BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(23)37

AND

BABER MALIK (01-22150)

DETERMINATION OF A SUBSTANTIVE HEARING
04-12 MARCH 2024

Committee Members:	Valerie Paterson (Chair/Lay) Ben Summerskill (Lay) Ann McKechin (Lay) Gaynor Kirk (Optometrist) Philippa Shaw (Optometrist) (4, 5, 6, 7 and 8 March)
Clinical adviser:	N/A
Legal adviser:	Kelly Thomas
GOC Presenting Officer:	Tope Adeyemi
Registrant present/represented:	Yes and represented
Registrant representative:	Nicholas Hall [Counsel] Nan Mousley [AOP]
Hearings Officer:	Arjeta Shabani
Facts found proved:	Allegations 1.a, 1.b, 1.c, 1.d, 3.a.ii, 3.a.iv, 3.b.ii, 3.c.i.
Facts not proceeded with:	Allegations 2, 3.a.i, 3.a.iii, 3.b.i and 4
Facts which fell as alternatives:	3.a.v, 3.b.iii, 3.c.ii.
Misconduct:	Found for particulars 1.a, 1.b and 1d.
Impairment:	Not found
Sanction:	Warning for a period of 12 months

ORIGINAL ALLEGATION

The Council alleges that in relation to you, Baber Malik (01-22150) a registered optometrist, whilst employed as a locum at Boots Opticians [redacted]:

1. *Between 28 January 2022 and 7 August 2022, you did not conduct an appropriate and/or adequate referral for the following patients listed in Schedule A, in that you:*

    a. *Did not appropriately and/or adequately refer Patient 7 for further investigation and/or treatment, by delaying the referral for 10 days despite clinically indicating flashes and floaters' – or words to that effect; and/or*

    b. *Did not appropriately and/or adequately refer Patient 8 for further investigation and/or treatment, by delaying the referral for 6 days despite clinically indicating 'sudden onset floaters…dilation showed no signs of RD' - or words to that effect; and/or*

    c. *Did not appropriately and/or adequately refer Patient 9 for further investigation and/or treatment, by delaying the referral for 4 days despite clinically indicating 'OCT shows subretinal fluid and RPE detachment in BE' – or words to that effect; and/or*

    d. *Did not appropriately and/or adequately refer Patient 11 for further investigation and/or treatment, by delaying the referral for 10 days despite clinically indicating 'ERM and fluid at macula, Amsler no different than before' – or words to that effect; and/or*

2. *Between January 2022 and September 2022, you conducted sight tests on the following patients listed in Schedule A and you did not communicate effectively with the patients, in that you:*

    a. *Told Patient 19 how insulted you were that she wanted a retest on her prescription, or words to that effect; and/or*

    b. *Did not discuss and/or prescribe the option of 'spectacles for over contact lenses' or words to this effect, despite being requested by Patient 23; and/or*

    c. *With regard to Patient 15:*

        i. *Made jokes to the patient whilst you were coughing saying you had Covid19 but was okay to work, or words to that effect; and/or*
        ii. *Acted impatiently towards the patient when checking her clarity of vision;*

3. Between *January 2022 and September 2022, you conducted sight tests on the following patients listed in Schedule A and you did not conduct an appropriate and/or adequate examination on the patients in that you:*

    a. *With regard to Patient 20, you:*

i. *Provided an incorrect prescription; and/or*
ii. *Did not record the previous prism prescription; and/or*
iii. *Did not record the amount of prism; and/or*
iv. *Did not perform the relevant binocular vision tests; and/or*
v. *Did not record the relevant binocular vision tests;*

b. *With regard to Patient 21, you:*

i. *Did not record the amount of prism; and/or*
ii. *Did not perform the relevant binocular vision tests; and/or*
iii. *Did not record the relevant binocular vision tests.*

c. *With regard to Patient 23, you*

i. *Failed to perform visual field tests; and/or*
ii. *Failed to record visual field tests;*

4. *On or around 2 September 2022, you conducted a sight test on Patient 16 and your conduct was unprofessional or otherwise inappropriate in that you:*

a. *Refused to wear a face mask despite coughing throughout the test; and/or*
b. *Picked your nose throughout the test; and/or*
c. *Chit chatting' throughout the test; and/or*

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

Schedule A

Key	**ID Number**
Patient 7	[redacted]
Patient 8	[redacted]
Patient 9	[redacted]
Patient 11	[redacted]
Patient 15	----
Patient 16	----
Patient 19	[redacted]
Patient 20	[redacted]
Patient 21	[redacted]
Patient 23	[redacted]

Application to admit hearsay

1. Ms Adeyemi responded to the skeleton argument submitted by Mr Hall which raised concerns regarding documents Mr Hall had identified as containing hearsay within the GOC bundle.

2. Ms Adeyemi submitted that this evidence is admissible as it is both 'fair and relevant' to the case as per the guidance found in *Rule 40(1) of the Fitness to Practice Rules ("the Rules").* Ms Adeyemi agreed in the first instance that the evidence referred to was hearsay. Ms Adeyemi outlined that a decision had been made by the GOC not to contact these patients for a statement or to give evidence as it was considered disproportionate, as the quality of the hearsay itself was considered by the GOC to be satisfactory. A view was taken that the information was recorded contemporaneously and signed by Person A from an "identifiable source" and therefore this evidence was demonstrably reliable and there was no need to call live witnesses or to advance witness statements.

3. Whilst Ms Adeyemi accepted that the principles in the case of *Thorneycroft v NMC [2014] EWHC 1565* do apply, those principles do not represent individual barriers to allowing hearsay to be admitted as it is a context-specific exercise. Ms Adeyemi accepted that the evidence in question is, in this case, the 'sole and decisive' evidence in relation to allegations 2 and 4. However, that alone does not prevent a bar to admission, and she submitted that it would still be open to the Committee to weigh up the merits of admitting such evidence.

4. Ms Adeyemi referred to the case of *El Karout v Nursing and Midwifery Council [2019] EWHC 28 (Admin)* and agreed there was a critical distinction between admissibility and weight. However, Ms Adeyemi advanced that the position has been refined by the case of *Mansaray v. Nursing and Midwifery Council [2023] EWHC 730 (Admin)* which clarified that in order to assess the degree of reliability and capability of the evidence being tested, it is to some extent necessary to weigh the evidence itself. Ms Adeyemi emphasised to the Committee that it was still ultimately their choice. Ms Adeyemi said it would be appropriate to admit this evidence, and there are safeguards to prevent unfairness, namely that the Committee can still consider the weight of the evidence at the later fact-finding stage.

5. Mr Hall for the Registrant opposed the admission of this evidence. Mr Hall indicated that it would be unfair to the Registrant for the hearsay to be admitted because the evidence, in particular in relation to the concerns of Patients 15 and 16, the evidence is third hand (i.e. multiple hearsay). In relation to allegations 2 and 4, Mr Hall submitted that hearsay evidence is the sole and decisive evidence presented by the GOC to prove those allegations. Mr Hall submitted that the GOC had failed to demonstrate any attempts to advance more reliable evidence such as obtaining witness statements from the patients themselves or calling live evidence. This prevents the Registrant from making any challenge to the evidence and therefore, following the principles in *Thorneycroft,* it should not be admitted.

6. Mr Hall referred to *paragraph 13.12 of the Hearings and Indicative Sanctions Guidance* ("the Guidance"), indicating that the Registrant should in principle have the right to test the evidence against him. In this case not only are the patients not present to give live evidence, but no witness statements have been taken or sought from the patients at all. Mr Hall states that if it is accepted by the GOC that this hearsay evidence is sole and decisive, it is therefore central to allegations 2 and 4. Mr Hall referred to *Paragraph 13.14 of the Guidance*, namely that the Committee should be reluctant to admit the evidence where, as in this case, hearsay is the only evidence to support a disputed charge.

7. Mr Hall pointed to the fact that some of the patient summaries in the Key Schedule A to the allegations (Patients 15 and 16) relied upon did not include an identification (ID) number and therefore they appeared as anonymous hearsay. Mr Hall stated the Committee should consider this when looking at the reliability of the evidence. Mr Hall relied on *paragraph 13.15 of the Guidance* which refers to the case of *(R (Bonhoeffer) v GMC [2011] EWHC 1585 (Admin),* that it is "difficult to conceive of circumstances in which the admission of significant evidence about the attitude and conduct of a registrant which is both anonymous and hearsay will not infringe the requirements of fairness."

8. The Legal Adviser provided advice to the Committee, namely that the Committee may admit any evidence it considers fair and relevant to the case before it according to *Rule 40(1) of the Rules*, and *paragraphs 13.12-13.15* of the *Guidance.* The Legal Adviser outlined the distinction between admissibility and weight of the evidence, and that the Committee should consider the principles in *El Karout v Nursing and Midwifery Council [2019]; NMC v Ogbonna [2010] EWCA Civ 1216*.

9. The Legal Adviser went on to outline the case of *Mansaray v. Nursing and Midwifery Council [2023] EWHC 730 (Admin)*, namely that in order to assess the degree of demonstrable reliability and the capability of it being tested in order to decide whether to admit it, it is to some extent necessary to weigh the evidence itself. However, that is a separate exercise to the weighing of the evidence and testing it against all the other evidence, including oral witness evidence and cross-examination of all the other witnesses, in order to make findings of fact. In other words, the Committee considering admissibility must read the evidence whose admissibility they are to determine and consider it in the context of all the other evidence in the case. However, it is not always appropriate to allow the hearsay evidence to be admitted with the caveat that the Committee will give it appropriate weight later at the fact finding stage.

10. Finally, the Legal Adviser outlined the leading case in this area, *Thorneycroft v NMC [2014] EWHC 1565* which set out the following principles:

- The admission of the statement of an absent witness should not be regarded as a routine matter. The FTP rules require the Committee to consider the issue of fairness before admitting the evidence.
- The fact that the absence of the witness can be reflected in the weight to be attached to their evidence is a factor to weigh in the balance, but it will not always be a sufficient answer to the objection to admissibility.

- The existence or otherwise of a good and cogent reason for the non-attendance of the witness is an important factor (*Ogbonna v NMC [2010] EWCA Civ 1216)*. However, the absence of a good reason does not automatically result in the exclusion of the evidence.
- Where such evidence is the sole or decisive evidence in relation to the charges, the decision whether or not to admit it requires the Committee to make a careful assessment, weighing up the competing factors. To do so, the Panel must consider the issues in the case, the other evidence which is to be called and the potential consequences of admitting the evidence. The Committee must be satisfied either that the evidence is demonstrably reliable, or alternatively that there will be some means of testing its reliability.

11. The Committee heard and accepted the advice of the Legal Adviser, and considered the issue of admissibility of hearsay, having regard to all of the documentation, the GOC's oral submissions, the Registrant's oral submissions and skeleton argument, *the Guidance* and *the Rules*. The Committee first considered whether the information which was the subject of the application was in fact hearsay. The Committee determined, as had been accepted by the parties, that the information was hearsay. The Committee noted that the information in relation to some of the patients was not only second-hand evidence, but third hand evidence (i.e. multiple hearsay), as it was reported to a different member of staff before it came to Person A.

12. The Committee then went on to consider whether it would be 'fair and relevant' to admit the hearsay to the evidence for the substantive hearing. The Committee considered all of the legal cases and in particular the principles in *Thorneycroft.*

13. The Committee took into account that the GOC conceded that the evidence in question was the sole and decisive evidence in relation to allegations 2 and 4. The Committee took into account that where such evidence is the sole or decisive evidence in relation to the charges, the decision whether or not to admit it requires the Committee to make a careful assessment, weighing up the competing factors. The Committee understood the fact that the absence of the witness can be reflected in the weight to be attached to their evidence, but in this case, given that it is the sole and decisive evidence for allegations 2 and 4, is not a sufficient answer to the objection to admissibility.

14. The Committee considered the reasons for the non-attendance of the witnesses, in this case the patients 15, 16, 19 and 21. The Committee was not satisfied that the GOC explanation for not inviting the witnesses or obtaining their signed statements in relation to allegations 2 and 4 was cogent. The Committee noted that some of the information was recorded by staff, referred to as second hand evidence, but there was no explanation from the GOC as to whether or why it would be considered disproportionate to call those members of staff to give evidence or even to make a witness statement. Whilst the Committee accepted that the absence of a good reason does not automatically result in the exclusion of the evidence, in this case the Committee determined that it was unfair for the Registrant not to have the means to challenge this 'decisive' evidence at all.

15. The Committee noted that it was able to admit evidence where it would be fair and relevant to do so. However, taking into account both the case law and the *Guidance* in this area, the Committee considered that the evidence is the sole and decisive evidence, and the Committee was not satisfied that it had been provided with a cogent reason as to why the witnesses have not been contacted. The Committee was not satisfied that the principles in the case of *Thorneycroft* had been followed in this case, and therefore did not agree to admit the hearsay as it would be unfair to the Registrant who would not have any opportunity to challenge the evidence.

16. Accordingly, the Committee does not agree to admit the evidence provided in the GOC's bundle as follows:

- Statement of Person A page 81 - exclude paragraphs 14, 15 and 16
- Exhibit AL/4 – attached to the statement of Person A
- Exhibit AL/5 – attached to the statement of Person A
- Exhibit AL/7 – attached to the statement of Person A
  - page 108 exclude from the sentence "I *get patients making passing comments daily about ….*" to "*so you can see the prescription variance*."
  - Page 109 full page excluded
- Exhibit AL/8 – attached to the statement of Person A, pg 111 – exclude sentence "*I am getting a lot of passing comments…their own eyes.*"
- Statement of Person B page 113 - exclude paragraph 9 from "*There were also additional concerns…"* to *"I submit this as Exhibit HH/3."*
- Exhibit HH/2 - attached to the statement of Person B pg 116
- Exhibit HH/3 - attached to the statement of Person B, pg 118

17. The Committee confirms to all parties that it will not consider any of the above evidence as part of any further deliberations in the substantive hearing.

Application to amend the Allegation

18. Ms Adeyemi served on all parties an addendum report dated 4 March 2024 from Professor Harper. In light of Professor Harper's further considerations, and the Committee's determination on the exclusion of hearsay, Ms Adeyemi then made an application to the Committee to amend the allegations to reflect the updated position of the Council. In particular, Ms Adeyemi indicated that the following allegations would not be pursued:

- Allegation 2
- Allegation 3.a.i
- Allegation 3.a.iii
- Allegation 3.b.i
- Allegation 4
- Schedule A – delete Patients 15 (----), 16 (----) and 19 (101-091-3117)

19. Mr Hall for the Registrant raised no objections to this.

20. The Committee accepted legal advice from the Legal Adviser, namely that it had the power to amend the allegations under ***Rule 46 (20) of the Rules***, which provides that:

Rule 46 (20) Where it appears to the Fitness to Practise Committee at any time during the hearing, either upon the application of a party or of its own volition, that—

a. the particulars of the allegation or the grounds upon which it is based and which have been notified under rule 28, should be amended; and

b. the amendment can be made without injustice,

it may, after hearing the parties and consulting with the legal adviser, amend those particulars or those grounds in appropriate terms.

21. The Legal Adviser outlined that the Committee should consider any prejudice to the Registrant, and balance this against the overarching objective of protection of the public (*s. 2A of the Opticians Act 1989*).

22. The Committee deliberated, considering the proposed amendments, in light of the addendum report of Professor Harper dated 4 March 2024 (received by the Committee on 5 March 2024) and the GOC's updated position. The Committee determined that there was no prejudice to the Registrant, nor was there a risk to under-charging given the position Professor Harper had outlined in relation to the seriousness of the case remained unchanged.

23. The Committee therefore agreed to the proposed amendments to the allegation and the allegation were agreed as follows:

ALLEGATION (as amended)

The Council alleges that in relation to you, Baber Malik (01-22150) a registered optometrist, whilst employed as a locum at Boots Opticians [redacted]:

1. *Between 28 January 2022 and 7 August 2022, you did not conduct an appropriate and/or adequate referral for the following patients listed in Schedule A, in that you:*

    a. *Did not appropriately and/or adequately refer Patient 7 for further investigation and/or treatment, by delaying the referral for 10 days despite clinically indicating 'flashes and floaters' – or words to that effect; and/or*

    b. *Did not appropriately and/or adequately refer Patient 8 for further investigation and/or treatment, by delaying the referral for 6 days despite clinically indicating 'sudden onset floaters...dilation showed no signs of RD' - or words to that effect; and/or*

    c. *Did not appropriately and/or adequately refer Patient 9 for further investigation and/or treatment, by delaying the referral for 4 days despite clinically indicating 'OCT shows subretinal fluid and RPE detachment in BE' – or words to that effect; and/or*

    d. *Did not appropriately and/or adequately refer Patient 11 for further investigation and/or treatment, by delaying the referral for 10 days despite clinically indicating 'ERM and fluid at macula, Amsler no different than before' – or words to that effect; and/or*

~~2. *Between January 2022 and September 2022, you conducted sight tests on the following patients listed in Schedule A and you did not communicate effectively with the patients, in that you:*~~

    ~~a. *Told Patient 19 how insulted you were that she wanted a retest on her prescription, or words to that effect; and/or*~~

    ~~b. *Did not discuss and/or prescribe the option of 'spectacles for over contact lenses' or words to this effect, despite being requested by Patient 23; and/or*~~

    ~~c. *With regard to Patient 15:*~~
        ~~i. *Made jokes to the patient whilst you were coughing saying you had Covid19 but was okay to work, or words to that effect; and/or*~~
        ~~ii. *Acted impatiently towards the patient when checking her clarity of vision;*~~

3. *Between January 2022 and September 2022, you conducted sight tests on the following patients listed in Schedule A and you did not conduct an appropriate and/or adequate examination on the patients in that you:*

    a. *With regard to Patient 20, you:*

~~*i. Provided an incorrect prescription; and/or*~~
ii. Did not record the previous prism prescription; and/or
~~*iii. Did not record the amount of prism; and/or*~~
iv. Did not perform the relevant binocular vision tests; and/or
v. Did not record the relevant binocular vision tests;

b. With regard to Patient 21, you:

~~*i. Did not record the amount of prism; and/or*~~
ii. Did not perform the relevant binocular vision tests; and/or
iii. Did not record the relevant binocular vision tests.

c. With regard to Patient 23, you

i. Failed to perform visual field tests; and/or
ii. Failed to record visual field tests;

~~*4. On or around 2 September 2022, you conducted a sight test on Patient 16 and your conduct was unprofessional or otherwise inappropriate in that you:*~~

~~*a. Refused to wear a face mask despite coughing throughout the test; and/or*~~
~~*b. Picked your nose throughout the test; and/or*~~
~~*c. Chit chatting' throughout the test; and/or*~~

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

Schedule A

Key	**ID Number**
Patient 7	[redacted]
Patient 8	[redacted]
Patient 9	[redacted]
Patient 11	[redacted]
Patient 15	----
Patient 16	----
Patient 19	[redacted]
Patient 20	[redacted]
Patient 21	[redacted]
Patient 23	[redacted]

Admissions in relation to the particulars of the Allegation

24. The Registrant admitted the facts of allegations 1.a, 1.b, 1.c, 1.d, 3.a.ii, 3.a.iv, 3.b.ii.

25. The Committee accepted that allegations 2, 3.a.i, 3.a.iii, 3.b.i and 4 were not to be proceeded with.

26. The Registrant denied the remaining allegations, those found at 3.a.v, 3.b.iii, 3.c.ii, which are alternative allegations.

Background to the allegations

27. The Registrant began working as a locum optometrist at Boots Opticians [redacted] branch practice on 25 January 2022. The Registrant faces two allegations arising from his care of patients in 2022 whilst he was employed at the practice.

28. The Council received a referral from Boots Opticians on 29 September 2022 in respect of the Registrant's conduct.

29. Ms Adeyemi stated that investigations into the concerns were undertaken and a statement was obtained from the manager of the [redacted] Branch. The key issues noted by the manager regarding the Registrant according to Ms Adeyemi were the timeliness of his referrals, the adequacy of the eye tests he performed and the adequacy of the records he kept. The Registrant was alleged to have repeatedly not referred cases on the same day patients were seen, as required by the company policy. This included those cases that he had deemed as urgent. An audit was completed by Person C (an employee at Boots at the time) in August 2022. Within his statement, Person C noted that there were delays in referrals associated with patients. The Registrant's conduct in this regard is reflected in allegation 1.

30. Allegation 3 captures issues noted around the quality of the Registrants sight tests and the recording of the same.

31. Expert evidence was obtained from Professor Robert Harper, Optometrist Consultant at Manchester Royal Eye Hospital. In preparation of his reports dated 7 August 2023, and his addendum report of 4 March 2024, Professor Harper reviewed the evidence obtained by the Council in relation to the care provided by the Registrant to Patients at the [redacted] Practice. This included the clinical records of the Patients referred to in the allegations. Professor Harper identified areas in which he asserted that the Registrant's conduct fell below the standard expected of a reasonably competent optometrist.

Findings in relation to the facts

32. Ms Adeyemi for the GOC opened the case and confirmed that there are no live witnesses to be called, but that the GOC would rely on the remaining admitted evidence found in the disclosure bundle, as well as the further addendum report of Professor Harper.

33. Ms Adeyemi indicated that as per her written skeleton argument, the key issues for concern were the timeliness of the Registrant's referrals and the adequacy of the sight tests conducted by the Registrant.

34. In relation to the referrals, Ms Adeyemi pointed out that the Registrant had admitted that there were cases that the Registrant himself had recorded as urgent but had still failed to submit same day referrals, despite that being the policy of Boots. Ms Adeyemi referred to the two reports of Professor Harper dated 7 August 2023 and 4 March 2024 which indicated that the delays are not one off, isolated incidents but reflect a wider pattern of behaviour. Professor Harper concluded that there was no evidence of harm to these patients but that there is a risk of harm with that approach to referrals. Professor Harper considered that a "stacking up" of sub-optimal delays would fall far below the standard expected of a reasonably competent optometrist.

35. In relation to the adequacy of the sight tests, Ms Adeyemi relied again upon the conclusions of Professor Harper, who indicated that an omission of assessing and recording of binocular vision or of visual field testing would reflect a failing falling below the standard expected of a reasonably competent optometrist.

36. Mr Hall for the Registrant indicated that the Registrant admits the facts of the allegations as at allegations 1 (a-d), 3)a)ii), 3)a)iv), 3)b)ii) and 3)c)i.

37. The Committee heard and accepted the advice of the Legal Adviser, namely that the facts are admitted and therefore should be determined as proven.

38. The Committee considered the full GOC bundle and the admissions of the Registrant and therefore found the facts of allegations 1.a, 1.b, 1.c, 1.d, 3.a.ii, 3.a.iv, 3.b.ii, 3.c.i admitted and proved.

39. The Committee, having found the above allegations admitted and proved, consequently accepted that the alternative remaining allegations 3.a.v, 3.b.iii, 3.c.ii fell.

Misconduct

40. Ms Adeyemi for the GOC relied on her skeleton argument in relation to misconduct, and submitted that the case of *Roylance v GMC [1999] Lloyd's Rep Med 139* contains guidance, namely that 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…"*

41. In relation to allegation 1, on the subject of delayed referrals, Ms Adeyemi stated that there were, on four separate occasions, delays which amounted to between 4-10 days, which was contrary to both Boots' company policy and good practice. Ms Adeyemi stated that each of these delays individually fell short of what was expected, and that such delays were not minor issues but should be regarded as serious. Ms Adeyemi further submitted that the potential consequences, if there were to be a deterioration in a patient's condition, could be serious and as such any delay would undermine the reputation of the profession. Ms Adeyemi pointed to the opinion of Professor Harper in his reports dated 7 August 2023 and 4 March 2024, that patients should, where a referral need is identified, expect the referral shortly after. In relation to Patient 11, for example, Ms Adeyemi stated that the Registrant himself had regarded the referral to be urgent, and as such, the Registrant should have made the referral urgently. The Registrant's practice manager also commented that the delays in referrals by the Registrant were not inconsequential but a matter of concern for her. Ms Adeyemi stated that in the Registrant's own reflections on this issue in his written statement dated 5 March 2024 he understood that the delay in the referral was wrong and a serious failure.

42. In relation to the eye examination allegations, namely those found in allegation 3, Ms Adeyemi also outlined that the Registrant's care was inadequate, as the Registrant had failed to record the previous prism, had not performed relevant binocular vision tests for two patients, and failed to perform a visual field test. Ms Adeyemi indicated that Patient 20 was 81 years old and had made complaints of deterioration, and in this instance, a binocular vision test was very important. Ms Adeyemi acknowledged that Professor Harper had commented that this information was not always recorded by the Registrant's colleagues, but Ms Adeyemi submitted that this did not assist the Committee further and did not minimise the impact of the Registrant's failings.

43. Ms Adeyemi summarised by stating that the failings of the Registrant were basic but important failings which go to the heart of what was expected of the Registrant as an optometrist. Ms Adeyemi indicated that taken individually or cumulatively they represented a serious failing falling short of the standard expected.

44. Ms Adeyemi submitted that by his admissions, the Registrant had fallen short of the following standards in the *Standards of Practice for Optometrists and Dispensing Opticians*:

- *Standard 6.2: Be able to identify when you need to refer a patient in the interests of the patient's health and safety and make appropriate referrals.*
- *Standard 7: Conduct appropriate assessments, examinations, treatments and referrals.*

- *Standard 7.2: Provide or arrange any further examinations, advice, investigations or treatment if required for your patient. This should be done in a timescale that does not compromise patient safety and care.*
- *Standard 7.5: Provide effective patient care and treatments based on current good practice.*
- *Standard 8: Maintain adequate patient records.*
- *Standard 17: Do not damage the reputation of your profession through your conduct.*

45. Mr Hall for the Registrant addressed the Committee on misconduct. In the first instance, Mr Hall's position was that the conduct admitted by the Registrant did not amount to serious misconduct as it was not a serious breach of the standards.

46. Mr Hall further submitted that even were the Committee to find a series of less serious misconduct (referred to by him as "non serious" misconduct), bearing in mind the relevant case law, it would be inappropriate for the Committee to consider accumulating any allegations together to amount to a finding of "serious" misconduct.

47. Mr Hall went through each of the admitted allegations in turn and made the following submissions.

48. In relation to allegation 1.a relating to Patient 7, Mr Hall pointed to the conclusions of Professor Harper in his report dated 7 August 2023, at para 5.1.6 and 5.1.7, namely:

5.1.6: "*The Registrant's decision to refer Patient 7 for a 1-2 week retinal opinion over a week after the examination on 31st July 2022 is sub-optimal for reasons of the apparent delay between his examination and the writing/sending of the referral; however, the necessity of the referral here is questionable, and while if one is wishing to make an urgent referral then the letter should be written on the same day/within 24 hours, the delay here does need to be seen within the context that many optometrists would not have referred Patient 7 at all in my view. Indeed, having apparently been seen very recently in the hospital for what appears to have been a 'flashes and floaters' or PVD related presentation, and with the subsequent optometry examination finding no escalation of symptoms ('no change' is noted) and an apparent normal examination upon dilation, then Patient 7 may not have needed a referral to the HES, and in particular in a scenario where they had been given advice on attending promptly if their symptoms deteriorated."*

5.1.7: "*In my view, the Registrant's examination and management of Patient 7 did not fall below the standard expected of a reasonably competent optometrist…"*

Mr Hall submitted that the necessity of the referral itself was questionable, and that the delay should be seen within the context of the fact that many optometrists may not have decided to refer at all, therefore this did not amount to serious misconduct.

49. In relation to allegation 1.b relating to Patient 8, Mr Hall referred to Professor Harper's report of 7 August 2023 at 5.2.9:

"*The Registrant's decision to refer Patient 8 for 'further investigation within 1-week' after the follow up examination on 30th June 2022 is* ***sub-optimal*** *for reasons of the apparent delay between his examination and the writing/sending of the referral. An urgent referral, the stated intent of the Registrant, should be written on the same day/within 24 hours; however, the delay here does need to be seen within the context that many optometrists would not have referred Patient 8 at all. As was the case with Patient 7, with an apparent normal examination upon dilation and the provision of advice on what to do should symptoms deteriorate, then Patient 8 may not have needed a referral at all.*

For this matter, Mr Hall repeated the submissions found at paragraph 48.

50. In relation to allegation 1.c relating to Patient 9, Mr Hall drew the Committee's attention to Professor Harper's report of 7 August 2023 at para 5.3.7:

"In my view such a delay to a suspected wet AMD referral would, under normal circumstances, constitute a failing, one falling below the standard expected of a reasonably competent optometrist; however, there are some nuances in this case. Given the Registrant's entirely appropriate examination of Patient 9 and given reasonable evidence Patient 9 had attended for a re-check on 11th February with some specific knowledge of an AMD status he declared to the Registrant, and further with Patient 9 having been 'flagged' as requiring ophthalmology/medical retinal care (with an appointment having apparently already been made via the GP for the following week), I would regard the 4 day delay in writing/sending the referral letter as sub-optimal rather than inadequate. In this specific circumstance, the Registrant's actions did not fall below the standard expected of a reasonably competent optometrist. Yet again however, a delay in sending a referral here is not an isolated event, and the matter of several instances of apparently delayed referrals does feed into a wider concern about the Registrant's referrals (see 5.10)."

Mr Hall submitted again that being "sub-optimal" was not sufficient for the Committee to find that the Registrant fell below or far below the standard expected, and therefore did not amount to serious misconduct.

51. For allegation 1.d in relation to Patient 11, Mr Hall submitted that the relevant paragraph can be found in Professor Hall's report dated 7 August 2023 at para 5.4.5:

"*The Registrant's examination of Patient 11 was, in my view, sufficiently detailed; however, the Registrant appears to have delayed his intended urgent referral by 10 days. In my view, it is unlikely that Patient 11 did need the level of urgency intended by the Registrant's referral and so his actions were not likely to be harmful to Patient 11; however, having decided to refer (and to do so urgently, requesting as he did a review "within 2-3 days") it was incumbent on the Registrant to write a referral on 22nd June 2022 or the next day, and not as he appears to have done some 10 days later. If the Registrant writes a referral letter*

and is asking for his patient to be seen within days, in makes no sense for him to write such referrals many days after his eye examinations. Regardless of intended urgency, it is also reasonable for patients expecting their care to be transferred for an opinion elsewhere to have their referrals made in a timely way. In my view, the Registrant's delay here, albeit for what would usually be expected to be a routine referral versus an urgent referral, did fall below the standard expected of a reasonably competent optometrist. Further, this case feeds into a wider concern about other delays to referral that escalates the gravity of his actions around referrals, a matter returned to in 5.10."

Mr Hall submitted again that the conclusions drawn did not meet the threshold of serious misconduct, and that each of the individual referrals needed to be seen in context.

52. Mr Hall submitted that throughout his report, Professor Harper was complimentary of the Registrant's practice, commenting at 5.10.3 that the Registrant's examination and records were:

"*very reasonable, with reasonably detailed comments on patients' presentations and no omissions of basic aspects of sight testing (other than as noted above in 5.10.2) including refraction, visual acuity, and internal/external eye examinations and, where appropriate, discretionary tests such as Amsler charts and measures of intraocular pressure, for example. In general, some of the registrant's referrals appear very cautious in terms of either necessity and/or urgency. I find the criticism of the Registrant's omission of an internal eye examination at rechecks to be very odd, and counter to reasonable expectations within the optometric profession, albeit any optometrist will always need to be mindful of expectations of their professional employment."*

53. Mr Hall concluded, in relation to allegation 1, the four sub-particulars needed to be assessed separately in terms of seriousness, and in the context of a timeframe that was over a nine month period, where the Registrant was dealing with approximately 16 patients per day, 95 patients per week and approximately 3500 patients in total.

54. In relation to particulars 3.a.ii (not recording the previous prism), 3.a.iv (not performing the relevant binocular tests), 3.b.ii (not performing the relevant binocular tests) and 3.c.i (not performing the visual field test), Mr Hall submitted that individually they were not serious misconduct. Mr Hall addressed the concerns of Professor Harper's addendum report dated 4 March 2024 at para 2.2.7:

"On the broader question posed in the addendum report instructions, if allegation 3 is found proven (and referencing here the elements of allegation 3 around assessment and/or recording of binocular vision for Patients 20 and 21, and omission of visual field testing for Patient 23), then in my view such a finding would reflect a failing falling below the standard expected of a reasonably competent optometrist."

Mr Hall stated that the Registrant accepted that he had fallen below the standard expected of a reasonably competent optometrist but not to the extent that it would constitute misconduct, and it should be noted that no patient harm arose from these failings.

55. Mr Hall submitted that Professor Harper has taken the four individual "sub-optimal" issues in allegation 1 and cumulated them into falling below the standard expected of a reasonably competent optometrist. Mr Hall expressed concern that Professor Harper had based his expert opinion on a presumed pattern of behaviour from the Registrant when that was not the case. Mr Hall submitted that the Committee should use their own judgement in this regard.

56. Finally, in relation to the issue of accumulation, Mr Hall referred to the case of *Schodlok v General Medical Council [2015] EWCA Civ 769 (Schodlok)* in relation to whether it was open to a Committee or misconduct panel to turn "non-serious" misconduct into serious misconduct by nature of the volume of occurrences. Mr Hall submitted that Professor Harper had "cumulated" the allegations throughout his reports and also in his conclusions, including considering hearsay evidence, and accordingly the Committee should have caution when considering Professor Harper's conclusion on an elevation of seriousness. Mr Hall also stated that whilst it was possible for the Committee to consider accumulation when assessing misconduct, it should consider in particular the comments of LJ Vos in that case:

"I do not think we should opine on the theoretical possibility that, in a particular case on different facts, a series of non-serious misconduct findings could, taken together, be regarded as serious misconduct. For my part, I would not think that the possibility of taking such a course in a very unusual case on very unusual facts should be ruled out, but I would prefer to leave the argument for a case in which such facts are said to arise. In the normal case, I do not think that a few allegations of misconduct can or should be regarded collectively as serious misconduct."

Legal advice in relation to misconduct

57. The Legal Adviser provided advice that under *Section 13D of the Opticians Act 1989* one statutory ground upon which to find impairment was misconduct. The Legal Adviser advised that the Committee should start by taking each allegation individually and consider whether it amounted to serious misconduct. The Legal Adviser advised that the relevant provisions of the *Guidance* were at para *15.5 to 15.9* namely*:*

15.5 There is also no statutory definition of misconduct. The FtPC must exercise its judgment to determine whether an act or omission amounts to misconduct.

15.6 In Roylance v GMC [1999] Lloyd's Rep Med 139 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".

15.7 Although the terminology has changed since the Roylance case, the Courts have been clear that it was "inconceivable" that the change in language should signify a lower threshold for disciplinary intervention.

15.8 Misconduct can be found in relation to a single act where the conduct has been particularly serious.

15.9 Where a registrant may have been negligent, misconduct may be constituted by a series of acts, unless the one act in question was particularly serious; see R (on the application of Vali) v General Optical Council [2011] EWHC 310 (Admin): "Mere negligence does not of itself show that the act was misconduct. A higher degree of gravity than mere carelessness is required. I also note and agree that a single act is less likely to cross the threshold of misconduct but that depends of course on the gravity of the act."

58. The Legal Adviser then advised that in the case of *Remedy UK Ltd v General Medical Council* [2010] EWHC 1245 (Admin) there were two principal kinds of misconduct identified, that is conduct linked to professional practice and/or conduct that otherwise brings the profession into disrepute.

59. The Legal Adviser advised the Committee to consider each of the particulars in turn to decide whether the Committee found them individually to be serious misconduct. If the Committee reaches the conclusion that there is more than one allegation of non-serious misconduct, then she advised that taking into account the principles set out in the case of *Schodlok,* the Committee should consider whether the cumulative effect of the non-serious matters, taken together, lead them to a finding that they have become serious misconduct as a consequence of their volume and similarity.

60. The Legal Adviser outlined the case of *Schodlok*, and advised that in principle it is possible that matters of non-serious misconduct, taken together, can be taken by the Committee to amount to serious misconduct. However, there has been judicial criticism of this approach, so the Committee would need carefully to consider the principles in *Schodlok* and to articulate its reasoning. The Legal Adviser advised that the Committee must consider both the volume and the similarity of the non-serious misconduct, as well as the presentation of the case, before it concluded that a series of non-serious misconduct in this case amounts to a finding of serious misconduct. Whilst Mr Hall's quote from *Schodlok* was accurate, there were slightly dissenting views, namely that Beatson LJ examines this possibility further, stating at paragraph 72:

"My tentative and very preliminary view is that, provided it is clear from either the charge brought by the GMC or the way the case against the doctor is presented at the hearing, that any adverse findings by the panel on matters identified in the charges might be cumulated in this way, so that the doctor is aware this is a possibility, such an approach should in principle be open to the panel. I recognise that a small number of allegations of misconduct that

individually are held not to be serious misconduct should normally not be regarded collectively as serious misconduct. Where, however, there are a large number of findings of non-serious misconduct, particularly where they are of the same or similar misconduct, I consider the position is different. In such a case, it should in principle be open for a Fitness to Practise Panel to find that, cumulatively, they are to be regarded as serious misconduct capable of impairing a doctor's fitness to practise."

61. The Legal Adviser also outlined the case of *Ahmedsowida v GMC (2021) EWHC 3466 (Admin)* in which there were three (proven) allegations which the tribunal were considering cumulating. The Legal Adviser stated that this case related to instances where a tribunal determined that a doctor had defied instructions from his superiors. The Legal Adviser further stated that in this case the tribunal was criticised by the Court of Appeal as it did not follow the principles in *Schodlok* and it had not properly understood the case. The Legal Adviser stated that the Court of Appeal criticised the tribunal for making no comparison with the facts in *Schodlok*, that it had not considered whether the facts were "*exceptional,*" and it had not considered whether the GMC had put its case on a cumulative basis, or whether there was a large number of incidents making up a series.

62. The Legal Adviser advised that the Committee was absolutely able to consider the accumulation of non-serious matters, however *Schodlok* had set a high bar for cumulation.

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

Determination in relation to misconduct

64. The Committee accepted the advice of the Legal Adviser and took account of the documentation provided, the *Guidance*, *Rules, Standards* and submissions of Ms Adeyemi and Mr Hall. The Committee had also received the full text judgments of *Schodlok* and *Ahmedsowida* whilst in camera. The Committee came to its own view in relation to misconduct, applying its own judgement to uphold public protection and the public interest, including upholding the standards of the GOC.

Allegation 1.a Between 28 January 2022 and 7 August 2022, you did not conduct an appropriate and/or adequate referral for the following patients listed in Schedule A, in that you:

a. Did not appropriately and/or adequately refer Patient 7 for further investigation and/or treatment, by delaying the referral for 10 days despite clinically indicating 'flashes and floaters' – or words to that effect; and/or

65. The Committee had regard to the expert report of Professor Harper dated 7 August 2023, where there is reference at para 5.1.4 to the Registrant ticking the

'urgent' box category in the referral. The Committee accepted Professor Harper's reports and conclusions regarding the delay and noted in particular at para 5.1.6:

> *"…and while if one is wishing to make an urgent referral then the letter should be written on the same day/within 24 hours…"*

66. The Committee accepted the opinion expressed by Professor Harper in the general observation elsewhere in his first report - at para 5.4.5 – that:

> "*Regardless of intended urgency, it is also reasonable for patients expecting their care to be transferred for an opinion elsewhere to have their referrals made in a timely way*."

67. The Committee noted that this patient had not been caused any harm by the delay.

68. However, the Committee determined that the proven matters highlighted two serious issues. The first was the appropriateness and/or adequacy of the referral. The second was that the Registrant had identified a need for an urgent referral, and having identified the need, delayed the referral. It was the second issue that caused the Committee particular concern.

69. Having made that decision, and considering this to be an urgent matter, the Registrant still went on to delay the referral by ten days. The Committee determined that to be a serious delay. The Committee determined that by its nature an urgent referral means that action must be taken urgently, meaning in the ordinary interpretation *without delay*.

70. The Committee found that this ten day delay did not meet Standard 7 of the *Standards*. The Committee found that a ten day delay was one which would far exceed the expectation of the public, including patients and professional colleagues. The Committee again accepted that there was no actual evidence of clinical harm, although there remained the potential. However, the Committee nevertheless determined that this misconduct had a serious impact on both the protection of the public and the standards which should be upheld by the profession.

71. The Committee considered the following *Standards* :

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

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

The Committee found that once the Registrant had decided that the patient needed an urgent referral, that should have happened without delay. The Registrant had not met those standards.

72. The Committee also found that the Registrant had behaved in a manner that damaged public confidence in the profession, contrary to Standard 17.1. The Committee found that to delay an urgent referral for ten days was likely to have a serious effect on public confidence in the profession and was behaviour which fell far below the standard expected of a reasonably competent optometrist. It therefore concluded that this amounted to serious misconduct.

Allegation 1.b Between 28 January 2022 and 7 August 2022, you did not conduct an appropriate and/or adequate referral for the following patients listed in Schedule A, in that you:

b. Did not appropriately and/or adequately refer Patient 8 for further investigation and/or treatment, by delaying the referral for 6 days despite clinically indicating 'sudden onset floaters...dilation showed no signs of RD' - or words to that effect; and/or

73. The Committee had regard to the expert report of Professor Harper dated 7 August 2023, in particular noting the following at para 5.2.7:

"The referral letter for the examination of 20th June 2022 references dilation on 30th June 2022, and this referral itself is undated; however, elsewhere the record notes the referral having been e-mailed on "06/07 (date referral written)". I interpret these notes to infer that the dilated examination was carried out when Patient 8 reattended on 30th June 2022 and that the referral letter was written after this second examination, being e-mailed on 6th July 2022."

74. The Committee accepted the opinion expressed by Professor Harper in the general observation elsewhere in his first report - at para 5.4.5 – that:

> "*Regardless of intended urgency, it is also reasonable for patients expecting their care to be transferred for an opinion elsewhere to have their referrals made in a timely way*."

75. The Committee noted that this patient had not been caused any harm by the delay.

76. However, the Committee determined that the proven matters highlighted two serious issues. The first was the appropriateness and/or adequacy of the referral. The second was that the Registrant had identified a need for an urgent referral, and having identified the need, delayed the referral. It was the second issue that caused the Committee particular concern.

77. Having made that decision, and considering this to be an urgent matter, the Registrant still went on to delay the referral by six days. The Committee

determined that to be a serious delay. The Committee determined that by its nature an urgent referral means that action must be taken urgently, meaning in the ordinary interpretation *without delay*.

78. The Committee found that this six day delay did not meet Standard 7 of the *Standards*. The Committee found that a six day delay was one which would far exceed the expectation of an ordinary member of the public, including patients and professional colleagues. The Committee again accepted that there was no actual evidence of clinical harm, although there remained the potential. However, the Committee nevertheless determined that this misconduct had a serious impact on both the protection of the public and the standards which should be upheld by the profession.

79. Additionally, in relation to this allegation, the Committee noted that according to Professor Harper's report at 5.2.7 (above) this patient had already had an initial appointment ten days earlier and was returning to have the dilation appointment. The Committee was satisfied that it would have already been clear to the Registrant that ten days had passed and therefore there should already have been concerns over the time that had elapsed since the patient had first presented. At this point, the Registrant assessed the matter as urgent, and so this should have been referred without delay.

80. The Committee found that this six day delay did not meet Standard 7 of the *Standards*. The Committee found that a six day delay was one which would far exceed the expectation of the public, including patients and professional colleagues. The Committee again accepted that there was no actual evidence of clinical harm, although there remained the potential. However, the Committee nevertheless determined that this misconduct had a serious impact on both the protection of the public and the standards which should be upheld by the profession.

81. The Committee, considered the following *Standards* :

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

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

The Committee found that once the Registrant had decided that the patient needed an urgent referral, that should have happened without delay. The Registrant had not met those standards.

82. The Committee also found that the Registrant had behaved in a manner that damaged public confidence in the profession, contrary to Standard 17.1. The Committee found that to delay an urgent referral for six days, especially in these circumstances, was likely to have a serious effect on public confidence in the profession and was behaviour which fell far below the standard expected of a

reasonably competent optometrist. It therefore concluded that this amounted to serious misconduct.

Allegation 1.c Between 28 January 2022 and 7 August 2022, you did not conduct an appropriate and/or adequate referral for the following patients listed in Schedule A, in that you:

c. Did not appropriately and/or adequately refer Patient 9 for further investigation and/or treatment, by delaying the referral for 4 days despite clinically indicating 'OCT shows subretinal fluid and RPE detachment in BE' – or words to that effect; and/or

83. The Committee looked at the evidence of Professor Harper's report dated 7 August 2023 at para 5.3.7:

"*In my view such a delay to a suspected wet AMD referral would, under normal circumstances, constitute a failing, one falling below the standard expected of a reasonably competent optometrist; however, there are some nuances in this case. Given the Registrant's entirely appropriate examination of Patient 9 and given reasonable evidence Patient 9 had attended for a re-check on 11th February with some specific knowledge of an AMD status he declared to the Registrant, and further with Patient 9 having been 'flagged' as requiring ophthalmology/medical retinal care (with an appointment having apparently already been made via the GP for the following week),* ***I would regard the 4 day delay in writing/sending the referral letter as sub-optimal rather than inadequate.*** *In this specific circumstance, the Registrant's actions did not fall below the standard expected of a reasonably competent optometrist. Yet again however, a delay in sending a referral here is not an isolated event, and the matter of several instances of apparently delayed referrals does feed into a wider concern about the Registrant's referrals (see 5.10).*"

84. The Committee accepted Professor Harper's assessment of the clinical skills of the Registrant. The Committee considered each of the allegations separately and without applying any cumulative test.

85. In this allegation, the Committee had particular regard to Professor Harper's comments at para 5.3.6:

"*The referral ought to have been urgent for a rapid access macula clinic appointment for suspected wet AMD using whatever the local pathway recommended at the time. Effectively the Registrant wrote such a referral (on a 'GOS18' form), but it is not clear he did so on the day of the examination/the next day as he ought to have done. Indeed, it appears from the notes that the referral was e-mailed 4 days later. It is unclear if the referral was emailed to the local eye unit's rapid access macula clinic service and/or to the GP. Either way, for an urgent eye condition such as wet AMD, the delay here would typically be potentially problematic for a patient. In mitigation, the Registrant's examination itself was very satisfactory, and he appears to have detected wet AMD. Further,*

he appears to be of the belief that Patient 9 may have had a GP initiated appointment pending in the eye clinic for a week after the eye examination by the Registrant on 11th February 2022 (i.e., on 18th February 2022).”

86. Professor Harper reported that the Registrant believed that Patient 9 had a GP-initiated appointment pending in the eye clinic for a week after the eye examination. Given that information the Committee determined that the Registrant, despite the urgent referral, may not have had a heightened concern regarding this Patient as there was already the safeguard of a GP-initiated appointment in place.

87. The Committee determined that there was a falling short of the standards, as the urgent referral should have been made within twenty-four hours. However, on this occasion, due to the shorter timescale of the delay of four days and the eye clinic appointment already in place, the Committee determined that the Registrant’s delayed referral fell below, but not far below, the standards expected of a reasonably competent optometrist. The Committee found this matter to be unsatisfactory, but did not find it to be serious misconduct, but instead non-serious misconduct.

Allegation 1.d Between 28 January 2022 and 7 August 2022, you did not conduct an appropriate and/or adequate referral for the following patients listed in Schedule A, in that you:

d. Did not appropriately and/or adequately refer Patient 11 for further investigation and/or treatment, by delaying the referral for 10 days despite clinically indicating ‘ERM and fluid at macula, Amsler no different than before’ – or words to that effect; and/or

88. The Committee accept the expert report of Professor Harper dated 7 August 2023, referring to Patient 11 at para 5.4.5:

“*The Registrant’s examination of Patient 11 was, in my view, sufficiently detailed; however, the Registrant appears to have delayed his intended urgent referral by 10 days. In my view, it is unlikely that Patient 11 did need the level of urgency intended by the Registrant’s referral and so his actions were not likely to be harmful to Patient 11; however, having decided to refer (and to do so urgently, requesting as he did a review “within 2-3 days”) it was incumbent on the Registrant to write a referral on 22nd June 2022 or the next day, and not as he appears to have done some 10 days later. If the Registrant writes a referral letter and is asking for his patient to be seen within days, in [sic] makes no sense for him to write such referrals many days after his eye examinations.* ***Regardless of intended urgency, it is also reasonable for patients expecting their care to be transferred for an opinion elsewhere to have their referrals made in a timely way. In my view, the Registrant’s delay here, albeit for what would***

usually be expected to be a routine referral versus an urgent referral, did fall below the standard expected of a reasonably competent optometrist."

89. The Committee noted that this patient had not been caused any harm by the delay.

90. However, the Committee determined that the proven matters highlighted two serious issues. The first was the appropriateness and/or adequacy of the referral. The second was that the Registrant had identified a need for an urgent referral, and having identified the need, delayed the referral. It was the second issue that caused the Committee particular concern.

91. Having made that decision, and considering this to be an urgent matter, the Registrant still went on to delay the referral by ten days. The Committee determined that to be a serious delay. The Committee determined that by its nature an urgent referral means that action must be taken urgently, meaning in the ordinary interpretation *without delay*.

92. The Committee found that this ten day delay did not meet Standard 7 of the *Standards*. The Committee found that a ten day delay was one which would far exceed the expectation of the public, including patients and professional colleagues. The Committee again accepted that there was no actual evidence of clinical harm, although there remained the potential. However, the Committee nevertheless determined that this misconduct had a serious impact on both the protection of the public and the standards which should be upheld by the profession.

93. The Committee, considered the following *Standards*:

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

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

The Committee found that once the Registrant had decided that the patient needed an urgent referral, that should have happened without delay. The Registrant had not met those standards.

94. The Committee also found that the Registrant had behaved in a manner that damaged public confidence in the profession, contrary to Standard 17.1. The Committee found that to delay an urgent referral for ten days was likely to have a serious effect on public confidence in the profession and was behaviour which fell far below the standard expected of a reasonably competent optometrist. It therefore concluded that this amounted to serious misconduct.

Allegation 3.a.ii Between January 2022 and September 2022, you conducted sight tests on the following patients listed in Schedule A and you did not conduct an appropriate and/or adequate examination on the patients in that you:

a.ii. With regard to Patient 20, you did not record the previous prism prescription; and/or

95. The Committee considered the comments of Professor Harper's report dated 7 August 2023 at para 5.7.5:

"The basis for the Registrant's prescribing of prism is not evident from this record card. Two matters arise: First, the Registrant's record does not document Patient 20's previous correction. It is possible, even very likely, that elsewhere (for example on an earlier/previous record this information was available to the Registrant); second, there is no assessment of binocular status to 'explain' Patient 20's requirement for prism."

96. The Committee accepted that it appeared very likely that the Registrant had previously been supplied with the record of prism. The Registrant admitted not recording this. The Committee did not conclude that this would be behaviour of concern to the wider public interest, nor would it fall short of upholding the standards of the profession. The Committee determined that this behaviour did not fall below the standards expected of a reasonably competent optometrist and therefore it found that this matter did not amount to misconduct.

Allegation 3.a.iv Between January 2022 and September 2022, you conducted sight tests on the following patients listed in Schedule A and you did not conduct an appropriate and/or adequate examination on the patients in that you:

a.iv With regard to Patient 20, did not perform the relevant binocular vision tests; and/or

97. The Committee took account of Professor Harper's report dated 7 August 2023 at para 5.7.9:

"In summary regarding Patient 20, the Registrant should have measured binocular vision status using a cover test at distance and near and checked ocular motility and recorded his findings in these respects. His assessment and/or recording of his assessment here was deficient and did fall below, but not far below, the standard expected of a reasonably competent optometrist in this regard."

98. The Committee concluded this was behaviour of concern. Whilst the Committee determined that there was a falling short of the standards, as binocular vision tests should have been conducted, the Committee determined that the failure fell below, but not far below, the standards expected of a reasonably competent optometrist. Whilst it was still unsatisfactory, the Committee did not find this allegation to be serious misconduct, but instead non-serious misconduct.

Allegation 3.b.ii Between January 2022 and September 2022, you conducted sight tests on the following patients listed in Schedule A and you did not conduct an appropriate and/or adequate examination on the patients in that you:

b.ii With regard to Patient 21 did not perform the relevant binocular vision tests; and/or

99. The Committee took account of the report of Professor Harper dated 7 August 2023 at para 5.8.8:

"*Patient 21 did not appear to get on with their changed prescription and reattended for a recheck. The Registrant has documented "Picking up new VDU specs + not happy with vision. Recheck". At this point a repeat refraction by the Registrant appears to have identified that the right eye's cylindrical correction for Patient 21's astigmatism was incorrect, and the Registrant proposed the revised prescription for an occupational (VDU) and general purpose bifocals to be re-made. While reasonably spotting an error in the prescription and finding a sufficient change to be explanatory for Patient 21's difficulties, the Registrant appears to have omitted to measure and/or to record to measure their binocular vision status again at this recheck. This omission is at this recheck stage is a failing, one falling below the standard expected of a reasonably competent optometrist. Patient 21 can reasonably have expected a more thorough look at her re-presentation in a broader spectacle tolerance context, and to do so should reasonably have included a check on Patient 21's binocular vision status. At the initial assessment this omission is sub-optimal, but having omitted to assess binocular status at the recheck as well does elevate matters to that of a failing falling below the standard expected of a reasonably competent optometrist."*

100. The Committee concluded that this was behaviour of concern. Whilst the Committee determined that there was a falling short of the standards, as binocular vision tests should have been conducted, the Committee determined that the failure fell below, but not far below, the standards expected of a reasonably competent optometrist. Whilst it was still unsatisfactory, the Committee did not find this allegation to be serious misconduct, but instead non-serious misconduct.

Allegation 3.c.i Between January 2022 and September 2022, you conducted sight tests on the following patients listed in Schedule A and you did not conduct an appropriate and/or adequate examination on the patients in that you:

c.i With regard to Patient 23 failed to perform visual field tests

101. The Committee took account of the relevant part of Professor Harper's report at para 5.9.7:

"*Further, it appears to be the case that Patient 23 has a previous ocular history of having had a laser iridotomy (owing to their risk of narrow angle glaucoma, and probably related to their high hypermetropia or long-sight). It is unclear when this likely hospital eye service or private ophthalmology treatment had occurred since the Registrant has not noted when this treatment was undertaken. The Registrant has examined the external eye and appears to have made a comment about the cornea and anterior chamber being 'clear', but there is no comment on the depth of the anterior chamber angle, nor on the presence/patency of any peripheral iridotomy. The Registrant's examination and/or record keeping in this specific respect is sub-optimal, but it does not fall below the standard expected of a reasonably competent optometrist."*

102. The Committee took account of the comments at para 5.9.8:

"If the laser iridotomy treatment episode was relatively recent, and there was therefore evidence of a recent ophthalmology consultation, for example within the past 6 months or so, then it may have been reasonable for the Registrant to not undertake additional glaucoma case finding testing at this routine eye examination; however, if the timeline for this treatment was not relatively recent, then I would consider it an omission to not undertake additional testing with visual fields to assess Patient 23's glaucoma risk. Although intraocular pressures were within normal limits with only a modest degree of asymmetry, and although the Registrant's view appears to have been that the optic disc looked healthy, the family history, previous ocular history, and poor sight in the right eye combine to create a risk profile for Patient 23 to mean that they should reasonably have been offered visual field testing. To omit such testing and/or to omit to document such testing falls below the standard expected of a reasonably competent optometrist."

103. The Committee considered in particular in this case the heightened risk of glaucoma for the patient.

104. The Committee concluded this was behaviour of concern. Whilst the Committee determined that there was a falling short of the standards, as a visual field test should have been conducted, the Committee determined that the failure fell below, but not far below, the standards expected of a reasonably competent optometrist. Whilst it was still unsatisfactory, the Committee did not find this allegation to be serious misconduct, but instead non-serious misconduct.

105. The Committee therefore confirm the following findings were made:

- 1.c non-serious misconduct due to delay in referral
- 3a.ii found not to be misconduct
- 3a.iv non-serious misconduct due to failing to conduct binocular vision test on Patient 20
- 3b.ii non-serious misconduct due to failing to conduct binocular vision test on Patient 21
- 3.c.i non-serious misconduct due to failing to conduct visual field test on Patient 23

106. The Committee considered the case of *Schodlok* and the subsequent case of *Ahmedsowida* further to the findings noted above. It was not satisfied that there was sufficient volume or similarity in the findings of non-serious misconduct which would cause it to conclude that the cumulation of these instances amounted to an escalation in seriousness sufficient to become serious misconduct.

107. The Committee determined that the Registrant had breached the following standards:

- Standard 7: Conduct appropriate assessments, examinations, treatments and referrals.
- Standard 7.2: Provide or arrange any further examinations, advice, investigations or treatment if required for your patient. This should be done in a timescale that does not compromise patient safety and care.
- Standard 7.5: Provide effective patient care and treatments based on current good practice.
- Standard 17: Do not damage the reputation of your profession through your conduct.
- Standard 17.1: Ensure your conduct, whether or not connected to your professional practice, does not damage public confidence in you or your profession.

108. The Committee therefore found the facts at matters 1.a, 1.b and 1.d amounted to serious misconduct.

Change to the number of Committee members

109. At the start of Day 6, on Monday 11 March 2024, for reasons entirely unconnected with this case, the optometrist Committee member Ms Shaw was unable to continue for the remainder of the case. The Committee invited submissions from the parties as to whether to continue with the substantive hearing.

110. The Committee heard and accepted the advice of the Legal Adviser, namely that *Rule 25 in the Schedule of the General Optical Council (Committee Constitution Rules) Order of Council 2005 (the Schedule)* allowed it to continue to sit as it remained quorate.

111. Ms Adeyemi for the GOC made reference to an apparent contradiction in the *Schedule,* namely that *Rule 22* stated that there should be two registered optometrists and three lay persons, yet *Rule 25* seemed to indicate that the Committee can proceed with a 'quorum' of one registered optometrist or registered dispensing optician and two lay persons.

112. Mr Hall for the Registrant made no submissions and confirmed that the Registrant had no objections. Mr Hall submitted that the Registrant would still consider the proceedings to be fair, in the public interest, and in the interests of efficiency to continue.

113. The Committee deliberated and decided to continue. Following this, the Committee consisted of three lay panel members and one optometrist member.

Impairment

114. The Committee went on to consider whether the Registrant's fitness to practise is currently impaired by virtue of his misconduct.

115. Ms Adeyemi for the GOC submitted that the Committee should have regard to para 16.1 to 16.7 of the *Guidance*. Ms Adeyemi acknowledged that the Registrant has made some positive steps to address the concerns. However, Ms Adeyemi submitted that there were gaps which might lead the Committee to conclude that the Registrant is currently impaired. In particular Ms Adeyemi stated that the Registrant had deflected blame and attributed his delays in making referrals to the set-up of the store. In paragraph 15 of the Registrant's first statement dated 27 February 2024 the Registrant stated:

"*When I worked at [redacted] I worked there from January to September 2022. Person A was my manager. The local arrangement was that the referrals would be placed on Person A's cabinet next to her desk. I did so at the end of each day. I did that every day except when maybe once or twice when I was unable to. This occurred when the store had been very busy with patients and I had been engaged with patient care all day. I was unable to stay on the premises beyond 5.30pm because the doors were locked and the staff responsible for locking the premises would not stay. On one occasion I was locked in the store and a security guard had to let me out. This occasionally led to a build-up in my paperwork and led to the delays identified in the allegations.*"

Ms Adeyemi submitted that the Registrant's failure to mention these factors when discussing the subject matter resulting in the allegations with his practice manager should cause the Committee concern about his lack of insight and his deflection of blame. Ms Adeyemi submitted that based on the evidence available, the issues are the Registrant's time management and motivation. Whilst the Continuing Professional Development (CPD) courses the Registrant had completed were positive, they do not address these factors. Ms Adeyemi submitted that there is insufficient evidence that the Registrant won't repeat these behaviours if personal issues were to arise again in the future. Ms Adeyemi submitted that it would be appropriate to find impairment as the misconduct related to a core aspect of practice, that of referrals, and therefore a potential risk of harm to the patients, which would cause a member of the public to be concerned.

116. Mr Hall for the Registrant submitted that the Committee should not make a finding of current impairment. Mr Hall outlined that when considering impairment, it is not a punitive exercise looking back, but an assessment of fitness to practise at a current moment and also forward looking. Mr Hall outlined the Registrant's career history, reminding the Committee that the Registrant qualified in 2006, and broadly speaking, has worked full time since then, until his contract was terminated in

September 2022 due to these proceedings. The Registrant had continued to work "without restrictions" and was currently working full time at Asda in [redacted].

117. Mr Hall submitted that there were three reasons why the Registrant should not be found to be currently impaired when considering the issue of the protection of the public:

    a. The Committee should not consider whether the Registrant was making inadequate/inappropriate referrals as that is not the nature of the allegation, but it is the delay that should be considered. To that extent, the Committee are considering three instances of late referrals over a nine month period with no patient harm. The Registrant had already started to remediate his behaviour by September 2022, and Mr Hall reminded the Committee of the evidence Person C and Person A in submitting that there was an immediate change to the Registrant's work, so much so that the practice manager had even made enquiries as to whether it would be possible to divert this matter away from the General Optical Council to become a performance review. However, it was not deemed possible by that stage.

    b. Mr Hall submitted that the Registrant had shown insight, and had not tried to minimise or deflect his behaviour. The Registrant had clearly admitted the allegations, expressed remorse for his poor behaviour, explained that he felt 'bad' and realised his failings had been fundamental to the values of patient safety and confidence. The Registrant had also put into practice procedures to prevent a recurrence of such behaviour. Those procedures included, as outlined in the Registrant's second statement, booking the last thirty minute slot off to complete paperwork, and making good use of the computerised system in Asda to ensure timeliness of referrals. Mr Hall submitted that insight is difficult to demonstrate but that the Registrant had done so in his own words in his statement as best he could. Mr Hall submitted that the Registrant had, in those words, demonstrated insight, reflection, remorse and contrition.

    c. Mr Hall submitted that there was no real risk of repetition. The Registrant has continued to practice in full time employment since September 2022 without restriction or incident. The three late referrals need to be seen in context of starting in 2006, an almost twenty year career, where there was no history of disciplinary or regulatory findings. Mr Hall took the Committee through the numerous CPD courses the Registrant has completed, summarising that the Registrant has completed twenty-seven of the thirty-six CPD points required, and still has the rest of this year to complete the remaining nine. Mr Hall submitted that the misconduct found was uncharacteristic of the Registrant which was reflected in all of the positive testimonials provided for this hearing.

118. Mr Hall submitted, in relation to the public interest grounds, that a fully informed member of the public who had been present during the hearing, who had noted the Registrant's engagement, read his reflections, seen the CPD courses the Registrant had completed, seen that the Registrant had remained in work

without any issues, and considered his previous unblemished nearly twenty years in practice, would not expect a finding of impairment on public interest grounds. Mr Hall concluded that the Registrant's engagement in the proceedings was a tribute to him, and the published findings of these proceedings will themselves meet the public interest requirement. Mr Hall invited the Committee to consider first that the Registrant was not impaired. Mr Hall submitted that he may address the Committee on whether a warning might be a suitable sanction in due course.

119. The Committee heard the advice of the Legal Adviser in relation to impairment. The Legal Adviser outlined the relevant factors for the Committee to consider when determining impairment, taken from the *Guidance Rules 16.1 to 16.7.* In addition, the Legal Adviser drew the Committee's attention to the following cases.

120. *Cohen v GMC (2008) EWHC 581* The Committee should be aware that not every case of misconduct results in a finding of impairment. Being impaired must take account of the need to protect the individual patient, and the collective need to maintain the confidence of the public in the profession. The public interest includes amongst other things the protection of patients, maintenance of public confidence in the profession as well as declaring and upholding proper standards of conduct and behaviour.

121. *Yeong v General Medical Council [2009] EWHC 1923* finding of impairment may be necessary to reaffirm clear standards of professional behaviour to maintain public confidence in profession.

122. *CHRE v Grant (2011) EWHC 927*. In determining impairment, the Committee should consider whether the Registrant's misconduct indicates any risk of harm to patients, breach of a fundamental tenet of the profession, bringing it into disrepute or dishonesty: It must consider any future risks. Questions to be asked may include the following:

    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; and/or

123. *GMC v Chaudhury (2017) EWHC 2561* reminds regulators of the importance of the overarching objective (in this case the protection of the public) and the need for a proper balancing exercise of considering the public interest test. The Committee must decide each case on its merits.

124. Finally, the Legal Adviser advised that the Committee could consider here the personal testimonials as to insight, the risk of repetition, and whether a finding of impairment was required at all on public grounds. At the impairment stage, there

is no burden or standard of proof. It was a question of judgement for the Committee alone.

125. The Legal Adviser also summarised all of *paragraph 20* of the *Guidance* to advise the Committee on its powers to consider a warning in the event that it was to make a finding of no impairment.

126. The Committee accepted the advice of the Legal Adviser. The Committee took account of the *Rules,* the *Guidance* and the *Standards, and* considered the submissions of both parties, as well as all of the documentation, including the Registrant's own statements and references submitted on his behalf. The Committee noted that only following a finding of no impairment would it then consider legal advice in relation to whether a Warning was appropriate, having heard parties' submissions in that regard.

127. The Committee determined firstly that the misconduct found against the Registrant was remediable. The Committee determined that allegations 1.a, 1.b and 1.d, whilst they do amount to misconduct, were not a 'fundamental tenet of the profession' such as in a case of dishonesty. The matters for which misconduct were found, despite their repetition, did not demonstrate that the Registrant had a poor or deep-seated attitude towards his work. The testimonials provided to the Committee evidence a lengthy unblemished previous history of approximately eighteen years in the profession, with further references which cover the period of time after the allegation as well as the up-to-date position with regards to the Registrant's behaviour.

128. The Committee then considered whether the conduct of the Registrant had been remedied. The Committee had careful regard to the Registrant's own statement and found this to be authentic. The Committee was satisfied that there was demonstrable evidence that the Registrant had addressed the misconduct. The Committee noted that the Registrant's behaviour immediately following the decision to terminate his contract demonstrated this, and had regard to paragraph 23 in the witness statement of the practice manager at Boots:

"*During this meeting Mr Malik explained to me that this was the 'kick up the backside' he had needed to set himself straight and realise what needs to be done. For the next two weeks, myself and the team noticed an improvement in referrals being sent on the day of the eye exam which I then fed back to Person C to advise him if there was anything we could do to support Mr Malik to perhaps extend his period to see if he would keep this up, or if it was just a brief period. Respectfully, the decision had already been made …"*

The Committee also considered the comments of Person C at para 30:

"Shortly after the decision to terminate, I was informed via a Microsoft Teams message from [Person A], of an immediate change to Mr Malik's work – that his work in store has improved, and she asked if he could be reinstated and a performance review plan be put in place to monitor. After I received the Teams message from Person A, I discussed this with Person B. I then responded back

to Person B that the decision by Professional Services had already been made and their standpoint was unchanged."

129. The Committee was satisfied that the Registrant had continued to take steps to remedy his conduct, namely that since this misconduct, the Registrant had remained in practice for a substantial period of time without further incident, and further that the Registrant fully engaged with the GOC Fitness to Practise process. It noted that the Registrant also had his locum contract terminated at the time of the allegations. The Registrant did not deny any allegations found proved but made full admissions. The Committee was reassured that the Registrant remained in employment and the Committee had not been advised of any further concerns. For the above reasons, the Committee was satisfied that the Registrant had remedied his conduct.

130. The Committee went on to consider whether the behaviour is likely to be repeated. The Committee was best assisted by the Registrant's own actions in this regard. From his first statement dated 27 February 2024, the Committee noted that the Registrant had, since becoming aware of the allegations, changed his practice by refusing to have any appointments in the last half an hour of the day, which enables him to check his paperwork and ensure no further delays. Further, the Committee considered the Registrant's second and more detailed statement which confirmed that the Registrant has taken a number of further steps to avoid this misconduct reoccurring, namely, starting a locum day early to meet with the store manager and using the Asda computerised records and referral systems. The Committee had regard to the Registrant's relevant efforts to maintain his CPD outlined in detail in his second statement dated 5 March 2024.

131. The Committee considered all of the Registrant's testimonials and the positive reflections within. The Committee noted that these contained references for the period both before and after the allegations were made. The Committee noted the Registrant's previous unblemished record.

132. The Committee also had regard to the [redacted] issues the Registrant was facing at the time of the misconduct and determined that the Registrant had been reassuringly open in this regard. The Committee was satisfied that the Registrant had showed insight into his behaviours, particularly outlined in his second statement, which reassured the Committee that the Registrant is unlikely to repeat the same mistakes again. The Committee noted the short timeframe of the allegations against the rest of the Registrant's time in practice. The Committee accordingly determined that the conduct was not likely to be repeated.

133. The Committee considered the overarching objective of the GOC, namely the protection of the public, and that in pursuing that objective the Committee should have regard to both the protection of the patients and to maintain public confidence in the profession. The Committee had determined that the Registrant's conduct is remediable, has been remedied and is not likely to be repeated. The Committee took into account the advice in respect of the case of *Grant and* was satisfied that in the particular circumstances of this case, the public interest did not require a finding of impairment on that ground alone.

134. For the above reasons, the Committee found that the fitness to practise of the Registrant was not currently impaired.

Submissions on Warning

135. The Committee invited submissions from the parties in respect of whether a Warning should be imposed following the finding that the Registrant is not currently impaired in respect of the allegations.

136. Ms Adeyemi for the GOC invited the Committee to use its power set out in *Section 13F(5) of the Opticians Act 1989* to issue a Warning against the Registrant. Ms Adeyemi outlined the *Guidance* at *para 20.4,* namely that:

"Warnings allow the FtPC to indicate to a registrant that certain behaviour, conduct, or practice represents a departure from the standards expected of its registrants and should not be repeated. Further, they highlight to the wider profession that certain behaviour or conduct is unacceptable."

137. Ms Adeyemi submitted that the misconduct found in relation to this Registrant related to core aspects of his work i.e. late referrals, with a potential to cause harm to patients and was therefore serious. Ms Adeyemi submitted that it would be appropriate to highlight this misconduct to the wider profession, as it endangered patients, was not acceptable and must not be repeated.

138. Mr Hall submitted that the overarching reason for not imposing a Warning in this case was that it was not necessary. Mr Hall submitted that giving a Warning is not the default position where no impairment was found. Mr Hall stated that the Committee had already concluded that the Registrant has remediated, that he did so almost immediately and that he poses "no risk" to the public with no risk of repetition. Mr Hall therefore submitted that the public interest was accordingly not engaged.

139. Mr Hall referred to *para 20.4* of the *Guidance* and submitted that for a Warning to be necessary, there should be a departure from the *Standards* which should not be repeated. Mr Hall stated that the Committee had already satisfied themselves that there was no risk of repetition. Mr Hall also referred to *para 20.5* when he submitted that the misconduct in this case was not sufficiently serious to require a formal response.

140. Mr Hall further outlined the *Guidance* at para 20.2:

"*A warning does not directly affect a registrant's ability to practise or undertake training but is published on the Council's website and disclosed if anyone enquires about the registrant's fitness to practise history."*

141. Mr Hall submitted that a Warning would have a punitive effect on the Registrant. Mr Hall stated that the Registrant has already suffered a punitive effect by the proceedings themselves which would serve as a Warning. The

Registrant has also missed seven days of paid employment to engage with these proceedings.

142. Mr Hall submitted that the Committee had already found that the misconduct had been remediated. This was demonstrated in the quick behavioural change after feedback was given to the Registrant and the systemic measures the Registrant had put in place, both of which occurred without the necessity of a Warning. Mr Hall submitted that this was not a case of serious misconduct due to the narrow timeframe of the three late referrals, the lack of patient harm and that the public interest test had not been met for impairment.

143. Mr Hall referred to the *Guidance at para 20.7*, namely:

20.7 If the Committee are satisfied that the registrant's fitness to practise is not impaired, they can take account of a range of aggravating or mitigating factors to determine whether a warning is appropriate, having regard to the public interest as part of their considerations. These might include:

a. Genuine expression of regret/apology;

b. Acting under duress;

c. Previous good history;

d. Appropriate rehabilitative/corrective steps have been taken; and

e. Relevant and appropriate references and testimonials.

144. Mr Hall submitted that all of these mitigation factors were present. He continued that there was a genuine expression of regret from the Registrant and that due to his [redacted] circumstances he was, to some extent, acting under duress. Mr Hall outlined the Registrant's previous good history and continued good history. The Registrant had also taken appropriate rehabilitative and corrective steps in the systemic changes he had put in place and his quick changes to his own employment procedures. Mr Hall also referred to the relevant references and testimonials supplied by the Registrant.

145. Finally, in response to a question from a Committee member, Mr Hall concluded in his submissions that although a Warning would, according to *para 20.4* of the *Guidance "highlight to the wider profession that certain behaviour or conduct is unacceptable,'* it was not necessary in this case as it was not behaviour which was so unacceptable, or so serious that a warning would be necessary.

146. The Committee did not hear further legal advice from the Legal Adviser in addition to the advice given on Warnings previously. All parties agreed to proceed on the basis of the previous advice on Warnings given.

147. During its deliberations the Committee returned into public session in order to invite the parties to make any submissions in respect of the length of any Warning, should one be imposed. Ms Adeyemi submitted that she was content for the Committee to determine the length of any such order and Mr Hall on behalf of the Registrant submitted it should be for the shortest possible length, and suggested this might be a 12 month period. The Legal Advisor advised the

Committee that there were no maximum periods set in the *Guidance.* The Committee accepted the advice of the Legal Adviser and returned to continue its private deliberations.

Decision on warning

148. The Committee took account of the *Rules,* the *Guidance* and the *Standards,* and considered the submissions of both parties, as well as the documentation, including the Registrant's own statements and the references submitted on his behalf. The Committee accepted the advice of the Legal Adviser.

149. The Committee considered the aggravating and mitigating factors in this case as suggested at *para 20.7* of the *Guidance.* In relation to mitigating factors, the Committee considered that aside from *para 20.7 b),* all of the mitigating factors were present in this case. The Committee acknowledged the Registrant's expression of regret, his previous good history, the appropriate rehabilitative steps and the supportive references and testimonials.

150. The Committee also took into account the factors at *Para 20.6* of the *Guidance:*

20.6 Factors when a finding of no impairment has been made and a warning may be appropriate:

a. A clear and specific breach of the Standards of Practice.

b. The particular conduct, behaviour, or performance approaches, but falls short of the threshold for current impairment.

c. Where the concerns are sufficiently serious that, if there were a repetition, they would likely result in a finding of impaired fitness to practise.

d. There is a need to record formally the particular concern(s).

151. The Committee did find the conduct to be a clear and specific breach of the *Standards.* The Committee also considered the aggravating factors. There were three separate instances of delay of urgent referrals, each one of which carried a potential risk of significant harm. The Committee determined that each instance was serious misconduct. The Committee also found that the particular conduct approached, but fell short of the threshold for current impairment. However, the Committee did determine that these concerns were sufficiently serious and, if there were a repetition, they would likely result in a finding of impaired fitness to practise. Consequently, the Committee determined that there was a need to record formally the particular concerns.

152. The Committee also determined that whilst its decision on impairment recorded a low risk of repetition, it did not record "no risk" of repetition. The Committee determined that the Registrant's conduct represented a departure from the standards expected of GOC registrants and should not be repeated under any circumstances. Further, the Committee determined that it was necessary to highlight to the wider profession that certain behaviour or conduct was

unacceptable. The Committee found that the behaviour did go to the core aspects of the Registrant's work, namely delay of urgent referrals. The Committee found that this had a potential to cause significant harm to patients and was therefore serious. The Committee deemed it appropriate for this behaviour to be highlighted to the wider profession as it endangered patients, was not acceptable and must not be repeated.

153. Further, the Committee found that the conduct would result in an adverse effect on public confidence in the profession as it represented a serious departure from the Standards expected.

154. The Committee recognised the mitigating steps taken by the Registrant. The Committee however concluded that a Warning to be imposed for a period of 12 months would be the most appropriate measure to avoid any repetition of the misconduct. The Committee decided that this was also a proportionate period to uphold public confidence in the profession, and maintain professional standards, whilst also reflecting the seriousness of the misconduct.

155. The Committee therefore imposed a Warning for 12 months on the Registrant in the following terms:

"The Committee warns you that the misconduct found proved did not meet the standards required of a professional optometrist. The required standards are set out in the Standards of Practice and associated guidance issued by the General Optical Council. You are specifically reminded to adhere to Standards :

- *7: Conduct appropriate assessments, examinations, treatments and referrals.*
- *7.2: Provide or arrange any further examinations, advice, investigations or treatment if required for your patient. This should be done in a timescale that does not compromise patient safety and care.*
- *7.5: Provide effective patient care and treatments based on current good practice.*
- *17: Do not damage the reputation of your profession through your conduct.*
- *17.1: Ensure your conduct, whether or not connected to your professional practice, does not damage public confidence in you or your profession.*

Any further matters brought to the attention of the regulator may result in a more serious outcome. This Warning will expire on 13 March 2025."

Chair of the Committee: Valerie Paterson

Signature **Date: 12 March 2024**

Registrant: Baber Malik

Signature ……present via video conference…….**Date: 12 March 2024**

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.
Contact
If you require any further information, please contact the Council's Hearings Manager at 10 Old Bailey, London, EC4M 7NG or, by telephone, on 020 7580 3898.