BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(22)30

AND

GARETH LONG (01-24213)

DETERMINATION OF A SUBSTANTIVE HEARING
20-30 NOVEMBER 2023 and 21-23 FEBRUARY 2024

Committee Members:	Rachel O'Connell (Chair/Lay) Mark McLaren (Lay) Asmita Naik (Lay) Gaynor Kirk (Optometrist) Denise Connor (Optometrist)
Clinical adviser:	N/A
Legal adviser:	Mike Bell (20 – 29 November 2023) Jennifer Ferrario (for 29 and 30 November 2023) Alice Moller (21-23 February 2024)
GOC Presenting Officer:	Matthew Corrie
Registrant present/represented:	Yes and represented
Registrant representative:	Christopher Saad (Counsel) Nan Mousley (AOP)
Hearings Officer:	Arjeta Shabani
Facts found proved:	1-5
Facts not found proved:	None
Misconduct:	Found for particulars 2,3, 4 and 5
Impairment:	Impaired
Sanction:	Suspension Order – 4 months (Without Review)

ALLEGATION

1. The Council alleges that in relation to you, Gareth Long (01-24213), a registered optometrist, whilst employed at [redacted] Newcastle under Lyme:

   1. On or around 14 December 2021 you:

      a. Did not verify Patient A's identity prior to the consultation taking place;

      b. Advised Patient A that he had cystoid macular oedema when he did not have cystoid macula oedema.

   2. On 14 December 2021 on or around 9.36 pm you inserted additional notes onto Patient A's record for 14 December 2021 including:

      a. That you had discussed the YAG capsulotomy with Patient A

      b. "Regarding the note stating, 'cystoid macular oedema' that Patient A had presented to his wife: I am not certain where this came from"

      c. "I did see another Patient ("Patient X") immediately after Patient A who I diagnosed with cystoid macular oedema, and this Patient asked me to write the name of the condition down for him";

      d. "I did note that as I handed the Patient this note as requested, he was sat next to Patient A in the waiting area;

      e. "It occurs to me that Patient A may have picked up paperwork belonging to this other Patient whilst in the waiting area"

      f. "Patient A was confused about the reason for his visit today".

3. The records referred to at 2 a – f above were inaccurate and/or misleading in that:

   a. In relation to 2 a, you discussed cystoid macular oedema with Patient A and not the YAG capsulotomy

   b. In relation to 2 b you had written the note for Patient A;

   c. In relation to 2 c it was Patient A and not Patient X who had asked you to write the note;

   d. In relation to 2 d Patient A and Patient X had not been sat next to each other in the waiting area;

   e. In relation to 2 e you had provided the note to Patient A;

   f. In relation to 2 f Patient A was not confused about the reason for his visit in that he understood his visit was for a YAG capsulotomy.

4. You recorded that it would be wise for Patient A to be accompanied by a chaperone and to use a dual consent form for any further Tx required when a chaperone and/or a dual consent form was not indicated.

5. Your conduct at 2a–f and/or 3a–f was dishonest in that:

   a. You knew the record was inaccurate and/or misleading; and/or

   b. You made the additional record in order to conceal that you had incorrectly advised Patient A that he had cystoid macula oedema.

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

DETERMINATION

Admissions in relation to the particulars of the allegation

2. The Registrant admitted particular 2 of the allegation in totality.

Background to the allegations

3. The Registrant is a registered optometrist who was, at the time of the allegation, employed by [redacted] as a hospital optometrist. As part of this role the Registrant carried out assessments of patients and procedures in relation to cataract surgery.

4. In the summer and early autumn of 2021 Patient A had undergone cataract surgery on both eyes at [redacted]. Complications had arisen from the procedure in relation to his right eye and he was referred back to [redacted] by his community optometrist for investigation.

5. On 22 June 2021 the Registrant examined Patient A and diagnosed a non-significant cataract in the right eye and a 1 + cortical cataract and a 1+ posterior subcapsular cataract in the left eye.

6. On 5 July 2021 Patient A had cataract surgery on his left eye. On 22 July 2021 Patient A attended a follow up appointment complaining of pain, photophobia and aching and was prescribed steroid drops. On 31 August 2021 Patient A attended a further follow up appointment and was discharged. On 21 September 2021 Patient A was assessed for right cataract surgery and on 1 October 2021 Patient A underwent right cataract surgery. None of these assessments or procedures were carried out by the Registrant.

7. On 18 October 2021, following a referral from his community optometrist, Patient A was seen by the Registrant. Patient A was recorded as having post operative uveitis and stated that he had right eye blurred vision, his right eye was sore and stinging was worse on instillation of steroid drops. The Registrant prescribed a different steroid drop and suggested a review appointment in around 4 weeks.

8. On 8 November 2021 the Registrant again saw Patient A and recorded that the post operative uveitis had resolved but that Patient A reported blurred vision in his right eye and that his community optometrist had not been able

to achieve any improvement on refraction. Patient A's record stated that some right eye posterior capsule opacification was noted and the treatment plan was for a YAG capsulotomy once the current course of drops had been completed.

9. On 26 November 2021 Patient A travelled to Birkenhead for an appointment arranged by [redacted] at which he understood he would have YAG laser treatment. Laser treatment was not completed as it was too soon after the surgery.

10. On 7 December 2021 Patient A again attended an appointment with the Registrant. The notes record that Patient A reported increasingly blurred vision in his right eye. Further, they record that there was significant right eye posterior capsule opacification and the Registrant confirmed that Patient A would benefit from a YAG capsulotomy. The Registrant noted that the risks and benefits were discussed and he offered to carry out the procedure that day but this was declined by Patient A.

11. On 14 December 2021 Patient A attended for a YAG capsulotomy and was due to be seen by the Registrant. It is alleged that Patient A was called in to the consultation room by the Registrant and duly reported that he was experiencing the appearance of a light shining down to the floor in his right eye. It is further alleged that the Registrant examined Patient A and explained to Patient A that he had a right cystoid macular oedema. Patient A states that he was told that he would be prescribed some medication for this and to go and wait outside for his medication. Patient A says that as he had been expecting laser surgery he then asked the Registrant to write down the condition he had been diagnosed with. He says the Registrant wrote down the name of the condition on a piece of paper.

12. It is alleged that whilst Patient A was waiting for his medication the Registrant came through the reception doors and walked past him calling Patient A's name, that Patient A stood up and said that he was there and told the Registrant that he had just been seen by him. It is alleged that the Registrant ushered Patient A into the YAG treatment room, seemed agitated and said he was going to do laser. It is alleged that Patient A took out the piece of paper and asked why he was having laser treatment when shortly before he had been told he did not need laser and the Registrant said '*forget that*' and that he was going to do laser. Thereafter, the procedure was completed.

13. It is alleged that after Patient A left the clinic he met Person A in the car park and told her what had happened in the clinic and showed her the piece of paper. It is alleged Person A then went into the clinic and raised concerns with the hospital manager.

14. It is also alleged that at 9.36pm on 14 December 2021 the Registrant made additional notes on Patient A's record that were inaccurate and alleged to be an attempt to conceal that he had advised Patient A that he had cystoid macula oedema when he did not.

15. Following the consultation a complaint was made by Patient A to [redacted]. [redacted] carried out an internal investigation into what had occurred at the consultation and into the additional notes made by the Registrant at 9.36pm on 14 December 2021.

Application to hold the hearing partially in private

16. During the course of Patient A giving evidence reference was made by him to a [redacted].

17. Mr Corrie therefore applied to have any matters relating to Patient A's [redacted] in private in terms of Rule 25 (2) of the Fitness to Practise Rules of 2013 (the Rules). Mr Saad did not object to the application.

18. The Committee accepted the advice of the Legal Adviser who referred it to Rule 25.

Rule 25 (2) states:

(2) The Fitness to Practise Committee may determine that the proceedings, or any part of the proceedings, are to be a private hearing, where the Committee consider it appropriate, having regard to—

1. *(a) the interests of the maker of an allegation (where one has been made);*
2. *(b) the interests of any patient or witness concerned;*
3. *(c) the interests of the registrant; and*
4. *(d) all the circumstances, including the public interest.*

19. The Committee determined that it was in the interests of Patient A for any matters relating to his [redacted] to be heard in private and this outweighed any public interest.

20. The Committee therefore decided that the hearing would be heard in private in relation to all matters relating to Patient A's [redacted].

21. Prior to the Registrant giving evidence Mr Saad indicated that during his evidence matters relating to the Registrant's [redacted] might arise and applied for these to be heard in private for similar reasons to those set out above. Mr Corrie did not object to the application.

22. The Committee accepted the advice of the Legal Adviser as set out above.

23. The Committee determined that it was in the interests of the Registrant for any matters relating to his [redacted] to be heard in private and this outweighed any public interest.

24. The Committee therefore decided that the hearing would be heard in private in relation to all matters relating to the Registrant's [redacted].

Application to Amend the Allegation

25. Prior to closing submissions Mr Corrie applied to delete the words '*and/or misleading'* where they occurred in the stem of particular 3 and particular 5 a. He explained that after discussion with Mr Saad it had been accepted that the use of this term was essentially duplicating the word '*inaccurate'* which occurred immediately prior to the words sought to be deleted in both

particulars. Mr Corrie submitted the words he sought to be deleted were unnecessary.

26. Mr Saad stated that he was neutral on the application.

27. The Committee accepted the advice of the Legal Adviser who referred it to Rule 46(20) and advised the Committee to consider if the proposed amendment was in the interests of justice and fair.

Rule 46 (20) states:

'(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—

1. *(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*
2. *(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.'

28. The Committee considered the proposed amendments could be made without injustice to any party and was in the public interest.

29. It therefore amended the particulars of the allegations as set out below.

3. The records referred to at 2 a – f above were inaccurate ~~and/or misleading~~ in that:

   a. In relation to 2 a, you discussed cystoid macular oedema with Patient A and not the YAG capsulotomy

   b. In relation to 2 b you had written the note for Patient A;

   c. In relation to 2 c it was Patient A and not Patient X who had asked you to write the note;

   d. In relation to 2 d Patient A and Patient X had not been sat next to each other in the waiting area;

   e. In relation to 2 e you had provided the note to Patient A;

   f. In relation to 2 f Patient A was not confused about the reason for his visit in that he understood his visit was for a YAG capsulotomy.

5. Your conduct at 2a–f and/or 3a–f was dishonest in that:

   1. You knew the record was inaccurate ~~and/or misleading~~; and/or

   2. You made the additional record in order to conceal that you had incorrectly advised Patient A that he had cystoid macula oedema.

Findings in relation to the facts

30. The Committee heard evidence in person from Patient A, Person A, Witness A and the Registrant.

31. Patient A told the Committee of the background to his consultation with the Registrant on 14 December 2021 and what he recalled had occurred at the consultation. He also explained what he had told his wife immediately following the consultation, how he later learnt of the additional note in his records and the complaint that had been made to [redacted]. Patient A also explained to the Committee the effect that the events of the 14 December 2021 had upon him.

32. Person A told the Committee about her prior involvement in attending at hospital with her husband and her knowledge of what had occurred when he attended at [redacted] on 14 December 2021. She also told the Committee of her involvement in the subsequent complaint and her perception of the effect that the events of 14 December 2021 had had upon Patient A.

33. Witness A explained to the Committee her position and responsibilities within [redacted]. She explained how she had become aware of the complaint made by Patient A and the nature of the investigation she had undertaken. She further explained how the CCTV evidence before the Committee had been obtained and how the timeline produced by her had been collated.

34. The Registrant told the Committee of his academic and professional background. He set out his interaction with Patient A in a clinical capacity prior to 14 December 2021. The Registrant also told the Committee his recollection of what had occurred during the consultation and subsequent to it on 14 December 2021. The Registrant explained what he recalled had occurred in relation to the YAG laser treatment and the circumstances of writing the additional notes on Patient A's record. The Registrant also told the Committee about [redacted] concerns.

35. <u>Submissions</u>

36. Mr Corrie submitted that the burden of proof was on the GOC and that the standard of proof was that of the balance of probabilities.

37. Mr Corrie submitted that the central issue of the case was whether or not the Registrant had advised Patient A that he had cystoid macular oedema. He further submitted that the case was one where it was essentially Patient A's word against the Registrant's and that parties' credibility was a central issue.

38. Mr Corrie submitted that Patient A was truthful and reliable and had been consistent in his evidence. Mr Corrie accepted that Patient A suffered from [redacted] difficulties but that there was no evidence that his [redacted] difficulties had impaired his communication on 14 December 2021. He further submitted that the Registrant had stated in evidence that he was experienced in dealing with patients with [redacted] and took measures to ensure that he could communicate with them. He also submitted that there was nothing in the records to suggest that the Registrant had concerns about Patient A's [redacted] on 14 December 2021.

39. Mr Corrie also accepted that Patient A had left the hearing room during his evidence but submitted that the Committee should take into account giving evidence was an unfamiliar and difficult process. He said that the important point was that Patient A had returned to complete cross examination and that his evidence had been tested.

40. Mr Corrie submitted that Patient A had immediately told his wife what had occurred at the consultation when he met her outside the hospital and that what had occurred had been a significant event in his life.

41. Mr Corrie referred the Committee to the note produced by Patient A which had '*right cystoid macular oedema'* written on it, the CCTV and timeline evidence, the prescription request for Patient X and Patient X's clinical records. He submitted that when these were considered along with the evidence of Patient A and Person A, whilst it might seem unlikely that a clinician would make a mistake, mistakes did happen and that the plausible explanation for what had occurred was that the Registrant had got mixed up when dealing with Patient A and Patient X.

42. Mr Corrie submitted that if the Committee accepted Patient A's evidence it should find particular 1 a and b proved.

43. Mr Corrie noted that the Registrant had admitted particular 2 in totality.

44. Mr Corrie took the Committee through each limb of particular 3 and identified the evidence he said supported his position that the additional notes in the records were inaccurate. He noted that the Registrant had accepted particular 3 c and d during the hearing and also accepted that he did write the note for Patient A.

45. In relation to particular 4 Mr Corrie submitted there was no evidence that Patient A had any issue with capacity and that this was now accepted by the Registrant.

46. Mr Corrie referred the Committee to the case of *Ivey v Genting Casino (UK) Ltd [2017] UKSC 67* and the test for dishonesty set out therein.

47. Mr Corrie submitted it was simply implausible that the Registrant had not realised he had made an error given that the writing of the note for Patient A was so unusual and also that Patient A then produced the note when the Registrant called Patient A in for laser treatment.

48. Mr Corrie also submitted that, even if the Registrant was not aware of the exact nature of any complaint on 14 December 2021, he was aware that concerns had been raised.

49. Mr Corrie submitted that it was therefore implausible that the Registrant would not have recalled this when he made the additional record at 9.36pm on 14 December 2021. Mr Corrie submitted that the only plausible explanation was that the Registrant had made the additional note to conceal his errors and that this was dishonest by the standards of ordinary decent people.

50. Mr Saad submitted that there were two explanations for what had occurred. The first was that the Registrant had provided appropriate treatment and diagnosis and something had put him and Patient A at cross purposes. The

second was that the Registrant had misdiagnosed Patient A and sought to cover it up.

51. Mr Saad submitted that the Registrant was softly spoken and that Patient A being [redacted] had misheard him. Patient A had then spoken to his wife after the appointment. Mr Saad submitted that both Patient A and Person A were already unhappy with [redacted] treatment of Patient A and after Patient A had discussed the consultation with Person A she had gone into the hospital and raised concerns with the hospital manager. He said that matters had then ‘snowballed’ from there.

52. Mr Saad referred the Committee to the positive references produced on behalf of the Registrant and submitted that the Registrant was a good clinician. He said that the Registrant had treated Patient A on a number of occasions prior to 14 December 2021 and that he had recognised Patient A when he saw him on that date and asked him into his consulting room by name. Mr Saad said the Registrant examined Patient A's eye, confirmed it was safe to proceed with laser treatment and conducted that treatment.

53. Mr Saad submitted that the GOC case was extremely convoluted and the suggestion that somehow the Registrant had mixed up Patient A with another patient was unlikely. He referred the Committee to the evidence which he submitted supported this position.

54. In relation to the Registrant making additional records at 9.36pm on 14 December 2021, Mr Saad submitted that the Registrant had been previously diagnosed with [redacted] and that this may have impacted on his actions that evening. He submitted that the Registrant made the additional record trying to piece together what had happened that day after becoming concerned about what had occurred and worrying about it when he got home.

55. Mr Saad submitted there were contradictions in Patient A’s evidence – for example he had said that his [redacted] was better in 2021 than now yet Person A had said it had been as bad in 2021. Mr Saad also submitted that Patient A had given evidence that he wouldn’t go against medical advice yet he had stopped taking prescribed medication before the course of medication had been finished.

56. Mr Saad submitted that Patient X had been diagnosed with cystoid macula oedema and been given medication for it by the Registrant. He submitted that Patient A and Patient X presented with distinct and different clinical pictures.

57. Mr Saad submitted that the fact that the Registrant’s account of what occurred did not fit with Witness A’s timeline of the CCTV did not mean the Registrant had acted dishonestly. He took the Committee through the CCTV and set out how it corresponded with the Registrant’s evidence of what had occurred that day.

58. In relation to particular 1 a, Mr Saad submitted that it was unlikely that this had occurred because the Registrant had called Patient A into the consulting room by his name and also submitted that the GOC had not sought to explain what they meant by ‘verify’. Mr Saad also submitted that it was unlikely that the Registrant had advised Patient A that he had cystoid macular oedema when he did not as set out in particular 1 b. He submitted

that had this been the case the Registrant would have told Patient A that he could not proceed with the laser treatment and apologised for another wasted journey.

59. Mr Saad noted that the Registrant had admitted particular 2.

60. In relation to particular 3, Mr Saad stated that the Registrant – having heard and reviewed all the evidence before the Committee - accepted particular 3 c and d may have occurred. Mr Saad re-iterated it was unlikely that the Registrant had acted as set out in particular 3. In respect of 3 a Mr Saad submitted that it was unlikely that this occurred as Patient A had received YAG laser treatment later – the Registrant would not have gone through the process of setting up the laser room and call Patient A in for treatment if he had advised Patient A, he had cystoid macular oedema. Mr Saad submitted that the Registrant's comments referred to in 3 b were merely the Registrant expressing his own doubt when he wrote the additional notes, about where the note had come from. Mr Saad stated that in relation to 3 e the Registrant again accepted this may have occurred. In respect of 3 f Mr Saad submitted that what the Registrant had written reflected his concerns when he reflected on what occurred – for example Patient A asking twice about eye drops – that Patient A might have been confused about what the Registrant had said to him.

61. In respect of particular 4 Mr Saad submitted that the GOC had not defined what the word 'indicated' meant. He said that the Registrant accepted in retrospect that his concerns about Patient A requiring dual consent were incorrect, but at the time it was entirely appropriate for him to express these concerns for future colleagues' reference.

62. In relation to particular 5, Mr Saad submitted that the additional notes in Patient A's record contained speculation by the Registrant as to what might be the explanation for what had happened on 14 December 2021. He stressed that the Registrant was recording what may have happened, what Patient A may have heard and tried to reach a conclusion. He stated that he was not seeking to conceal anything and was not acting dishonestly. Mr Saad submitted the Registrant had nothing to gain from lying about what had occurred.

63. The Committee accepted the advice of the Legal Adviser. He referred the Committee to the cases of *Suddock v NMC* [2015] EWHC 3612 (Admin), *Dutta v GMC* [2020] EWHC 1974 (Admin), *Khan v GMC* [2021]EWHC 374 (Admin) and *Byrne V GMC* [2021] EWHC 2237 (Admin) in relation to its approach to the assessment of witness evidence and to the case of *Ivey v Gentings Casinos (UK) Ltd* [2017] UKSC 67 in relation to the test for dishonesty. He gave a good character direction in respect of the Registrant.

Committee's Decision

64. The Committee considered each remaining particular of the allegation in turn. In reaching its decision the Committee considered how the relevant witness evidence fitted with the non-contentious or agreed facts, contemporaneous documents, the inherent probability or improbability of any account of events and any consistencies and inconsistencies.

65. In reaching its decision in respect of the remaining particulars of allegation, the Committee took into account all evidence before it. This included the written witness statements and subsequent oral evidence of Patient A, Person A, Witness A and the Registrant, and all relevant documentary evidence, including the testimonials provided on behalf of the Registrant. The Committee also took into account the uncontested CCTV evidence produced by the GOC and all relevant documentation from the GOC and the Registrant. The Committee took into account the Legal Adviser's advice on the Registrant's 'good character'. It also took into account the submissions of Mr Corrie and Mr Saad in respect of all the particulars of the Allegation.

Particular 1

1. *On or around 14 December 2021 you:*

    a. *Did not verify Patient A's identity prior to the consultation taking place;*

66. The Committee noted that both parties agreed that in relation to particular 1 the primary issue was particular 1b. Mr Corrie submitted that if the Committee were to consider 1b first and find it proved that it would follow that the Registrant had not verified Patient A's identity.

67. The Committee considered, that although unusual, it understood the logic of Mr Corrie's assertion.

68. The Committee noted that when it recalled parties and requested further submissions on the approach it might decide to adopt in respect of the use of the words '*verify Patient A's identity'.* Mr Corrie submitted that the GOC's position was that the Registrant '*did not make sure that Patient A was Patient A before carrying out the initial part of the consultation.'* Mr Saad referred to the fact that the Council used the general term 'verify'.

69. The Committee having heard further from parties adopted the interpretation of the particular as suggested by Mr Corrie i.e. that the Registrant had not ensured he had the right patient before him when carrying out the consultation. Aside from calling out Patient A's name, according to Patient A, the Registrant did not ask his date of birth. Furthermore, the timeline suggests that the Registrant had Patient X's electronic records open at or around the time of the consultation with Patient A which indicates that the Registrant saw Patient A at some point between 12.47 and 13.06, that he filed a prescription request for Patient X at 13.03 and that he completed Patient X's record at 13.06.

70. For the reasons fully set out in respect of particular 1 b below the Committee considered that had the Registrant verified Patient A's identity the facts found proved in particular 1 b were unlikely to have occurred.

71. The Committee therefore found, on the balance of probabilities, that on or around 14 December 2021 the Registrant did not verify Patient A's identity prior to the consultation taking place.

72. Particular 1 a is found proved.

Particular 1 b

b. Advised Patient A that he had cystoid macular oedema when he did not have cystoid macula oedema.

73. In considering Particular 1 b the Committee took into account the evidence of Patient A, Person A, Witness A, the Registrant and the CCTV evidence and all relevant documentation.

74. The Committee considered that Patient A's oral evidence before it was consistent with his witness statement to the GOC and the terms of the initial issues raised with [redacted] by Person A on 14 December 2021, the complaint made to [redacted] by Patient A and subsequent correspondence between Patient A and [redacted]. The Committee considered that any inconsistencies in Patient A's evidence were of a minor nature and did not go to the core elements of his evidence in relation to this particular. In particular, the Committee did not consider that the evidence before it indicated that Patient A had at times had doubts about his recollection of what had taken place on 14 December 2021 nor that he was the type of person who wanted to rush through health examinations. The Committee considered that, as with most witnesses, there were minor issues where Patient A may have been unclear or unable to provide an explanation, but noted that where this had occurred, he told the Committee that he could not recall or was unclear and that no such matters related to the core elements of his evidence in relation to this particular.

75. The Committee also took into account that Patient A left the hearing room during cross examination by Mr Saad and that it was some time before he returned to complete his oral evidence. The Committee reminded itself that giving evidence under affirmation in person is an unfamiliar and stressful process for witnesses. It considered that Patient A's leaving the room reflected this stress and concluded that, particularly as he returned to complete his evidence, it was not an attempt to avoid being questioned under cross examination. Further, Patient A did return to the hearing room, Mr Saad was able to complete his cross examination and the Committee was able to ask questions of Patient A. The Committee did not consider that the integrity of the process of the examination of Patient A was adversely affected by his leaving the room and his actions did not undermine the evidence he gave to the Committee.

76. The Committee also took into account that Patient A accepted that he had thought about his memories of what had occurred on 14 December 2021 'again and again'. The Committee determined that this was understandable, given that a complaint had been made, initially to [redacted] and then to the GOC. The Committee did not consider this undermined the evidence Patient A gave to the Committee.

77. The Committee also took into account the inconsistency between Patient A's evidence that his [redacted] difficulty in 2021 was better than it was when he appeared before the Committee and the evidence of Person A that it had been the same in 2021 as it was when he gave evidence. The Committee

considered that Patient A's comments were his personal subjective belief about the state of his [redacted] in 2021 and that this inconsistency again did not undermine the evidence that he gave and that neither Patient A nor Person A were saying that Patient A's [redacted] was better now than on 14 December 2021.

78. Overall, the Committee considered that Patient A was a truthful witness who gave a genuine account of his recollection of events and had been consistent in his evidence in respect of particular 1b.

79. The Committee considered that Person A's oral evidence to the Committee was consistent with the complaint and subsequent correspondence with [redacted and with her statement to the GOC. The Committee considered that she gave her evidence in a straightforward manner and sought to assist the Committee. If she could not recall a matter, she told the Committee this was the case.

80. The Committee considered that Witness A gave her evidence in a professional manner, was straightforward, and spoke clearly about her involvement in the internal investigation process at [redacted]. This included how the CCTV had been reviewed and a timeline produced. The Committee found her evidence credible.

81. The Committee considered that parts of the Registrant's oral evidence were inconsistent with his position during the internal investigation of [redacted], in particular it was inconsistent with the notes of the investigation meetings with him on 31 January and 7 February 2022. The Committee further considered that parts of the Registrant's oral evidence were inconsistent with his witness statement for this hearing dated 6 November 2023. In particular, the Committee noted that the Registrant's recollection of what occurred on 14 December 2021 became much better and significantly more specific in relation to the details of his interaction with Patient A as the Registrant gave his oral evidence. The Committee considered that aspects of the Registrant's oral evidence before it – more specifically as set out below – were inherently implausible.

82. In considering this particular, the Committee addressed the issue of Patient A's [redacted] and his [redacted] on 14 December 2021. The Committee had the opportunity itself to assess Patient A's [redacted] when he gave evidence and it concluded that, whilst he had impairment to his [redacted], it was not such that he could not hear or understand what was being said to him or questions asked of him. In particular, the Committee determined that any [redacted] impairment suffered by Patient A on 14 December 2021 would not have resulted in him not being able to hear or understand anything said to him by the Registrant during the consultation on 14 December 2021. Further, the Committee determined that Patient A's [redacted] impairment did not result in his lacking [redacted] in December 2021. The Registrant himself accepted during his testimony that Patient A had heard him during the consultation on 14 December 2021 and that Patient A did not lack [redacted] at the time.

83. The Committee took into account Patient A's evidence that in the initial consultation the Registrant had asked him if anything new had occurred with his eye and he had explained that it appeared to him that a light was shining down to the floor in his right eye. Patient A stated that the Registrant made

no comment about this but did check his eye. Patient A said that the Registrant then stated that he knew what the problem was, and that Patient A had right cystoid macular oedema. Patient A said that the Registrant told him to go and sit in the waiting area and wait for medication to be brought to him by a nurse.

84. The Committee carefully considered the Registrant's evidence regarding what he said occurred on 14 December 2021. In particular, the Committee considered the Registrant's evidence that he did discuss the condition cystoid macular oedema with Patient A on 14 December 2021, but that he did so in relation to risk factors arising from the YAG laser treatment and that he had tailored this advice to concentrate on those risks that were greater for Patient A. The Committee took into account that the only direct evidence of what was said in the examination room was that of Patient A and the Registrant. However, the Committee also had before it a copy of a note which Patient A had obtained from the Registrant on 14 December 2021, and which had been provided to the GOC. The Committee also noted that during his evidence the Registrant had accepted that this note was in his handwriting and, in contradiction to his prior position, also did not seek to dispute that he had given this note to Patient A. The Committee considered the Registrant's previous position that Patient A may have picked up another patient's note and believed the condition referred to therein applied to himself to be inherently implausible. The Committee reviewed this note and in particular noted that it states, '*Right Cystoid Macular Oedema'*. The Committee found it inherently implausible that this note would specify *right* cystoid macular oedema if the Registrant had been raising cystoid macular oedema as a risk factor when performing YAG.

85. The Committee further determined that, for the reasons set out above in respect of credibility and reliability, it accepted what Patient A had told it in relation to what had occurred when he had his initial consultation with the Registrant. The Committee considered the CCTV evidence before it and the timeline produced by Witness A that was not challenged by Mr Saad. This indicated that Patient A had an initial consultation at some point between 12.47 and 13.06. The Committee noted that there was no record of any initial examination of Patient A in Patient A's notes on 14 December 2021. However, the Committee did note that there was a time stamp of 13.06 on the record of Patient X indicating an entry of a diagnosis of right cystoid macular oedema by the Registrant, while the CCTV and timeline show that Patient X was not seen until 13.23. The Committee also noted that the Registrant had made an electronic prescription request for Patient X at 13.03. The Committee noted the Registrant's explanation for the prescription request that he reviewed Patient X's OCT scans, therefore knew what medication Patient X would require and 'to get ahead' ordered the medication before actually seeing Patient X. The Committee, however, noted that when interviewed during the internal investigation, the Registrant stated that he would not order medication before examining a patient. The Committee therefore considered the explanation provided by the Registrant at this hearing to be inherently implausible.

86. The Committee also took into account the evidence of the Registrant that Patient A had asked him on two occasions about being prescribed eye drops when he was in the room for the YAG laser treatment. The Committee

considered that there was no reason for Patient A to ask about drops if he had not been told by the Registrant that he had cystoid macular oedema.

87. The Committee also examined the records for Patient X that it had been provided with and noted that Patient X is recorded as having right cystoid macular oedema. The Committee noted that in his evidence the Registrant had stated that on 14 December 2021 he had in front of him a patient list, a *'stack'* of patient files and the electronic records of patients. Whilst it is not possible to determine how or why Patient A was provided with a diagnosis of right cystoid macular oedema in the Committee's view it is not inherently implausible that when the Registrant initially consulted with Patient A that he mistakenly referred to Patient X's records.

88. For the reasons set out above, the Committee determined that the Registrant's account of what occurred on 14 December 2021 was contradictory, was not supported by documentary evidence and was inherently implausible.

89. In these circumstances the Committee concluded, on the balance of probabilities that on or around 14 December 2021 the Registrant advised Patient A that he had cystoid macular oedema when he did not have cystoid macula oedema.

90. Particular 1 b is therefore found proved.

Particular 2

91. The Registrant having admitted particular 2, the Committee went onto consider particular 3.

Particular 3

3. The records referred to at 2 a – f above were inaccurate in that:

a. In relation to 2 a, you discussed cystoid macular oedema with Patient A and not the YAG capsulotomy

b. In relation to 2 b you had written the note for Patient A;

c. In relation to 2 c it was Patient A and not Patient X who had asked you to write the note;

d. In relation to 2 d Patient A and Patient X had not been sat next to each other in the waiting area;

e. In relation to 2 e you had provided the note to Patient A;

f. In relation to 2 f Patient A was not confused about the reason for his visit in that he understood his visit was for a YAG capsulotomy.

92. As set out above, Patient A told the Committee that during the initial consultation with the Registrant, the Registrant advised him that he had

cystoid macular oedema. Patient A stated that the Registrant said that he did not need a YAG capsulotomy.

93. For the reasons above in Particular 1, the Committee accepted the evidence of Patient A. It considered that the only comment made to him by the Registrant at the initial consultation in relation to YAG capsulotomy was that Patient A did not need it. The Committee determined that this was not the discussion recorded by the Registrant in the additional notes. The Committee therefore was satisfied that the Registrant did not discuss the YAG capsulotomy with Patient A at the initial consultation and that the record in respect of 2 a was inaccurate.

94. Particular 3 a is therefore found proved.

b. In relation to 2 b you had written the note for Patient A;

95. The Committee noted that it was accepted by the Registrant that the note was in his handwriting. The Registrant's evidence was that he did not recall writing it for Patient A.

96. The Committee accepted Patient A's evidence that the note was written for him at Patient A's request following the Registrant advising Patient A that he had cystoid macular oedema.

97. The Committee therefore concluded that the record referred to in particular 2 b that the Registrant recorded 'I am not certain where this came from' was inaccurate.

98. Particular 3 b is therefore found proved.

c. In relation to 2 c it was Patient A and not Patient X who had asked you to write the note;

99. The Committee noted that during the internal investigation interviews the Registrant was informed that Witness A had contacted Patient X who had denied asking the Registrant to write down the name of the diagnosis on 14 December 2021. The Committee noted that it was now accepted by the Registrant that the statement in 2 c may be inaccurate. Further, the Committee has found in 3 b above that the note which stated '*right cystoid macular oedema'* was written for Patient A. The Committee therefore decided the record in 2 c was inaccurate.

100. Particular 3 c is therefore found proved.

d. In relation to 2 d Patient A and Patient X had not been sat next to each other in the waiting area;

101. The Committee noted that it was now accepted by the Registrant that Patient A and Patient X may not have been sitting next to each other in the consultation waiting area as shown by the CCTV footage. The Committee therefore determined that the record in 2 d was inaccurate.

102. Particular 3 d is therefore found proved.

e. In relation to 2 e you had provided the note to Patient A;

103. The Committee has already found that the Registrant wrote the note for Patient A. The Committee further accepts the evidence of Patient A that the

Registrant provided the note to him at Patient A's request. The Committee also noted that during his evidence the Registrant did not seek to dispute that he had given this note to Patient A. The Committee considered the Registrant's previous position that Patient A may have picked up another patient's note and believed the condition referred to therein applied to himself to be inherently implausible. The Committee therefore determined that the record in 2 e was inaccurate.

104. Particular 3 e is therefore found proved.

f. In relation to 2 f Patient A was not confused about the reason for his visit in that he understood his visit was for a YAG capsulotomy.

105. The Committee took into account Patient A's evidence, as corroborated by Person A, that he was clear that he was attending the clinic on 14 December 2021 for laser treatment. The Committee was satisfied that when making this comment Patient A was referring to YAG capsulotomy. The Committee considered that any confusion in the mind of Patient A arose not about the reason for his attending the clinic initially, but what occurred during the initial consultation with the Registrant. The Committee determined there was no evidence before it that Patient A was confused about the reason for his attendance at the clinic and that he was clear it was for a YAG capsulotomy.

106. The Committee therefore determined that the record in 2 f was inaccurate.

107. Particular 3 f is therefore found proved.

Particular 4

4. You recorded that it would be wise for Patient A to be accompanied by a chaperone and to use a dual consent form for any further Tx required when a chaperone and/or a dual consent form was not indicated.

108. It was confirmed to the Committee that the use of '*Tx*' referred to treatment.

109. As set out above, the Committee has concluded that, whilst Patient A may have suffered from [redacted] difficulties there was no evidence before it that he lacked capacity at the time of the consultation on 14 December 2021. The Registrant in his oral evidence explained that a dual consent form was required where the patient did not have capacity to consent and made reference to the '*Mental Capacity Act*'. There was no evidence that Patient A met the threshold for a dual consent form. The Registrant specifically stated that a dual consent form was not required for a patient who only had [redacted] difficulties. The Committee further noted that during the hearing the Registrant accepted that Patient A had not lacked and did not lack capacity.

110. There was no evidence before the Committee regarding any criteria for a patient to require a 'chaperone' and Mr Corrie submitted that it was a matter for the Committee.

111. The Committee therefore concluded that there was no evidence that either a chaperone or a dual consent form was indicated.

112. Particular 4 is therefore found proved.

Particular 5

Your conduct at 2 a–f and/or 3 a–f was dishonest in that:

a. *You knew the record was inaccurate and/or*

b. *You made the additional record in order to conceal that you had incorrectly advised Patient A that he had cystoid macula oedema.*

113. In considering particular 5 the Committee adopted the test as set out in the case of *Ivey v Genting Casinos (UK) Ltd [2017] UKSC 67,* which states:

'*When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest'.*

114. In relation to this particular the Committee took into account the Registrant's good character and the positive testimonials provided on the Registrant's behalf.

115. Having accepted Patient A's evidence, the CCTV, the timeline provided and the Committee's prior determination on previous particulars as set out above, the Committee has concluded the following:

i. The Registrant did not verify Patient A's identity.
ii. The Registrant advised Patient A that he had cystoid macular oedema when he did not.
iii. The Registrant provided a written note to Patient A which said '*right cystoid macular oedema'.*

iv. Patient A presented the note to the Registrant in the YAG treatment room and the Registrant told him to '*forget that'* and apologised.
v. Patient A left the YAG treatment room at 13.23 after receiving the YAG treatment.
vi. Immediately afterwards at 13.23 the Registrant started a consultation with Patient X. Patient X's record showed he was given a diagnosis of right cystoid macular oedema on 14 December 2021.
vii. A request for a prescription with a diagnosis of '*CMO'* '*RE'* for Patient X was made at 13.03.
viii. Patient X's record was completed at 13.06.
ix. The Registrant had been told by the hospital manager on the afternoon of 14 December 2021 that Person A had asked questions about the diagnosis in the note and was likely to file a complaint.
x. Certain parts of the day- such as writing a '*risk factor'* on a piece of paper for a patient, Patient A presenting that note to the Registrant in the YAG treatment room and the Registrant finding Patient X's notes had been completed prior to seeing Patient X – were likely to have been memorable to the Registrant.

116. Taking all the above points into consideration, the Committee concluded it was inherently implausible that, at the point at which the Registrant made the additional note in Patient A's record at 9.36pm on 14 December 2021, he did not know that the additional notes in the record were inaccurate.

117. The Committee noted the Registrant's explanation that he made the additional notes later that evening because the events of the day had been playing on his mind and that the purpose of the additional notes was to document concerns for Patient A. The Committee did not accept that the additional note was made by the Registrant to try to understand and '*piece together'* what had occurred that day as suggested by Mr Saad in his submissions. In light of the Committee's findings set out above, the Committee determined that these explanations were inherently implausible.

118. The Committee noted that the Registrant made reference of [redacted] issues during his evidence. There was no independent evidence before the Committee in relation to any [redacted] issues suffered by the Registrant at the time of the allegation or how any such issues may have impacted on him, particularly in the evening of 14 December 2021 when he made the additional note to Patient A's record. The Committee did not consider therefore that there were any issues relating to the Registrant's [redacted] which were relevant to its consideration of this particular.

119. The Committee did not find any other plausible explanation for the Registrant's action. In these circumstances, the Committee determined that, on the balance

of probabilities, the Registrant made the additional notes in order to conceal that he had incorrectly advised Patient A that he had cystoid macular oedema.

120. The Committee determined that this conduct in both limbs a and b would by the objective standards of ordinary decent people be considered dishonest.

121. Particular 5 is therefore found proved.

Misconduct

122. Having found the facts alleged proved, the Committee next considered whether the facts found proved amounted to the statutory ground of misconduct.

123. The Committee heard submissions from Mr Corrie. He said that as there is no burden or standard of proof for this stage of the hearing or statutory definition, that it is entirely a matter for the Committee's own judgement whether the conduct amounted to misconduct. Mr Corrie invited the Committee to remind itself of paragraphs 40 – 44 of the Council's statement of case and said that the Committee should assess whether the conduct is sufficiently serious. He said that for particulars 1a and b, this was a serious error and referred the Committee to the impact upon Patient A as described in his witness statement. He said that whilst in isolation 1a may not reach the threshold of misconduct, that in view of the context of 1b, that it should.

124. Mr Corrie said that the Committee may find that particular 4 was a serious failure by the Registrant and could amount to misconduct. For particular 5 he said that this was serious dishonesty because it had involved the deliberate creation of false patient records. He submitted that honesty was a cornerstone of an Optometrist's practice. Mr Corrie referred the Committee to paragraph 45 of the Council's statement of case in terms of the professional standards which the Council submit have been breached. These were professional standards 2, 7, 8, 16, 16.1, 17, 18 and 19 and he said that it is a matter for the Committee to determine if there were additional standards that have been engaged.

125. Mr Saad made submissions and told the Committee that the Registrant accepted that the factual finding of dishonesty in terms of particulars 2, 3 and 5 amounted to professional misconduct. In relation to particulars 1a and b, Mr Saad said that there had been no expert evidence produced by the Council, no clinical consequences and the conduct had occurred over a limited time period. In relation to particular 4, Mr Saad submitted that there had been no expert evidence produced by the Council to assist the Committee with their misconduct assessment and he invited the Committee to find that the Registrant had taken overly cautious steps that may have been 'over the top'. He said that the conduct for particulars 1a, 1b and 4 should not be regarded as

deplorable, are stand-alone matters, do not form part of the dishonesty and should not amount to misconduct.

126. The Committee received and accepted advice from the Legal Adviser. This included advice that in the absence of a statutory definition of misconduct, the Committee should exercise its own judgement and consider paragraphs 15.5 – 15.9 of the Council's Hearings and Indicative Sanction Guidance ('ISG'). The Legal Adviser invited the Committee to consider each particular of the allegation separately and to have regard to any professional standards that may have been breached. The Legal Adviser also invited the Committee to refer to the judgment in the case of ***Roylance v GMC [2000] 1 AC 311***:

'misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a practitioner in the particular circumstances. The misconduct is qualified in two respects. First it is qualified by the word 'professional' which link the misconduct to the profession … Secondly, the misconduct is qualified by the word 'serious.' It is not any professional misconduct which will qualify. The professional misconduct must be serious.'

The Committee's decision on Misconduct

127. The Committee reminded itself of the relevant paragraphs of the Council's Hearings and Indicative Sanctions Guidance. The Committee also reminded itself that the factual particulars found proven included deliberate dishonesty.

128. The Committee first considered particulars 1a and b in terms of misconduct. It considered the following professional standard in the Council's Standards of practice 2016:

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

129. The Committee having reminded itself of the factual circumstances found that the conduct itself represented an isolated error or 'mix up' between patients. The situation had been rectified with no clinical consequences for Patient A. Whilst there had been some impact for Patient A in terms of confusion regarding his diagnosis the Committee noted that the Registrant had seen Patient A as an extra patient on that day, in order to satisfy the patient's desire for timely laser treatment. Patient X, who the Committee understood to be the 'other' patient involved, appeared also to have received the correct diagnosis and treatment. The Committee concluded that the Registrant's conduct fell below the standard that may be expected of an Optometrist but not sufficiently far below as to amount to misconduct.

130. The Committee went on to consider particular 4. It reminded itself of the submissions from Mr Saad when he had said that the conduct did not form part of the dishonesty and should be regarded as overly cautious and not deplorable. Together with professional standard 17.1, the Committee found the following standard to be engaged:

8: Maintain adequate patient records.

131. The Committee determined that this standard had been breached by the Registrant. Having reminded itself of the factual circumstances it found that the Registrant had deliberately recorded the information when there had been no indication of a lack of capacity or the need for a chaperone. The Committee did not accept as submitted by Mr Saad that the Registrant had acted in an overly cautious manner and found that in the absence of any indication for including the information, that it had been a deliberate act. Of significance for the Committee was the content of the information related as it was to Patient A's capacity and the potential implications for Patient A should other professionals read the record subsequently. The Committee considered Patient A's distress at the time of the conduct and concluded that in the circumstances, the Registrant's conduct had fallen far short of the professional standards.

132. The Committee consequently determined that the facts found proved at particular 4, amounted to misconduct.

133. The Committee considered particular 5 and in doing so, took into account particulars 2 and 3 which were inextricably linked. The Committee noted that Mr Saad had said that the Registrant accepted that his conduct amounted to misconduct. The Committee however, carried out an assessment before arriving at its own independent decision.

134. The Committee determined that professional standards 16.1 and 19 were engaged. Professional standards 16.1 and 19 provide as follows:

16.1: Act with honesty and integrity to maintain public trust and confidence in your profession.

19: Be candid when things have gone wrong.

135. The Committee found that standards 16.1, 17.1, 8 and 19 had been breached by the Registrant in respect of particulars 2, 3 and 5. The Committee found that the Registrant had created inaccurate records and he had acted in a deliberate and dishonest manner in that he had attempted to conceal that he had incorrectly advised Patient A that he had cystoid macular oedema when he

inserted the additional notes into Patient A's records. The Registrant created multiple false entries in Patient A's record, the creation of which had implications for Patient A's future care by subsequent clinicians reading those records. Further the inaccurate entries which portrayed Patient A as confused and potentially lacking in capacity were made to support the Registrant's version of events in the event that a complaint was received, which it was.

136. The Committee considered its overarching objective and in relation to public confidence, considered the nature of the misconduct and determined that the factual circumstances that led the Committee to arrive at its decision in relation to dishonesty were equally applicable when assessing seriousness. Upon reminding itself of these circumstances together with the fact that the conduct occurred in relation to the Registrant's clinical practice, the Committee went on to find that the nature of the misconduct was sufficiently serious such that it fell far below the professional standards expected. Further, the Committee determined that a fellow practitioner, in light of the deliberate and dishonest nature of the misconduct, would regard the Registrant's actions as deplorable.

137. The Committee consequently determined that the facts found proved at particulars 2, 3 and 5 amounted to misconduct.

138. In summary, the Committee found that particulars 2, 3, 4 and 5 amounted to misconduct.

Decision on Impairment

Submissions on behalf of the GOC

139. On behalf of the GOC, Mr Corrie submitted that the Registrant's fitness to practise is currently impaired because his conduct has not been sufficiently remediated and there remains a risk to patients and other members of the public. He also submitted that a finding of impairment is required to satisfy the wider public interest. This would mark the seriousness of his actions in making an inaccurate record, concealing a mistake and being dishonest.

140. Mr Corrie provided a Skeleton argument to the Committee in relation to all potential stages of this hearing in November 2023. He referred to the 'volume of case law' providing guidance on determining impairment and relied on principles in the following judgments:

- CHRE v NMC and Grant [2011] EWHC 927
- Cohen v General Medical Council [2008] EWHC 581
- Cheatle v GMC [2009] EWHC 645
- PSA v Health Care Professions Council and Ajeneye [2016] EWHC 1237
- Yeong v GMC [2009] EWHC

- Kimmance v GMC [2016] EWHC 1808.

141. In his oral submissions, Mr Corrie acknowledged that no misconduct had been found in relation to particular 1 of the Allegation. This should now be treated as background information. He also said that the Allegation focused on a single instance in an otherwise unblemished career. The Registrant has provided CPD certificates in support of remediation, and good testimonials. However, the Committee should ask, if there is no finding of impairment, whether public confidence in the optometry profession, or need to uphold standards, would be undermined.

142. The Committee should also ask whether the Registrant had now developed sufficient insight to enable the Committee to be satisfied that he does not pose a risk of repetition. The Registrant's first witness statement included his reflections on the case as he presented it at the time. He only accepted flaws in his communication with Patient A and record-keeping. He reflected only cursorily on the duty of candour, with no reference to dishonesty.

143. Mr Corrie said that the Registrant's recent statement (dated 20 February 2024) refers to the importance of honesty, its importance to patient confidence in clinicians and public confidence in the profession, the impact of his conduct on Patient A and the need to be open when something has gone wrong.

144. The Registrant now recognises the need to improve record-keeping for pre-operative assessments. He has completed Continuing Professional Development (CPD) on probity, ethics and investigation of complaints. Whilst the Council accepts that the Registrant has reflected on the impact of dishonesty, he should have known this at the time of these events.

145. Mr Corrie submitted that insight is relevant to consideration of current impairment. In general terms the Registrant acknowledges that dishonesty has potential to seriously damage patient and public confidence, but it is difficult to assess the extent of his insight as he is not giving evidence today and has not been cross-examined. Although his written reflections demonstrate a general acceptance of the need to be honest, there is no specific exploration of the conduct found proved; the Council accepts that this is difficult to do and does not invite the Committee to hold his continued denial against the Registrant. But the Registrant has not reflected on triggers for his errors of judgment or catalysts for his attempt to hide errors.

146. Mr Corrie submitted that a case-specific analysis could be made in an academic or hypothetical sense, even where denials are maintained. In the absence of such analysis the Committee may conclude that the Registrant's insight is not sufficiently developed in relation to the circumstances of this case. The

Committee may consider that further work is required to minimise any risk of repetition.

147. Although this was an isolated incident and the Registrant has no previous fitness to practise history, Mr Corrie said that the Committee may consider that the public has a right to expect clinicians to be open when things go wrong and for clinical records to be accurate. The Registrant had no financial motivation (or gain) and his conduct was not sophisticated.

148. Mr Corrie submitted that it amounted to a clumsy dishonest cover-up to conceal a previous error. However, Mr Corrie submitted that this type of conduct brings the profession into disrepute. It has an adverse impact on public confidence because patients rightly expect optometrists to be open about their errors, even minor ones. The effect of his actions on Patient A add to the gravity of his misconduct, as does the element of dishonesty.

149. In conclusion, Mr Corrie submitted that a finding of impairment is required in the wider public interest, as well as to protect patients from harm.

Submissions by Counsel Mr Saad

150. On behalf of the Registrant, Mr Saad submitted that he poses no risk to patients or other members of the public. Mr Saad adopted a neutral position in relation to the wider public interest including the need to maintain public confidence in optometrists.

151. Mr Saad reminded the Committee that the Registrant accepts that the facts found proved at particulars 2, 3, 4 and 5 amount to misconduct. Although the Registrant has not admitted the Allegations, he fully understands the significance and seriousness of the findings against him.

152. Mr Saad said that the Registrant has undergone relevant learning and reflection since the hearing in November 2023. He has submitted a new bundle of materials, with a reflective statement for the Committee to consider.

153. In relation to legal principles, Mr Saad accepted the relevance of authorities cited by Mr Corrie. He referred to additional cases including:

- Biswas v GMC [2006] EWHC 464
- Meadow v GMC [2006] EWCA Civ 1390
- Awan v GMC [2020] EWHC 1553
- Vali v General Optical Council [2011] EWHC 301
- Amao v NMC [2014] EWHC 147
- Watters v NMC [2017] EWHC 1888

- PSA v GMC and Uppal [2015] EWHC 1304.

154. Mr Saad invited the Committee to take account of the fact that the Registrant does admit fault in this case and blames himself for how the matter has unfolded. This is not a situation in which the Registrant suggests he has no culpability whatsoever.

155. Mr Saad submitted that the Registrant does not present a current risk to members of the public. He relied on the following arguments:
    i) On any view, these allegations relate to an isolated incident. The Registrant qualified in October 2008.
    ii) Prior to the allegations, the Registrant had an entirely unblemished career. Indeed it is a distinguished career having supervised pre-registration optometrists and dispensing optometrists, completed several Wales Optometry Postgraduate Education Centre (WOPEC) qualifications and acted as a WOPEC assessor.
    iii) There have been no allegations of wrongdoing since these allegations took place in December 2021 – he has been promoted to Regional Team Lead Optometrist for the West Midlands at [redacted] and is part way through the Independent Prescribing course.
    iv) By virtue of his detailed and eloquent reflective statement, he has shown genuine reflection and insight into the importance of honesty and integrity issues. He apologises to Patient A, recognises the impact this has had on him and his family. He recognises the importance of the integrity of a healthcare professional and public confidence in the profession. For example, he writes: *"it is important that the public know that when they seek clinical attention, that they see people with integrity"* and *"Honesty and integrity are highly important in all healthcare professions, not just optometry. Dishonesty raises ethical dilemmas, as it conflicts with the core principles of beneficence, non-maleficence, autonomy, and justice that underpin medical ethics. The public have a right to know that advice given will always be truthful and accurate, and actions taken always in their best interests, in order for them to make informed decisions about their own healthcare."*
    v) The Registrant has completed relevant continuing professional development, including a course on Probity and Ethics.

vi) The Registrant's clinical abilities have not been called into question at any stage. Indeed in this case Patient A received the correct clinical treatment, as did Patient X.

vii) He has already met the target for the current CPD cycle, ten months in advance.

viii) There is evidence of competent and safe practice conducted by the Registrant from both before and after December 2021.

ix) He is part way through completing an Independent Prescribing Course, having completed the academic placement in August 2023 with distinction, and is due to complete the qualification by undertaking the clinical element of the course this year.

156. Mr Saad submitted that, owing to the Registrant's previously unblemished career, the isolated nature of the incident, his acceptance of misconduct, the upward trajectory of his career both before and after December 2021 and the rigorous disciplinary assessment that has been conducted, the Committee may safely conclude that the Registrant does not present a current risk to the public. To his credit, the Registrant has acknowledged that a finding of impairment on public confidence grounds is open to the Committee in light of its findings of fact and misconduct.

157. The Registrant has provided references from colleagues including Person B, Director of Optometry at [redacted]. The Committee was asked to take account of her testimonial:

'Gareth was introduced to me by his previous line manager as one of the most diligent and reliable optometrists at [redacted], and I can honestly say that has borne true in my experience. He has been promoted twice since 2021 – taking on two more senior roles within the team. He is currently known as a Senior Optometrist for File Reviews – which means he looks at complex cases and advises on management, and he is also currently the Regional Team Lead Optometrist for the West Midlands (maternity leave cover). For both roles he was interviewed by senior peers and was successful...

Gareth is an excellent clinician – I underwent some training in clinic with him for my own knowledge and can say first hand that his clinical skills and ability are exemplary. I will regularly seek his advice about patients under our care and would trust him with my own eye health – as an optometrist myself that endorsement should not be under-estimated. I was a lecturer/senior

lecturer/Professor in my academic optometry career, and at one me I led Postgraduate Education at WOPEC, so I have good appreciation of what defines a proficient and diligent optometrist, and Gareth is one. I have no hesitation in endorsing Gareth's skills and abilities as an optometrist.

He has the respect of all his peers at [redated], and takes responsibility for other optometrists' well-being and training… The team in our Newcastle-under-Lyme hospital demonstrate great respect for him and our hospital managers across the West Midlands seek Gareth's advice for clinical input.'

158. In oral submissions Mr Saad argued that the Registrant has contributed a lot to his profession throughout a long career. He has recognised that autonomy and justice underpin medical ethics. His written reflections accept that the public has a right to expect health professionals to act with integrity and in patients' best interests.

159. He has provided excellent testimonials. Partly due to the ignominy of going through fitness to practise proceedings, there is no risk of repetition. There have been no allegations of misconduct in the past two years. Many years of successful practice before 2021 indicate that there are no deep-seated attitudinal issues.

160. This was an isolated incident in a long career. The Registrant has participated in a rigorous disciplinary process. The Committee is asked to find that he poses no risk and to consider that his fitness to practise is not currently impaired by reason of misconduct.

Legal Advice

161. The Legal Adviser advised the Committee of relevant law. There were no comments on this legal advice from Counsel.

162. The Committee must follow a staged process in regulatory proceedings. After it made findings of fact, the Committee determined that those at particulars 2, 3, 4 and 5 amounted to misconduct.

163. The Committee must now consider whether current fitness to practise is impaired by reason of that misconduct. It should be aware that not every case of misconduct results in a finding of impairment: *Cohen v GMC 2008 EWHC 581*.

164. At the impairment stage, there is no burden or standard of proof. It is a question of judgment for the Committee alone. Impairment may be based on historical matters or a continuing situation, but it is to be decided at the time of the

hearing. To do this the Committee must look forward, taking account of any reparation, changes in practice, conduct or attitude since December 2021. Mitigation has less relevance, but an effort to accept and correct remediable errors should be taken into account.

165. 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: *CHRE v Grant 2011 EWHC* 927. 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

    d. Has [the Registrant] in the past acted dishonestly and/or is [he] liable to act dishonestly in the future.'

166. The need to maintain public confidence in the profession or declare standards of behaviour may mean that an optometrist's fitness to practise is impaired due to certain acts of misconduct in themselves. This is because the public would not have confidence in him, or in the profession's standards, if the Committee regarded that sort of conduct as leaving fitness to practise unimpaired. A finding of impairment may be necessary to reaffirm to the public and health professionals the standard of conduct expected: *Yeong v GMC 2009 EWHC 1923.*

167. M*otala v GMC 2017 EWHC 2923:* maintaining innocence does not necessarily indicate lack of insight.

168. *Ahmedsowida v GMC 2021 EWHC 3466: c*ontesting the charges, even robustly, should not be treated of itself as evidence of lack of insight; something more must be shown. A finding that blatant lies were told to the Committee is one possibility.

169. *Sawati v GMC 2022 EWHC 283:* a rejected defence may be relevant to insight and thus risk, but it is permissible to deny an allegation of dishonesty: a health professional has a right to a fair hearing.

170. *Chaudhury 2017 EWHC 2561* reminds regulators of the importance of the overarching objective and the need for a proper balancing exercise of all three

elements of the public interest test. The Committee must decide this case on its merits.

The Committee's Decision

171. The Committee took account of submissions from both Counsel and accepted the legal advice. It had to consider whether the Registrant poses a risk to patients or others, as well as the wider public interest. This includes upholding standards and maintaining public confidence in optometrists.

172. The Committee considered written reflections of the Registrant and all other evidence. In a statement provided in February 2024 he wrote:

> '*As a result of this case, I have completed CPD on Probity and Ethics, as well as a course on Investigation of Incidents and Complaints. I have found these courses incredibly helpful and insightful, and a welcome opportunity to openly discuss and reflect upon this case with a group of my peers.*
>
> *Honesty and integrity are highly important in all healthcare professions, not just optometry. Dishonesty raises ethical dilemmas, as it conflicts with the core principles of beneficence, non-maleficence, autonomy, and justice that underpin medical ethics. The public have a right to know that advice given will always be truthful and accurate, and actions taken always in their best interests, in order for them to make informed decisions about their own healthcare. Regulatory cases of dishonesty often receive negative media coverage, and lead to reputational damage not only to the individual practitioner, but to the profession as a whole. This can erode trust in both the individual and the profession as a whole, and result in patients being less likely to follow medical advice and disclose pertinent information during consultations. It can even mean patients are less likely to seek medical advice when needed. Maintaining honesty, transparency, and ethical conduct is essential to preserve the credibility and effectiveness of the profession. Healthcare professionals must uphold the highest standards of integrity in order to fulfil their responsibilities to their patients, and to the public as a whole.*
>
> *I have learned that it is important to address someone with a complaint directly and listen to the patient's concerns, even if that concern is simply a misunderstanding with no blame to be apportioned; an apology early on makes so much difference to the patient in question.*
>
> *Subsequent to studying these courses, I have overhauled my record keeping practices, particularly in respect to YAG capsulotomies. I now record pre-op examination checks and post operative advice given for every patient treated, whereas previously I only recorded any changes to clinical status from the pre-operative assessment. I have taken further training on communicating with vulnerable patients. Now I ensure I have confirmed the patient's understanding of their treatment and their consent…*'

'I *was given the opportunity to talk to Patient A and Person A to clear the air and I did not take it. I prioritised the patients waiting for their appointment over him and his concerns. If there was any error I made, it was one of communication. As an optometrist I have to exercise a duty of candour - being open if anything has gone wrong - and I did not exercise it in this case. I have been critical of my response ever since. If I was ever in a similar position again, I would want to address the complaint head on, in person and as early in the process as possible.'*

173. In relation to factors identified as relevant in *Grant*, the Committee considered that the Registrant's deliberately inaccurate record-keeping had put Patient A at unwarranted risk of harm. His dishonest actions had potential to bring the profession of optometry into disrepute and to undermine standards of good practice. The Registrant had breached fundamental tenets of the profession as he was found to have acted dishonestly. The Committee had to consider future risk.

174. After analysis of the evidence, in the context of submissions from both Counsel, the Committee concluded that the misconduct in question is remediable. Although dishonesty may be difficult to remediate (compared with lack of competence) it is not impossible. The Committee took account of the fact that the Registrant's actions amounted to an isolated incident involving dishonesty in an otherwise unblemished career. No further allegations have been made since 2021.

175. The Committee considered whether, and to what extent, the Registrant's misconduct had been remediated. He provided relevant evidence of remediation including CPD on ethics and probity, as well as how to respond to complaints. This has provided him with an opportunity to consider and discuss these issues with a group of his peers.

176. The Registrant has now put new procedures in place for pre- and post-operative assessments and record-keeping. He has also strengthened his approach to handling complaints. The Committee took account of the Registrant's reflections, which demonstrate an understanding of the importance of honesty and integrity in professional practice. In addition, the Registrant has demonstrated an understanding of, as well as remorse for, the impact of his actions on Patient A and his family.

177. The Committee considered the Registrant's statements, testimonials and CPD certificates, in the context of other information and submissions, to identify evidence of insight.

178. The Committee accepted the point made by Mr Corrie that there was a general recognition of the need to be honest, but that the Registrant had not specifically explored the conduct found proven, nor identified triggers for dishonesty; Mr

Corrie accepted that it was difficult to do so when allegations continue to be denied.

179. The Committee was aware that the Registrant's emphasis, in his written reflections, was on the miscommunication reflected in particular 1, as opposed to the nature of the misconduct found at particulars 2-5. However, he has accepted that he did not comply with his duty of candour in December 2021.

180. The Committee took account of the principle in *Motala:* that, where a registrant continues to deny impropriety, it makes it more difficult for them to demonstrate insight. The Committee recognised the difficulty in demonstrating insight in circumstances where a registrant maintains their denial of an allegation.

181. The Committee made a distinction between a failure to have insight into past misconduct and a failure to have insight into the need to avoid future misconduct and to act with integrity.

182. Although the Registrant does not accept the finding of dishonesty, he has attempted to demonstrate that he understands the importance of probity, in the context of his practice. This understanding is fundamental to his insight into how he should act in future if a similar situation were to arise. The Committee took account of the Registrant's statement:

> *'As an optometrist I have to exercise a duty of candour - being open if anything has gone wrong - and I did not exercise it in this case. I have been critical of my response ever since. If I was ever in a similar position again, I would want to address the complaint head on, in person and as early in the process as possible.'*

183. The Registrant also showed insight by selecting relevant CPD courses to enable him to demonstrate remediation to the best of his ability. The Committee concluded that the Registrant has shown insight into how to avoid future misconduct.

184. The Committee considered that the Registrant's insight and steps taken to remediate reduce the risk of repetition of the misconduct found proved. He accepts that he did not handle the situation well and has taken steps to address relevant concerns.

185. The Committee also took account of the fact that the Registrant's testimonials allude to honesty as being one of his characteristics. This tends to suggest that the Registrant is not inherently (or generally) dishonest and that he acted out of character in December 2021. The Director of Optometry at [redacted] said the Registrant was '*unfailingly honest'* as well as being a trusted clinician. Since

the time of these events, the Registrant has been promoted to a responsible position by the same employer.

186. The Committee took account of the Registrant’s regret and remorse for the impact of his actions in December 2021 on Patient A. It found that he had demonstrated insight into the potential impact of his misconduct on patients and public confidence in optometrists. This is relevant to the risk of repetition of similar conduct in future.

187. The Committee concluded, that in all the circumstances, the Registrant’s misconduct is highly unlikely to be repeated. Relevant steps have been taken to minimise the risk of repetition. The Committee concluded that a finding of impairment is not necessary to protect patients and other members of the public.

188. The Committee has found that the Registrant’s actions set out at particulars 2, 3, 4 and 5 of the Allegation amounted to misconduct. His dishonest attempt to cover up the fact that he had mixed up two patients had a very significant impact on Patient’s A psychological wellbeing and could have compromised his future care.

189. Therefore, the Committee concluded that it would send out the wrong message to the profession, and the public, if the Registrant’s fitness to practise was not found to be impaired. A finding of impairment is needed to declare and uphold standards, as well as to maintain public confidence in the profession.

190. In *Uppal* the court said that ‘*public confidence in the profession could be maintained by the fact that the registrant had undergone a rigorous disciplinary assessment of their fitness to practise, resulting in a finding of misconduct*’…

191. The Committee concluded that the Registrant’s experience of a fitness to practise hearing may contribute to minimising risk of repetition, but regulatory proceedings (alone) are insufficient, in this case, to maintain public trust and confidence in the profession. Optometrists and other members of public would be very concerned about the retrospective amendment of records and dishonesty.

192. In considering whether the Registrant’s fitness to practise is currently impaired by reason of misconduct, the Committee considered the statutory overarching objective to maintain confidence in the profession, to uphold standards and to protect the public.

193. A finding of impairment on public interest grounds is required to uphold standards and to maintain public confidence in the profession of optometry.

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

Decision on Sanction

Submissions on behalf of the GOC

195. The Committee heard submissions from Mr Corrie on behalf of the Council. He submitted that the Registrant had engaged in serious misconduct which involved dishonesty. He reminded the Committee that any sanction imposed should not be 'primarily punitive': *Bolton v Law Society [1994] 1 WLR 512*. However, the first concern for the Committee should be public protection with the impact of a sanction on the registrant being secondary *PSA v NMC [2015] EWHC 1887*.

196. Mr Corrie recognised that there is no blanket rule or presumption that erasure is the appropriate sanction in all cases of dishonesty. The Committee must balance all the relevant issues in a proportionate manner whilst putting proper emphasis on the effect a finding of dishonesty has on public confidence in the profession: *Hassan v GOC [2013] EWHC 1887* and *Siddiqui v GMC [2013] EWHC 1883*.

197. Mr Corrie accepted that there is a spectrum of dishonesty, adding that it would be wrong to treat all proven dishonesty as being equally serious. So, where an act sits in the scale must be reflected in the sanction. Mr Corrie acknowledged that not all dishonesty found proved would result in exclusion, as alluded to in *Watters v NMC [2017] EWHC 1888* and *Lusinga v NMC [2017] EWHC 1458.*

198. In relation to the approach to be adopted by a Committee, Mr Corrie cited principles in *PSA v GDC and Hussain [2019] EWHC 2640*. The Court in *Hussain* provided a summary of case law relevant to sanction in cases involving dishonesty and said '*the cases make clear that dishonesty in any health care professional is always to be considered as serious and as adversely affecting the public interest. That is because trust and honesty lie at the heart of the relationship between such a professional and the public.*'

199. He invited the Committee to focus its deliberations on the wider public interest and what is required to promote standards and maintain confidence in the profession. Proportionality indicates that the least onerous measure required to protect the wider public interest should be imposed.

200. Mr Corrie said that the Council does not submit that the sanction should be more severe due to the Registrant's continued denial. However, it should take account of the fact that his dishonesty was motivated by a desire to conceal his

mistake. The Committee should take account of the adverse impact on Patient A and the fact that the Registrant has brought the profession into disrepute.

201. Mr Corrie invited the Committee to take account of relevant mitigation. This includes the fact that the Registrant had no previous fitness to practise history, nor any subsequent complaints. The Committee has found that he is not at risk of repeating his misconduct.

202. Only exceptional circumstances would justify the Committee taking no action. Being honest in general or in future would not amount to anything exceptional. Taking no further action would not be an adequate response and would not satisfy the wider public interest.

203. A Conditions of Practice Order would not be appropriate as the Committee did not find an ongoing risk of repetition.

204. Mr Corrie submitted that the mitigation relied on by the Registrant is personal and that the Committee is entitled to give greater weight to the public interest. However, a 12-month suspension is not necessarily reserved for the most egregious dishonesty as the Committee has the power to erase the Registrant's name from the register.

205. Mr Corrie submitted that a 9-month Suspension Order is the least onerous sanction required to uphold the public interest; this would also take account of the mitigation. As no future risk has been identified, a review hearing was not appropriate.

206. In all the circumstances the Council submits that a 9-month Suspension Order would be a fair and appropriate way to deal with this matter.

Submissions on behalf of the Registrant

207. The Committee also heard from Mr Saad on behalf of the Registrant. He said it should balance mitigation with the public interest.

208. Mr Saad submitted that the Registrant's misconduct related to an isolated incident in an (otherwise) unblemished career and that there had been no incidents since December 2021.

209. The Committee was invited to find that no further action would be a realistic and appropriate way to protect the wider public interest. The High Court in *Uppal* recognised that public confidence was maintained by virtue of a health professional going through a rigorous disciplinary process and having a finding of misconduct on their record.

210. This Registrant has a finding of misconduct as well as impairment so a strong message has already been sent out. Impairment was found despite the fact that the Registrant has shown insight, taken remedial steps and poses no further risk. This is a significant, long-lasting mark against his name.

211. Mr Saad argued that the regulatory process has already worked, in relation to risk of repetition and submitted that the process is complete in terms of maintaining public confidence in the profession.

212. An impairment finding with no further action is a way to mark the seriousness of the misconduct found in the public interest, if a restrictive sanction cannot be justified. The circumstances would have to be exceptional, but *Uppal* confirms that there is a wide range of potentially appropriate outcomes.

213. However, if the Committee were minded to impose Conditions of Practice on the Registrant, Mr Saad relied on a list of potentially appropriate conditions, submitted in writing to reflect the Registrant's instructions that he would comply. These included standard conditions as well as supervision by an approved supervisor.

214. Mr Saad said that the Registrant's skillset may place him in a minority, but he does not claim that there is a shortage of optometrists with the Registrant's skillset. Taking account of the public interest in returning an otherwise competent practitioner to safe practice, Mr Saad asked the Committee to recognise that nine months is a considerable length of time for an optometrist to be suspended from practice.

215. Mr Saad invited the Committee to conclude that erasure would be wholly disproportionate. Erasure was not suggested by the GOC.

216. In conclusion, Mr Saad invited the Committee to consider taking no further action or, if a sanction was deemed necessary, to impose a short Suspension Order of around three months.

Legal Advice

217. The Legal Adviser gave advice to the Committee on the approach to be adopted. There was no comment on it from Counsel and the Committee accepted it.

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

219. *Raschid and Fatnani v GMC 2007 1 WLR 1915* indicates that the Committee is centrally concerned with the reputation or standing of the profession, rather

than the punishment of Registrant, despite the fact that sanctions may have a punitive effect. *Bijl v GMC 2001 UKPC 42* said that a Committee should not be obliged to erase an otherwise competent and useful Registrant who presents no danger to the public in order to satisfy public demand for blame and punishment.

220. The aim of the *Hearings and Indicative Sanctions Guidance* (ISG) revised in December 2021 is to promote consistency and transparency in decisions. The Committee must have regard to the ISG, although each case will depend on its own facts and guidance does not set down a rigid tariff.

221. If the Committee has sound reasons for departing from the ISG it must state those reasons clearly in their decision. Although a Committee need not 'adhere' to the ISG, it should have proper regard to and apply it: *Bramhall 2021 EWHC 2109*. If departing from the ISG, a Committee must give '*clear, substantial and specific reasons*' for the departure.

222. Mitigation can affect the type of sanction, as well as the length of a relevant order: *Wisniewska v NMC 2016 EWHC 2672*.

223. In *PSA v GMC and Doree 2017 EWCA Civ 319* it was confirmed that a Committee may reasonably find that a registrant has shown insight or remorse without hearing oral evidence to demonstrate it, even if it has rejected Registrant's evidence on some or all of the allegations.

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

225. A rejected defence may be relevant to insight and thus risk, but it is permissible to deny an allegation of dishonesty: a registrant has a right to a fair hearing. Erasure for dishonesty is not automatic, the nature and extent of the dishonesty must be evaluated: *Sawati v GMC 2022 EWHC 283.*

226. The Committee was reminded that the following outcomes are available:

a) order that no further action be taken;

b) impose a financial penalty order (which may also be imposed in conjunction with another sanction);

c) impose conditional registration for up to 3 years;

d) impose a period of suspension for up to 12 months; or

e) erasure.

227. The Committee was reminded to take account of the current *ISG*. The Committee was advised to take a proportionate approach, weighing the interests of the public against the interests of the Registrant; also, that any sanction imposed must be appropriate to satisfy the need to uphold standards and maintain public trust in optometrists.

228. If it decides that a sanction is required, the Committee should discuss the least restrictive option first and only move on to consider the next sanction (in terms of severity) if the one under consideration does not sufficiently address the public interest, in all the circumstances. However, the Committee may consider the ISG in relation to all available options.

Determination on Sanction

229. The Committee considered the Registrant's statements and reflections on the events in December 2021, in the context of all evidence, Counsel's submissions and legal advice.

230. The Committee accepted that being subject to fitness to practise proceedings and receiving a finding of impairment by reason of misconduct is likely to have a real impact on a registrant.

231. A public fitness to practise hearing does contribute to the maintenance of public confidence in optometrists and the regulator, as submitted by Mr Saad. The Committee reminded itself of the principles in *Uppal*, which said that: '*public confidence in the profession could be maintained by the fact that the registrant had undergone a rigorous disciplinary assessment of their fitness to practise, resulting in a finding of misconduct*.'

232. The Committee considered testimonials provided in light of the facts found proved; also, whether the authors of the testimonials were aware of the events leading to the hearing and what weight, if any, to give to the authors' views.

Aggravating and mitigating factors

233. The Committee considered the aggravating features of this case. It has determined that the Registrant's dishonest actions were to cover up his error, as opposed to being motivated by financial or other factors.

234. After reviewing the guidance in the ISG it identified two aggravating factors:

- Where the registrant has been dishonest.
- Misconduct involving a vulnerable person, Patient A.

The Committee gave most weight to the dishonesty in its analysis.

235. The Committee then identified mitigating factors. The Committee acknowledged that the Registration had no previous fitness to practise history and had determined that the Registrant's misconduct is highly unlikely to be repeated.

236. The Committee reviewed the ISG and identified two mitigating factors:

- Evidence that the registrant has shown insight and remorse. The Registrant accepted he should have behaved differently; he has taken steps to remediate and expressed remorse for causing distress to Patient A.
- His actions amounted to an isolated incident in an unblemished career, without previous or subsequent allegations.

The Committee gave most weight to the fact that the misconduct amounted to an isolated incident in a long, unblemished career.

Outcomes / Sanctions

237. The Committee went on to consider sanction. It reminded itself of its key findings.

238. The Committee took the view that the dishonesty in this case was serious. The Registrant acted in a deliberate and dishonest way to cover up his own error. He made false entries in Patient A's clinical record to be able to address any formal complaint. Patient A and his relatives were distressed by the Registrant's implication that Patient A had been confused about events and may lack capacity to make decisions. The Registrant's actions were described as deplorable by the Committee.

No further action

239. The Committee considered whether taking no further action was proportionate or appropriate. This was a serious case of dishonesty and there were no exceptional circumstances that would justify taking no further action. A sanction is required to protect the public interest: to uphold standards and to maintain public confidence in optometrists.

Financial Penalty

240. A financial penalty may be appropriate in a case where a Registrant is financially motivated or gains financially from their actions. As there was no financial gain or motivation in this case, a financial penalty would be inappropriate in all the circumstances. Counsel did not suggest otherwise.

241. The Committee determined that a financial penalty order would not be proportionate or appropriate in the circumstances. It would not protect the public interest and is not required.

Conditional Registration

242. There is no suggestion that the Registrant's impaired fitness to practise is related to lack of clinical competence. The criteria for conditions in the ISG are mostly not met.

243. The Committee was unable to identify any appropriate, proportionate or workable conditions that would uphold standards, maintain public confidence or be sufficient to protect the wider public interest.

244. The primary purpose of Conditional Registration would be to protect patients and other members of the public, but this Registrant's fitness to practise was found to be impaired on the basis of the wider public interest.

245. The conditions listed by Mr Saad do not relate to dishonesty or address the concerns of the Committee. There are no aspects of the Registrant's practice that require him to re-train or do further CPD. He has provided evidence of remediation.

246. The Committee concluded that Conditional Registration would not be appropriate or proportionate to deal with the concerns in this case.

Suspension

247. The Committee took account of the criteria listed at paragraph 29 of the ISG which says that a Suspension Order may be appropriate when some, or all, of the following factors are apparent (the list is not exhaustive):

    a) A serious instance of misconduct where a lesser sanction is not sufficient. ⁄

    b) No evidence of harmful deep-seated personality or attitudinal problems. ⁄

    c) No evidence of repetition of behaviour since incident. ⁄

    d) The Committee is satisfied the registrant has insight and does not pose a significant risk of repeating behaviour. ⁄

    e) …

248. The Committee considered that this was a serious instance of misconduct and a lesser sanction would not suffice. Taking account of testimonials from senior

professional colleagues (fully aware of the allegations) the Committee found no evidence of harmful deep-rooted personality or attitudinal problems.

249. There has been no suggestion of any similar conduct since December 2021, over two years ago. The Registrant had been practising without restriction and without complaint; he continues to work for his employer at the time of the events in question.

250. The Committee was satisfied the Registrant has insight and does not pose a significant risk of repeating his behaviour. A Suspension Order would mark the seriousness of the misconduct found and is the most appropriate and proportionate sanction.

251. As part of its deliberations, the Committee also considered whether the Registrant's name should be erased from the register in the context of the ISG. Although the Registrant had been dishonest, he has demonstrated insight into the impact of his actions on Patient A and public trust in optometrists. He has attended CPD on ethics, record-keeping and handling complaints and provided reflections on probity and the need to act in an honest and open way.

252. Although this case involves a dishonest cover-up, it was on one occasion only and the Committee did not consider the Registrant's dishonesty to be at the most serious end of a spectrum of dishonesty.

253. The Committee took account of the Registrant's contribution to the profession and his otherwise unblemished record, but gave this factor limited weight, as all optometrists are required to behave with integrity.

254. The Committee was also aware that there is a public interest in enabling an otherwise competent optometrist to resume safe practice. This must be balanced with the need to uphold standards and maintain public confidence in optometrists. The Committee considered that public confidence requires a proportionate approach from health regulators, who must weigh the public need for optometrists with other factors, such as the need to ensure that dishonest misconduct results in an appropriate response.

255. After balancing all the features of this case, the Committee determined that erasure would be disproportionate. The Committee did not consider the Registrant's misconduct to be fundamentally incompatible with continued registration as an optometrist.

256. The Committee has determined that a suspension order is the most appropriate and proportionate order. It is sufficient to mark the seriousness of the Registrant's behaviour.

257. The Committee took account of the ISG and accepted that, once an appropriate sanction has been identified, the Committee should not impose a more severe or restrictive sanction. The Committee concluded that to exclude the Registrant from practice and to deprive the public of his services would be disproportionate in all the circumstances.

Length of Suspension Order

258. The Committee determined that a short order of suspension would be sufficient to declare and uphold standards and to maintain public confidence in the profession.

259. The Committee determined that a review hearing, before the order expires, is not necessary in the circumstances, taking account of the fact that impairment was found on public interest grounds.

260. The Committee took account of all evidence and submissions in determining the appropriate length of the Suspension Order. The Registrant is a respected Optometrist, with excellent testimonials alluding to his clinical excellence and general probity.

261. However, the Committee took account of the effect of his misconduct on Patient A as well as the potential impact on public confidence in optometrists.

262. The Committee considered that a 4-month Suspension Order is the minimum necessary to satisfy the public interest.

263. An order of suspension for four months is required to maintain public confidence in the profession and the regulator, as well as to declare and uphold professional standards.

264. The Committee determined to impose a Suspension Order for four months.

Chair of the Committee: Rachel O'Connell

Signature **Date: 23 February 2024**

Registrant: Gareth Long

Signature ……joined via video conference………. **Date: 23 February 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.
Effect of orders for suspension or erasure
To practise or carry on business as an optometrist or dispensing optician, to take or use a description which implies registration or entitlement to undertake any activity which the law restricts to a registered person, may amount to a criminal offence once an entry in the register has been suspended or erased.
Contact
If you require any further information, please contact the Council's Hearings Manager at 10 Old Bailey, London, EC4M 7NG or, by telephone, on 020 7580 3898.