BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(23)11

AND

ANDREW MAYNARD (01-32510)

DETERMINATION OF A SUBSTANTIVE REVIEW
2 SEPTEMBER 2024

Committee Members:	Julia Wortley (Chair) Ann McKechin (Lay) Ubaidul Hoque (Lay) Kamlesh Gohil (Optometrist) Amit Jinabhai (Optometrist)
Legal adviser:	Chloe Hudson
GOC Presenting Officer:	Holly Girven
Registrant:	Present
Registrant representative:	Stephen George Smith
Hearings Officer:	Humera Asif

Outcome: Suspension Order for 12 months with Review

General Optical Council

DETERMINATION

Factual Allegation as found proved

Patient A

1) On or around 23 July 2021 you examined Patient A and you failed to keep an adequate record of your consultation with Patient A in that you did not record:
   a. the number of times per day the chloramphenicol was to be administered by Patient A, and / or
   b. the duration of use of the chloramphenicol by Patient A, and / or
   c. to which eye the chloramphenicol should have been administered;

Patient B

2) On or around 18 July 2021 you examined Patient B and you failed to:
   a. carry out an adequate examination and/or assessment of Patient B in that you did not:
      i. check for staining with fluorescein, and / or
ii. make any or sufficient enquiries about Patient B's:
         1. care system, and / or
         2. compliance with the cleaning regimen, and/or
         3. poor comfort,
iii. establish contact lens age and / or condition,
   b. keep an adequate record of your consultation with Patient B in that you did not record:
      i. which eye the symptoms of dryness and / or stickiness occurred in, and / or
      ii. details regarding the 'poor comfort', and / or
      iii. whether the problem occurred when the contact lenses were new as well as old, and / or
      iv. the number of days per week or month the contact lenses were worn, and / or
      v. details of Patient B's care system, and / or
      vi. details of Patient B's compliance with the cleaning regimen, and / or
      vii. contact lens age, and / or
      viii. contact lens condition;

Patient F

3) On or around 25 June 2021 you examined Patient F who present with signs and symptoms suggestive of neurological disease, including but not limited to:
   a. headaches, and/or
   b. patchy vision, and/or
   c. swollen right optic disc, and / or
   d. reduced visual acuity in the left eye, and / or
   e. hemianopic visual field defect;

4) *sent Patient F home without discussing with and / or advising them that a very prompt referral was necessary to investigate the signs and symptoms.*
5) *You failed to appreciate that Patient F's presentation required an emergency referral.*
6) *As a result of 4 and 5 above you exposed Patient F to the risk that the specialist assessment of their condition would be inappropriately delayed.*

Patient G

7) *On or around 17 August 2021 you examined Patient G and you failed to:*
    a. *keep an adequate record of your consultation with Patient G in that you did not record details in respect of the action plan, and / or*
    b. *make an urgent referral regarding Patient G's:*
        i. *presenting intra-ocular pressures, and / or*
        ii. *reduced acuity, and / or*
        iii. *deteriorated visual fields*

Background

1. The Registrant was first registered as an Optometrist in February 1985. At the time of the events, the Registrant was working as an Optometrist in the [redacted] practice of Boots Opticians, which was a role that he commenced in June 2021. Prior to starting with Boots Opticians, the Registrant had been on a break from practice for over a year. The Registrant has no past fitness to practise history.

2. The allegations relate to the Registrant's failings in relation to four patients (A, B, F, G) whom he examined between 25 June 2021 and 17 August 2021.

Patient F

3. On 25 June 2021, the Registrant carried out an eye examination on Patient F who presented with signs and symptoms of neurological disease, which included headaches and patchy vision for some six weeks previously. The examination revealed that Patient F had swollen optic discs (the right severely swollen), reduced visual acuity in the left eye and a bilateral visual field defect. These symptoms were indicative of a serious diagnosis such as a brain tumour or stroke and Patient F was subsequently diagnosed with a brain tumour.

4. The Registrant had examined Patient F in the morning and after the examination allowed Patient F to leave the practice, informing her that there would need to be a hospital referral. The Registrant failed to appreciate that Patient F's presentation required an emergency (i.e. within 24 hours) referral. The Registrant failed to discuss with and/or advise Patient F that a very prompt referral was necessary to investigate the serious clinical signs and symptoms that had been detected.

5. The Registrant sought advice from a colleague, Ms A, at lunchtime as to the correct referral tab to use on the SCI Gateway, the electronic referral system, which has options for routine or urgent referrals. This prompted that colleague to review the patient record of Patient F and advise that the hospital needed to be telephoned for an appointment that day, as an electronic referral on the SCI

Gateway could take up to seven days even when marked as urgent. It was the opinion of Dr Kwartz that the Registrant did not heed a very strong combination of clinical signs strongly suggestive of an abnormality and that Patient F should not have left the practice without being informed of the seriousness of the concerns and the potential implications of the same.

Patient B

6. On 18 July 2021, the Registrant carried out a contact lens aftercare on Patient B, who attended for a contact lens appointment. The Registrant's examination of Patient B was incomplete, as he did not use fluorescein, in order to conduct an examination of the cornea. Further, the Registrant did not make any or sufficient enquiries about Patient B's: care system, and/or compliance with the cleaning regimen, and/or poor comfort, establish contact lens age and/or condition, as these matters were not recorded within Patient B's patient record.

7. There were further failings in relation to the standard of the Registrant's record keeping, with there being a number of omissions identified by Dr Kwartz, for example in relation to the scant history of the dryness and stickiness experienced by Patient B and their lens fitting characteristics.

Patient A

8. On 23 July 2021, the Registrant carried out an eye examination on Patient A, who had injured his right eye on a tree branch when running several weeks earlier. The Registrant had examined Patient A at an earlier examination on 19 July 2021, when he recommended that Patient A be re-examined in 5 days. At the follow up examination on 23 July 2021, the Registrant advised the use of an antibiotic, chloramphenicol.

9. There were failings in the Registrant's record keeping, by not keeping an adequate record of his consultation with Patient A. He failed to record the number of times per day the chloramphenicol was to be administered by Patient A, and/or the duration of use of the chloramphenicol by Patient A, and/or to which eye the chloramphenicol should have been administered. When the Registrant's colleague, Ms B, examined Patient A in a further follow up appointment on 27 July 2021, she struggled to decipher the Registrant's notes.

Patient G

10. On 17 August 2021, the Registrant carried out an eye examination on Patient G. Patient G had been previously diagnosed with glaucoma, which had been initially difficult to manage. Patient G attended on 17 August for a community glaucoma check, which at that time, due to COVID, was being carried out by Boots Opticians. The Registrant's examination of Patient G identified significantly elevated intra-ocular pressures ('IOPs') at a level very likely to cause damage to the eye (34mmHg), reduced acuities and a deterioration in her visual fields, which could indicate advancing glaucoma which warranted referral back to the glaucoma clinic in the hospital.

11. The Registrant's assessment and record keeping in respect of Patient G was inadequate in that an inadequate history was recorded, it did not record whether

the patient was compliant with her eye drops and no action plan was stated. Further, there was no urgent referral of Patient G to the Hospital Eye Service (HES), which was required. Whilst a referral appears to have been drafted by the Registrant on the practice's electronic referral system, this was 'parked' as a draft referral and not sent until 29 September 2021, when it was picked up and sent by the Registrant's colleague.

12. Concerns were raised by the Registrant's colleagues and the Registrant was suspended by Boots Opticians on 28 September 2021, whilst the concerns were investigated further. Following an investigation meeting on 7 October 2021 and a disciplinary meeting on 21 October 2021, the Registrant was dismissed from his employment. On 2 December 2021, Boots Opticians made a referral to the Council regarding the Registrant.

13. Between 16-19, 24-26, 30 October, 1 and 7 November 2023, a substantive hearing was held, for which the Registrant attended and was represented. The Committee found all facts proved save for 7(c), and found that those facts found proved amounted to misconduct. It went on to find that his fitness to practise was impaired by reason of that misconduct. The Committee concluded that there was a real risk of repetition of similar conduct, it was of the view that the public would be concerned if no finding of impairment was made, given the lack of remediation and the Registrant's limited insight. The Committee determined that it was also necessary to make a finding of impairment in this case in order to maintain confidence in the profession and in order to uphold proper professional standards, particularly in respect of the Registrant's failings in respect of Patient F.

14. The Registrant's registration was made subject to conditions for 18 months with a review within 3 months.

15. The Registrant's registration was reviewed on 15 March 2024 and made subject to conditions for 18 months with a review hearing to take place within 6 months.

16. The order is due to expire on 15 September 2025.

2nd Sub Review – 2 September 2024

Findings regarding impairment

17. For the purpose of the Review, the Committee has been provided with documentation, including but not limited to the following:

    a. The determination from the substantive hearing, dated 7 November 2023;

    b. The determination from the first substantive review dated 15 March 2024;

    c. Correspondence from the GOC to the Registrant subsequent to the 1st Substantive Review hearing regarding the Registrant's compliance with the conditions imposed;

    d. A skeleton argument on behalf of the GOC, dated 23 July 2024.

18. The Committee has heard submissions from Ms Girven on behalf of the Council and from Mr Smith on behalf of the Registrant. Ms Girven reminded the Committee that it was not bound by the view of the earlier Committees and must

make its own independent judgment based on all of the information placed before it today.

19. Ms Girven highlighted to the Committee what had happened since the conclusion of the Substantive Review hearing in March 2024. Ms Girven submitted that the Council's position was that the Registrant's clinical and record keeping failures were of serious concern and presented a risk of harm to patients. The amended conditions and in particular, the requirement for the reflective statement, were imposed to address some of the deficiencies in his practice and that nothing has changed since the First Review Hearing. The additional requirements placed upon the Registrant have not been complied with.

20. The Committee then heard from Mr Smith on behalf of the Registrant. Mr Smith informed the Committee that the Registrant accepted that his fitness to practise was impaired and that no evidence was required under the order of conditions.

21. The Committee heard and accepted the advice of the Legal Adviser who advised that upon Review, the Committee will need to consider impairment afresh (*Clarke v GOC [2017]* EWHC 521 Admin). She advised that although the Registrant conceded his current fitness to practise is impaired, the question of impairment was a matter for the Committee's independent judgment taking into account all of the evidence it has seen and heard so far and that a finding of impairment does not automatically follow a finding of misconduct and reminded the Committee of the relevant principles set out in *Cohen v GMC [2008]* EWHC 581 (Admin).

22. The Legal Adviser reminded the Committee to consider facts material to the Registrant's fitness to practise looking forward and for that purpose to take into account evidence as to his present skills or lack thereof and any steps taken since the conduct criticised to remedy any deficiencies.

23. The Committee noted that the focus of a review hearing is upon the current fitness of the Registrant to resume unrestricted practice, judged in light of what they have, or have not, done since the substantive hearing and whether they remained currently impaired.

24. The Committee identified that the misconduct found proved involved clinical concerns, record keeping, history taking and patient management failures. Whilst in principle the Committee considered this misconduct easily remediable, there was no evidence from the Registrant to demonstrate that it had been remediated, and therefore the Committee was concerned that a risk of repetition remained.

25. The Committee was mindful that the onus at a Review hearing was on the Registrant to demonstrate that he was no longer impaired and in effect there is a persuasive burden upon him to show that he is currently fit to practise unrestricted.

26. The Committee determined that there has been no change in circumstances since the substantive hearing in November 2023. As such there remains in the Committee's view a risk to the public, and a finding of impairment was necessary on public protection grounds. Furthermore, the Committee also concluded that the public interest required a finding of current impairment was necessary on public interest grounds because if a well-informed members of the public was aware of the facts and history of the case, they would be concerned if no finding of impairment was made.

27. Accordingly, the Committee found that the fitness of the Registrant to practise as an optometrist is currently impaired.

Sanction

28. Having decided that the Registrant's fitness to practise is impaired, the Committee next considered what direction it should make pursuant to s13F(13) of the Act. The Committee heard submissions from Ms Girven on behalf of the Council and from Mr Smith on behalf of the Registrant.

29. Ms Girven referred the Committee to paragraphs 21.20 and 21.25 (d) of the Indicative Sanctions Guidance ('ISG') and reminded the Committee that, having found the Registrant to be impaired, it had the power to maintain the conditions, vary them, or to change the type of order to one of suspension. The General Optical Council's position was that because of the Registrant's failure to comply with the conditions, and to provide any evidence that this has been addressed that the risk to the public has been addressed the proportionate response was to impose an order of suspension because conditions were no longer workable.

30. The Registrant took the affirmation and gave evidence to the Committee. The Registrant stated that he had not understood how the conditions worked in practice but appreciated if he had engaged sooner he would have been better able to seek employment. The Registrant said he had no recollection of the requirement made at the First Substantive Review to provide a reflective statement to this Review Hearing but could do so promptly.

31. The Registrant accepted that he had received emails from the Council chasing for updates regarding his compliance with the conditions but he had not acted upon them.

32. The Committee then heard from Mr Smith on behalf of the Registrant. Mr Smith said there was no risk to the public from the Registrant returning to work. He informed the Committee that the Registrant had been labouring under a misapprehension about how the conditions would work in practice but the Registrant now understood how he could reactivate his registration and work subject to the conditions. It was accepted that the Registrant had not prepared a personal development plan ('PDP') or provided a reflective statement but these would be done within one month. Mr Smith invited the Committee to leave the current conditions in place to give the Registrant a further opportunity to comply and find work. In the alternative he invited the Committee to impose a short suspension to enable the Registrant to provide a personal development plan and reflective statement.

33. The Committee has accepted the advice of the Legal Adviser. She advised that the Committee should impose the least onerous sanction sufficient to meet the identified risks, having regard to the principle of proportionality and the public interest.

34. The Committee considered the sanctions available to it from the least restrictive to the most severe (revoke or vary the current order of conditions, direct that the current period of conditions be extended, suspension or erasure). The Committee applied the principle of proportionality by weighing the Registrant's interests with the public interest.

35. The Committee was of the view that given the Registrant's lack of engagement with the Council since the substantive hearing in November 2023 his failure to evidence compliance with the existing conditions and the lack of any evidence supporting his remediation and insight, it would not be appropriate or proportionate to revoke the order. The Committee was of the view that an

aggravating factor in this case was the Registrant's failure to demonstrate any appreciation of the seriousness of these matters.

36. The Committee next went on to consider whether the Conditional Registration Order remained a sufficient and proportionate response to the risks identified. The Committee noted that the original order was imposed for a period of 18 months on the grounds that there had been serious clinical deficiencies, record keeping deficiencies and patient management failures in the Registrant's practice. The Committee was of the view that 10 months have passed since the imposition of the conditions with no material action on the Registrant's part, no engagement by the Registrant with his regulator, and no evidence that conditions had been complied with. The Committee was mindful of the Registrant's statement in evidence that he wants a return to safe practice.

37. However, the Committee considered that the Registrant had failed to comply with the conditions imposed upon him and has had sufficient opportunity to demonstrate full compliance, particularly given the outcome of the First Substantive Review. The Committee considered that the current conditions were not working as the Registrant had not complied with them. It was of the view that the conditions were no longer proportionate in dealing with the risk the Registrant poses to the public. He had not engaged with his regulator despite being an experienced Registrant who had acknowledged during his evidence the importance of doing so. The Committee considered that the risks to the public are increasing, given the amount of time the Registrant has been out of practice without any evidence of keeping his clinical skills and knowledge up to date particularly maintaining his CPD requirement or addressing the failings identified in his practice.

38. The Committee considered that in all the circumstances the proportionate response was to impose a period of suspension.

39. The Committee considered that the period of 12 months' suspension would give the Registrant sufficient time to produce the PDP, reflective statement and any other evidence which the Registrant considers would assist the next Committee in determining whether his fitness to practice is impaired. Any period less than 12 months would not be long enough to give the Registrant time to address the concerns highlighted by the previous Committees' decisions.

40. The Committee is of the view that it will be necessary to review the order within 6 months to assess the Registrant's progress in providing the evidence to reassure a future Review Committee that the Registrant is fit in due course to resume unrestricted practice or to practice with conditions.

41. The Committee therefore imposed a Suspension Order for a period of 12 months from today's date, with a review hearing to take place within 6 months.

General Optical Council

Chair of the Committee: Julia Wortley

Signature **Date: 2 September 2024**

Registrant: Andrew Maynard

Signature present and received via email **Date: 2 September 2024**

General Optical Council

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.