is the key component towards repeating his conduct. The Registrant has looked at external factors to explain his misconduct, and does not appear to recognise that his own actions are the key risk factor in determining his future risk. The Committee determined that until the Registrant recognises that he is responsible for these failings, he will be unable to recognise the future risk. Given its findings in relation to the *Cohen* questions, the Committee determined that the Registrant was *in the future* likely to put patients at unwarranted risk of harm, to bring the profession into disrepute and to breach one of the fundamental tenets of the profession.

221. The Committee concluded that a finding of impairment was necessary for the protection of the public, because patients were potentially put at risk by the Registrant's failings.

222. The Committee then considered the public interest element. The Committee considered that the public would be shocked to discover that the Registrant was not keeping contemporaneous notes and deliberately delaying referrals due to time management. The Registrant's conduct did amount to a serious falling short of the professional *Standards.* The Committee determined that there was a need to uphold proper professional standards and public confidence in the profession, and in the reputation of the profession would be undermined if a finding of impairment of fitness to practise were not made in the circumstances of this case.

223. For the above reasons, the Committee determined that an informed and fair-minded member of the public, if they were appraised of all the facts, would be shocked by the Registrant's misconduct, and would reasonably conclude that a finding of impairment was necessary to protect, promote and maintain the health, safety and well-being of the public, the protection of the public by promoting and maintaining public confidence in the profession and promoting and maintaining proper professional standards and conduct.

224. The Committee therefore found that the Registrant is currently impaired.

Submissions on sanction

225. Mr Nwokedi on behalf of the GOC submitted that the purpose of any sanction is to protect patients and the wider public interest. Mr Nwokedi outlined all of the sanctions available to the Committee and submitted it should start with the least severe sanction first until the most appropriate sanction is reached.

226. Mr Nwokedi submitted that a 6 month suspension order would be appropriate in this matter, as it would acknowledge the Registrant's lack of fully developed insight and uphold public confidence in the profession. Mr Nwokedi submitted that there were 12 particulars found by the Committee to be individually serious and 5 further particulars found to be cumulatively serious. The Registrant has repeatedly failed to timely refer patients, and has minimised his failings as administrative, which presents a material risk of repetition.

227. Mr Nwokedi submitted that the aggravating features are that the Registrant has, for 11 patients, repeatedly caused a potential risk of harm, in particular to patients J and H as per the Committee's findings. The Registrant had also been previously told in June/July 2022 regarding his record keeping failures and yet the issues persisted.

228. Having been found to have breached many of the Standards, Mr Nwokedi submitted a warning would not address the live risk of repetition and would seriously undermine public confidence in the profession. Mr Nwokedi submitted that a financial penalty would not be appropriate in this case as this was not a financial matter.

229. Mr Nwokedi also submitted that a conditions of practice order would not be appropriate because the Registrant has demonstrated that even under supervisory conditions for two years, his insight remains partial and attitudinal concerns still exist. Mr Nwokedi submitted that conditions would be inadequate and the public would expect a more firm response to such serious breaches.

230. Mr Nwokedi indicated that erasure would be disproportionate, especially where the Committee have found that the misconduct is remediable and the Registrant has engaged in supervision and demonstrated a willingness to improve. Mr Nwokedi submitted that the misconduct is not fundamentally incompatible with being a registered professional and therefore erasure would be disproportionate.

231. Mr Nwokedi submitted that a suspension for 6 months with a review would strike the necessary balance to uphold public protection and the public interest, but also to allow the Registrant time to deepen his insight. It would mark the gravity of repeated wide range and clinical failures, and visibly upholds public confidence that the regulator takes these breaches seriously

232. Mr Nwokedi suggested that a reviewing Committee would expect to see a reflective statement from the Registrant showing an understanding of delayed referrals and inaccurate records, as well as evidence of a targeted training plan.

233. Ms Curzon, on behalf of the Registrant submitted that the Committee should consider a shorter period of suspension than 6 months. Ms Curzon reminded the Committee that the purpose of sanctions was to protect patients and the wider public interest, not to punish the Registrant, and therefore the Committee should consider proportionality.

234. Ms Curzon submitted that there were mitigating factors, namely that the Registrant has no fitness to practise history, has made full admissions and complied with conditions of supervision for over 2 years which have produced positive reports and patient feedback. The Registrant has taken steps to remediate and made efforts to prevent recurrence, and there has been no repetition of this behaviour. He has also engaged with a University course and relevant and targeted CPD.

235. Ms Curzon submitted that as the Committee have found that remediation is not complete, a further conditions order will serve no purpose in remediation and accepted that a suspension order must be considered. However, Ms Curzon submitted that a shorter suspension than one of 6 months, is all that is required to mark public interest and remain proportionate. This will allow the Registrant time to continue to remediate and develop his practice, to gain a greater understanding of the Standards, values and patient safety.

236. The Legal Adviser referred to the Guidance Paragraphs 20-23 and 13F - 13H of the Opticians Act 1989 in outlining the sanctions available to the Committee. The Legal Adviser stated that the sanctions guidance is not a ‘straightjacket’, but if the Committee were to deviate, they must give reasons. It is not the purpose of

sanctions to punish, but the Committee should consider proportionality and balance the interests of the public against those of the Registrant. As per the Guidance at Paragraph 8.3, the Committee should work through the sanctions starting with no order and then the least restrictive first.

237. The Legal Adviser advised that the Committee may also wish to set a review hearing before any order expires to be satisfied that the Registrant is fit to return to unrestricted practice. It may wish to give guidance, or clarify its expectations regarding the evidence or matters the review committee may find useful to take into account in reconsidering the case.

238. **Findings on sanction**

239. In reaching its decision on sanction the Committee took into account the submissions on behalf of the parties, the facts found proved and its previous findings on misconduct and impairment.

240. Throughout its deliberations the Committee had regard to the Guidance, in particular paragraphs 20-23.

241. The Committee had regard to the overarching objective, giving equal consideration to each of its limbs as follows:

"To protect, promote and maintain the health, safety and well-being of the public, the protection of the public by promoting and maintaining public confidence in the profession and promoting and maintaining proper professional standards and conduct."

242. The Committee considered the following to be aggravating factors:

- Insight and remediation is not complete and there remains a risk of repetition;
- This involved a pattern of repeated failures in record keeping and failure of timely referrals across 11 patients from June-September 2022;
- There was a potential harm for patients in particular J and H ;
- The Registrant was previously alerted to concerns in his record keeping by his practice manager;
- A wide range of *Standards* were breached.

243. In mitigation, the Committee acknowledged the following factors:

- The misconduct was over one period of time of a few months, 3 years ago, and has not been repeated since;
- The Registrant has undertaken significant CPD training for clinical matters, cataracts and glaucoma, as well as record keeping and accountability;
- The Registrant has engaged with the fitness to practice process including his supervisory conditions, and made admissions to the allegations;
- The Registrant demonstrates developing insight;

- It has been confirmed independently by the area manager that there were concerns around the level of staffing in store at the time of the misconduct.

244. The Committee considered and weighed the aggravating and mitigating factors above when applying the *Guidance* at *8.3* and considered the possible sanctions, starting with the least severe, that being to take no further action. The Committee had found impairment on the grounds of all three limbs of the overarching objective.

245. The Committee determined, having regard to the Guidance, that there were no exceptional circumstances to justify taking no further action, it would not reflect the seriousness of the misconduct and therefore it would be inappropriate.

246. The Committee decided that the imposition of a financial penalty was not appropriate or proportionate as this was not a financial matter, and it would not reflect the seriousness of the misconduct.

247. The Committee next considered a period of conditional registration. The Committee considered the *Guidance* at *21.25:*

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

a. *No evidence of harmful deep-seated personality or attitudinal problems.*
b. *Identifiable areas of registrant's practise in need of assessment or retraining.*
c. *Evidence that registrant has insight into any health problems and is prepared to agree to abide by conditions regarding medical condition, treatment, and supervision.*
d. *Potential and willingness to respond positively to retraining.*
e. *Patients will not be put in danger either directly or indirectly as a result of conditional registration itself.*
f. *The conditions will protect patients during the period they are in force.*
g. *It is possible to formulate appropriate and practical conditions to impose on registration and make provision as to how conditions will be monitored.*

248. The Committee considered that factors *a)-f)* applied, although factor c) was not applicable. However, the Committee noted that the Registrant has been on, and complied with, conditional registration for a period of two years and has not yet developed full insight or fully remediated. The Registrant does not recognise that his understanding of his misconduct is important in mitigating the risk of repetition. The Registrant has looked at external factors to explain his misconduct, and does not appear to recognise that his own actions are the key risk factor in determining his future risk. For those reasons, the Committee did

not consider that factor g) was engaged, because the Committee were unable to formulate appropriate or practical conditions that meet those concerns.

249. The Committee went on to consider a suspension order and the relevant sections of the *Guidance* contained within *paragraph 21.29* namely

    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 the 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.*

250. The Committee considered that factors a)-c) applied in this case with e) not being applicable. The Committee considered that the Registrant has limited insight and whilst there is a risk of repetition, it did not amount to a significant risk and therefore factor d) was also engaged. The Committee considered that the misconduct was remediable and the Registrant is in an early stage of his career, having qualified in 2019. He has engaged willingly with the GOC proceedings and has undertaken some targeted CPD and training. The Committee determined it would want the Registrant to have the ability to continue to remediate and to allow the Registrant the opportunity to gain further insight into the professional values he must uphold. The Committee considered that the Registrant was making positive progress and it would be a disservice, given his positive engagement, for him to be removed from optometry, as with further remediation he clearly has the potential to return as a valuable member of the profession.

251. The Committee went on to test this proposition against the next most serious sanction, that of erasure at *Paragraph 21.35*. The Committee noted that this is likely to be appropriate when the behaviour is fundamentally incompatible with being a registered professional and involves any of the following (this list is not exhaustive):

    a. *Serious departure from the relevant professional standards as set out in the Standards of Practice for registrants and the Code of Conduct for business registrants;*
    b. *Creating or contributing to a risk of harm to individuals (patients or otherwise) either deliberately, recklessly or through incompetence, and particularly where there is a continuing risk of harm to patients;*
    c. *Abuse of position/trust (particularly involving vulnerable patients) or violation of the rights of patients;*

d. *Offences of a sexual nature, including involvement in child pornography;*
e. *Offences involving violence;*
f. *Dishonesty (especially where persistent and covered up);*
g. *Repeated breach of the professional duty of candour, including preventing others from being candid, that present a serious risk to patient safety; or*
h. *Persistent lack of insight into seriousness of actions or consequences.*

252. The Committee did consider that there were concerns regarding factors a), b) and h). However, factors c)-g) plainly did not apply and therefore the Committee considered that erasure would be a disproportionate sanction.

253. The Committee considered a suspension order to be the lowest sanction which is appropriate to mark the seriousness of this misconduct. Whilst a suspension order may have the effect of being punitive to the Registrant, this sanction will allow the Registrant to develop his insight, and, on balance, will allow an otherwise competent Registrant to return to the profession, which is both in his interests and in the interests of the profession. The Committee considered that this sanction would protect patient safety, maintain public confidence in the profession and promote and maintain proper professional standards and conduct.

254. The Committee was satisfied that the seriousness of the misconduct was reflected in the imposition of a suspension order. The Committee concluded that when taking into account the Registrant's interests and balancing those against the public interest, in order to ensure patient safety, public confidence and proper professional standards, a suspension order was the most appropriate and proportionate sanction.

255. In terms of the length of the order, the Committee again weighed the aggravating and mitigating factors it had identified, and had regard to the principle of proportionality. The Committee considered that the proceedings alone would have had an impact on the Registrant, and that he was likely to be developing further insight as a result. The Committee determined that the most appropriate and proportionate length of suspension to meet the need to protect patient safety, uphold public confidence in the profession and to uphold proper standards, and to allow the Registrant to return to practise and become a valued member of the profession, would be a suspension order of 3 months.

Review hearing

256. The Committee had determined that the Registrant had not yet fully remediated and there was a risk of repetition of his misconduct. The Committee determined that a Review Hearing will be held prior to the expiration of this order.

257. The Review Committee may be assisted by:

- A reflective statement demonstrating insight and understanding of the impact on patients in delayed referrals and inaccurate records;

- Any evidence of further CPD, including self-directed learning or peer review and/or training which enables the Registrant to appreciate the significance of him keeping contemporaneous records and maintain professional standards and ethics.

Immediate Order

258. Mr Nwokedi submitted that an Immediate Order should be imposed.

259. Mr Nwokedi submitted that an immediate suspension order should be made for 18 months. This order would cover the appeal period, after which the substantive order will take effect if no appeal is lodged under Section 13I of the Opticians Act 1989. There is a period in which the Registrant may be able to appeal, and the order will not take effect until this matter is resolved. As the Committee have determined that there were patient concerns in this case, and also found that remediation has not been completed, to allow the Registrant to practice unrestricted during the appeal period would be to put the public at risk. An immediate order provides clarity for the Registrant. The Committee has rejected conditional registration and therefore a period of time with no restrictions will not meet the concerns identified. The Committee should ensure continuous public protection during the appeal period given those concerns and no lesser measure will adequately protect patients or the reputation of the profession.

260. Mr Nwokedi submitted that an immediate order was necessary as in Paragraph 23.3 of the Guidance for the protection of members of the public, otherwise in the public interest and in the best interests of the Registrant to have an order which starts with immediate effect.

261. Ms Curzon made no submissions in relation to an immediate order.

262. The Committee heard and accepted advice from the Legal Adviser, namely that the Committee should refer to Paragraph 23.3 of the Guidance. The Committee may impose an immediate order if it determines that it is 'necessary to protect members of the public, is otherwise in the public interest, or is in the best interests of the Registrant.'

263. The Committee decided that there is a necessity for an immediate order. The Committee had made a finding that the Registrant's fitness to practise is impaired such that members of the public may be at risk of harm if he were entitled to practice without restriction, and it had determined that a suspension order is to be imposed. Having made those findings, the Committee determined that it was necessary to protect the public and was otherwise in the public

interest. The Committee did not consider that the grounds of being in the interests of the Registrant was made out.

264. The Committee therefore imposed an Immediate Order.

Revocation of interim order

265. The Committee hereby revokes the current existing interim order for conditional registration.

Chair of the Committee: Andy Brennan

Signature ……**Date: 08/07/2025**

Registrant: Mohammed Ul Haq

Signature …Present via Microsoft Teams ……. **Date: 08/07/2025**

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 Floor 29, One Canada Square, London, E14 5AA or, by telephone, on 020 7580 3898.