BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(23) 30 & 31

AND

THOMAS DUPEYRAT (D-14229)

DETERMINATION OF A SUBSTANTIVE HEARING
27-30 NOVEMBER 2023

Committee Members:	Ms Pamela Ormerod (Chair/Lay) Ms Alice Robertson Rickard (Lay) Ms Vivienne Geary (Lay) Mr Ian Taylor (Dispensing Optician) Ms Judith Stodel (Dispensing Optician)
Legal adviser:	Mr Graeme Dalgleish
GOC Presenting Officer:	Mr Sam Thomas
Registrant present/represented:	Present, not represented
Registrant representative:	N/A
Hearings Officer:	Mr Terence Yates
Facts found proved:	1 ,2, 3,4 & 5
Facts not found proved:	None
Misconduct:	Found
Impairment:	Found
Sanction:	Erasure
Immediate order:	Yes

Application to amend the allegation

1. Mr Thomas for the Council made an application for the Allegation to be amended. This was not opposed by the Registrant. Mr Thomas submitted that the Registrant had sought to add the words "*to your supervisor*" in allegation particular 3. This was not a matter of contention and had been agreed with the Council at the case management hearing on 9 November 2023.
2. The Committee also considered that it was appropriate to change the word *"you*" to "*were*" in particular 5 to read "*were submitted*" in respect of the case records referred to in particular 3.
3. The Committee accepted advice from the legal adviser as to the interests of justice and fairness. The Committee decided that the amendment did not alter the nature or gravity of the allegation and helped to clarify the Registrant's position. The Committee decide that it was fair and appropriate to allow the proposed amendment.

ALLEGATION (as amended at the hearing)

It is alleged that you, Mr Thomas Dupeyrat (D-14229), a registered Dispensing Optician:

1) Between 7 November 2018 and 28 August 2021, whilst training to become a qualified Contact Lens Optician:

a) Undertook 29 contact lens assessments and/or aftercare clinics without the required supervision of your primary supervisor and/or secondary supervisor;

b) Your conduct at 1) a) above was inappropriate in that you knew or ought to have known about the requirement for supervision and your responsibility for ensuring that your clinical examinations were appropriately supervised;

2) You failed to maintain adequate patient records, namely:

a) In relation to some or all of the patients in Schedule A, you failed to record sufficiently or at all their visual acuity and/or over-refraction;

b) In relation to some or all of the patients in Schedule B, you failed to record their toric lens rotation;

c) In relation to some or all of the patients in Schedule C, who were presbyopic patients wearing contact lenses, you failed to record a near correction;

d) In relation to some or all of the patients in Schedule D, you failed to record their care and/or hygiene regimen;

e) In relation to some or all of the patients in Schedule E, you failed to adequately record the description of contact lens fitting characteristics;

f) *In relation to some or all of the patients in Schedule F, you failed to record that emergency advice was given to patients who wore their contact lenses on a continuous-wear basis;*

g) *In relation to some or all of the patients in Schedule G, you did not adequately record your clinical investigation of their tear assessment and/or tear film assessment;*

h) *In relation to Patient 32, you did not adequately record details of whether their symptoms were improved with new contact lenses;*

i) *In relation to Patient 53, you did not adequately record details of their macropunctuate staining and/or contact lens peripheral ulcer;*

j) *In relation to Patient 148, you did not adequately record details of their corneal neovascularisation;*

k) *In relation to some or all of the patients in Schedule H, your record keeping was inadequate as detailed in the supporting table;*

l) *In relation to some or all of the patients in Schedule I:*

i) *a score of 0 was given for their Anterior Segment Grading; and*

ii) *Your recording was inaccurate as it's improbable that these patients would score 0 for all structures examined;*

3) *Around November 2021 you submitted inaccurate case records to your supervisor for the purposes of your Association of British Dispensing Opticians ("ABDO") accreditation, with some or all discrepancies as detailed in Schedule J;*

4) *Your conduct at 3) above was:*

a) *Misleading and/or*

b) *Dishonest in that you knew that the case records submitted for scrutiny contained inaccurate information;*

5) *You failed to maintain patient confidentiality, in that you did not adequately anonymise the case records that were submitted to ABDO*

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

DETERMINATION

Admissions in relation to the particulars of the allegation

4. The Registrant admitted particulars 1, 2, 3 and 5 of the Allegation, as amended. He denied particular 4 as to both misleading and dishonest. The Committee accordingly found particulars 1, 2, 3 and 5 proved by reason of the Registrant's admission in terms of Rule 40(6) and 46(6) of the Council's Fitness to Practise Rules.

Background to the allegations and opening submissions for the Council

5. Mr Thomas opened the case for the Council. On 28th February 2022, Mr A, a Professional Services Consultant supporting Specsavers Stores, sent an email referring the Registrant to the Council on behalf of [redacted] ("Company A") who trade as Specsavers [redacted] ("The Practice").

6. The Registrant was a registered dispensing optician at the Practice and was training as a contact lens optician. At a meeting on 10 December 2021, as part of that training, the Registrant provided his primary supervisor, Mr B, also a director for Company A, with ten case records for review before submission to the Association of British Dispensing Opticians (ABDO) as a precursor to sitting an examination. However, Mr B was concerned that there were discrepancies between the case records and the corresponding records held on the Specsavers electronic patient record system, Socrates.

7. The Registrant resigned from his position at the Practice on 13 January 2022. He was informed prior to leaving that an investigation would be undertaken in relation to the submission of these records. On 31 January 2022, Mr A completed his investigation in relation to these ten records.

8. Mr A provided an outline of the discrepancies in his referral email to the Council on 28 February 2022. This contained details of discrepancies in ten case records provided by the Registrant between the electronic and physical records at the Practice, including discrepancies in details such as date of birth, assessment dates, and contact lens history.

9. The investigation report by Mr Al forms the basis of the referral email to the Council and contains the same information as the email referred to above. However, that investigation report also includes a recommendation to invite representatives of ABDO to undertake an investigation into the ten case records. The investigation report stated:-

'Recommendations

ABDO have already been alerted to the fact that an investigation into the records was due to be commenced and the partners of [Company A] *had agreed to share the report with ABDO whether or not any evidence of discrepancies were found. Representatives of ABDO should be invited into the store to compare the case records against the store test room records which provide a clearer view of the total test record, as opposed to the contact clinical reports.*

The partners also agreed that, should evidence of discrepancies in the case records be present, that the GOC should be informed in due course. This has now been confirmed and the GOC will be informed.'

10. On 18 March 2022, Mr C, [Redacted] in Contact Lens Practice at ABDO attended the Practice to undertake an investigation on behalf of ABDO.

11. On 20 March 2022, Mr C completed his report with regard to these ten records. He concluded that there was: *'evidence that the 10 case records submitted for assessment purposes had either been fabricated or falsified to meet certain assessment category requirements.*' That report from Mr C dated 23 May 2022 provides the basis of the allegations and sets out in detail the specific differences identified in the ten cases. He summarises his findings for each case record (CR) as follows ('TD' being the Registrant, Px the patient) :-

- CR 1 - While This Px exists on the system, the CR bears little resemblance to the system details for the Px. I couldn't find any evidence of any patients whose details and appointment patterns on the CR matching with the records on the system.
- CR 2 - While this appears to be the correct Px, who was fitted by TD, there is clear evidence that there are several inconsistencies between the CR and the system.
- CR 3 - There is no evidence on the system that this patient exists as there is no system evidence for this Px at all.
- CR 4 - While this Px exists and has been seen by TD in the past, there appears to be clear inconsistencies of lens type, Rx, and dates of appointments that have taken place.
- CR 5 - This Px clearly exists and has been seen by TD in the past. However, there is still evidence of inconsistencies between the CR and system records. While there are several links between the system and the CR, there are numerous instances of the records not matching and so do not appear to be a true reflection of what has taken place.
- CR 6 - as TD appeared to have done no clinical work at all (just 1 vision and fit check), then there is evidence that TD has created the CR based on the records of other practitioners, although the dates do not match at all.

- CR 7 - It appears that TD did ONE routine appt with this Px, but all other appointments have been performed by other practitioners. There is no matching of the dates between the CR and the system and so there is evidence that the CR has been created based mainly on the work of others.
- CR 8 - Original lenses not fitted by TD and there are a lot of inconsistencies between the records, although it is clear that there has been some interaction with the Px by TD. However, there is evidence to suggest that the information on the CR is not a true reflection of what took place on the system.
- CR 9 - There is little doubt that the case record is a genuine patient, and that TD did the majority of the work with the Px. There are clear inconsistencies between the dates on the CR and the system, and discrepancies as to what took place at these appts. However, there is some level of similarity between the CR and system records.
- CR 10 - This appears to be at least partially true, but the dates and the findings are inconsistent between the CR and the system and the 13.11.19 appointment does not appear to have been conducted at all.

12. Mr C concluded his report stating "*I would recommend that these case records should not be counted in their entirety, as all 10 case records have at least some evidence of falsification, fabrication or inconsistencies with the records on the SOCRATES system. With respect to case records, there would appear to be strong evidence of falsification, particularly on case records 1,2,3,4,6,7 and 8."*

13. On 3 February 2022 Mr C provided a further statement in an email to the Council setting out the ABDO requirements and criteria for case records stating:-

"For Section 5 of the ABDO Certificate in Contact Lens Practice examination, candidates are required to present 10 case records chosen from the patients fitted during the personal clinical experience period. A number of the case records will be discussed in detail with the candidate, including decisions made and actions taken.

The records must reach ABDO by 31st May [for Summer practical examinations] or 30th November [for Winter practical examinations]. They should demonstrate the range and depth of experience of the candidate and are required to meet the following criteria.

A mix and range of prescriptions, replacement modalities, lens designs and materials to include -
• myopes and hyperopes and a minimum of 2 patients with Rx of more than 5 dioptres

• a minimum of 2 patients demonstrating bifocal/multifocal contact lens management of their near vision requirements
• a minimum of two rigid lens patients
• a minimum of two toric lens patient
• a minimum of two aftercare problems – to show clinical problems caused by contact lens wear [issues with the cornea or adnexa which require refitting or a major change in management]: these case records do not need to have been originally fitted by the candidate but must meet the same aftercare requirements of the other records.

Case Record Requirements

The cases should be selected from those patients fitted during the personal clinical practical experience and should demonstrate a depth and breadth of experience. The patients are required to have been monitored over a minimum period of 6 months."

14. Mr C concluded :- "*So, for example, the dates on some of the case records did not appear to match the dates that the patients were seen in practice. This, is perhaps to ensure that they met the date condition of 6 months continuous aftercare There were patients were the optical prescription was different to the prescription in the case record. This is likely to make sure that the case record filled one of the minimum criteria of a toric lens or a multifocal, etc."*

15. Mr Thomas for the Council invited the Committee to accept the opinion evidence of Mr C as an expert. He is the [redacted] in Contact Lens Practice at ABDO. Mr C's opinion was that the changes found in the ten case records were made to meet the ABDO criteria.

16. Mr Thomas referred to the witness statements from Mr A and from Mr C setting out these circumstances and the investigation and ABDO reports. He submitted that the Committee should carefully consider the changes that had been identified, and consider why they had been changed when assessing the issues of whether they were misleading and/or dishonest.

17. Mr Thomas submitted that the inconsistencies were clear and were not mistakes by the Registrant. Mr Thomas submitted that the changes had been deliberately made by the Registrant in order for the case records to meet the criteria for the ABDO assessment. Mr Thomas submitted that the differences and inconsistencies were such that they were intentional and were objectively misleading and that there was an intention and clear motivation by the Registrant to mislead ABDO. He submitted that the changes had been made to "*crowbar*" the records into meeting the ABDO criteria. Mr Thomas submitted that there was a clear benefit to the Registrant, as he was seeking to become a qualified contact

lens practitioner, and there was therefore a clear inference that the Registrant was dishonest.

The Registrant's evidence

18. The Registrant said that he was not told about the investigation into the case records until 13 January 2022, and said that he was not given prior notice. He said he felt he had been "*pushed under a bus*" as he had been aware there were discrepancies. He had alerted his supervisor to this, and he had assumed the supervisor would have been in touch to discuss this before any formal steps were taken. He said he was not given the opportunity to rectify the records. He said he had decided to defer his examinations before he was advised of the investigation, and this was due in part to Covid and because he was waiting to hear from his supervisor.

19. The Registrant said that he had worked at the Practice between November 2018 and November 2021, when he had seen hundreds of patients, and there had been no issue with records in that whole period. He said that there was not ever a single "*sit down"* with his supervisor or any feedback on his records. He indicated that latterly relationships with his supervisor had broken down over an internal management issue, and communication had been strained. He said, in hindsight, that he should have asked for more supervision. He said he had worked for Specsavers for 18 years and it was a high volume practice where you were expected to "*get on with things"*. He said he had been given no time to go over his records and had been "*overwhelmed."*

20. The Registrant accepted that he had made up some of the records. He said that whilst it was hard to agree with every statement Mr C had made, without being able to cross reference his findings with the records, over all he knew what he had done, which was for the purpose of taking the exam. He said he felt sorry for letting himself down and his patients, and that he should have taken time to reflect on his professional role. He said he had lost track of the time period in which to submit the records.

21. In cross examination, the Registrant said that he had made the changes set out in the ten cases detailed by Mr C, those in schedule J before the Committee. He said he had been trying to pick one patient who would meet each of the requirements for ABDO but none fitted exactly what was required. He said that he had been overwhelmed and had not been organised. He said in CR1 for example that he had changed the date of birth and was trying to "*condense*" all the experience of all the patients he had seen. Whilst he said that he did "*fabricate*" some details, he had been prepared for his supervisor to challenge him and that would have been the end of the matter.

22. The Registrant accepted that ABDO were looking for genuine patient records, but believed that the role of the supervisor was to prevent anything happening that was not correct. He said he could not justify what he did, but he had not sought to deceive ABDO, as that did not happen. He agreed that the case records were tailored to meet the ABDO requirements. He said that deception was "*hypothetical"* as he had not expected his supervisor to accept the records. He did not think he had been dishonest, and said it was not "*black and white*". He said that he had not forged anything, but had "*made them up.*" He did not think they would make it to ABDO. He said he had spent several months preparing the case records for submission to ABDO.

23. The Registrant said that he understood the Council's Code of Practice, but said that these were not actual patient records and, in any event, this had been confidential and should have been addressed by his supervisor. He knew the case records he submitted contained incorrect information, and said that he was aware there were discrepancies and he had told his supervisor. He had applied to withdrew from the ABDO winter examination in an email dated 20 December 2021, as he had been expecting his supervisor to correct the records and discuss that with him. He subsequently withdrew entirely from the examination. He accepted that what he had done was wrong. He said that this took place at a time when he also had a grievance with his employer about the environment he worked in which was not conducive to dealing with this issue. He said that if he had not been challenged, he would have proceeded to sit the ABDO contact lens examination in the winter of 2021/2022.

Closing Submissions

24. Mr Thomas closed the case for the Council. He reminded the Committee that the evidence was that the Registrant knew that what he was doing was wrong. He had been a Dispensing Optician for over ten years and knew about the professional standards required of him. Mr Thomas submitted that the Registrant's evidence made it clear that the steps he took were objectively misleading. Mr Thomas submitted that the Registrant knew that was so. He submitted that there was clear motivation by the Registrant to falsify those records in order to become qualified as a contact lens optician, and the Registrant had accepted that he had changed and fabricated the case records to fit the ABDO criteria. Mr Thomas submitted that was dishonest.

25. The Registrant submitted to the Committee that the environment and circumstances in the work place had given him little guidance and support. He had chosen to defer the examination before being advised that an investigation was taking place. He said he had not been dishonest and questioned whether his supervisor had acted properly in submitting the case records without discussing it further with him.

Findings in relation to the facts

26. The Legal Adviser advised the Committee that the burden of proof rested on the Council and the standard of proof was the balance of probabilities. He reminded the Committee that, whilst it had the benefit of some expert evidence, it was the Committee who were the principal fact finders and it was for it to decide on the facts, including dishonesty. He advised the Committee on the guidance on dishonesty in *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67. The Legal Adviser gave a good character direction to the Committee in respect of the Registrant.

27. The Committee considered all the evidence and was mindful that particulars 1, 2, 3 and 5 are proved by way of admission. It considered the evidence in respect of particular 4 and was mindful of the guidance in the *Ivey* case and the good character direction. The Registrant has been a registered dispensing optician for some 10 years and, as such, he is well aware of his professional standards, the importance of honesty and integrity in the workplace, and the need to keep accurate patient records. He accepted that in his own evidence.

28. The Committee considered all the evidence before it, including the evidence from the Registrant. He has admitted that the case records were inaccurate and he accepted in his evidence that he had changed the case records and that he had "*fabricated*" them. He accepted in his evidence that he knew when he submitted them that he had altered them, and he knew that they were intended to be submitted to ABDO, albeit he said he expected that his supervisor would challenge the accuracy of the case records and they would not "*go forward".*

29. The Committee found that it was clear from the Registrant's own evidence that he knew when he did so, that he had altered and fabricated the case records. Further, he also knew and understood that the purpose of submitting them in that fabricated and altered state was to permit him to take the professional examination with ABDO in order to qualify as a contact lens optician.

30. The Committee noted that the Registrant said he would have taken the ABDO examination had the matter not been investigated, and had the discrepancies with the case records not been discovered. The Committee noted the evidence from the Registrant about poor support from his supervisor, fractured work relationships and the busy working environment that the Registrant said existed at the time. Those circumstances did not provide any justification for knowingly fabricating case records in order to gain a professional qualification. He accepted in his evidence that he had spent some months preparing and altering the case records.

31. The Committee was mindful that the ordinary meaning of the word "*fabricate*" is to invent or to produce something false in order to deceive. That word carries a

distinct element of deliberate conduct which is designed to deceive. One cannot fabricate inadvertently or honestly. The Committee concluded that what the Registrant did in respect of the relevant case records was misleading, and was deliberately designed by the Registrant to be so.

32. The Committee was mindful of the guidance in *Ivey.* The Committee heard from the Registrant who accepted that he had knowingly altered and fabricated the case records. The Committee found that, subjectively, the Registrant did so knowing to whom those records would be sent, ABDO, and the purpose for which that they would be used. He accepted in his evidence that he made the alterations specifically to meet the ABDO requirements. He said that he knew it was wrong, but he did not accept it was dishonest because it had not, in the event, actually been relied upon by ABDO as a result of the investigation.

33. The Committee decided that the Registrant knew that what he did was wrong and that it was dishonest. He deliberately changed the case records in order to deceive ABDO to allow him to sit the examination. The Committee did not accept his evidence that although deliberately fabricated by him and specifically designed by him to meet the ABDO criteria, that it was conduct that was not dishonest. The Registrant knew that the case records submitted for scrutiny contained inaccurate information as he had fabricated that information. Further, the Committee was clear that this was conduct, which viewed objectively by an ordinary, decent member of the public, would be seen as dishonest.

34. The Committee concluded that the admitted conduct was both misleading and dishonest and it found allegation particular 4 proved.

Submissions on Misconduct

35. Mr Thomas referred the Committee to the entire Allegation and reminded it to consider the admitted clinical allegations set out in paticulars 1 and 2. He referred to the relevant case law and he submitted that the clinical matters in particulars 1 and 2 were, alone, sufficiently serious to amount to misconduct. He referred the Committee to the expert report provided to the Council by Dr Anna Kwartz who examined the patient records covered by the allegation.

36. Mr Thomas submitted that the Registrant's acts and omissions in particular 1 in respect of all 29 matters set out, and admitted, were sufficiently serious to amount to misconduct. Mr Thomas submitted that allegation 2 set out the Registrant's admitted acts and omissions in respect of a large number of patients as detailed in schedules A to I. Schedule H details what Mr Thomas submitted was, collectively, a series of 14 instances of inadequate record keeping. He submitted this was serious and amounted to misconduct. He submitted that although the Committee may find that allegation 2 (b) did not amount to misconduct (in light of

Dr Kwartz's opinion that the conduct in question fell below the standard expected rather than far below) overall, the record keeping failures in particular 2 were serious and amounted to misconduct.

37. Mr Thomas also referred the Committee to its findings in particulars 3, 4 and 5. He reminded the Committee that these allegations were in respect of those patients listed in schedule J. He further reminded the Committee that the Registrant had admitted the breach of confidentiality, as alleged in particular 5. He submitted these findings were serious and amounted to misconduct

38. Mr Thomas referred to the conclusions of the expert, Dr Kwartz, who conducted a detailed analysis of the patient records as set out in her report for the Council dated 22 February 2022. Dr Kwartz concluded at paragraph 10 of her report:-

"10.1 There were multiple aspects of Thomas Dupeyrat's contact lens records which did not meet the required standard. I found that many of his records had poor narrative power, in that I was not able to follow his clinical thinking and action plan. There were areas of practice where patient safety could be compromised, for instance: patients who use durable contact lenses whose compliance with their care regime was not reviewed; patients who use continuous wear contact lenses who were not warned about the risks of adverse events and action to take; and, a patient with a suspected contact lens peripheral ulcer where there was no record of safety-netting advice. There were also multiple occasions where conflicting information was presented within the record (eg regarding lens type) and it was difficult, as the reader, to establish the background to the patient's attendance and also the ongoing patient management.

10.2. In undertaking unsupervised contact lens examinations, Thomas Dupeyrat breached The General Optical Council (Contact Lens (Qualifications etc.) Rules) Order of Council 1988. He also did not comply with ABDO's rules for trainee contact lens opticians which state that supervision is required.

10.3. Table 2 shows which of the General Optical Council's Dispensing Optician Core Competencies (2011) and Contact Lens Speciality Competencies (2011) were, in my opinion, not met by Thomas Dupeyrat during his examination of the patients whose records I have reviewed .

10.4. Table 3 shows which of the General Optical Council's Standards of Practice for Optometrists and Dispensing Opticians (2016) were, in my opinion, not met by Thomas Dupeyrat during his examination of the patients whose records I have reviewed."

39. Mr Thomas submitted that it was for the Committee to decide on misconduct and he commended Dr Kwartz's report to it. He referred to the relevant professional standards referred to in her report in the tables referred to in paragraphs 10.3 and

10.4 which in her opinion the Registrant had breached. He submitted that the following standards of the General Optical Council's Standards of Practice for Optometrists and Dispensing Opticians (2016) had been breached by the Registrant - 5.1, 5.3, 6.1,6.3,6.4,7.1,9.5,9.6, 14 and 16.1.

40. The Registrant submitted that he had prided himself on being ethical and having his patients' interests at heart. He said he had let all these patients down and said he understood the seriousness of it. He said he had felt lonely and without guidance. He said he had never had the support of his supervisor and was often unsupervised. He said there had been about six clinics a day in the Practice, one being a contact lens clinic. He said he had been surrounded by optometrists who were available for him to consult. He said that neither his primary or secondary supervisor ever observed his clinics, and he relied on the help and intervention of the other optometrists he worked with, whom he said were always present given the size of the practice and the volume of work.

41. The Registrant said he had lost sight of the need for a primary supervisor. There was no log kept of supervisions until he raised a grievance which he wished he had done sooner. He accepted that all of the findings were serious, including the issues with record keeping. The findings of dishonesty were very serious and he said he felt "*desperate*" and he understood the seriousness of the findings. As to confidentiality, he said he had left the names of patients on the case records to assist his supervisor, and he had understood that the case records would be discussed with his supervisor before submission to the ABDO. He had given the names in confidence to his supervisor at the first stage only for the purposes of cross checking.

Findings regarding misconduct

42. The Committee accepted the advice of the Legal Adviser who referred it to the guidance on misconduct in *Roylance v GMC (no 2) [2000] 1 AC 311* where misconduct was defined as "*a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.*" He also reminded the Committee as to the significance of seriousness and referred to *R (Remedy UK Ltd) v General Medical Council* [2010] EWHC 1245, where it was held that the conduct must *be "sufficiently serious that it can properly be described as misconduct going to fitness to practise".* The Committee should consider the important issue of seriousness and it should be satisfied that the conduct is sufficiently serious to amount to misconduct. A finding of misconduct is a matter for the Committee's own professional judgement and there was no onus or burden of proof in that regard.

43. The Committee bore in mind the submissions from Mr Thomas and from the Registrant. The Committee was mindful of its findings of fact and took account of the report from Dr Kwartz. It considered each particular of the allegation in turn.

44. The Committee noted that particular 1 was a breach of a statutory requirement to have supervision and the Registrant ought to have been aware of that requirement. Dr Kwartz quotes the relevant Statutory instrument, The Contact Lens (Qualifications etc.) Rules 1988, and the connected ABDO guidelines about supervision which state:- *"Supervision requires that the supervising optometrist/contact lens optician is on the premises when the fitting is taking place, is able to exercise their professional skill and judgement as a clinician, and can intervene in the fitting if necessary. It is essential that both the registered professional in a supervisory capacity and those being supervised* [Committee emphasis] *are aware of their roles and duties and particularly what functions cannot be carried out without a GOC/ GMC registered supervisor being present on the premises and in a position to intervene."*

45. This particular was admitted by the Registrant and held proved, supervision did not take place as required. To conduct this clinical work in the absence of the required supervision placed patients at risk of harm, and that was a serious breach of the legal requirements and the ABDO guidelines. This regulatory regime exists for good reason, primarily to protect the public. By breaching it the Registrant failed to do so, and the Committee concluded that this conduct was inappropriate and was serious. It fell far below what was acceptable and amounted to misconduct.

46. The Committee considered particular 2 and Dr Kwartz's report. She analysed each patient record in detail, and the Committee was satisfied that the report sufficiently, fairly and appropriately analysed the patient records. She expresses the opinion that in respect of each allegation sub-particular a) to g), except for sub-particular b), that the records keeping was inadequate and it fell "*far below"* the required level or standard.

47. The Committee considered the position and agreed with that opinion and found that sub-particulars a) – g) taken together, except for b), were a course of conduct by the Registrant that fell below what would have been proper and are serious enough to amount to misconduct.

48. The Committee found that particular 2, sub-particulars k) and l) represent evidence of further multiple deficiencies in the record keeping as detailed in schedules H and I. Whilst, in addition, sub-particulars h), i) and j) refer to individual patients only, and may therefore not have amounted to misconduct of themselves,

the conduct in h), i), j), k) and l) should be considered in the context of the other record keeping failings and contributes to the misconduct.

49. The Committee considered particulars 3 and 4 which it found were inextricably linked. The Registrant admitted submitting inaccurate case records for ABDO accreditation. The Committee has found that the Registrant knowingly submitted inaccurate records and that his conduct in doing so was misleading and dishonest. Honesty is at the heart of professional standards and behaviour. The finding in this case is that the Registrant deliberately altered case records to seek to obtain a professional qualification. The Committee found that was serious, the conduct clearly fell far short of what would have been proper in the circumstances, and the Committee found that it amounted to misconduct.

50. The Committee considered particular 5 and the circumstances in which that conduct took place. The Committee did not find that it was fair or appropriate to aggregate this distinct finding with the other allegations, which covered different issues and areas of professional practice. The Registrant explained to the Committee that he had submitted these case records to his supervisor for consideration at supervision. He had not, at that point in time, anonymised them in order to allow his supervisor to check the records. Whilst at supervision those records may have remained confidential, the Registrant said he had expected discussions to take place with his supervisor before the case records were submitted on to ABDO. In the event, those discussion never took place.

51. The Committee found the Registrant's explanation about this issue was plausible and credible and it accepted his evidence in this respect. It has found that not adequately anonymising the case records at that point was a failure to maintain confidentiality. However, the records were not disclosed by the Registrant to a third party, but to his supervisor with whom he understandably expected to discuss them before they were submitted to ABDO. In these particular circumstances, the Committee concluded that whilst this conduct was below what was proper, it was not, of itself, sufficiently serious to amount to misconduct.

52. The Committee found that the following Standards of practice for optometrists and dispensing optician had been breached 5.1, 5.3, 6.1, 6.3, 6.4, 8, 9, 16 and 17:-

> *5.1 Be competent in all aspects of your work, including clinical practice, supervision, teaching, research and management roles, and do not perform any roles in which you are not competent.*
>
> *5.3 Be aware of current good practice, taking into account relevant developments in clinical research, and apply this to the care you provide.*

6.1 Recognise and work within the limits of your scope of practice, taking into account your knowledge, skills and experience.

6.3 Ensure that you have the required qualifications relevant to your practise.

6.4 Understand and comply with the requirements of registration with the General Optical Council and the legal obligations of undertaking any functions restricted by law, i.e. sight testing and the sale and supply of optical devices.

8 Maintain adequate patient records

9 Ensure that supervision is undertaken appropriately and complies with the law

16 Be honest and trustworthy

17 Do not damage the reputation of your profession through your conduct

Submissions on Impairment

53. Mr Thomas made submissions on impairment of fitness to practise. He submitted that it was clear that the Registrant did not have supervision that was best practice and this was reflected in the ABDO report on the Practice. He submitted that it was a matter for the Committee, but it appeared that the supervision the Registrant had received could have been better. The Registrant had replied in detail to the Council's investigation and Mr Thomas asked the Committee to consider those representations.

54. Mr Thomas referred to the relevant case law on impairment and he submitted that the Registrant's practice was currently impaired in light of the findings. There were both clinical findings that may be easier to remedy, and there were also allegations in relation to probity and honesty.

55. Mr Thomas submitted that there was no significant remediation in relation to the clinical allegations and presently he showed little insight into his failings. Mr Thomas submitted that the Registrant had suggested in his evidence that his deception should not have been revealed and should have been dealt with internally at the Practice which Mr Thomas submitted was concerning.

56. Mr Thomas referred to the guidance in *CHRE v NMC and Grant* [2011] EWHC 927 (Admin) and indicated he could not point to any actual harm being caused to patients, although the potential; for harm existed. Further, the misconduct breached fundamental tenets of the profession and brought the profession into disrepute. Mr Thomas submitted that given the limited insight shown there was a risk of repetition. In relation to the wider public interest, he submitted that the

probity concerns alone ought to give rise to a finding of impairment, which was necessary to uphold public confidence.

The Registrant's evidence

57. The Registrant told the Committee that he appreciated it taking account of the circumstances surrounding his training as a contact lens optician. However, he fully accepted his responsibilities and that it should not have impacted on his patients. He said it was unbearable that he had placed patients at risk of harm but, he had to live with that suggestion. He said that was mindful of his conduct and that his actions contradicted his beliefs. He said he had reflected for two years and considers daily the implications of his conduct and the negative impact on the public. He had not appreciated the long term impact of his altering the case records he submitted, and he now recognised the severity of the mistakes he had made.

58. The Registrant said he had tried to learn from his mistakes, and was ashamed to say he had lost sight of the fundamentals and the rules and regulations, and he constantly reminded himself of the standards. He said he always has patients' best interests at heart. He said he understood that missing information from patient records had a potential long term impact and placed the patient's health at risk. Not leaving an accurate trail of information affected the continuity of care. He said he recognised that his conduct had placed a "*negative light"* on the profession, and the last thing he wanted was for the public to lose trust and confidence in the profession.

59. The Registrant said he himself had in the past acted as a supervisor to trainee dispensing opticians, and that he would expect more from those training than he had in fact applied to himself. If he saw someone acting as he had, he said he would be disappointed and concerned about the reputation of the profession as the public might not visit an optician due to the loss of confidence. He said he would never falsify actual patient records. He said he understood that an act of dishonesty can mean that you will be dishonest again, and that by altering the case records he could have qualified as a contact lens practitioner without having the correct professional experience. With hindsight, he said he should much earlier have raised the alarm and expressed concern about his supervision.

60. The Registrant said he was presently working as a sales representative for a manufacturing company within the optical industry, and intended to remain within that industry. His current role was at risk due to the current proceedings. He had not completed any formal CPD on record keeping, but said he had tried to keep up with publications.

Decision on Impairment

61. The Committee accepted the advice of the Legal Adviser on impairment. He referred it to the guidance issued by the Council and in *CHRE v NMC and Grant* [2011] EWHC 927 (Admin) and he reminded the Committee to consider the crucial issues of insight, remorse, remediation and the risk of repetition. Further, the Committee should not lose sight of the important public interest issues stressed in Cohen v GMC [2008] EWHC 581 described as:- "…*the need to protect*

the individual and the collective need to maintain confidence in the profession as well as declaring and upholding proper standards of conduct and behaviour which the public expect."

62. The Committee considered that the clinical misconduct is potentially remediable, although dishonesty is difficult to remedy. The Committee found that the Registrant showed genuine remorse and that he demonstrated a full acceptance of the findings. He did not seek to minimise his misconduct and he accepted its seriousness. He demonstrated in his evidence the impact of his misconduct on patients, colleagues and on the wider public. He explained the impact of his misconduct and dishonesty, particularly with respect to the risk to the public of him gaining a qualification for which he did not in fact have the appropriate level of experience.

63. The Committee was mindful of *Grant* where the court stated that:- "*An assessment of current fitness to practise will nevertheless involve consideration of past misconduct and of any steps taken subsequently by the practitioner to remedy it* [and]*… the necessity to determine whether the misconduct is easily remediable, whether it has in fact been remedied and whether it is highly unlikely to be repeated.*

64. The Committee took account of the approach suggested by Dame Janet Smith when assessing impairment expressed as follows:-

"Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:

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

65. The Committee found that all four limbs were engaged. The Registrant was impaired at the time because he placed patients at risk, brought the profession into dispute and breached fundamental tenets of the profession and had been dishonest.

66. The Committee next considered the important issues of insight, remediation and the risk of repetition of the clinical failings and the dishonesty. The Committee found that the Registrant has not taken steps to remedy his failings, albeit he said he would do any training required if he remained on the Register. He remains working in the optical industry, but he has not undertaken relevant, formal CPD.

67. The Committee was mindful that the Registrant had been entitled to exercise his right to defend himself with regard to particular 4, but he now appeared to accept the findings. As a result, the Committee found that his insight was limited, it was

new and developing. He demonstrated a clear grasp of the central importance of professional integrity and honesty, although he appeared to recognise that he had failed to live up to those standards.

68. In these circumstances, the Committee concluded that there remains a real risk of repetition of both the clinical failings and the dishonest conduct. Given the limited insight and lack of any remediation the Committee was not able to conclude that the conduct was "*highly unlikely to be repeated*."

69. The Committee considered that given the nature and the gravity of the findings the public would be concerned, and the public confidence in the profession would be undermined, were a finding of current impairment not made. That finding is required in order to maintain proper professional standards and uphold the reputation of the profession.

70. The Committee therefore concluded that the Registrant's fitness to practise is currently impaired on both the personal and public interest elements of impairment.

Submissions on Sanction

71. Mr Thomas referred the Committee to the Council's Indicative Sanctions Guidance (ISG) at paragraph 17 being the guidance on dishonesty which is described as a "*particularly serious*" finding. He submitted that there was a range of seriousness of dishonesty and the findings in this case were toward the higher end of dishonesty. It included dishonesty to ABDO and involved the Registrant's professional practice.

72. Mr Thomas submitted that the Council's position was that erasure was the appropriate sanction and that any lesser sanction would not deal with the seriousness of the findings. He submitted that the only appropriate options were suspension for the maximum period, or erasure. Mr Thomas submitted that the Registrant had shown almost no insight or reflection. He accepted that there had been no repetition of the conduct.

73. Mr Thomas referred the Committee to paragraph 21.29 of the ISG regarding suspension. He reminded the Committee that the Registrant had been a Dispensing Optician for some 10 years and submitted that the Registrant's suggestion that this dishonest alteration of case records should have been dealt with in-house was concerning. Mr Thomas referred to paragraph 21.35 of the ISG and emphasised that the clinical matters alone were a significant departure from professional standards. Mr Thomas reminded the Committee of the finding of dishonesty which was not discovered due to any actions by the Registrant. He submitted that erasure was the appropriate sanction.

74. The Registrant said that he was a family man with [redacted] and tried to pass on the best core values, such as tolerance and honesty. Despite having allowed himself to act dishonestly he said he was not a dishonest person, and he was a professional as demonstrated by his previous track record. He had always been keen to better himself. He said he had found it difficult to *"move on*" without knowing the outcome of this hearing. He said he was aware that erasure was a possibility and had almost been preparing himself for that. He accepted that he could have done things differently.

75. The Registrant asked the Committee to give him the opportunity to prove he had learned his lesson and said it was a single incident of dishonesty in his career. He said he would accept any decision and needed to face the consequences of his actions. He sought a suspension order with a review to allow him to show that he had taken steps to make sure this conduct would not be repeated. He would undertake CPD and he said he should have taken account of the limit of his abilities and did not think he had the clinical abilities in respect of contact lens fitting to qualify. He said he would want time to reflect and think what he could do next.

76. Although he was not in clinical practice, he remained in the optical industry as a sales representative for a lens manufacturer. The Registrant said that he expected to be investigated by his current employer as a result of this hearing. He said he would do whatever it took to show he had gained insight, but needed time to step back to see what he could put in place and to do what he needed to do to remain a Dispensing Optician. He would not seek to qualify as a contact lens optician as he recognised that it was beyond his clinical abilities.

Decision on Sanction

77. The Legal Adviser reminded the Committee of the guidance in the Council's ISG and the need to act proportionately. The Committee should consider that guidance and impose the least restrictive sanction that is proportionate and sufficient to protect the public and the wider public interest, and it should balance the interest of the public with those of the Registrant.

78. The Committee found that the Registrant had fully engaged in this process and that he has genuinely sought to assist the Committee and was open and candid in his evidence.

79. The Committee accepted the legal advice and carefully considered the ISG. It first considered the aggravating and mitigating features. The Committee found the following mitigating features :-

- The serious lack of supervision and support in the Practice
- Evidence of emerging insight
- No previous regulatory history
- No evidence of actual harm to patients
- Evident remorse

80. The Committee found the following aggravating features:-

- The dishonesty was in order to obtain a professional qualification
- Premeditated and sustained dishonesty
- Potential risk of harm to patients had he obtained the qualification coupled with the numerous, wide ranging deficiencies in record keeping
- His lengthy period as a qualified Dispensing Optician, and his experience of supervising trainee Dispensing Opticians in this capacity.

81. The Committee considered the ISG at paragraph 22, in particular paragraph 22.5 regarding dishonesty. Given the nature, circumstances and context of the dishonesty, the Committee found that it was at the higher end of the spectrum of dishonest conduct. It took place in the context of the Registrant's professional role, and it was motivated in order to obtain a professional qualification as a contact lens optician. The Committee was mindful of the impact of that conduct on the wider reputation of the profession, the public perception of the profession, and the extent to which important standards had been undermined.

82. Given the nature and gravity of the findings the Committee did not find that taking no further action, imposing a financial penalty or conditional registration were appropriate or proportionate sanctions. Those sanctions would not sufficiently mark the seriousness of the misconduct and would fail to protect the public and uphold proper professional standards, and would not maintain confidence in the profession.

83. The Committee considered suspension and the factors in the ISG paragraph 21.29 regarding suspension:-

a. *serious instance of misconduct where a lesser sanction is not sufficient.*
b. *No evidence of harmful deep-seated personality or attitudinal problems.*
c. *No evidence of repetition of behaviour since incident.*
d. *The Committee is satisfied the registrant has insight and does not pose a significant risk of repeating behaviour.*

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

84. The Committee found that factors a) and c) were engaged, and factor d) was engaged to some extent. However, the Registrant has demonstrated limited insight and there was a finding of a risk of repetition, although there is no evidence of repetition. There was no evidence of remediation of either the clinical or dishonesty misconduct.

85. In all the circumstances of this case, the Committee was not satisfied that imposing a 12 months' suspension would send a sufficiently strong message to the profession and the public given the seriousness of the dishonesty. Whilst suspension would protect the public for the period of suspension, the Committee was particularly mindful of the finding of dishonesty and the impact on the public interest. It considered the guidance in *Bolton v Law Society* [1994] 1 W.L.R. 512 where Lord Bingham stated:- "*Th'e reputation of the profession is more important than the fortunes of any individual member. Membership of a profession brings many benefits, but that is part of the price."*

86. The Committee considered the sanction of erasure and the factors in paragraph 21.35:-

a. *Serious departure from the relevant professional standards as set out in the Standards of Practice for registrants and the Code of Conduct for business registrants;*
b. *Creating or contributing to a risk of harm to individuals (patients or otherwise) either deliberately, recklessly or through incompetence, and particularly where there is a continuing risk of harm to patients;*
c. *Abuse of position/trust (particularly involving vulnerable patients) or violation of the rights of patients;*
d. *Offences of a sexual nature, including involvement in child pornography;*
e. *Offences involving violence;*
f. *Dishonesty (especially where persistent and covered up);*
g. *Repeated breach of the professional duty of candour, including preventing others from being candid, that present a serious risk to patient safety; or*
h. *Persistent lack of insight into seriousness of actions or consequences.*

87. The Committee found that factors a) and f) were engaged. In relation to factor b) there would have been a potential risk of harm if the Registrant had succeeded in obtaining a qualification for which he did not have the requisite experience, and the wideranging deficiencies in the record keeping could also have exposed

patients to a risk of harm. Further, the Committee was satisfied that the dishonesty was at the higher end of the scale.

88. It is a fundamental to the role of the Committee to maintain confidence in the profession. In all these circumstances, the Committee concluded that nothing less than erasure would be sufficient to maintain public confidence and uphold proper professional standards. The Committee took account of the impact on the Registrant but concluded, balancing the interests of the Registrant with the public interest, that nonetheless erasure was the proportionate order.

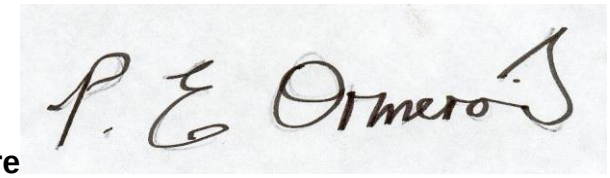
89. The Committee accordingly imposed an order for erasure.

Immediate order

90. The Committee heard submissions from Mr Thomas who submitted that an immediate order of suspension was required primarily on public interest grounds, but there were also public protection concerns. The Registrant said that he was not currently practising and he did not resist the making of the order. The Committee accepted the advice of the Legal Adviser as to the tests for imposing an immediate order, it being necessary to protect the public or otherwise in the public interest or in the interests of the Registrant.

91. The Committee has decided to impose an immediate suspension order as not to do so would be inconsistent with its earlier findings. Such an order was required in the public interest to maintain confidence in the profession, and to protect the public.

Chair of the Committee: Pamela Ormerod

Signature  **Date: 30 November 2023**

Registrant: Thomas Dupeyrat

Signature present and received via email **Date: 30 November 2023**

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.