BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(23)28

AND

KIRSTY WATSON (01-31393)

DETERMINATION OF A SUBSTANTIVE HEARING
29 JANUARY – 01 FEBRUARY 2024

Committee Members:	Ms Sara Fenoughty (Chair) Mr Mark McLaren (Lay) Mr John Vaughan (Lay) Ms Gemma O'Rourke (Optometrist) Dr Ewen MacMillan (Optometrist)
Legal adviser:	Ms Alecsandra Manning-Rees
GOC Presenting Officer:	Ms Tope Adeyemi
Registrant present/represented:	Yes and represented
Registrant representative:	Mr Chris Gillespie
Hearings Officer:	Ms Humera Arif
Facts found proved:	All
Facts not found proved:	N/A
Misconduct:	Found
Impairment:	Impaired
Sanction:	3-month suspension – no review
Immediate order:	No order

ORIGINAL ALLEGATION

The Council alleges that you, Kirsty Watson (01-31393), a registered Optometrist:

1. On or around 31 October 2019 you failed to conduct an adequate eye examination on Patient A in that you:

    a. Did not perform a dilated eye examination on Patient A; and/or
    b. Failed to refer Patient A on an urgent basis for further investigation; and/or
    c. Failed to detect signs of choroidal melanoma; and/or
    d. Failed to identify changes to Patient A's choroidal naevus that required further investigation; and/or
    e. Failed to appropriately refer Patient A for a changed lesion and/or suspicious retinal and/or choroidal lesion and/or treatment of a choroidal melanoma

2. On or around 31 October 2019 you failed to maintain an adequate standard of record keeping in that you:

    a. Did not record why the pupils were not dilated;

3. On or around 19 November 2020 you failed to conduct an adequate eye examination on Patient A in that you:

    a. Failed to refer Patient A on an urgent basis for further investigation; and/or
    b. Failed to effectively and/or appropriately communicate with Patient A the degree of urgency in the referral; and/or
    c. Failed to urgently refer Patient A to the hospital eye service (HES);

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

AMENDED ALLEGATION

The Council alleges that you, Kirsty Watson (01-31393), a registered Optometrist:

1. On or around 31 October 2019 you failed to conduct an adequate eye examination on Patient A in that you:

a. Did not perform a dilated eye examination on Patient A; and/or
b. Failed to refer Patient A on an urgent basis for further investigation; and/or
c. Failed to detect signs of choroidal melanoma; and/or
d. Failed to identify changes to Patient A's choroidal naevus that required further investigation; and/or
e. Failed to appropriately refer Patient A for a changed lesion and/or suspicious retinal and/or choroidal lesion and/or treatment of a choroidal melanoma

2. On or around 31 October 2019 you failed to maintain an adequate standard of record keeping in that you:

    a. Did not record why the pupils were not dilated;

3. On or around 19 November 2020 you failed to conduct an adequate eye examination on Patient A in that you:

    a. Failed to refer Patient A on an urgent basis for further investigation; and/or
    b. Failed to urgently refer Patient A to the hospital eye service (HES);

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

1. The Committee heard that original allegation 3b was subject to an application to amend and as such it invited submissions from the parties. The Council submitted that the mischief in allegation 3b was captured by the particulars in 3a and 3c and as such they did not pursue their case in this respect. There was no objection from the Registrant. The Committee accepted the advice of the Legal Adviser.
2. The Committee considered the application and acceded to the application for the removal of this sub-particular and as a result allegation *3b – (*On or around 19 November 2020 you failed to conduct an adequate eye examination on Patient A in that you: *3b)* Failed to effectively and/or appropriately communicate with Patient A the degree of urgency in the referral); was withdrawn and did not form part of the inquiry.

DETERMINATION

Admissions in relation to the particulars of the allegation

3. The Registrant admitted the factual particulars of the allegation.

4. In light of the Registrant's admission to all of the factual particulars, the Chair announced all the factual particulars as proved, in accordance with Rule 46(6), which states: *"where the facts have been admitted, the Chair must announce that such facts have been found proved*."

Background to the allegations

5. The Registrant is an Optometrist registered with the GOC since 2019.

6. The allegations concern the Registrant's failure to undertake adequate eye examinations in respect of Patient A in 2019 and 2020 and a failure to maintain adequate records in 2019. At the time of the allegations the Registrant practised as an Optometrist at [redacted] (the Practice).

7. Prior to the Registrant undertaking the care of Patient A, in around 2012 a lesion was discovered on Patient A's right eye. The lesion was subsequently diagnosed as an amelanotic choroidal naevus. At the point of diagnosis, the lesion described as a "*freckle*" was not regarded as suspicious of melanoma.

8. Over the next 10 years, Patient A, attended regular eye examinations at the Practice. As time went on, she began to experience symptoms in one of her eyes which she described as "*bubble like roundish and bright – much like a lava lamp*". Initially the symptoms were intermittent but as the years passed, they became more frequent. Patient A states that she reported her symptoms to the practitioners she was seen by at the Practice. In October 2018 Patient A was seen by the Registrant for the first time. Patient A went on to see the Registrant again in October 2019 and November 2020.

9. In November 2020, the Registrant noted that the lesion on Patient A's eye was growing and informed Patient A that she would refer her to the ophthalmology department of Hospital A. By April 2021, Patient A had not yet been notified of an appointment and was concerned that her symptoms were getting worse. Upon contacting Hospital A she was told that a referral had been made but that it had not been marked as urgent.

10. Patient A was prompted to contact the Practice again in May 2021 as her symptoms continued to get worse. She attended the Practice on 28 May 2021 and was seen by a different optometrist (not the Registrant). An urgent appointment was booked for 31 May 2021. At the appointment on 31 May 2021, Patient A underwent an ultrasound, following which she was informed that it was suspected she had a choroidal melanoma in her right eye. A right eye amelanotic choroidal melanoma was subsequently confirmed and Patient A went on to undergo Ruthenium Plaque treatment.

11. A complaint was received by the GOC from Patient A dated 7 March 2022.

Evidence adduced in relation to the facts

12. In advance of the hearing, the Committee was provided with witness statements and exhibits and the expert report of Professor Harper from the GOC in support of the factual particulars, and a witness statement from the Registrant in response to them.

13. The Committee was provided with witness statements from the following:

- Patient A (statement dated 25 May 2022), the patient seen by the Registrant and the subject of the allegation;
- Professor Harper (expert report dated 09 September 2022), the expert Optometrist at Manchester Eye Hospital, instructed by the GOC to give an opinion on the Registrant's acts and omissions.

14. The Committee was provided with a bundle of exhibits, including:

- Patient A's formal complaint to the GOC, dated 7 March 2022
- Correspondence between Patient A's and the Practice;
- Patient A's clinical records at the Practice;
- Patient A's hospital records from Hospital A;
- Patient A's hospital records from [redacted] Hospital B.

15. The Committee was provided with the Registrant's witness statement, dated 18 January 2024.

Findings in relation to the facts

16. The Committee accepted the admissions of the Registrant under Rule 40(6) of the General Optical Council Fitness to Practice Rules 2013 ("the Rules").

Findings in relation to misconduct

17. Having announced that the admitted facts were found proved, the Committee went on to determine whether in accordance with Rule 46(12), on the basis of the facts found proved, the alleged ground of impairment, namely misconduct was established. The Committee understood that if it concluded that it did, then it would go on to determine whether or not the Registrant's fitness to practise is currently impaired by reason of that misconduct, in accordance with Rule 46(14).

18. Ms Adeyemi on behalf of the Council submitted that the facts found proved do amount to misconduct. She submitted that the Registrant had breached *Standards of practice for optometrists and dispensing opticians* 1, 4, 6.2,7, 7.1, 7.2, 7.5, 10 and 17.

19. Mr Gillespie, on behalf of the Registrant, conceded that the admitted facts at allegation 1 amounted to misconduct. However, he drew the Committee's attention to the isolated nature of Patient A's case as the failings were not repeated in that allegations at 2 and 3 were not reproductions of earlier failures. Mr Gillespie drew the Committee's attention to the Registrant's witness statement and submitted that the Registrant had made the referral however the system had defaulted the referral from urgent to routine.

20. The Committee accepted the advice of the Legal Adviser. She cited the case of *Roylance v GMC (No.2) [2000]* 1 AC 311, drawing the Committee's attention to the need for a serious departure from the standards expected of an Optometrist, for a finding of misconduct. The Committee understood that any findings of misconduct were matters for the independent judgement of the Committee, notwithstanding the acceptance of misconduct by the Registrant. It had regard to the GOC Standards and understood that not every breach of the Standards would necessarily amount to misconduct.

21. In relation to the clinical failings admitted by the Registrant at allegations 1 to 3, the Committee accepted the expert opinion evidence of Professor Harper. It was his opinion that that these were significant failings which in relation to allegations 1 and 3 fell far below the standards expected of a reasonably competent Optometrist. It was Professor Harper's opinion in relation to allegation 2 that the failure to record reasons fell below the standard of a reasonably competent optometrist.

22. In relation to allegation 1 the Committee noted that Professor Harper at 5.6.2 of his report stated:

> *In October 2019, the Registrant appears to have not detected change in the lesion that should, in my opinion, have been detected. They did not dilate Patient A's pupils for fundus examination which they properly ought to have done, potentially contributing to a failure to detect change in appearance of this previously noted naevus. In my view, this failure to dilate, failure to be suspicious of a changed lesion, and the related failure to refer urgently for an ophthalmological opinion, falls far below the standard expected of a reasonably competent optometrist.*

23. In relation to allegation 2, the Committee noted that at paragraph 5.7.3 of Professor Harper's report he stated that the failure to record why the pupils were

not dilated was a failing that fell below but not far below the standards. Individually the Committee considered that this would not meet the requisite standard for misconduct, however when viewed in the collective, the Committee determined that in terms of the overall failings, this was sufficiently serious to amount to misconduct.

24. In relation to allegation 3 the Committee accepted the opinion of Professor Harper at 5.6.3 where he stated:

> *In November 2020, the reduced eye examination was reasonable, as was the decision to make a referral. However, the lack of urgency provided in the Registrant's referral (which was listed as 'routine') does reflect a serious failing in my opinion, given the serious nature of the differential diagnosis (i.e., an ocular melanoma), a condition with a threat to sight and potentially life. In mitigation, there was, in my view, information within the referral for the HES team to have appropriately prioritised the Registrant's referral, in that she had indicated there were symptoms, that the lesion had changed, and she had noted some evidence of sub-retinal fluid. Nevertheless, in so far as the optometrist's referral is concerned, it is a serious failing to have made a routine referral versus the required urgent referral, and this difference reflects a serious failing, one falling far below the standard expected of a reasonably competent optometrist.*

25. In addition, the Committee considered that the language used by the Registrant in the referral itself should have reflected the urgency of the referral.

26. The Committee next considered the Standards. The Committee decided that the Registrant had breached the following standards:

- *6.2 – Be able to identify when you need to refer a patient in the interests of the patient's health and safety and make appropriate referrals.*
- *7- Conduct appropriate assessments, examinations, treatments and referrals*
- *7.1 – Conduct an adequate assessment for the purposes of the optical consultation, including where necessary any relevant medical, family and social history of the patient. This may include current symptoms, personal beliefs or cultural factors.*
- *7.2 – Provide or arrange any further examinations, advice, investigations or treatment if required for your patient. This should be done in a timescale that does not compromise patient safety and care.*
- *7.5 – Provide effective patient care and treatments based on current good practice.*

27. And by virtue of the above the Committee also determined that standard 17 was breached.

28. Accordingly, the Committee found that the admitted facts amount to misconduct.

Findings regarding impairment

29. The Committee was provided with documentation relevant to the impairment stage from the Registrant, which comprised a bundle of 126 pages. This bundle contained:

- CPD certificates;
- Testimonials;
- Reflective written accounts; and
- Audits of patient records that the Registrant and her colleague had undertaken.

30. The Registrant gave evidence at the impairment stage. The Committee also heard evidence from her colleague, [redacted] Witness A.

31. In evidence, the Registrant told the Committee of the detailed reflective learning she had undertaken focussing on the particular issues identified within the admitted allegation. The Registrant outlined the courses she had undertaken and took the Committee through various reflective logs and case studies in which the Registrant had dealt with patients who had similar presentations to the complainant in this case and how she managed these patient episodes differently. The Registrant explained that her employment at the Practice where this conduct took place was not unsupported but that there was a much smaller team of qualified optometrists. As a result, the Registrant felt that her role at her current Practice was more supported in that there were more qualified staff for her to speak to and receive feedback from.

32. In addition, the Registrant told the Committee that since moving to her current Practice in April 2022 her supervisor had undertaken monthly audits of her clinical record keeping and her referral letters to ensure that these were all appropriately worded and comprehensive. She explained that she had found this process helpful.

33. The Registrant explained that her errors in 2019 were as a result of failing to compare Patient A's previous fundus images with the images taken at that appointment and that she had remedied her practice to ensure that she now always did this. She now always dilated patients' pupils when they complained of any visual disturbances such as flashing lights or floaters unless there was a clinical reason to not do so.

34. The Registrant gave the Committee detailed examples of cases which had similar themes to the concerns in this case and where she had successfully undertaken interventions. They had been appropriately referred and documented and she had sought second opinion guidance from colleagues.

35. The Registrant was plainly affected by her actions in this case. She explained her clear remorse and upset resulting from her actions and offered her apologies to Patient A. The Registrant explained that she understood Patient A would have suffered not only personally as a result of her actions, but also the experience would have left her and those connected to her with a lack of trust in optometrists generally. She explained that she understood the harm that she had potentially caused to the reputation of the profession but felt that the public, having had sight of her work since the complaint would be content that she had addressed these issues.

36. The Registrant's supervisor, Witness A gave evidence to the Committee regarding the Registrant's current practice. Witness A is an experienced optometrist, having qualified in 2001, and he is the Registrant's employer at her current practice. Witness A explained that since the Registrant had been informed of this complaint, she had been open and honest with him about it. He had put in place monthly audits of both the Registrant's record keeping and referrals and although he made critical comments on them, these were not in his opinion significant. In this regard she was comparable to the standard of record keeping of her peers in his practice. He had no concerns about the Registrant's record keeping, ability to make referrals or her clinical practice. He explained that she was receptive to feedback, and she was a valuable member of the team. The Committee found Witness A to be a reliable and reassuring witness.

37. The Committee heard submissions from Ms Adeyemi on behalf of the Council and from Mr Gillespie on behalf of the Registrant.

38. Ms Adeyemi submitted that although it was accepted that the Registrant had undertaken remedial steps, her insight in respect of the impact upon Patient A was developing, rather than developed. Furthermore, she stated that a finding should also be made on public interest grounds reflecting the seriousness of the Registrant's conduct which fell far short of the expected standards in the core areas of optometry, namely appropriate examinations, adequate care and referrals.

39. Mr Gillespie submitted that the Registrant was not impaired on either public interest or public protection grounds. He outlined that at this stage the Committee could consider the level of experience that the Registrant had at the time, namely that she was junior in her profession, that she had done all she could to reflect and remediate on the misconduct and that her learning was now embedded in

her practice. In terms of the wider public interest, he outlined that a well-informed member of the public would not be surprised if the misconduct were not marked by a finding of impairment.

40. The Committee heard and accepted the advice of the Legal Adviser. She advised the Committee to keep in mind the critically important public policy issues, namely the need to protect the individual patient and the collective need to maintain public confidence in the profession as well as declaring and upholding proper standards of conduct and behaviour. The Committee should understand that in relation to impairment, what has to be determined is whether there is current impairment of fitness to practise, today and looking forward from today.

41. The Committee considered the two aspects of impaired fitness to practise, namely public protection and public interest. It recognised that it should not only consider the question of current impairment in respect of public protection, but also consider it in respect of the equally important public interest considerations of maintaining public confidence in the profession and upholding professional standards.

42. The Committee firstly considered the ground of public protection in respect of the Registrant's misconduct.

43. The Committee considered whether the misconduct was capable of remediation. In this respect the Committee determined that conduct of this kind was remediable. It acknowledged that the Registrant's clinical failings had occurred in respect of a single patient as a newly qualified optometrist, but it also recognised that the failings identified were fundamental and there had been two occasions on which the Registrant's actions had fallen far below the standards expected. The Committee considered that in the period since this complaint the Registrant had undertaken extensive and targeted CPD courses and training in the relevant areas. The Committee considered that the Registrant had also demonstrated a greater understanding of her responsibilities in relation to record-keeping, and a sincere commitment to be more thorough in conducting examinations and making referrals. It was satisfied that the Registrant had good insight into her failings and the impact they had had on the patient and on the reputation of the profession.

44. The Registrant's evidence, and that of her supervisor, made plain that the Registrant had worked collaboratively with colleagues and that she was well liked and respected by them. She had excellent patient feedback.

45. The Registrant was visibly affected by her actions and the Committee considered she had done sufficient in the circumstances to remediate her misconduct. The Committee understood from the Registrant's evidence that the consequence of her actions on Patient A weighed heavily on the Registrant's mind. The

Registrant had demonstrated that she was on high alert for cases of this kind in the future. The Registrant demonstrated that she had learnt from the issue of failing to adequately assess and appropriately refer. The Committee determined that there was a low risk of repetition and as such the Committee concluded that there would be no risk to the public if the Registrant were to resume unrestricted practice.

46. The Committee then considered the need for the regulator to declare and uphold proper standards of behaviour and maintain public confidence in the profession. In particular the Committee considered that the case of *CHRE v (1) NMC and (2) Grant* [2011] EWHC 927 (Admin) and the test set out by Dame Janet Smith in the Fifth Shipman Inquiry was engaged in that the Registrant's conduct:

    - has in the past placed a patient at unwarranted risk of harm;
    - has in the past brought the profession into disrepute; and
    - has in the past breached one of the fundamental tenets of the profession.

47. Although these actions were in the past, these were significant failings in core areas of the Registrant's clinical practice in 2019 which were then compounded by further errors made by the Registrant in 2020.The Committee considered that the misconduct found proven was very serious, and whilst it only related to one patient, it could not be described as an isolated incident. The Patient had been attending the Practice annually for the specific purpose of monitoring the lesion, and was entitled to place trust and confidence in the advice she was receiving from the Registrant. The Patient's diagnosis and treatment were significantly delayed by the failing of the Registrant, as such, the Committee considered that the public would be concerned that the Registrant's conduct on these two occasions fell far short of what was expected of her. Whilst the outcome of the delay is not known, the Committee considered that it was relevant that the Registrant had by her actions placed the Patient at greater risk of serious harm. Professor Harper in his report stated:

    "…in my qualified opinion, it is likely that the risks to Patient A, both in terms of preservation of her vision and the eye itself, and potentially too in relation to her risks of metastatic disease, would have been likely to be more favourable had earlier referral for sub-specialist opinion resulted in more timely sub-specialist ocular oncology care."

48. The Committee determined that conduct of this kind required a finding of impairment on public interest grounds. Although the public would be reassured by the remedial work undertaken by the Registrant, the public would expect that misconduct of this kind, which had placed a patient at risk of significant harm,

should be marked in order to maintain and uphold standards and public confidence in the profession.

49. The Committee determined that the fitness of the Registrant to practise as an optometrist is impaired on the public interest grounds.

Sanction

50. The Committee heard submissions from Ms Adeyemi on behalf of the Council and from Mr Gillespie on behalf of the Registrant.

51. Ms Adeyemi drew the Committee's attention to the GOC's Hearings and Indicative Sanctions Guidance (the Guidance). She reminded the Committee that the key principles were of proportionality balancing the Registrant's interests with the public interest. She outlined mitigating and aggravating features in respect of the Registrant.

52. In addition, Ms Adeyemi drew the Committee's attention to a Warning issued by the General Optical Council that was received by the Registrant in December 2021 that related to conduct in September 2020. The Warning was issued at the Case Examiner stage of the fitness to practise process. That matter did not go to a FTP hearing, however the allegations included concerns relating to record keeping, patient examination, pupil dilation and referral. The Warning is operational until December 2025.

53. Furthermore, Ms Adeyemi outlined the seriousness of the allegations found proven and submitted that it was plain from the evidence before the Committee that Patient A's trust and confidence in the profession was affected. She submitted that the most appropriate sanction was one of suspension.

54. Mr Gillespie drew the Committee's attention to its earlier findings that the Registrant had undertaken detailed and targeted remediation and there was a low risk of repetition. He further submitted that the hearing process and the finding of impairment were sufficient to mark the misconduct in this case. He drew the Committee's attention to the passage of time without repetition of similar behaviour. Mr Gillespie submitted that suspension would be disproportionate given the Committee's previous findings as to the Registrant's insight, remorse and remediation.

55. The Committee heard and accepted the advice of the Legal Adviser. She advised the Committee to have regard to the Guidance and that it should consider the sanctions in ascending order of severity. The Legal Adviser advised that the purpose of a sanction was not to be punitive, but to protect members of the public, and to safeguard the wider public interest, which includes upholding

standards within the profession together with maintaining public confidence in both the profession and the regulatory process.

56. The Committee first considered the aggravating and mitigating factors. It identified the following aggravating factors:

- The misconduct found proved was serious.
- The conduct was not isolated.
- The conduct was a serious departure from the Standards of Practice for registrants.
- The conduct created or contributed to a risk of harm to a patient in 2019 and this was compounded by the errors in 2020.
- The impact on Patient A in a delay of diagnosis and treatment

57. The Committee identified the following mitigating features:

- The Registrant had made full admissions and engaged with the Council.
- The Registrant had demonstrated detailed and targeted remediation.
- The positive testimonials contained within the bundle
- The positive evidence from the Registrant's workplace supervisor
- No evidence of attitudinal issues
- Low risk of repetition

58. The Committee considered the sanctions available to it from the least necessary to the most severe. The Committee first of all considered whether or not it was appropriate to impose no sanction. It noted that the Registrant's representative had drawn their attention to paragraph 21.7 of the guidance.

59. However, the Committee did not agree that this case was exceptional within the definitions given in the guidance. Whilst the Committee was satisfied that the risk to the public was low, and the Registrant had undertaken sufficient remediation, the misconduct itself was too serious to justify a finding of no further action and such a decision would not suitably address the public interest.

60. The Committee were not invited to impose a financial penalty. Nonetheless they considered whether one would be appropriate. The Committee noted that the Guidance made reference to financial penalties being appropriate in cases which

involve financially motivated misconduct and/or cases involving financial gain. The Committee therefore determined that a financial penalty would not be appropriate in the circumstances of this case.

61. Both the Council and the Registrant's counsel submitted that conditions would not be appropriate in this case given the previous findings of the Committee, nonetheless the Committee considered whether a conditions of practice order would be appropriate and workable. In the circumstances of this case, the Committee did not feel that there were relevant or workable conditions which would satisfy the public interest in this case. The Committee had already determined that the Registrant's practice had been appropriately remediated and therefore they did not consider conditions to be an appropriate sanction.

62. The Committee went on to consider a Suspension Order. Paragraph 21.29 of the Guidance set out factors which may be relevant to the imposition of a Suspension Order. The Committee decided the following factors applied in this case:

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

63. The Committee took account of the previous warning issued to the Registrant but did not find that it aggravated the case before them, but it confirmed the view of the Committee that a suspension order was appropriate. The conduct in that case had occurred within the time frame of these allegations. The Committee noted that those allegations appeared to be of a similar nature but felt there was limited evidence before them on the matter.

64. Despite the low risk of repetition, the misconduct was serious and was a significant departure from the core skills of optometrists and from the relevant professional standards. The Committee therefore considered that a Suspension Order of three months was the appropriate and proportionate sanction. It had no evidence of the impact that a Suspension Order would have on the Registrant but considered that a suspension of three months was sufficient to mark the gravity of the misconduct in this case and that a longer duration would be disproportionate.

65. In order to satisfy itself that a Suspension Order was indeed the correct sanction, the Committee went on to consider erasure. The Committee considered that the Registrant's actions had clearly been a serious departure from the relevant professional standards and her clinical failures had resulted in the delay in

diagnosis and treatment for Patient A and so had contributed to a risk of harm to her. However, the Committee did not consider that in all the circumstances, the misconduct was fundamentally incompatible with being a registered professional. The Committee considered that erasure in this case would be unfairly punitive on a practitioner who presents no future risk to the public.

66. The Committee next considered the matter of a review hearing. Given the length of the suspension ordered and the Committee's findings that the Registrant has appropriately remediated the misconduct and that there is a low risk of repetition, the Committee determined to not order a review hearing.

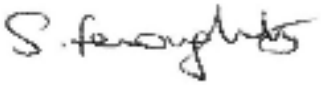
Immediate order

67. The Chair of the Committee enquired of Ms Adeyemi whether there was any application for an immediate order to cover the appeal period. Ms Adeyemi made an application for an immediate order of suspension on the public interest ground outlining that should the Registrant appeal, that appeal may not take place for some months. She explained that this would undermine public confidence given the public interest concerns identified by the Committee in their decision.

68. Mr Gillespie, on behalf of the Registrant, opposed the application. He submitted that the Council only relied on public interest grounds. Should the Registrant appeal then a relatively short suspension could in fact become much longer which would be disproportionate on the facts and findings of this case. He submitted that the public interest would be served by the substantive three-month Suspension Order.

69. The Committee, having heard and accepted the advice of the Legal Adviser, decided not to impose an immediate order. In light of its findings that there was no ongoing risk to the public due to the Registrant's significant remediation in this case, the Committee did not consider that such an order was necessary to protect the public. Further, the Committee was not satisfied that an immediate order was otherwise required in the public interest. It was satisfied that the public interest would be addressed by the substantive three-month Suspension Order. To impose an immediate order would be disproportionately punitive and may cause unfairness. Therefore, no immediate order is required to address the public interest.

Chair of the Committee: Sara Fenoughty

Signature  **Date: 01 February 2024**

Registrant: Kirsty Watson

Signature: [received via email] **Date: 01 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.