BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(23)23

AND

SIMON ROSE (01-13102)

DETERMINATION OF A SUBSTANTIVE HEARING
08-16 JANUARY 2024

Committee Members:	Pamela Ormerod (Chair/Lay) Paul Curtis (Lay) Alice Robertson-Rickard (Lay) Kalpana Theophilus (Optometrist) Gemma O'Rourke (Optometrist)
Clinical adviser:	N/A
Legal adviser:	Megan Ashworth
GOC Presenting Officer:	Zarah Ahmed
Registrant present/represented:	Yes, and represented
Registrant representative:	Nicholas Hall [Counsel] Nan Mousley [AOP]
Hearings Officer:	Arjeta Shabani
Particulars withdrawn	4a to 4i, 6a, 6j, 6k
Facts found proved:	1, 2a, 2b, 2c, 2d, 2e, 2f, 2g, 3a, 3b, 3c, 3d, 3e, 3f, 3g, 3h, 3i, 5a, 5b, 5c, 6b, 6c, 6d, 6e, 6f, 6g, 6h, 6i, 6l, 6m, 7, 8, 9a and 9b
Facts not found proved:	None
Misconduct:	Found
Impairment:	Found on public interest grounds
Sanction:	Suspension Order – 6 months No review
Immediate order:	None

ALLEGATION (as amended)

The Council alleges that you, Simon Rose (01-13102), a registered Optometrist:

1. Between 2018 and 2020 you failed to **recognise the clinical signs and symptoms of Patient A's glaucoma** ~~diagnose Patient A with Glaucoma~~; ~~and/or~~

2. On or around 6 March 2018 you:

    a. failed to adequately assess or manage Patient A's glaucoma risk; and/~~or~~
    b. failed to ~~document~~ **take** Patient A's family history; and/~~or~~
    c. failed to recognise the glaucoma damage on the image acquisition; and/~~or~~
    d. failed to undertake visual fields despite Patient A's optic disc appearing abnormal; and/~~or~~
    e. failed to identify suspected glaucoma based upon Patient A's optic disc appearance; and/~~or~~
    f. failed to refer Patient A for an ophthalmological opinion for her suspicious or abnormal optic disc appearance; and/~~or~~
    g. failed to refer Patient A for further assessment and/or treatment even though Patient A presented with clear signs of glaucoma that were clinically indicated.

3. On or around 23 January 2019 the eye examinations conducted were not adequate in that you:

    a. failed to assess ~~and/or record~~ Patient A's glaucoma risk; and/~~or~~
    b. failed to assess ~~and/or record~~ Patient A's family history; and/~~or~~
    c. failed to recognise the glaucoma damage revealed on the image acquisition; and/or
    d. failed to assess ~~and/or record~~ a proper evaluation of symptoms and history including family history and related glaucoma risk; and/~~or~~
    e. failed to ~~assess and/or~~ record the assessment of basic binocular vision status; and/~~or~~
    f. failed to ~~assess and/or~~ record an assessment of the external eye; and/~~or~~
    g. failed to ~~assess and/or~~ record an assessment of the internal eye; and/~~or~~
    h. failed to assess ~~and/or record~~ visual field testing; and/~~or~~
    i. failed to assess ~~and/or record documentation of~~ a management plan appropriate to Patient A's risks.

4. On or around 6 February 2019 you:

    a. failed to adequately assess or manage Patient A's glaucoma risk; and/or
    b. failed to document Patient A's family history; and/or
    c. failed to recognise the glaucoma damage revealed on the image acquisition; and/or
    d. conducted examinations and did not adequately assess Patient A for her ocular health; and/or
    e. failed to conduct visual field testing; and/or
    f. failed to comment on Patient A's optic discs scans for March 2018 which appeared suspicious; and/or
    g. failed to refer Patient A for a specialist opinion in relation to suspected glaucoma; and/or
    h. failed to refer Patient A for further assessment and/or treatment even though Patient A presented with signs of glaucoma; and/or
    i. failed to refer the patient for investigation and/or treatment despite this being clinically indicated.

5. On or around 12 December 2020 you:

    a. failed to record the visual field test outcomes; and/or
    b. failed to record the companion imaging of the macula/optic nerve head; and/or
    c. failed to refer Patient A for further assessment and/or treatment even though Patient A presented with clear signs of glaucoma that were clinically indicated. **failed to adequately assess and/or manage Patient A's glaucoma risk**

6. Between 2018 and 2020 your record keeping was inadequate in that you:

    a. failed to take and/or flag Patient A's family history; and/or
    b. failed to record the findings from the imaging relating to the optic nerve; and/or
    c. failed to record the findings from the imaging relating to the retinal nerve fibre layer damage; and/or
    d. failed to comment on abnormal images acquired as part of the examination's; and/or
    e. recorded limited information relating to Patient A's examination and/or
    f. record keeping is limited and especially in the context of a new patient presenting to the practice; and/or
    g. failed to record a proper symptoms and history evaluation for Patient A; and/or
    h. failed to record basic binocular vision status; and/or
    i. failed to record findings from an internal eye examination other than images captured; and/or
    j. failed to record visual field testing; and/or
    k. failed to record a management plan for Patient A's suspicious or abnormal optic disc appearance; and/or

l. failed to comment on the internal eye examinations; and/~~or~~
m. failed to write and act upon expected management plans including referring Patient A on multiple occasions for suspected glaucoma.

7. Your actions at ~~1-5~~ **1-3 and 5** were inappropriate in that the treatment required by Patient A was delayed due to your actions.

8. In or around February 2021, you retrospectively amended clinical notes relating to Patient A

9. Your conduct at 8 above was inappropriate and~~/or~~ dishonest in that;

   a. You amended Patient A's records to include clinical findings from 2018, 2019 and 2020; and/or
   b. Your amendments of the record were intended to cover up any failure to make an adequate record of the results of the previous sight tests.

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

a. Misconduct.

~~And/or~~

~~b. Deficient professional performance~~

PRELIMINARIES

Application to amend the allegation

1. Ms Ahmed applied to amend a number of particulars within the Allegation, to remove what she submitted were, essentially, duplicates of other particulars, or where other particulars sufficiently captured the mischief alleged. She explained that the particulars were based on the opinion of Professor Harper, an Optometrist Consultant, the expert witness instructed by the GOC. Ms Ahmed informed the Committee that she had been able to have a conference with him in order to clarify his opinion on certain matters, before making the applications to amend.
2. In relation to particular 1, following concerns raised by the Committee, Ms Ahmed, at the suggestion of the Committee, applied to delete the word "diagnose" and replace it with the words "recognise the clinical signs and symptoms of Patient A's glaucoma".
3. In relation to particular 2b, Ms Ahmed applied to amend the Allegation to allege a failure to "take" the family history, as opposed to a failure to record it. She explained that the Registrant accepted that it was a clinical failing on his part rather than a failure in record keeping.
4. In relation to particular 2c, Ms Ahmed submitted that the purpose of the proposed deletion was to avoid repetition. She explained that the mischief, which related to

the failure to recognise the glaucoma damage revealed on the image acquisition, was sufficiently captured in the remainder of particular 2. She submitted that there would be no injustice as the proposed amendment would not increase the scope of the Allegation and the proposed amendment represented the agreed position between the parties.

5. In relation to particular 3h, Ms Ahmed applied to delete the words “and/or record”, as the Registrant accepted that he had not carried out visual field testing. She explained that he accepted that it was a clinical failing on his part as opposed to a failure in record keeping.

6. In relation to particular 4, Ms Ahmed explained that a sight test had been carried out on 23 January 2019 (to which particular 3 relates) and the appointment on 6 February 2019 (two weeks later) was a contact lens appointment. Ms Ahmed informed the Committee that Professor Harper had clarified that given their proximity to each other, no repetition of the tests over the two appointments would typically be indicated or expected. It was Professor Harper’s opinion that the eye examination of 23 January 2019 had been inadequate and so there was no requirement to duplicate them on 6 February 2019. Ms Ahmed submitted, therefore, that particular 4 should be withdrawn in its entirety so as to avoid double charging of the failures.

7. In relation to particular 5c, Ms Ahmed explained that Professor Harper was of the opinion that, in December 2020, there was a reasonable body of practitioners who would have wished to consult and call the patient back for further assessment rather than make the referral on that day. She took the Committee to the clinical notes in which the Registrant had recorded “dilate and full scans” which appeared to indicate an intention to call the patient back rather than refer on that day. In light of this, Ms Ahmed applied to amend particular 5c to replace the words “refer Patient A for further assessment and/or treatment, even though Patient A presented with clear signs of glaucoma that were clinically indicated” with the words “adequately, assess and/or manage Patient A’s glaucoma risk”.

8. In relation to particular 6a, Ms Ahmed acknowledged that if particular 2b were amended to “fail to take a family history”, a clinical failing accepted by the Registrant, then particular 6a would essentially be a repetition of the mischief captured in particular 2b. She therefore applied to withdraw particular 6a.

9. In relation to particular 6j and particular 6k, Ms Ahmed explained that the charges had been derived from the expert report of Professor Harper, whose opinion was that the standard expected of an Optometrist, was not just that the required assessments should be carried out, but also that they should be appropriately recorded. Ms Ahmed acknowledged that if the assessments were not carried out, there would be nothing to record. She applied to withdraw both particular 6j and 6k as the Registrant accepted the clinical failing, and it was implicit that there would be no record.

10. In relation to the statutory grounds of misconduct and deficient professional performance which had been alleged in the alternative, Ms Ahmed explained that the GOC’s position was that the factual particulars amounted to misconduct. She acknowledged that the question of whether a statutory ground was made out was for the judgement of the Committee, but given the indication that the Registrant did not challenge misconduct, it was appropriate for only misconduct to be

alleged. Accordingly, she applied for the words “and/or b. deficient professional performance to be deleted from the Allegation.

11. Mr Hall, on behalf of the Registrant, did not object to any of the proposed amendments, and indicated that the Registrant would admit all of the factual particulars and that they amounted to misconduct.

12. The Committee heard and accepted the advice of the Legal Adviser. She advised in accordance with Rule 46(20) of the GOC Fitness to Practise Rules 2013 (the Rules) that the Committee should satisfy itself that there would be no injustice if the proposed amendments were permitted.

13. The Committee accepted all of the proposed amendments except the proposed withdrawal of particular 2c. In relation to particular 2c, the Committee did not agree that this was a duplication and that the mischief of failing to recognise the glaucoma damage on the image acquisition was sufficiently captured in the remainder of particular 2. The Committee noted that Professor Harper, in his expert report, opined that the nerve fibre layer imaging taken at the first appointment in March 2018 was suggestive of optic nerve damage due to glaucoma, but the Registrant had made no comment in the clinical notes about the apparent abnormality revealed on the scan.

14. In relation to particular 1, the Committee considered that it may not be the responsibility of an Optometrist to formally diagnose glaucoma, rather the responsibility was on the Optometrist to recognise the signs and symptoms of glaucoma and take appropriate steps to assess and manage the risk, including referral for ophthalmological opinion where glaucoma is suspected. The Committee, therefore, agreed to amend particular 1 to delete the word “diagnose” and replace it with “recognise the clinical signs and symptoms of Patient A’s glaucoma”

15. In relation to all the proposed amendments (excluding particular 2c), the Committee was satisfied that there would be no injustice caused to the Registrant if they were allowed. It noted that Mr Hall, on behalf of the Registrant, had not opposed the proposed amendment, and had not identified any injustice.

16. In relation to the withdrawal of particulars 4a to 4i, the Committee was satisfied that particular 4 related to a contact lens appointment, some two weeks after the sight test appointment on 23 January 2019, and so there would not necessarily be a duty upon the Registrant to repeat the required elements of a sight test. The Committee was satisfied that the failures of the Registrant in relation to sight testing were sufficiently captured in particulars 3a to 3i and so withdrawing particular 4 would not represent an undercharging of the case.

17. In relation to the withdrawal of particulars 6a, 6j, and 6k, the Committee was satisfied that these were, essentially, duplicates of other particulars and did not add anything to the case. It was satisfied that withdrawing them would not represent an undercharging of the case.

DETERMINATION

Admissions in relation to the particulars of the allegation

18. The Registrant admitted all of the factual particulars of the Allegation.

19. In respect of particular 3, where individual sub-particulars had been drafted as a "failure to assess and/or record", Mr Hall indicated whether the Registrant was admitting a failure to assess or a failure to record. Having clarified which failure was being admitted, the Committee, further amended the allegation to delete the failure alleged in the alternative. It also deleted the word "or" from the end of each sub-particular, given that the Registrant had admitted all of the factual particulars.

20. 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 approved."

Background to the allegations

21. The Registrant is an Optometrist registered with the GOC since 1988.

22. The allegations concern inadequate eye tests conducted in respect of Patient A, and failing to diagnose Patient A with glaucoma during his care of her between 2018 and 2020.

23. Patient A is a myopic (short-sighted) patient who, at the material time in 2021 was [redacted]. Patient A had been a spectacle wearer since childhood and later, a part time contact lens wearer for many years.

24. Between 1998 and October 2017, Patient A attended another practice for both routine assessments and contact lens assessments. Patient A had a close family history of glaucoma (her mother) and attended for regular sight-testing. When the other practice stopped operating in around October 2017, Patient A sought care from the Registrant at [redacted] (the Practice), where she was seen from March 2018.

25. On 6 March 2018, Patient A had her first consultation at the Practice. A sight test and contact lens appointment were conducted by the Registrant. Particular 2 relates to this appointment. Thereafter, Patient A was seen at the Practice for consultations for sight testing and/or contact lens assessments and/or various imaging.

26. On 23 January 2019, Patient A attended the Practice for a sight test appointment with the Registrant. Particular 3 relates to this appointment. On 6 February 2019, she was seen by the Registrant for a contact lens and follow up appointment.

27. On 25 January 2020 and 1 February 2020, Patient A attended a sight test and contact lens check appointment and was seen by another Optometrist at the Practice, Ms A.

28. On 12 December 2020, Patient A attended a sight test and contact lens appointment with the Registrant. Particular 5 relates to this appointment.

29. On 3 February 2021, Patient A attended an appointment with Ms A under the Minor Eye Conditions Scheme (MECS), whereby a routine suspected glaucoma referral was made via [redacted] for 18 May 2021.

30. On 10 February 2021, Patient A was seen at the [redacted] Practice, by Optometrist Mr B, who urgently referred Patient A for further assessment and management by an Ophthalmologist.

31. On 11 February 2021, Patient A, experiencing blurred vision and ongoing dark areas, referred herself by attending the Emergency Department of the [redacted]. Patient A was noted to have advanced optic disc cupping and significant field loss in both eyes. Normal tension glaucoma was formally diagnosed in both eyes and she was commenced on treatment with topical eyedrops to lower her intraocular pressure. She has since remained under ophthalmology care for her bilateral glaucoma.

32. Between 23 and 27 February 2021 the Registrant retrospectively amended the clinical notes relating to Patient A.

33. On 4 March 2021, Patient A made a formal written complaint against the Registrant to the GOC.

34. On 12 March 2021, Ms A (Optometrist at the Practice) referred the Registrant to the GOC.

Evidence adduced in relation to the facts

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

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

- Patient A (statement dated 15 November 2021), the patient seen by the Registrant, and the subject of the Allegation;
- Ms A (statement dated 28 September 2021), the Optometrist who saw Patient A on 25 January 2020, 1 February 2020 and 3 February 2021;
- Professor Harper (export report dated 31 January 2022), the expert Optometrist Consultant at Manchester eye Hospital, instructed by the GOC to give an opinion on the Registrant's acts and omissions;

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

- Patient A's formal complaint to the GOC, dated 4 March 2021;
- Optical Coherence Tomography (OTC) scans, and Pachymetry and visual fields in respect of Patient A, taken 6 February 2018, 23 January 2019, and 1 February 2020;
- Scans taken 3 February 2020;
- Visual field test for glaucoma in respect of Patient A, taken at the Practice on 10 February 2021;
- Copy of the Amsler Grid Test from 10 February 2021;

- Correspondence between Patient A and the Practice;
- Correspondence with the [redacted];
- Patient A's clinical records at the Practice;
- Routine Patient Ophthalmology Referral for suspected glaucoma, dated 3 February 2021, made by Ms A;
- [redacted] Opticians eye examination report, dated 5 March 2021;
- [redacted] Opticians clinical records of eye examinations on 4 March 2021;
- Patient A's clinical records prior to her becoming a patient at the Practice;
- Patient A's clinical records from [redacted];
- Patient A's clinical records from [redacted] Eye Hospital;
- Ms A's referral to the GOC, emailed on 12 March 2021;
- Email correspondence between Ms A and the Registrant, dated 23 February 2021, regarding lack of clinical notes from the Registrant's sight tests with Patient A; and
- Photographs taken by Ms A in February 2021, of the electronic clinical records of Patient A for 6 March 2018, 23 January 2019, and 12 December 2020;

38. The Committee was provided with the Registrant's witness statement, dated 2 January 2024.

Expert evidence in respect of particular 1

39. Professor Harper stated in his report that in his qualified view, and on the balance of probabilities,

> *'Patient A was likely to have had visual loss in at least her right eye by December 2016, given the following: (a) the optic nerve damage already evident on imaging at* [the Practice] *in March 2018; (b) the very extensive field loss she manifested in February 2020 (and the cooperative objective evidence for the disc/retinal nerve fibre layer damage at the same time), and the right eye, progression and symptomatic shift was more likely to be due to a change close to the centre of vision in the right eye between February 2020, and February 202; and (c) her significant left eye visual field defect had not progressed much, if at all, in the previous 12 months. It is on this basis that it is more likely, on the balance of probabilities, there would have been some evidence of optic disc and/or visual field change evident upon examination by the previous optometrist…in 2016'.*

Professor Harper's opinion was that by 6 March 2018 and the timeline of the first examination of Patient A at the Registrant's practice, it was almost certainly the case that normal tension glaucoma was present and there was objective disc/retinal nerve fibre layer imaging taken at the time to support his view.

40. Professor Harper noted from the patient records that imaging had been conducted on 6 March 2018 for the front of the eye (cornea) and back of the eye (macula and optic disc). Having reviewed all the clinical records, the images and Patient A's referral to the GOC, Professor Harper stated the following:

> *'Patient A was at risk of glaucoma. She was aged 61 in 2018. She was myopic and most significantly, she had a family history of glaucoma in a first degree relative. While the Registrant had found normal intraocular pressures, he had also documented optic nerve and/or retinal nerve fibre layer damage in Patient A with the imaging tests he had conducted at the appointment on 6th March 2018. The Registrant did not undertake visual fields at this did not undertake visual fields at this first visit at this first visit, or shortly thereafter in an at-risk patient who had manifested at the very least a suspicious (if not abnormal) optic disc appearance… there is also a related failure to identify suspected glaucoma based upon Patient A's optic disc appearance in March 2018…'*

Expert evidence in respect of particulars 2a to 2b, the 6 March 2018 appointment

41. Professor Harper's view of the examination on 6 March 2018 was that it was limited and inadequate, especially in the context of a new patient presenting to the Practice. He identified an absence of a proper symptoms and history evaluation (notably the patient's risk of glaucoma); basic binocular vision status; findings from an internal examination; visual field testing; and a management plan for the patient's suspicious or abnormal optic disc appearance. He also identified a missed opportunity to refer Patient A for an ophthalmological opinion for her suspicious or abnormal optic disc appearance.

Expert evidence in respect of particulars 3a to 3i, the 23 January 2019 appointment

42. Professor Harper noted that the Registrant had made a note about a fall and Patient A's concern about an eye injury. He identified that Patient A had undergone an OCT scan of her macula and the Registrant had undertaken a refraction and measurement of visual acuity at distance and near and that her intraocular pressures had been measured and found to be normal. Professor Harper's opinion of the 23 January 2019 appointment was:

> *'The eye examinations conducted by the Registrant in 2019, are not adequate in that there is a failure to assess or record: a proper evaluation of symptoms and history (including family, history, and related glaucoma risk); the assessment of basic binocular vision status; an assessment of the external eye (potentially images aside); an assessment of the internal eye (imaging of the macula notwithstanding); visual field testing; and documentation of a management plan appropriate to Patient A's risks'.*

43. Professor Harper observed:

> *'in 2019 Patient A was visiting [the Practice] for the second time…, approximately 11 months after her first visit. [The Registrant's]*

examinations did not adequately assess Patient A for her ocular health… a second opportunity to have undertaken visual field testing appears to have been missed. Furthermore, no comment is made in 2019 in relation to the March 2018, scan of patient A's optic discs which shows at least a suspicious (if not already abnormal) optic nerve head appearance. Had visual fields been undertaken (as it was subsequently in 2020), then it is much more likely than not that a definite defect would have been present in each eye.

The 2019 examinations represented a second opportunity, after the first appointment with the Registrant of March 2018, to have referred Patient A for a specialist opinion in relation to suspected glaucoma.'

Expert evidence in respect of particulars 5a to 5c, the 12 December 2020 appointment

44. Professor Harper noted that Patient A had re-attended the Registrant's practice on 1 February 2020, for an appointment which was undertaken by Ms A, and for which there was evidence of Patient A having had ocular biometry (measurement of central corneal thickness, and anterior chamber depth), OCT, imaging of the macular, OCT, imaging of the retinal, nerve, fibre layer, and visual fields. His opinion was that both the imaging and visual field results were indicative of advanced glaucoma.

45. In relation to the appointment on 12 December 2020, Professor Harper noted that it appeared to be a sight test with refraction and visual acuity being noted along with eye pressures being measured (and found to be normal once again). Professor Harper stated:

'There does not appear to be any mention of either the visual field test outcome from earlier in 2020, nor the companion imaging of the macular/optic nerve head, and, regardless, there does not appear to have been any referral actions at this time.

The 2020, examination by the registrant should have resulted in him flagging the previous tests from February 2020, and the apparent loss to follow up for the intended repeating of tests.'

Expert evidence in respect of particular 6

46. Professor Harper's opinion in respect of the Registrant's record keeping in respect of Patient A was:

In summary, the most striking examination and/or recordkeeping omissions by the Registrant, in this case, relate to… a failure to specifically comment on the internal eye examinations that ought to have formed a key part of an adequate eye examination and a failure to write (and act upon) expected management plans including referral on multiple occasions from March 2018 for Patient A's suspected glaucoma status.

Expert evidence in respect of particular 7, the delay to required treatment as a result of the failures at particular 1-3 and 5

47. Professor Harper's opinion was that as a consequence of the Registrant's failures, Patient A was not referred in March 2018, nor in 2019, and nor in 2020, and an almost 3-year delay ensued before her condition was formally diagnosed and treated.

Evidence in respect of particulars 8 and 9, dishonestly amending Patient A's clinical notes retrospectively

48. Ms A conducted a sight test appointment with Patient A on 3 February 2021, which included OCT imaging and undertaking visual field testing, following which she made routine referral for suspected glaucoma. On 11 February 2021, Patient A referred herself by attending the Emergency Department of the [redacted] Hospital. At the ophthalmological assessment a formal diagnosis of glaucoma was made.

49. In late February 2021, Patient A requested a copy of her clinical notes. On 23 February 2021, Ms A was informed by a colleague that Patient A had been in touch to say that she had been diagnosed with glaucoma. Ms A corresponded with the Registrant by email, pointing out to him that there were no clinical notes for his appointments with Patient A. After this, Ms A met with the Registrant at a coffee shop away from the Practice and he said to her "*It's bizarre how I missed something like that, I just feel bad for the patient"*.

50. In relation to Patient A's request for the clinical notes, Ms A said:

> *'As a result, I saved my notes as PDF documents and shared them to my NHS email account. I could not generate PDF documents for [the Registrant's] notes as there was no information contained within the notes, so I took pictures of the computer screen which shows the time and date of the photographs [23 February 2021].'*

51. Ms A's evidence was that she spoke to the Registrant on 24 February 2021, at which point he made the comment '*I'm in trouble ain't I'.*

52. On 27 February 2021, Ms A attended work and found the clinical notes which she had made in respect of Patient A on the floor of the clinical room where sight tests were normally carried out. They had not been tampered with, but she took further photographs of the computer screen of the Registrant's clinical notes for Patient A, and noted that information had been added to these since she had taken the photographs on 23 February 2021.

53. The Registrant, in his witness statement, dated 2 January 2024, admitted that he added data to the records, and that *'What I did in altering the data was wrong and inappropriate and on reflection dishonest'*.

Findings in relation to misconduct

54. 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).

55. Ms Ahmed submitted that the facts found proved do amount to misconduct. She submitted that the Registrant had breached Standards 6.2, 7.1, 7.2, 7.5, 8.1, 16.1, 17.3, and 19.1.

56. Mr Hall, on behalf of the Registrant, conceded that the admitted facts amount to misconduct and did not make any further submissions in respect of misconduct.

57. 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.

58. In relation to the clinical failings admitted by the Registrant at particulars 1, to 7, the Committee accepted the expert opinion evidence of Professor Harper. It was his opinion that that these were significant failings which individually and collectively fell far below the standards expected of a reasonably competent Optometrist. In the Committee's judgement the admitted facts were so serious as to amount to misconduct. It considered that they represented repeated failures by the Registrant between 2018 and 2020 to conduct adequate testing and assessments and to recognise the signs and symptoms of glaucoma, which resulted in several missed opportunities to refer Patient A for a specialist opinion regarding suspected glaucoma, with the consequence that appropriate treatment for Patient A was delayed. The Committee also considered that the ongoing failure to maintain accurate and comprehensive records in respect of Patient A between 2018 and 2020 was so serious as to amount to misconduct.

59. In relation to particulars 8 and 9, the Registrant admitted to dishonestly amending clinical notes relating to Patient A retrospectively, to include clinical findings from 2018, 2019 and 2020, in order to cover up his failure to make an adequate record of the results of previous sight tests. Further, this was dishonesty within a clinical context. The Committee was of the view that patients and clinicians wishing to access clinical records must be able to rely upon those records as accurate and be confident that they are a contemporaneous record, or, if not, that it is clear they were made retrospectively. In the Committee's judgement, honesty is a fundamental tenet of the profession, and therefore the Registrant's dishonesty was so serious as to amount to misconduct.

60. The Committee was of the view 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.*
- *7.1 – 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.*
- *8.1 – Maintain clear, legible and contemporaneous patient records which are accessible for all those involved in the patient's care.*
- *8.2. – As a minimum, record the following information:*
- *8.2.4 – The details and findings of any assessment or examination conducted.*
- *16.1 – Act with honesty and integrity to maintain public trust and confidence in your profession.*
- *17 – Do not damage the reputation of your profession through your conduct.*
- *19.1 – Be open and honest with your patients when you have identified that things have gone wrong with their treatment or care which has resulted in them suffering harm or distress or where there may be implications for future patient care. You must:*

  19.1.1 Tell the patient or, where appropriate, the patient's advocate, carer or family) that something has gone wrong.

  19.1.2 Offer an apology.

  19.1.3 Offer appropriate remedy or support to put matters right (if possible).

  19.1.4 Explain fully and promptly what has happened and the likely short-term and long-term effects.

  19.1.5 Outline what you will do, where possible, to prevent reoccurrence and improve future patient care.

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

Findings in relation to impairment

62. The Committee was provided with documentation relevant to the impairment stage, which included the following:

- The Registrant's written reflections, dated 2 January 2024;
- Positive references and testimonials from Optometrists who had supervised him over the previous two years under an Interim Conditions of Practice Order, fellow professionals, and patients;
- Details of CET undertaken for the years 2016 to 2023, inclusive;
- An email from Professor Harper, dated 8 January 2024, giving his opinion on the Registrant's insight and remediation, namely that it was 'impressive';

- Two years' worth of supervisors' summary reports and findings (on 20 patient records selected at random), provided to the GOC every two months in accordance with the Interim Conditions of Practice Order imposed in 2021; and
- An anonymised patient record from 2023, as an example of the way in which the Registrant had amended his record template and now completed such a record during and following an appointment.

63. The Registrant also gave evidence at the impairment stage.

64. Ms Ahmed submitted, essentially, that the Registrant's fitness to practise is currently impaired, in particular on public interest grounds. She emphasised the importance of considering not just future risk to the public, but also of maintaining public confidence in the profession and upholding standards.

65. In relation to the failures in record keeping, Ms Ahmed acknowledged that in light of the evidence of the Registrant's remediation, the Committee may conclude that the risk of repetition was low, such that a finding of impairment may not be required on public protection grounds. She reminded the Committee that it must nevertheless still consider whether a finding of impairment was required in the wider public interest.

66. In relation to the clinical failings, Ms Ahmed submitted that these occurred in 2018, 2019 and 2020, and were collectively and individually serious. She acknowledged the Registrant's evidence of remediation, in particular the courses that he had undertaken, and said that it was for the Committee to assess whether or not his remediation and insight was sufficiently developed, such that there may not be concerns on public protection grounds. However, she again reminded the Committee that the question for it to consider was broader; it was not limited to public protection and the risk of repetition, but also whether to mark the public record with a finding in order to uphold public confidence in the profession.

67. In relation to the dishonesty, Ms Ahmed submitted that this was more nuanced, because it was attitudinal and so difficult to remediate. She acknowledged that the Registrant had shown remorse, had not minimised his dishonesty and had accepted that he had breached the standards of practice. She reminded the Committee of the case of *Bolton v Law Society [1994] 1 WLR 512 CA*, in which it was indicated that the reputation of the profession needed to be jealously safeguarded, even if it came at a cost to the individual practitioner.

68. Mr Hall submitted that the Registrant was not impaired on public protection grounds for either the clinical failings of glaucoma detection and record keeping, or for the dishonesty. He submitted that this was because of the nature of the allegations themselves as well as the remediation undertaken since and the insight subsequently demonstrated, which meant that there was no risk of repetition, and therefore no requirement of a finding of impairment on public protection grounds.

69. In relation to the clinical failings, including both the failure to detect glaucoma and the failures in record keeping, Mr Hall submitted that no finding of impairment was required on public interest grounds. He submitted that a reasonable and well informed member of the public would not require a finding of current impairment having looked at the Registrant's reflections, CPD, courses, testimonials, and Professor Harper's view that the Registrant's remediation and insight were impressive.

70. In relation to the dishonesty, Mr Hall, on the Registrant's behalf, conceded that the Registrant's current fitness to practise was impaired in this respect on public interest grounds alone.

71. 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.

72. The Committee considered the two components 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.

73. The Committee considered the ground of public protection in respect of the clinical failings, in particular, of failing to detect the signs and symptoms of glaucoma in Patient A.

74. The Committee considered whether the misconduct was capable of remediation. It acknowledged that the Registrant's clinical failings had occurred in respect of a single patient in a long career spanning over 30 years. The Committee considered that in the period since, the Registrant had undertaken targeted CPD courses and training in glaucoma to heighten his skills. He had recognised that the Practice had not previously given enough time for sight tests and so he had increased the length of sight test appointments from 20 to 30 minutes. He had also invested in new equipment and software to implement a fully integrated system of record keeping, with all information accessible in one place. Over the two years that the Registrant had been on an Interim Conditions of Practice Order, every two months his supervisors had audited 20 record cards selected at random and provided summary reports and findings, which were very positive about the Registrant's current practice. The Committee noted that he had gone beyond what was required under the Interim Order and had implemented monthly peer reviews within the Practice to benefit and evaluate each other's work.

75. The Committee was also satisfied that the Registrant had thoroughly reflected on his clinical failings. It was satisfied that he had demonstrated genuine remorse and regret for his failures in both his witness statement and his oral evidence. The Committee considered that the Registrant fully understood the impact of his failures on Patient A herself, on his colleagues and on the profession, in particular how it would have damaged public confidence in Optometrists.

76. It was apparent to the Committee that the Registrant had fully remediated his practice and developed good insight into his failings, such that the risk of him failing to detect the signs and symptoms of glaucoma and refer accordingly in the future was now very low.

77. The Committee considered the ground of public protection in respect of the record keeping failures. It had regard to the two years' worth of bi-monthly supervisors' reports and comments on the randomly selected records, previously provided to

the GOC in accordance with the Interim Order of Conditions which the Registrant had been subject to. The Committee noted that the references from his supervisors submitted for this final hearing positively attested to the consistently high standard of record keeping maintained by the Registrant throughout the previous two years. The Committee considered that the Registrant had also demonstrated a good understanding of the importance of maintaining clear, accurate and contemporaneous records, taking steps to re-design his record template so as to ensure that all relevant information was captured, as well as implementing peer review sessions at the Practice.

78. It was apparent to the Committee that the Registrant had fully remediated his practice in respect of record keeping and had developed good insight into his previous failings in this regard, such that the risk of him failing to maintain accurate and comprehensive records in the future was low.

79. The Committee considered the ground of public protection in respect of the dishonesty. It had regard to the references and testimonials, each of which confirmed that the author was aware of the nature of allegations faced by the Registrant and that he was admitting them. The Committee noted that the references and testimonials positively attested to his usual high standards of integrity and honesty in his practice and that the authors were keen to express how out of character the conduct appeared to them in their, sometimes quite lengthy, knowledge of him. The Committee accepted the Registrant's evidence that he had panicked following being made aware that Patient A had been diagnosed with glaucoma, and this led to him altering the patient records in order to cover up that he had missed something apparently so obvious on the images which he had taken in 2018, and which should have led to the detection of glaucoma and timely referral. The Committee considered that the Registrant had demonstrated a good understanding of the impact of his dishonesty both on public confidence in the profession and on colleagues and had not sought to diminish the seriousness of his dishonesty or its impact. In all the circumstances, the Committee considered that the risk of repetition was low.

80. In light of the extensive remediation and impressive level of insight in each of the three areas of misconduct (clinical failures, record keeping failures and dishonesty), such that the risk of repetition of any of the areas of misconduct was low, the Committee did not identify any ongoing risk to the public. Accordingly, the Committee did not consider that the Registrant was impaired on the ground of public protection.

81. The Committee considered the ground of public interest in respect of the clinical failings, in particular, of failing to detect the signs and symptoms of glaucoma in Patient A. The Committee had regard to the expert opinion of Professor Harper, to the effect that the signs of glaucoma should have been detectable from the images which the Registrant had taken at the initial sight test appointment on 6 March 2018 and it appeared to him that the Registrant had, therefore, 'disregarded' these images. The Committee bore in mind that the Registrant had conducted sight tests with Patient A on 6 March 2018, 23 January 2019 and 12 December 2020, which, in the Committee's view represented a three year period of missed opportunities to detect the signs and symptoms of glaucoma and refer Patient A for an ophthalmological opinion and treatment. The consequence of these failures was, according to Professor Harper a delay of three years before Patient A's glaucoma

was formally diagnosed and treated. By the time she had the emergency ophthalmological assessment on 11 February 2021, the visual fields, which had been taken by another Optometrist at the Practice six days earlier, showed, according to Professor Harper, *"advanced field loss, superiorly and inferiorly in the right eye, and largely inferiorly only in the left eye"*. The Committee acknowledged that the Registrant had now fully remediated his practice in this regard. Nevertheless, it was of the view that these were serious failings with serious consequences for Patient A, such that a finding of current impairment was required in order to maintain public confidence in the profession and to uphold standards.

82. The Committee considered the ground of public interest in respect of the record keeping failures. The Committee accepted that the Registrant had taken considerable steps to ensure that not only his own record cards were accurate and comprehensively maintained, but also that the records within the Practice were regularly peer reviewed so as to maintain standards. Nevertheless, the Committee noted that Patient A's electronic records, when photographed by Ms A in 2021, were almost entirely absent of information for the three sight tests conducted in 2018, 2019 and 2020. In the Committee's judgement, the record keeping failures were intrinsically linked to the failure to detect glaucoma. It considered that the failure to document the findings of each of the sight tests would have added to the risk of failing to detect the signs and symptoms of the glaucoma and, therefore, have implications for future treatment. The Committee also bore in mind that the record keeping failures were basic and fundamental omissions by an experienced practitioner with over 30 years' experience and who had been a supervisor of trainees in the past. In light of this, the Committee was of the view that a finding of current impairment in respect of the record keeping was required in order to maintain public confidence in the profession and uphold standards.

83. The Committee considered the ground of public interest in respect of the dishonesty. The Committee noted that Mr Hall, on behalf of the Registrant, had conceded that a finding of impairment was required on public interest grounds in order to maintain public confidence in the profession. The Committee bore in mind that the Registrant had amended three sets of records for Patient A, in order to cover up his failure to make adequate records for those three sight tests, so this was dishonesty in a clinical context. The Committee considered that it is paramount that the public is able to trust the honesty of members of the profession, and have confidence that they will keep accurate, comprehensive and contemporaneous clinical records. Given that honesty is a fundamental tenet of the profession, and the Registrant had breached that tenet, the Committee concluded that a finding of current impairment in respect of the dishonesty was required in order to maintain public confidence in the profession and uphold standards.

84. Accordingly, in the Committee's judgement, the Registrant is currently impaired on the ground of public interest in respect each of the three areas of misconduct.

Sanction

85. Having determined that the Registrant's fitness to practise is currently impaired on public interest grounds by reason of each of the three areas of misconduct, the Committee went on to consider whether it was impaired to a degree which required action to be taken on his registration.

86. Ms Ahmed, on behalf of the GOC, submitted that the appropriate and proportionate sanction was that of a Suspension Order of not less than 9 months. Mr Hall, on behalf of the Registrant, submitted that this was an exceptional case on the basis that the sole point of impairment in this case was the public interest ground, and as such, no further action was required. He conceded that conditional registration was not an appropriate sanction, and so if the Committee considered that a sanction was required, it should be a short period of suspension, such as 28 days.

87. The Committee heard and accepted the advice of the Legal Adviser and was advised to exercise its independent judgement. She advised the Committee to have regard to the GOC's Hearings and Indicative Sanctions Guidance (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.

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

- The clinical failures included not using the available material (images taken at the 2018 sight test) to inform his assessment at the sight test, such that Professor Harper opined that the Registrant appeared to "disregard" them;
- There was a failure to undertake basic tests and gather fundamental information (including family history) at each of the sight tests;
- The Registrant's failures were repeated and prolonged, resulting in three missed opportunities over three years to recognise the signs and symptoms of glaucoma;
- The three year delay in recognising Patient A's glaucoma had the effect of delaying treatment with the potential to cause serious harm to Patient A;
- In respect of the record keeping, the Registrant repeatedly failed to record basic information over the three year period;
- The dishonesty occurred in course of the Registrant's professional practice and had the potential to adversely impact upon Patient A and colleagues; and
- The Registrant's dishonesty was to cover up his failure to make adequate records of the previous sight tests.

89. The Committee identified the following mitigating factors:

- The Registrant had no previous adverse findings of misconduct or impairment in his long and professional career;
- The Registrant had demonstrated excellent remediation and an impressive level of insight in each of the three areas of misconduct (clinical failures, record keeping failures and dishonesty), such that the risk of repetition of any of the areas of misconduct was low;

- The positive references and testimonials demonstrated that the Registrant was a highly regarded practitioner and that the dishonesty was out of character;
- The Registrant had since taken and continued to take steps to ensure the integrity of his and the Practice's records; and
- The dishonesty was a one-off event, committed during a time of challenging personal circumstances.

90. The Committee went on to consider whether a sanction was necessary. It was mindful that this was a case involving a failure to carry out the basic requirements of a sight test and failing to recognise or have regard to the results of those tests he did undertake. This led to him repeatedly failing to recognise the signs and symptoms of glaucoma over a prolonged period as well as acting dishonestly in a clinical context. The Committee bore in mind that it had concluded at the impairment stage that the Registrant did not pose an ongoing risk to the public, due to his excellent remediation and impressive level of insight, and so a sanction was not required for public protection purposes. In the Committee's view, the crux of this case was the public interest aspect, in particular the promotion and maintenance of public confidence in the profession, as well as declaring and upholding proper standards of conduct and behaviour. In the Committee's judgement, the case involved serious departures from the professional standards required by an optometrist and was too serious to be dealt with by no further action as such a course would not promote public confidence in the profession or uphold professional standards. Accordingly, the Committee concluded that a sanction was required in this case.

91. The Committee considered the available sanctions in ascending order of severity. It did not consider that the imposition of a financial penalty was relevant in the circumstances of this case.

92. In relation to conditional registration, the Committee was of the view that a Conditional Registration Order would serve no useful purpose in light of its finding that the Registrant had already demonstrated excellent remediation and insight, such that the risk of repetition was low. In any event, the Committee considered that a Conditional Registration Order would not sufficiently address the public interest considerations in this case.

93. In relation to suspension, the Committee had regard to paragraph 21.29 of the GOC Hearings and Indicative Sanctions Guidance (the Guidance), which states as follows:

> *This sanction may be appropriate when some, or all, of the following factors are apparent (this list is not exhaustive):*
>
> *a. A serious instance of misconduct where a lesser sanction is not sufficient.*
>
> *b. No evidence of harmful deep-seated personality or attitudinal problems.*
>
> *c. No evidence of repetition of behaviour since incident.*
>
> *d. The Committee is satisfied the registrant has insight and does not pose a significant risk of repeating behaviour*

e. (not relevant)

94. The Committee considered that each of the relevant factors identified at paragraph 21.29 of the Guidance was evident in this case. The Committee considered that the three areas of misconduct were serious and it had concluded that conditional registration would not sufficiently address the public interest concerns. Whilst the Committee recognised that dishonesty was typically viewed as an attitudinal trait, in this case, given the testimonials and the Registrant's insight, remorse and remediation, the Committee did not consider that the Registrant's dishonesty in 2021 was representative of a general attitudinal trait, but had been a one-off occasion which was out of character. The Committee did not consider that there was evidence of harmful deep-seated personality or attitudinal problems. The Registrant had been under interim conditions since 2021, during which time he had fully remediated his clinical misconduct, and the Committee was satisfied that there was no evidence of repetition of either the clinical or dishonest misconduct. The Committee took account of its earlier findings, to the effect that the Registrant had extensively reflected and developed good insight and that the risk of repetition was low.

95. The Committee considered that a Suspension Order was the appropriate and proportionate sanction, but in order to satisfy itself that a Suspension Order was indeed the correct sanction, it went on to consider erasure, and in particular paragraphs 21.35 and 21.37 which state:

21.35 –

Erasure is likely to be appropriate when the behaviour is fundamentally incompatible with being a registered professional and involves any of the following (this list is not exhaustive):

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. (not relevant);

e. (not relevant);

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;

h. Persistent lack of insight into seriousness of actions or consequences.

Paragraph21.37 –

Erasure from the register is appropriate if it is the only means of protecting patients and/or maintaining public confidence in the optical profession. The

Privy Council in Bijl v GMC (Privy Council Appeal No. 78 of 2000) emphasised that a Committee should not feel it necessary to remove:

> *"…an otherwise competent and useful [registrant] who presents no danger to the public in order to satisfy [public] demand for blame and punishment."*

96. The Committee considered that factors a, b, c and f of paragraph 21.35 of the Guidance were potentially engaged in this case at least to an extent. The Committee considered that the Registrant's actions had clearly been a serious departure from the relevant professional standards and his 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. The Registrant had been in a position of trust, which was how he had access to Patient A's records to amend them, and his dishonesty in amending them had been an attempt to cover up his previous record keeping failures.

97. However, whilst the Committee considered that some factors relevant to erasure were potentially engaged in this case, the Committee did not consider that in all the circumstances, the misconduct was fundamentally incompatible with being a registered professional. Further, having regard to paragraph 21.37 of the Guidance, the Committee did not consider that erasure from the Register was the only means of maintaining confidence in the optical profession. The Committee had regard to the observations from the case of *Bijl v GMC* and considered that erasure in this case would be unfairly punitive on a practitioner who presents no danger to the public.

98. Accordingly, the Committee concluded that a Suspension Order of 6 months was the appropriate and proportionate sanction in the circumstances of this case. In deciding this length, the Committee bore in mind the Registrant's extensive steps taken to achieve excellent remediation and to demonstrate a good level of insight, and that there was a public interest in a competent optometrist returning to community practice. The Committee considered that a longer period would be unduly punitive in the circumstances of this case.

99. In terms of the principle of proportionality, the Committee noted that the Registrant would be prevented from working in the profession by the Suspension Order for the period it is in place. However, it was of the view that the public interest in maintaining public confidence in the profession and declaring and upholding standards outweighs his own interests in this regard.

100. Given that the sanction is imposed to mark the seriousness of the case and that there are no public protection issues, the Committee does not consider that a review of the Suspension Order before its expiry is required as it would be of no value.

101. Following the imposition of the substantive 6 month Suspension Order, the Committee formally revoked the Interim Conditions of Practice Order under section 13L(11) of the Opticians Act 1989.

Immediate Order

102. The Chair of the Committee enquired of Ms Ahmed whether there was any application for an immediate order to cover the appeal period, in light of the

sanction imposed. Ms Ahmed explained that she was instructed to apply for an immediate order of suspension on the public interest ground which would be consistent with the Committee's substantive determination.

103. Mr Hall, on behalf of the Registrant, opposed the application. He submitted that there needed to be a reason for an immediate order, and such a reason did not exist in these circumstances. He submitted that the public interest would be served by the substantive 6 months suspension order. Mr Hall further submitted that the 28 day appeal period would give the Registrant the time to put in place appropriate measures at the Practice to ensure continuity of care for patients.

104. 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, 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 6 month Suspension Order and no immediate order was required in addition to address the public interest.

Chair of the Committee: Pamela Ormerod

Signature  **Date: 16 January 2024**

Registrant: Simon Rose

Signature ……joined via video conference……. **Date: 16 January 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.