BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(22)38

AND

JOHN WATSON (01-15228)

DETERMINATION OF A SUBSTANTIVE HEARING
09 – 12 MAY, 18 MAY,
15-17 NOVEMBER 2023,
15-16 APRIL 2024

Committee Members:	Hermione McEwen (Chair/Lay) Nigel Pilkington (Lay) [Days 1-5 only] Vivienne Geary (Lay) Amit Jinabhai (Optometrist) Claire Roberts (Optometrist)
Legal adviser:	Ms Aaminah Khan
GOC Presenting Officer:	Ms Wafa Shah
Registrant present/represented:	Yes and represented by the AOP
Registrant representative:	Mr Alex Mills instructed by the AOP
Hearings Officer:	Ms Nazia Khanom Ms Humera Asif
Facts found proved:	1(b)(i) & (ii), 2(a)(i) & (ii), 3(a)(i), 4(a)(i) & (ii), 5(a), 5(b), 5(c)(i), 6(a), 7(a), 8(a), 8(b)(i) & (ii), 9(a)(i), 12(a)(i), 14(a)(ii) & (iii), 16(a), 17(a), 17(b)(i) & (ii), 18(b)(i), 19 (a)(i), (ii) & (iii), 20(a)(i) & (ii), 21(a)(i), (ii) & (iii), 22(a)(iv), 22(e), 23(a)(i) and 24(a)(ii) & (iii) were found proved at the start of the hearing following the Registrant's admissions. 22(a)(iii) was admitted during the course of the hearing by the Registrant.

	3(c)(i), 7(c)(as amended to right eye only), 9(b)(i) and (ii), 11(a)(i) and (ii), 12(b)(i) and (ii), 12(c), 13(a)(i),(ii) and (iii) and 22(c)(i) found proved at the end of the facts stage.
No case to answer:	14(a)(i) & 24(a)(i) determined by the Committee after hearing submissions by the Registrant. 22(b) was withdrawn by the Council after submissions by the Registrant.
Facts not found proved:	1(a), 10(a)(i), 22(a)(ii)
Misconduct:	Found
Impairment:	Impaired
Sanction:	Suspension for two months – (Without Review)
Immediate order:	No

FINAL ALLEGATION

(AS AMENDED ON DAY 1 OF THE HEARING AS DESCRIBED IN PARAGRAPHS 4-24 BELOW)

The Council alleges that you, John Anthony Watson, a registered Optometrist:

Patient A

1. On 12 November 2020, you conducted an examination on Patient A and you:

a. failed to adequately and/or appropriately record sufficient details regarding suprathreshold visual fields as you did not state the number of stimuli out of 26;

b. Failed to adequately and/or appropriately record clinical data by retrospectively amending Patient A's record of their original intraocular pressures (IOPs) from:

i.23, 24, 26 to 20, 20, 20 in their right eye.

ii.25, 28, 24.to 20, 20, 20 in their left eye.

Patient B

2. On or around 07 September 2020 you conducted an examination of Patient B and you:

a. Failed to adequately and/or appropriately record clinical data by retrospectively amending Patient B's record of their 'original' Intraocular pressure (IOPs) from:

i.23, 23, 25 to 20, 20, 20 in their right eye.

ii.21, 22, 23 to 20, 20, 20 in their left eye.

Patient C

3. On or around 09 November 2020 you conducted an eye examination of Patient C and you:

a. Failed to adequately and/or appropriately assess the depth of the anterior chamber given that:

i. the patient was at risk of having a narrow anterior chamber which could have led to angle closure glaucoma;

(Particular b was removed)

c. Amended Patient C's clinical records in that you

i. overwrote the IOP reading for the left eye which resulted in an inconsistency of the average data from your records with that of the general raw data

Patient D

4. Between 21 September 2020 and 17 March 2021, you conducted an examination on Patient D and you failed to adequately and/or appropriately record clinical data in that you

a. overwrote Patient D's record of the IOP value with:

i. 20, (18) and 20 in the right eye;

ii. Three readings of 20 in the left eye.

Patient E

5. On or around 16 October 2020, you conducted an examination on Patient E and you:

a. Failed to adequately and/or appropriately record sufficient details about their symptom of double vision which is clinically significant;

b. Failed to adequately and/or appropriately assess the depth of their anterior chamber necessary to determine the patient's risk factor for developing angle closure glaucoma; and

c. Failed to adequately and/or appropriately document if advice was provided regarding patient management of his dry eye;

i. and what that advice was.

(Particular d was removed)

Patient F

6. On or around 07 September 2020 you conducted an examination of Patient F and you:

a. failed to adequately and/or appropriately record sufficient information about the threshold of the visual field test.

Patient G

7. On or around 16 October 2020, you conducted an examination on Patient G and you:

a. Failed to adequately and/or appropriately record sufficient information about their flashes a symptom that may be suggestive of retinal detachment;

(Particular b was removed)

c. Failed to adequately and/or appropriately record clinical data by retrospectively amending Patient G's record of the IOP value from 21mmHg to 20mmHg for both eyes. (late amendment made by Committee right eye only)

Patient H

8. Failed to adequately and/or appropriately record clinical data in that you:

a. Did not record near visual acuity;

b. amended Patient H's record of the IOP value from;

i. 20, 21, 22 to 20mmHg in the right eye;

ii. 28, 24 and 23 to 20mmHg in the left eye.

Patient I

9. On or around 24 August 2020, you conducted an examination on Patient I and you

a. failed to adequately and/or appropriately document

i. whether there was any corneal staining within their dry eye given that the patient was already using treatment for this condition;

b. Failed to adequately and/or appropriately record clinical data by overwriting Patient I's record of the IOP value in their left eye from:

i.23mmHg to 20mmHg during the first test; and then from

ii. 22mmHg to 21mmHg.

Patient J

10. On or around 24 August 2020, you conducted an examination on Patient J

and you:

a. Failed to adequately and/or appropriately record clinical data in that you;

i. overwrote Patient J's record of the IOP value in their right eye from 12mmHg to 14mmHg.

Patient K

11. On or around 07 September 2020, you conducted an examination on Patient K and you:

a. failed to adequately and/or appropriately record clinical data in that you:

i. overwrote Patient K's record of the IOP raw value reading in the left eye from 23mmHg to 20mmH; and

ii. the average in that eye from21mmHg to 20mmHg.

Patient L

12. On or around 17 October 2020, you conducted an examination on Patient L and:

a. failed to adequately and/or appropriately document including:

i. whether there was any corneal staining within their dry eye given that the patient was already using treatment for this condition.

b. failed to adequately and/or appropriately record clinical data in that you

i. overwrote Patient L's record of the IOP raw value reading in the left eye from 25mmHg to 20mmHg; and

ii. the average in that eye from 23mmHg to 20mmHg.

c. failed to adequately and/or appropriately record clinical data in that you:

i. recorded the average value in the left eye as 20mmHg instead of the correct result of 21mmHg arising from clinical data of 22, 20 and 22.

Patient M

13. On or around 17 October 2020, you conducted an examination on Patient M and:

a. failed to adequately and/or appropriately record clinical data in that you;

i. Overwrote Patient M's record of the IOP final data in the right eye as 18mmHg,

ii. whilst in the left, the first value altered from 21mmHg to 20mmHg;

iii. and recorded the average value of the left eye as 20mmHg instead of

19mmHg.

Patient N

14. On or around 17 October 2020, you conducted an examination on Patient N and you:

a. failed to adequately and/or appropriately record sufficient information regarding his diabetes such as:

i. the type; (NB. No Case to Answer was found in respect of this Particular)

ii. duration; and

iii. quality control of the condition.

(NB. There is no patient O nor Particular 15)

Patient P

16. On or around 17 October 2020, you conducted an examination on Patient P and you failed to adequately and/or appropriately record clinical data;

a. Including near visual acuity.

Patient Q

17. On or around 13 August 2020, you conducted an examination on Patient Q, and you:

a. failed to adequately and/or appropriately conduct a visual field test; indicated as necessary due to borderline IOPs.

b. failed to adequately and/or appropriately record clinical data in that you overwrote Patient Q's record of the IOP mean value from:

i. 23, 25, 22, 24 to 20, 20, 21, 20 in the left eye; and

ii. recorded the average value of both eyes as 21mmHg instead of the original value of 21mmHg in the right eye and 23mmHg in the left eye.

Patient R

18. On or around 19 September 2020, you conducted an examination on Patient R, and you:

(Particular a was removed)

b. Failed to adequately and/or appropriately record clinical data in that you

i. overwrote Patient R's record of the IOP mean value in the right eye.

Patient S

19. On or around 19 September 2020, you conducted an examination on Patient S, and you failed to adequately and/or appropriately record clinical data:

a. by overwriting Patient S's record of the IOP raw value reading from:

i. 20, 23, 22, 20 to 20, 22, 22, 21 in the left eye;

ii. 22, 20, 21, 25 to 22, 20, 21, 22 in the right eye; and

iii. Reducing the averages from 22mmHg to 21mmHg in each eye.

Patient T

20. On or around 13 August 2020, you conducted an examination on Patient T and you:

a. failed to adequately and/or appropriately record clinical data by retrospectively amending Patient T's record of the IOP raw value reading from;

i. 24, 23, 20,24, to 24, 20, 20 and 22 in the left eye; and

ii. Reducing the averages from 23mmHg to 22mmHg in the left eye.

Patient U

21. Between 25 September 2020 and 9 October 2020 you conducted an examination on Patient U and you:

a. failed to adequately and/or appropriately record sufficient information including:

i. whether a visual field test was performed on collection; and

ii. if so, its outcome:

iii. to determine if Patient U's symptoms was suggestive of retinal detachment.

Patient V

22. On or around 20 August 2020 you conducted an examination on Patient V and you:

a. Failed to adequately and/or appropriately document:

(Particular (i) was removed)

ii. Patient V's diagnosis of a retinal problem in their right eye;

iii. whether Patient V was under the care of the hospital eye service; and

iv. if so, when their most recent and subsequent appointments as

scheduled

(Particular b was removed)

and

c. Failed to adequately and/or appropriately record clinical data by

i. overwriting the intraocular pressures in Patient V's right eye from 13, 13, 13 to 10, 10, 10.

(Particular d was removed)

e. Failed to conduct and/or record visual fields in the left eye.

Patient W

23. On or around 11 November 2020 you conducted an examination on Patient W, and you:

a. failed to adequately and/or appropriately record sufficient information including:

i. whether a visual field test was performed given the patient's family history of glaucoma and the optic disc appearance.

Patient X

24. On or around 25 September 2020:

a. You conducted an examination on Patient X and failed to adequately and/or appropriately record sufficient information regarding their diabetes including:

i. The type; (NB. No Case to Answer was found in respect of this Particular)

ii. The duration; and

iii. Quality control of the condition

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

DETERMINATION

Preliminary issues and applications

1. At the outset of the hearing, it was raised by the Chair that Mr Jinabhai, an Optometrist member of the Committee, had indicated that he was professionally acquainted with one of the witnesses for the Council, Person B, in that they had sat on a panel together on one occasion. Both Ms Shah, on behalf of the Council and Mr Mills, on behalf of the Registrant, confirmed that having considered this

matter, they had no issues with Mr Jinabhai being a member of the Committee and hearing this case.

2. Ms Shah, on behalf of the Council, indicated that she would be making an application to amend the wording of the Allegation, from what had been notified to the Registrant under Rule 28 of the General Optical Council (Fitness to Practise) Rules Order of Council 2013 ("the Rules").

3. However, before proceeding to make the amendment application, time was requested by Ms Shah in order for the Council to consider a number of issues that had been raised by Mr Mills, on behalf of the Registrant, in his skeleton argument that had been served that morning. Ms Shah explained that she needed to review the expert evidence again, and take further instructions, in order to respond to the queries raised on behalf of the Registrant and to confirm the exact amendments to the Allegation that the Council would be seeking. No objection was taken by Mr Mills to the Council's request for further time and the Committee agreed for the hearing to start later in the afternoon of the first day.

4. When the hearing reconvened, Ms Shah made an application to amend the original Allegation in various respects, which included changes to some dates, where there was a discrepancy between the date alleged and the date contained in the patient records, as well as proposing a number of changes to the wording of the original particulars of the Allegation, in order to make it better reflect the evidence.

5. For example, in respect of the overwriting allegations in relation to Patient A (paragraph 1(b)) and Patient B (paragraph 2(a)), the original wording of the particulars of the Allegation was to the effect that the Registrant had taken the initial intraocular pressure ('IOP') readings himself, whereas it was the Registrant's case that these original IOP readings had been taken and written on the patient records by the optical assistant, which he accepted that he had then subsequently overwritten.

6. In relation to some of the amendments proposed, the Council's reason for seeking the amendment was to make the Allegation more accurate, for example, by adding the word 'field' to the visual test referred to in relation to Patient Q (paragraph 17(a)).

7. In addition, it was proposed that some of the particulars of the Allegation should be removed, following the Council's review of further material from the Registrant's former employer and/or after reviewing points made on behalf of the Registrant.

8. Ms Shah referred the Committee to her skeleton argument, which set out the amendment application being made and in particular, to Rule 46(20), which is in the following terms:

> *"(20) Where it appears to the Fitness to Practise Committee at any time during the hearing, either upon the application of a party or of its own volition, that—*
>
> *(a) the particulars of the allegation or the grounds upon which it is based and which have been notified under rule 28, should be amended; and*

(b) the amendment can be made without injustice, it may, after hearing the parties and consulting with the legal adviser, amend those particulars or those grounds in appropriate terms."

9. Ms Shah submitted that the amendments that were proposed by the Council could be made without injustice and were not contentious, as they were in the main as a result of proposals made on behalf of the Registrant. The proposed removal of some of the particulars was in the Registrant's interests, as it followed his representations, some further disclosure of evidence and the Council had agreed that it was not proper to proceed with these parts of the Allegation. In relation to the dates being amended, it was submitted by Ms Shah that it was only proper to include the correct dates and the proposed amendments would allow the Allegation to better reflect the evidence.

10. Mr Mills, on behalf of the Registrant, did not oppose the amendment application, but made a number of observations. He agreed that the proposed amendments in relation to Patients A and B having their IOPs taken by the optical assistant reflected the Registrant's case on this point, and these parts of the Allegation could be admitted on this basis, providing that the Council were not suggesting that by using the word 'retrospectively' that the Registrant had come back to these records on a later date (which would not be accepted).

11. Mr Mills also observed that in respect of some of the paragraphs of the Allegation where between dates had been used, the Registrant had left his position by the end of that time period. However, he accepted that the eye examinations had taken place at the start of those time periods. Mr Mills further confirmed that he had no objection to the Council removing allegations that it no longer wished to proceed with.

12. In addition to the preliminary application in respect of the amendment of the Allegation, Mr Mills also raised that he would be applying for the hearing to sit partly in private, as and when the private matters detailed in the Registrant's bundle were raised. Mr Mills set out which matters he submitted should be heard in private within his skeleton argument, which included [redacted].

13. [redacted]

14. Ms Shah confirmed that the Council was not objecting to those parts of the hearing being heard in private.

15. The Committee heard and accepted the advice of the Legal Adviser in relation to the preliminary issue of sitting in private and amending the Allegation. In relation to sitting in private, the Legal Adviser referred the Committee to Rule 25, which states that,

"(25) (1) Substantive hearings before the Fitness to Practise Committee must be held in public.

This is subject to the following provisions of this rule.

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

(a) the interests of the maker of an allegation (where one has been made);

(b) the interests of any patient or witness concerned;

(c) the interests of the registrant; and

(d) all the circumstances, including the public interest.

(3) A hearing, or any part of a hearing, of the Fitness to Practise Committee must be a private hearing where the Fitness to Practise Committee is considering the physical or mental health of the registrant.

This is subject to paragraph (4).

(4) Where the Fitness to Practise Committee is considering matters referred to in paragraph (3), it may meet in public where it considers that it would be appropriate to do so, having regard to the matters set out in paragraph (2).”

16. The Legal Adviser referred the Committee to the relevant sections of the Council’s ‘Hearings and Indicative Sanctions Guidance (Revised November 2021)’ on sitting in private, with reference to the competing factors of privacy, transparency, and the need for proportionate measures so that no more of the hearing is heard in private than is necessary.

17. In relation to the amendment application, the Legal Adviser advised that the Committee had a discretion under Rule 46(20) to make amendments, at any stage of the hearing, either on an application by a party or of its own motion, if satisfied that the amendment can be made without injustice and that issues of prejudice and fairness had to be considered from both parties’ perspectives. It may also be considered to be in the interests of justice for the Allegation to be clear and unambiguous, so that all concerned understand the case that the Registrant faces.

18. The Committee retired in private to consider the Council’s application to amend the Allegation and the Registrant’s application for parts of the hearing to be heard in private.

19. In relation to the application to sit partly in private, the Committee was satisfied that there was information within the Registrant’s witness statement and bundle, which raises private information regarding [redacted], engaging Article 8 (right to respect for private and family life) of the European Convention on Human Rights. In relation to the information relating to the Registrant’s [redacted], the Committee was of the view that under Rule 25(3) there was in effect a presumption that such matters would be heard in private, unless there were sufficient countervailing considerations.

20. The Committee noted that the Council did not oppose the application and was mindful that proportionate measures could be taken to ensure that no more of the hearing was heard in private than was necessary. In the circumstances, considering the private nature of the information and having regard to the factors in the Rule 25(2), the Committee was satisfied that it was appropriate for parts of the hearing, where the private matters included in the Registrant’s bundle were raised, to be heard in private.

21. The Committee went on to consider the Council’s application to amend the Allegation and considered carefully whether the amendments could be made without injustice. Each of the individual proposed amendments were considered separately and in turn. The Committee noted that many of the proposed

amendments were to correct dates, or to make the Allegation clearer regarding the actions of the Registrant. It further noted that none of the proposed amendments were opposed.

22. The Committee concluded that the proposed amendments more accurately reflected the evidence, including what was recorded in the patient records. Accordingly, there was nothing in the proposed amendments which would take the parties by surprise and in fact, the amendment application had been prompted by representations made on behalf of the Registrant. The amendments proposed were in the Registrant's interests, as they addressed the points raised by his representatives and narrowed the issues.

23. The Committee was satisfied that the proposed amendments could be made without unfairness or prejudice to either party. Accordingly, the Committee allowed the Council's application to amend the Allegation in full. In addition, the Committee made some further amendments of its own motion, which it considered were appropriate and did not cause injustice, for example, by correcting typographical errors and adding the word 'field' in further places where it was missing, for the sake of clarity and consistency throughout the Allegation.

24. The Allegation set out above reflects the final version of the Allegation after the applications by the Council to make amendments were granted and the Committee made some further amendments of its own motion. One further amendment was made during the Committee's deliberations at the end of the facts stage, in respect of Patient G (particular 7(c)), to refer to the right eye only rather than both eyes, as set out further at paragraphs 108-111 below. Particular 22(b) of the Allegation was withdrawn by the Council after the Committee heard 'no case to answer' submissions from the Registrant.

Admissions in relation to the particulars of the Allegation

25. The Registrant admitted the following particulars of the Allegation; 1(b)(i) & (ii), 2(a)(i) & (ii), 3(a)(i), 4(a)(i) & (ii), 5(a), 5(b), 5(c)(i), 6(a), 7(a), 8(a), 8(b)(i) & (ii), 9(a)(i), 12(a)(i), 14(a)(ii) & (iii), 16(a), 17(a), 17(b)(i) & (ii), 18(b)(i), 19 (a)(i), (ii) & (iii), 20(a)(i) & (ii), 21(a)(i), (ii) & (iii), 22(a) (iv), 22(e), 23(a)(i) and 24(a)(ii) & (iii). These were found proved at the start of the hearing following the Registrant's admissions and 22(a)(iii) was admitted during the course of the hearing. The Committee proceeded to hear evidence in relation to the remaining particulars of the Allegation that were disputed by the Registrant.

Background to the Allegation

26. The Registrant was first registered as an Optometrist in July 1994. From March 2003 to October 2019, he worked as Director Optometrist at his own 'Specsavers' franchise practice with nine employees. He sold the practice in October 2019. At the time of the events subject of the Allegation the Registrant was working at Boots Opticians, having commenced employment with Boots Opticians on 9 March 2020. Initially the Registrant was working in Practise A and Practise B branches. However, as a result of the COVID-19 pandemic, he

was subsequently required to work as a mobile Optometrist, working at six different practices of Boots Opticians, from June 2020 until his employment ended in November 2020.

27. On 12 November 2020, the Registrant carried out an eye test on Patient A. During that appointment Patient A's IOP readings were taken, and they were at a level where a referral to the Hospital Eye Service (HES) ought to have been considered by the Registrant. It is alleged that the IOP readings that had been written on Patient A's records were overwritten by the Registrant to show lower IOPs, to a level that would be considered normal.

28. On 14 November 2020, the Registrant attended an investigatory meeting following a complaint by a whistle-blower. During the meeting he was questioned about altering Patient A's IOP readings and he was accused of falsifying records. The Registrant initially admitted altering Patient A's IOPs, stating '*I don't know why I've changed it. I have changed it, so the pressures don't look so high, no referral, fields looked ok*'.

29. Following a break in the meeting, the Registrant resiled from this admission and claimed he had not falsified the IOP readings to make them appear lower but had instead re-checked the '*pressures with the pulsair in the test at the start*'.

30. At a further meeting on 20 November 2020, the Registrant maintained that he had taken a second IOP reading and contested he had falsified Patient A's IOPs on the patient record card. The Registrant was summarily dismissed following this meeting, a decision which he appealed unsuccessfully, on the basis that he had updated the readings rather than falsified them. After the Registrant's appeal was dismissed, he made a self-referral to the Council on 22 December 2020.

31. Following the dismissal of the Registrant, Boots Opticians conducted an audit of all the Registrant's patient records since he had commenced employment with them. On conclusion of this investigation, 23 patient records were identified as having IOP readings over-written. Of the 23 patients, 3 were recalled as the readings were too high or illegible. With the 3 patients recalled no harm was caused. The results of the audit, including the case of Patient A, form the basis for the Allegation.

32. The particulars of the Allegation are in two categories, firstly, a series of similar particulars of alleged overwriting of patient IOP readings and secondly, particulars relating to various clinical concerns, including failures to adequately assess or record aspects of the patients' conditions. A Case Management Meeting for this case was held on 23 March 2023 and both parties were legally represented. Despite the Registrant indicating in this meeting that the Allegation would be admitted in its entirety, he later through his representatives, raised a number of discrete issues with some of the clinical aspects of the Allegation and

disputed a number of the overwriting allegations, as he did not believe the handwriting was all his.

The hearing

33. The Council relied upon the agreed evidence of Person A and Person B who were both employed by Boots Opticians and involved in the local investigation. As the evidence of these witnesses was not challenged by the Registrant they were not required to attend for cross-examination.

34. The Council also relied upon the live expert evidence of Dr Anna Kwartz, who had provided two expert reports dated 7 February 2022 an addendum dated 1 May 2023 respectively. The Registrant also gave live evidence to the Committee.

35. The Committee was also provided with bundles of documentary evidence on behalf of both parties, which were supplemented with additional material as the hearing progressed. The documents in the Council's bundle included the witness statements of Person A and Person B, records relating to the disciplinary process, the local investigation reports, Boots Opticians patient records for patients A – X and various correspondence between the Council and Boots Opticians regarding further information requests relating to the patient records and a Council case management meeting record dated 23 March 2023.

36. The Registrant provided a bundle containing his original witness statement, reflective statement, Continuing Professional Development (CPD) documents, professional references, and supervisor's reports. The Registrant also provided the Committee with two addendum witness statements during the hearing, clarifying his position in respect of particulars of the Allegation.

37. On the third day of the hearing, 11 May 2023, the Committee heard evidence from the expert witness Dr Kwartz, who was questioned by Ms Shah for the Council, Mr Mills on behalf of the Registrant, and the Committee. Dr Kwartz's evidence was set out in her expert report dated 7 February 2022 and in an addendum report dated 1 May 2023.

38. At the close of the Council's case, it was indicated that there was a list of facts that had been agreed between the parties, which were put before the Committee, as follows:

"*The following facts are agreed between the parties:*

1. In August and September 2022 the GOC instructed a handwriting expert in respect of the overwriting of IOP values. Having reviewed patient records the expert informed the GOC that:

"[…] it will not possible to reach a significant conclusion as to whether or not:

1. The overwritten entries are by the same person as other writings on a given form; or

2. The overwritten entries on two or more forms were made by the same person.

That is, the evidence is inconclusive."

2. The expert further informed the GOC that no useful comparison could be made between the overwritten entries with a sample known to be of Mr Watson's handwriting."

39. Following the close of the Council's case, Mr Mills, on behalf of the Registrant, made a submission that there was no case to answer in respect of the particulars of the Allegation that the Registrant failed to adequately and/or appropriately record sufficient information regarding the type of diabetes experienced by patients N and X. The application was made on the basis of the expert evidence that had been given by Dr Kwartz on this issue. During cross-examination, Dr Kwartz had agreed that the type of diabetes that patients N and X had, could be inferred from the medications that the Registrant had recorded that they were taking, which were medications prescribed for non-insulin dependent type 2 diabetes. Dr Kwartz had agreed that a reasonably competent Optometrist would be able to draw this inference from the patient records and it was submitted by Mr Mills that in these circumstances there was no failing of recordkeeping.

40. Mr Mills referred the Committee to the test for considering a submission of no case to answer in the case of *R v Galbraith* [1981] 1 WLR 1039 and submitted that in light of Dr Kwartz's concession that it was adequate recordkeeping, given the inference that could reasonably be drawn by a fellow Optometrist, these particulars of the Allegation should go no further.

41. After consideration of the application, Ms Shah, on behalf of the Council, conceded that there was no case to answer in respect of these particulars of the Allegation, as Dr Kwartz had considered this was an acceptable level of recordkeeping, on the basis that any reasonably competent Optometrist could determine the type of diabetes from the medications listed.

42. At the time of responding to the no case to answer submission, Ms Shah also sought to withdraw a further particular of the Allegation (particular 22(b)), which the Council accepted was duplicitous having heard the expert evidence in

relation to it and it was submitted that this could be amended without prejudice to the Registrant, as it was bringing the Allegation closer to the evidence.

43. The Committee heard and accepted the advice of the Legal Adviser on the submission of no case to answer and on the Council's further application to amend the Allegation. In relation to the submission of no case to answer, the Legal Adviser confirmed that *Galbraith* was the leading case and although it was a criminal case it was well established that the same principles apply to regulatory proceedings. The test in *Galbraith* is that, firstly, if there is no evidence that the charge alleged has been committed, the charge must be dismissed. Secondly, if there is some evidence but it is of a tenuous character, for example, because of inherent weakness or vagueness or because it is inconsistent with other evidence the charge must also be dismissed. Where however the evidence is such that its strength or weaknesses depends on the Committee's view of it, for example, a witnesses' reliability, and where on one possible view of the facts there is evidence on which a Committee could properly come to the conclusion that a particular allegation(s) can be found proved, then the matter shall proceed. Further, the Committee should consider the evidence as a whole and not only the strongest parts.

44. The Committee retired in private to consider the submission of no case to answer. The Committee was of the view that the expert witness Dr Kwartz had been clear in her evidence that a reasonably competent Optometrist would be able to infer the type of diabetes suffered by patients N and X, from the medications that the Registrant had recorded on their patient records, and as such it was adequate recordkeeping in this respect. In the circumstances and noting that the application was not opposed by the Council, the Committee was satisfied that there was no case to answer in respect of these particulars of the Allegation (particulars 14(a)(i) and 24(a)(i)).

45. The Committee also considered and agreed with the Council's application to amend the Allegation further to remove what was particular 22(b), as given the original wording of that particular, it was duplicitous with what was alleged in particular 22(a)(ii). The Committee was satisfied that this amendment should be made and that it could be done without injustice being caused to the parties. The Committee updated the amended Allegation, the final version of which is as shown at the start of this determination.

46. Mr Mills opened the case for the Registrant by outlining the Registrant's position on the remaining disputed particulars of the Allegation. There were eight 'overwriting' allegations that were denied by the Registrant. In relation to seven of them it was denied either that it was his handwriting or that he was not sure that it was his handwriting. In relation to Patient V he accepted that he had overwritten the entry but it was to correct the original entry he had made. The Registrant's case was that the initial transcription of the IOP results was completed by an optical assistant and whilst he was not putting forward a

positive case of this, it was possible that errors had been made by them, which they had then corrected. Mr Mills submitted that there was no consistent pattern of changes, and it was notable that none of the IOP values were near the NICE or SIGN (the applicable guidance in Scotland) thresholds for further investigations, with only one of the disputed patients (Patient L) having a significant change in an IOP value from 23 mmHg to 20 mmHg.

47. Mr Mills outlined the Registrant's case in relation to the discrete clinical particulars that were in dispute. In respect of the particulars of the Allegation that the Registrant failed to adequately and/or appropriately record sufficient details regarding Patient A's suprathreshold visual fields, by not stating the number of stimuli out of 26 (particular 1(a)), the Registrant relied upon there being a printout of the test results. Whether it was a failure to not write this information on the patient record card, may turn upon the Committee's view of the expert evidence on this issue, which was based upon the expert's experience rather than any published guidance.

48. Mr Mills outlined the Registrant's position in relation to the denied particulars in respect of Patient V and the alleged failure of the Registrant to adequately and/or appropriately document information relating to Patient V's diagnosis of a retinal problem in their right eye, whether they were under the care of the Hospital Eye Service (HES), and details of their most recent and subsequent appointments. Mr Mills stated that these were denied on the basis that the Registrant had written 'HES' on the patient record form and it was not clear what further information was required.

49. The Registrant gave evidence and was questioned by his representative, Mr Mills, Ms Shah, on behalf of the Council and the Committee. During the course of his evidence, the Registrant made admissions in respect of the recordkeeping particular for Patient V, by failing to adequately record that they were under the current care of HES (Allegation 22(a)(iii)), which was subsequently confirmed by Mr Mills as being an informal admission to this particular of the Allegation. Ms Shah invited the Committee to formally put the particular of the Allegation to the Registrant again so that this could be admitted and found proved by admission. However, Mr Mills raised whether this was procedurally possible at this stage of the hearing. Following legal advice from the Legal Adviser, which was that the Committee could note and take into account the informal admission, as confirmed by Mr Mills, the Committee did not consider it was necessary to formally put the particular of the Allegation to the Registrant at this stage.

50. The Committee then heard closing submissions from both parties on the fourth day of the hearing, 12 May 2023. Ms Shah outlined that the burden of proof was on the Council to prove the disputed particulars of the Allegation, on the balance of probabilities i.e., that the disputed fact was more likely than not to have occurred. Ms Shah highlighted that this was a lower standard than the criminal

standard of beyond reasonable doubt and the difference was relevant in this case, particularly in relation to the overwriting aspect of the case.

51. Ms Shah addressed the disputed clinical particular 1(a) of the Allegation in respect of Patient A, and the alleged failure of the Registrant to properly record the result of the suprathreshold visual field test by not writing the number of stimuli out of 26 onto the patient record card. Ms Shah submitted that it was clear from the patient records that this box had not been fully completed and the Registrant ought to have done so. She asserted that by not completing the number of stimuli, there was a failure to record sufficient details of the results, regardless of the printed-out results. Ms Shah invited the Committee to accept the expert evidence of Dr Kwartz on this issue, which had been maintained after cross-examination. Dr Kwartz had considered that this was a failing on the basis that the information in the patient record card was incomplete, and the printed-out results could become detached or not be easily accessible for the next clinician to see, and the information on the record card (if completed) can prompt the next clinician to locate and look at the printed-out results, if necessary.

52. Ms Shah submitted that the Registrant had changed his account when giving evidence as to whether he would complete the box in future or not and that there had been inconsistencies in his evidence on this issue. There was a box for this information on the patient records and it ought to be completed, either by the Registrant, as the examining Optometrist, or by the optical assistant, with this then being checked and signed by the Registrant as being a complete record.

53. In relation to the disputed overwriting allegations, Ms Shah submitted that there were clearly changes to the IOP values in question, and the issue disputed was that the Registrant did not recognise this as his own handwriting. Ms Shah invited the Committee to find on the balance of probabilities this was most likely the Registrant's writing, given his previous admissions made at the case management stage, which she invited the Committee to take into account. Ms Shah submitted that throughout the investigation the Registrant had given inconsistent accounts and that he had a history of denying his failings, as he had in the employer's disciplinary investigation, in which he had maintained a fabricated account of having taken a second set of IOP readings with a different device. Ms Shah invited the Committee to find the Registrant's explanations for his fabricated account to Boots Opticians, namely panic and [redacted], to be inadequate reasons for maintaining this position over a period of at least a month.

54. Ms Shah submitted that the Registrant had fallen into the practise of adjusting the IOP readings during this time period, which he admitted in his evidence and the Committee could safely find that it was likely that he had also overwritten the IOPs in the disputed particulars of the Allegation, especially where the Registrant was unsure if it was his handwriting.

55. In relation to the clinical particular in respect of Patient V, Ms Shah highlighted that the Registrant had made some admissions in his evidence in respect of inadequately documenting Patient V's right eye retinal diagnosis and that they were under the current care of the HES (in relation to particular 22(a)(ii) & (iii)). In relation to whether there was further information from Patient V, that the Registrant ought to have recorded, for example in relation to appointments, Ms Shah submitted that the Committee only had the Registrant's word that Patient V was unable to provide further information and there was nothing in the records to support this, for example a note to that effect. Ms Shah invited the Committee to find that the Registrant was not a credible witness and that they could not accept his word about Patient V, and to conclude that there was a failure in his recordkeeping in this respect.

56. Ms Shah also highlighted in her closing submissions that she had noted that in relation to the overwriting particular of the Allegation in respect of Patient G (particular 7(c)), the wording of the Allegation was that the IOP values had been amended for both eyes. However, from the patient records for Patient G, it was only the right eye that has been overwritten. Ms Shah confirmed that she was not making a further application to amend the Allegation at this stage and that it was a matter for the Committee as to whether they wished to make this amendment of their own accord, whilst deliberating on this issue.

57. In Mr Mills' closing submissions, he relied upon and added to the submissions that he made in opening the Registrant's case. In relation to the disputed clinical particular 1(a) in respect of Patient A, and the alleged failure of the Registrant to properly complete the result of the suprathreshold visual field test by not writing the stimuli out of 26 onto the patient record card (particular 1(a)), Mr Mills highlighted that this was not raised in the expert, Dr Kwartz's, reports and her criticism of the Registrant in relation to this was expressed for the first time during her evidence. It was submitted that there was no basis for this view, apart from her experience.

58. Mr Mills submitted that there was a distinction to be drawn between a failure to do something that was required and what would be regarded as best practice, which he invited the Committee to keep in mind. Mr Mills submitted that it was not necessarily an acceptance of a failure for the Registrant to change his practise from something he did previously, as he had given evidence that he now completes the relevant boxes on patient records. Further, Mr Mills highlighted what the Committee may think was a difference in approach in the evidence of the expert, Dr Kwartz, in respect of the acceptability of relying upon the printout between a suprathreshold and a more detailed full threshold visual field test. The extent of the alleged failure was not recording the number of stimuli missed and Mr Mills invited the Committee to find that there was an insufficient basis to find that there had been a recordkeeping failure in the circumstances.

59. In respect of the disputed overwriting allegations, Mr Mills submitted that the Council had overlooked, in both Ms Shah's cross-examination of the Registrant and in her closing submission, that a letter had been sent on behalf of the Registrant in May 2022, in which the issue of the handwriting being denied for some patients had been raised, therefore it was not a recent change in position. Mr Mills submitted that whilst the Registrant had previously indicated that he would be admitting all of the particulars of the Allegation, had he done so, he would have admitted various aspects that had since been withdrawn by the Council. The suggestion that he was seeking to avoid responsibility was difficult to reconcile with the fact that the Registrant had admitted large parts of the Allegation.

60. Mr Mills further invited the Committee to consider the manner and tone of the Registrant's evidence and suggested that if he was lying, he would not have expressed his case in such a careful way. Mr Mills submitted that it was reasonable for the Registrant to await the outcome of the employer's investigation before self-referring to the Council. Mr Mills asked the Committee to be cautious about the reasoning adopted by the Council that because the Registrant had not been truthful in the local investigation, which was some years ago, that he could not be relied upon now, when dealing with a different Allegation to what he faced then.

61. Mr Mills invited the Committee to analyse in detail the IOP values that had been changed in the disputed particulars, which Mr Mills submitted there was no motivation for the Registrant to change in respect of these specific patients. Many of the changes were clinically insignificant. Some of the changes were to one reading for one eye, and it was quite possible that this was to simply correct a mistake. Further, there was evidence, in the agreed evidence of Person B and his investigation report, of the limited number of occasions that the overwriting had occurred, which equated to 3% of the patients seen by the Registrant during his employment with Boots Opticians.

62. In relation to Patient V, there was no obvious reason why the Registrant would want to deliberately change the readings from 13 mmHg to 10 mmHg. Mr Mills submitted that when the particulars for the admitted overwriting were compared to those that were denied, the majority were cases of higher readings being lowered, for example Patient A whose reading was above the SIGN threshold. The admitted changes were consistent with the Registrant's explanation for why he did it, whereas this does not apply to the ones that are denied.

63. Mr Mills turned to the clinical particular of the Allegation in respect of Patient V, relating to alleged inadequate recording of their condition. Mr Mills invited the Committee to have regard to the addendum witness statement of the Registrant and the evidence of the expert, Dr Kwartz, who accepted that if Patient V had no further information to provide, then the Registrant's recordkeeping was adequate. The Committee had not heard from Patient V and there was no

evidence that Patient did have more to say about their condition, therefore the factual pre-condition to this particular of the Allegation was not established. If the Committee agreed with that, all that was left was whether it was a failing for the Registrant not to note down that Patient V had no further information and whilst that may have been a preferable practice, it was not sufficient to be a failing.

64. The Committee heard and accepted advice from the Legal Adviser at the end of the facts stage, which included advice that the burden of proof throughout lies on the Council to prove, on the balance of probabilities, each of the facts alleged in the Allegation. In relation to those particulars of the Allegation that refer to an alleged failure upon the Registrant, the Committee were advised that they should firstly consider whether a duty or obligation exists upon the Registrant to act in that manner, before going on to consider if the failure is established.

Findings in relation to the facts

65. The Committee considered all of the evidence in this case, including the documentary evidence, the uncontested evidence of Person A and Person B from Boots Opticians, the agreed facts, the documentary and live evidence of the expert witness Dr Kwartz and that of the Registrant. The Committee also considered the submissions from the parties.

66. The Committee firstly considered the discrete clinical particulars of the Allegation that were in dispute, before turning to the disputed overwriting particulars of the Allegation.

<u>Patient A - Particular 1(a)</u>

67. This particular of the Allegation related to the Registrant's alleged failure to adequately and/or appropriately record sufficient details regarding Patient A's suprathreshold visual fields test, as the Registrant did not state the number of missed stimuli out of 26 on Patient A's patient record card.

68. The Committee noted that the Council's bundle contained the print out of Patient A's suprathreshold visual field results for the examination on 12 November 2020, as well as a copy of Patient A's record card for the examination on that date, which had been signed by the Registrant. This had a box with the title 'Visual Fields', where someone had hand written ' /26' for both the left and right eyes in this box. However, there was no entry written above the line to indicate how many stimuli out of 26 had been missed. The results print out shows that 1/26 stimuli had been missed in Patient A's left eye and 2/26 in their right eye.

69. The Committee considered the Registrant's case, as set out in his witness statement and his live evidence, namely that the entry in the 'Visual Fields' section had been completed by the optical assistant and not the Registrant. Further, there was a printout of the suprathreshold visual field results, which was attached as part of the records; it was the Registrant's case that this obviated the need for the Registrant to hand write the number of stimuli onto Patient A's record card. The Committee noted that the Registrant had accepted when giving evidence that this information was something he would complete on the patient record card in future.

70. The Committee had regard to the expert opinion evidence of Dr Kwartz on this issue, which was that the patient record for Patient A was incomplete by not having this information written into the 'Visual Fields' box by the Registrant. Dr Kwartz's opinion was that the standard to be expected of a reasonably competent Optometrist was for the visual fields box to also be completed on the patient record card, primarily because the printout could become separated from the records. Writing the results onto the record card, this was a safety net that ensured that they would be seen by the next clinician. It was the Council's case that if this section was incompletely filled in by the optical assistant, it would be the Registrant's responsibility, as the Optometrist, to have either completed this himself or ensured that the assistant did so.

71. The Committee considered whether, in the circumstances of there being a printout of the results available, the Registrant was nonetheless under a duty to manually record the stimuli results onto the patient record card. The Committee noted that Dr Kwartz's opinion that this was a failing based upon her personal experience of working in various clinics and reviewing many sets of patient records over her career. The Committee had asked Dr Kwartz whether there were any guidelines or other similar documents, which set out this requirement for Optometrists to follow and she was not aware of any.

72. The Committee also noted the point made by Mr Mills, on behalf of the Registrant, that there appeared to be a difference in approach by Dr Kwartz in her reports between what was acceptable practice with regard to recording the results of a suprathreshold test and a full threshold test (in respect of the latter, Dr Kwartz's opinion was that it was acceptable practice to attach a printout of the results to the patient record card, as the information could not be concisely summarised). The Committee agreed with the observations of Mr Mills, that there was a difference in approach in the Council's case between how these two tests' results should be captured, which did not appear logical, as the full threshold test results printout could also become separated from the patient record.

73. The Committee considered the written report of Dr Kwartz, dated 7 February 2022, which stated at paragraph 10.5.1, that:

"*If a patient produced a suprathreshold visual field test result where a number of points have been missed (eg 4 or more), then I would expect a reasonably competent optometrist to print and retain the results*."

74. In addition, the Addendum report of Dr Kwartz, dated 1 May 2023, at paragraph 2.1.1 states:

"*If a patient's visual field results are suspect or abnormal, then a reasonably competent optometrist would print the results and retain them with the record (for both full threshold and supra-threshold tests). Common practise is also to write a summary of the results in the record*."

75. The Committee was of the view that these extracts of Dr Kwartz's reports described what the Registrant did, in printing the suprathreshold visual field test results and retaining them with Patient A's records.

76. The Committee was mindful of the fact that where a clinical failure is alleged, it ought to first be satisfied that there was an identifiable duty upon the Registrant to have acted in that manner. In this instance, whilst the Committee accepted the expertise of Dr Kwartz and noted that there was no contrary expert relied upon by the Registrant, she was unable to direct the Committee to an established standard expected of Optometrists to nonetheless complete a written summary of the visual fields on the patient record card, in the circumstances where a test results printout was available.

77. The Committee understood the reasoning of Dr Kwartz as to why it would be desirable for the results from the print out to also be handwritten onto the patient record card, in case the print out became detached. However, the Committee was mindful that when considering whether a practice fell below what was required, the standard by which to gauge that practice was what was reasonably required as acceptable practice, rather than what was desirable, gold standard or best practice.

78. The Committee was of the view that without clear guidelines on this issue, there may be a range of practice in this area and some Optometrists may follow the approach previously adopted by the Registrant of relying upon the printout being attached. The Committee also noted the wording of these particulars of the allegation, which was that the Registrant had not adequately or appropriately recorded the missed stimuli out of 26.

79. Considering all of the above, the Committee determined that on the balance of probabilities the Council had failed to discharge the burden of proving that the Registrant had failed to adequately and/or appropriately record sufficient details regarding Patient A's suprathreshold visual fields, as although the Registrant did not state the number of missed stimuli out of 26 on Patient A's patient record

card, this information was included in the test results printout, which was within Patient A's records. The Committee was of the view that the practice described by Dr Kwartz of additionally handwriting the stimuli missed onto the patient record card, was a desirable or best practice, but that this was more than was required for an adequate standard of recordkeeping.

80. Particular 1(a) is therefore found not proved.

Patient V - Particulars 22(a)(ii) and (iii)

81. These particulars of the Allegation related to the Registrant's examination of Patient V, and his alleged failure to adequately and/or appropriately document Patient V's diagnosis of a retinal problem in their right eye, as well as whether Patient V was under the care of the HES.

82. The Committee had regard to the patient records in respect of Patient V, which had been completed by the Registrant, following the examination that took place on 20 August 2020. The Committee was of the view that the notes made by the Registrant on the patient record card in relation to Patient V were comprehensive and detailed, for example, noting the details of the various medications that Patient V was taking.

83. The Committee considered the evidence of the Registrant, in both his witness statements and his live evidence, regarding Patient V. In his witness statement the Registrant stated that:

> *"I dispute charges 22a/ii and 23a/iii on the grounds that the patient presented with an existing historical ocular condition seen by Hospital eye service (HES) and record reads "HES RE poor vision, leukocoria and retinal problems, Atropine and Latanoprost and Predforte drops Right Eye only".*

84. The Committee considered the addendum witness statement of the Registrant, dated 9 May 2023, in which he stated that he did not specifically remember Patient V. However, his practice was to ask patients about any diagnosis and treatment. It was the Registrant's case that had Patient V provided him with information when he asked about any diagnoses then this would have been recorded by him in Patient V's records.

85. The Committee noted that Registrant had admitted during his evidence that whilst he had made the note regarding HES, that it was not clear from this record whether Patient V was under the current care or had in the past been under the care of HES. Accordingly, the Committee found that on the basis of the Registrant's admission, as confirmed by his representative Mr Mills, that particular 22(a)(iii) was proved.

86. In relation to particular 22(a)(ii), whether the Registrant had failed to adequately or appropriately document Patient V's diagnosis of a retinal problem in their right eye, the Committee had regard to the expert evidence of Dr Kwartz on this issue, which in summary was that the Registrant should have asked Patient V questions about their diagnosis and if Patient V was vague or unsure, then this fact ought to have been documented so that any subsequent clinician would be aware of it.

87. The Committee was of the view that Dr Kwartz's evidence in respect of this issue was not a strongly held, firm, opinion, as it was unclear what information about their diagnosis Patient V was able to provide to the Registrant. Dr Kwartz acknowledged in her report that "*it is possible that Patient V was not aware of their diagnosis and if this was the case, then I aver that JW should have documented the fact*."

88. In her addendum report, Dr Kwartz stated that it was not possible to ascertain what level of understanding the patient had about their condition and,

> *"If it is accepted that the Registrant enquired about the diagnosis and the patient was not able to give a detailed response, then I consider that the record meets the required standard in terms of recording a diagnosis."*

89. The Committee was of the view that this particular of the Allegation was based upon what Patient V might have said to the Registrant. However, it could not determine, on the evidence before it, what information Patient V was able to provide to the Registrant regarding their diagnosis. The Registrant was unable to recall the conversation, Patient V had not complained about any aspect of the examination and the Committee had heard no evidence from Patient V. The Committee considered that the diagnosis could have been a long standing one, in which case it was possible that Patient V was unable to provide any further details.

90. The Committee was satisfied that there had been a conversation about the diagnosis, as the Registrant had noted all of the names of the different eye drops that Patient V had been prescribed for their right eye. The Committee considered that given the full record that the Registrant had made in other respects in relation to Patient V, it was plausible that the Registrant had recorded all of the relevant information that Patient V had been able to provide.

91. Therefore, the Committee determined that on the balance of probabilities the Council had failed to discharge the burden of proving that the Registrant had failed to adequately and/or appropriately document Patient V's diagnosis of a retinal problem in their right eye.

92. Particular 22(a)(ii) is therefore found not proved and particular 22(a)(iii) was found proved, given the Registrant's admission during his live evidence in relation to this aspect.

The overwriting allegations

93. These particulars of the Allegation turned upon whether the Committee was satisfied that the overwriting in question had been deliberately done by the Registrant, to intentionally alter the correct original IOP values, rather than for a legitimate reason, for example to correct a transcription error. The Committee was satisfied that if it found the former had occurred, then this would constitute an inappropriate recording of clinical data, as it was effectively falsifying patient records.

94. The Committee first considered the evidence of the Registrant in relation to these particulars generally, as set out in his witness statement and his live evidence. The Committee noted that the Registrant had made admissions in respect of the overwriting of eight patients. However, in relation to patients C, G, I, J, K, L, M and V, these were denied on the basis of either the overwriting handwriting was not his, or he was unsure that it was his handwriting or in relation to Patient V only, that it was his handwriting but that he was correcting his own transcription error.

95. The Committee noted the agreed admissions that confirmed that expert handwriting evidence had been explored by the Council. However, it was not possible for it to be conclusive in this case.

96. In all of the denied overwriting allegations, the Committee was satisfied that there was evidence of overwriting, which could be seen from the patient records. What were believed to be the original values were transcribed into the table produced by Person B as part of their internal investigation, and these were the values that were relied upon by Dr Kwartz in her reports. In all of the disputed patients, the Registrant had been the Optometrist that had examined the patient and had signed off the record card, although in relation to some patients there had been pre-screening undertaken by an optical assistant.

97. Person B's investigation report also set out the total number of patient records that were examined in the audit carried out by Boots Opticians. A total of 475 examinations were reviewed, as a result of which IOPs had been allegedly inappropriately amended in 16 patients (with 8 admitted and 8 disputed). The Committee noted Mr Mills' submission that this was only a small proportion of the examinations conducted by the Registrant and that this was a relevant factor to consider. However, the Committee bore in mind that not all patients would have IOPs measured, such as children and adults aged under 40 years.

98. The Committee noted the history of the case, and how the Registrant's position had changed during the course of the investigation, in that he had made an initial admission in respect of Patient A, which he then resiled from during the investigatory meeting and later appeal, leading his former employer Boots Opticians to believe that he had remeasured the patient's IOPs using a Pulsair tonometer when he had not.

99. The Committee bore in mind the Registrant's explanation for the conduct that he had admitted. In his witness statement he described that at the time of the relevant events he was working under time pressures due to the COVID-19 pandemic and the challenges around personal protective equipment (PPE) and enhanced hygiene rules, which required cleaning the test room and equipment between patients. His explanation for altering the IOPs of some patients was in essence to save time, as values approaching the SIGN guidance levels would require consideration of either further investigations and/or a referral.

100. The Registrant accepted that at the time of the over writing of the patient IOPs he considered that any IOPs over 22 mmHg would require further investigation. During his live evidence the Committee noted that the Registrant accepted he had developed a practice of amending the IOPs at that time.

101. Against this background, the Committee considered and determined whether these facts were proved in relation to each particular patient separately and in turn.

Patient C (Particular 3(c)(i))

102. This particular alleged that the Registrant had amended Patient C's clinical records, by overwriting the IOP reading for the left eye, which resulted in an inconsistency of the average data. The Committee considered the records for Patient C, which indicated that one reading in the left eye had been overwritten.

103. The evidence of the Registrant in relation to the overwriting to Patient C's IOP reading, was that it did not look like his handwriting and the optical assistant has written the pre-screening results from the auto-refractor and IOPs onto the card. The Registrant did accept in his witness statement that he had written the time into the "time" section of the record card. The implication of the Registrant's position that the overwriting was not his handwriting was that it may have been the optical assistant who had amended the IOPs.

104. The Committee had regard to the uncontested evidence of Person B, who in their investigation report had set out the 'original' IOP data and from this it could be seen that one of the IOP values for Patient C's left eye had been reduced from originally being 21 mmHg, to what appeared to now read 20 mmHg.

105. However, the Committee's reading of the patient record for Patient C was that the original value appeared as if it had been originally 25 mmHg. The Committee further noted that a value of 25 mmHg would have made the average figure of 21 mmHg correct (whereas if the original value was 21 mmHg, the average would have been incorrect). In the Committee's view, the evidence supported that the original reading was in fact reduced from 25 mmHg, not 21 mmHg. The Committee considered that this was a clinically significant change, as this original value of 25 mmHg was close to the SIGN threshold, where further investigation may have been required.

106. The Committee was of the view that having found that the original value was 25 mmHg, this was a further example of a high IOP being reduced, which was more likely than not to have been done intentionally by the Registrant, to avoid further investigations, in line with his admissions in respect of other patients.

107. Therefore, the Committee determined that on the balance of probabilities the overwriting of the IOP for Patient C was done by the Registrant and this resulted in the average data being inconsistent with the original data. Accordingly, the Committee found particular 3(c)(i) proved.

Patient G (Particular 7(c))

108. In relation to Patient G, it was originally alleged that the Registrant failed to adequately and/or inappropriately record clinical data by retrospectively amending Patient G's record of the IOP value from 21 mmHg to 20 mmHg for both eyes. However, during Ms Shah's closing submissions, she highlighted on behalf of the Council, that the evidence of overwriting was only in relation to the right eye and she invited the Committee to consider amending the Allegation of their own motion, to better reflect the evidence.

109. The Committee considered and agreed to make the amendment proposed by Ms Shah in her closing submissions, to amend particular 7(c) to read right eye, as opposed to both eyes. The Committee agreed that this amendment better reflects the evidence, and noted that the original drafting may have arisen from a misreading of the expert evidence of Dr Kwartz, at paragraph 6.7 of her report. However, it was apparent from reviewing the patient records that amendments had only been made to the right eye and in the view of the Committee, making this amendment, even at this stage, was in the interests of justice and would cause no prejudice to the Registrant.

110. The Registrant's evidence in relation to the overwriting of Patient G's IOPs was that "*It is not my hand writing and looks like Optical Assistant (OA) has changed their entry*." The Committee noted that the overwriting amendments made in this case were only to two digits, both were overwritten to '0', both in respect of the right eye. With such limited overwriting, the Committee was

unclear on how the Registrant was able to say it was not his writing. This was a lowering of the value, which whilst may be clinically insignificant overall, fitted the pattern of the Registrant's admitted conduct of lowering IOPs when they were approaching the level where he would need to consider further investigations.

111. Having regard to the lowering of the IOP values, the Registrant's evidence that he had developed a practice of overwriting IOPs at this time, and the admissions made in similar circumstances, the Committee found it more likely than not that the Registrant had also made these overwriting amendments to Patient G's record. Accordingly, the Committee found particular 7(c), as amended to the right eye only, proved.

Patient I (Particulars 9(b)(i) and (ii))

112. In relation to Patient I, it was alleged that the Registrant had failed to adequately and/or inappropriately record clinical data by overwriting Patient I's IOP value in their left eye from 23 mmHg to 20 mmHg during the first test and then from 22 mmHg to 21 mmHg in respect of the average.

113. The Registrant's position in relation to the overwriting of Patient I's records was, as set out in his witness statement, "*I am not sure if it is my hand writing and looks like OA has changed their entry*."

114. The Committee noted from Person B's report that the 'original' IOP value that had been overwritten was 23 mmHg and that this was a higher value which was close to the SIGN guidance threshold. A clinically significant alteration had been made to this value in this instance, of a reduction of 3 mmHg.

115. In this case, the average had been amended from 22 mmHg, the level where the Registrant would have considered further investigations, to a lower figure of 21 mmHg. In the view of the Committee, this was consistent with the circumstances in which the Registrant had admitted to overwriting some patients, to avoid having to carry out further investigations and to save time, due to the pressure he was working under.

116. Having regard to the reductions in the values, which the Committee found were clinically significant and the Registrant's evidence that he had developed a practice of overwriting IOPs at this time, and the admissions made in similar circumstances, the Committee found it more likely than not that the Registrant had also made these overwriting amendments to Patient I's record. Accordingly, the Committee found particulars 9(b)(i) and (ii) proved.

Patient J (Particular 10(a)(i))

117. In relation to Patient J, it was alleged that the Registrant failed to adequately and/or appropriately record clinical data, in that he overwrote a single value in the right eye from 12 mmHg to 14 mmHg.

118. In relation to Patient J, the Committee considered the Registrant's evidence, as summarised in his witness statement, which was,

> "*It is not my hand writing and looks like OA has over written their entry. I use "open fours" and not "closed fours" as seen by recall date on same record*."

119. The Committee considered the change that had been made to the IOPs in the patient records and noted that the IOPs appeared to have been taken by an optical assistant, who had completed this part of the record, rather than the Registrant. The Committee noted the Registrant's evidence regarding how he would normally write the number 4. However, it did not consider this was significant, as when overwriting another style of writing number 4 could be adopted particularly to ensure that the change in figure was clear.

120. The Committee considered that it was relevant that the change made from amending one IOP value from 12 mmHg to 14 mmHg, was clinically insignificant, as this was a slight change in value and the numbers were not close to the SIGN threshold. The Committee further noted that the average remained correct and had not been changed, which in the Committee's view, supported that this had been someone overwriting in order to correct an error or to write the number more clearly.

121. On balance, the Committee was satisfied that that in respect of this particular patient it was more likely that this amendment was in order to correct an error, and had a legitimate explanation, rather than being an inappropriate amendment to clinical records. Accordingly, the Committee found particular 10(a)(i) not proved.

Patient K (Particulars 11(a)(i) and (ii))

122. In relation to Patient K, it is alleged that the Registrant failed to adequately and/or appropriately record clinical data in that he overwrote Patient K's record of the IOP raw value reading in the left eye, from 23 mmHg to 20 mmHg and amended the average from 21 mmHg to 20 mmHg. The Committee considered these allegations together, given that they were allegations of a similar nature in respect of the same patient.

123. The Registrant's position in relation to the overwriting on Patient K's record was that he was not sure if it was his hand writing and that it "*looks like OA has changed their entry*".

124. The Committee noted that, according to Person B's report, the 'original' value that had been overwritten was 23 mmHg and this was a higher value, which was close to the SIGN guidance threshold. In addition, it was of a level that the Registrant accepted on his own evidence, as set out in his witness statement, that he would ordinarily consider whether further investigations were required (at 22 mmHg and over).

125. The Committee were of the view that the overwriting that had occurred in respect of Patient K was consistent with the Registrant's own explanation in respect of the overwriting that he had admitted, namely that he would do so to avoid further investigations and to save time. The Committee noted that the amendment to the average from 21 mmHg to 20 mmHg reflected the amended original IOP values and also reduced the level from being close to where further investigations may have been considered.

126. Having regard to the values, which the Committee found were clinically significant and the Registrant's evidence that he had developed a practice of overwriting IOPs at this time, and the admissions made in similar circumstances, the Committee found it more likely than not that the Registrant had also made these overwriting amendments to Patient K's record. Accordingly, the Committee found particulars 11(a)(i) and (ii) proved.

Patient L (Particulars 12(b)(i) and (ii), 12(c))

127. In relation to Patient L, it is alleged that the Registrant failed to adequately and/or appropriately record clinical data, in that he overwrote Patient L's record of the IOP raw value reading in the left eye from 25 mmHg to 20 mmHg and changed the average in that eye from 23 mmHg to 20 mmHg.

128. Further, it is alleged that the Registrant inadequately and/or inappropriately recorded the average value in the left eye as 20 mmHg instead of the correct result of 21 mmHg, arising from the readings of 22 mmHg, 20 mmHg and 22 mmHg. The Committee considered these particulars of the Allegation together, given that they were allegations of a similar nature in respect of the same patient.

129. The Registrant's evidence in relation to these overwriting amendments, as set out in his witness statement, was that "*I am not sure if it is my hand writing and looks like OA has changed their entry*."

130. The Committee considered that the original values that had been changed were clinically significant with this patient, as they were close to the SIGN threshold and higher than the value (22 mmHg) that the Registrant had accepted in his evidence that he would ordinarily consider further investigations. The Committee was of the view that the 'original' IOP readings that had been amended in this case fitted with the Registrant's explanation of his motive for the overwriting allegations that he had admitted, namely so he would not need to carry out further investigations and therefore save time, as he was working under pressure.

131. In addition, it was notable that the average reading had been overwritten for Patient L's left eye, but this was altered to an incorrect average figure, which suggested that the overwriting was not done to correct a genuine error. By making this amendment, the average was then incorrect.

132. The Committee was satisfied on the balance of probabilities that the overwriting in respect of Patient L was deliberately done by the Registrant, as part of his practice of overwriting IOPs that he had accepted during his evidence he had at this time adopted, to avoid having to carry out further investigations. Accordingly, the Committee found particulars 12(b)(i) and (ii) and 12 (c) proved.

Patient M (Particulars 13(a)(i),(ii) and (iii))

133. In relation to Patient M, it is alleged that the Registrant failed to adequately and/or appropriately record clinical data, in that he overwrote Patient M's record of the final data in the right eye as 18 mmHg, changed a value in the left eye from 21 mmHg to 20 mmHg and recorded the average value of the left eye as 20 mmHg instead of 19 mmHg. The Committee considered these three particulars of the Allegation together, given that they were allegations of similar changes to the same patient's records.

134. The Registrant's case in relation to the overwriting to Patient M's record was that he was "*not sure if it is my hand writing and looks like OA has changed their entry.*" The Committee noted that this was not a firm denial by the Registrant, rather he was not sure if it was him who had made these changes to the record.

135. The Committee had asked the Registrant during his evidence whether there was any particular reason why he was not sure about whether he had made the changes or whether it was simply not recognising the handwriting and the Registrant did not raise any other factors that made him question whether it was him.

136. The Committee was of the view that it was significant that the average was incorrect and the overwriting change to the value in the left eye, did not make

the average correct. The Committee considered that an inference could be drawn from this that the overwriting was not to correct an error. The Committee considered that on balance, it was more likely than not that the overwriting had been done intentionally by the Registrant, as part of his practice of overwriting IOPs that he had accepted during his evidence he had developed at this time. Accordingly, the Committee found particulars 13(a)(i),(ii) and (iii) proved.

Patient V (Particular 22(c)(i))

137. In relation to Patient V, it was alleged that the Registrant had failed to adequately and/or appropriately record clinical data by overwriting the IOP readings for Patient V's right eye to change them from 13 mmHg, 13 mmHg, 13 mmHg to 10 mmHg, 10 mmHg, 10 mmHg. The Registrant accepted that this was his handwriting in the IOP section of the record card, and that he had made these changes. However, his explanation, as set out in his witness statement was that,

> "*It is my correction of my own entry for Right Eye because I accidently wrote the Left Eye IOPs into the Right IOP section at the time of entry on the day of eye exam."*

138. The Committee considered this explanation and noted that the left eye IOPs, as recorded on the patient record card for Patient V, were 13 mmHg, 14 mmHg, 13 mmHg and not 13 mmHg, 13 mmHg, 13 mmHg, which is what the Registrant had originally written for the right eye. The Committee was of the view that this inconsistency did not support the Registrant's case that he was correcting a transcribing error. The Committee considered that if the Registrant had been simply correcting a transcription error, the appropriate action would have been to strike through the original writing, and to write the figures again separately (not by overwriting), so that the entries made on the record card were more legible.

139. The Committee also had regard to the expert evidence of Dr Kwartz, whose evidence, in summary, was that there was no particular clinical significance to the IOP changes made to Patient V's records, other than noting that the pressure readings were on the low side bearing in mind the medications that Patient V was taking. The Committee noted that the medications included an eye drop for Patient V's right eye, that lowers the IOP and if readings were not lower in that eye, that could be a cause for concern. The Committee further noted that the Registrant had not written out the averages for the IOP readings, which could suggest that this was another occasion that the Registrant was working under time pressure.

140. The Committee also bore in mind when considering the reliability of the account given by the Registrant that he had admitted making similar amendments to IOPs in respect of other patients, and that he had given an untruthful account in the internal disciplinary investigation, which was relevant to his credibility.

141. Having considered all of the above matters, on balance, the Committee determined that it did not accept the evidence of the Registrant that he overwrote the IOP results for Patient V because he was correcting his own error, as it found the Registrant's evidence on these matters to lack credibility. The Committee considered it was more likely that the Registrant had made a deliberate amendment to Patient V's IOPs, to avoid further investigations, which in the circumstances was an inappropriate recording of clinical data. Accordingly, the Committee found particular 22(c)(i) proved.

Misconduct

142. The Committee reconvened on 15 November 2023 to consider, pursuant to Rule 46(12) of the Rules, whether the facts admitted and/or found proved, amounted to misconduct, which was serious. The Committee sat as a four member Committee, under paragraph 26 of the Committee Constitutional Rules 2005, as the lay member Mr Pilkington was unavailable for unforeseeable, important personal reasons. The parties were notified of this change and had no objection.

143. The Committee heard submissions from Ms Shah, on behalf of the Council, and from Mr Mills, on behalf of the Registrant. Further material was put before the Committee at this stage, including written submissions from both parties, an addendum bundle from the Registrant and a letter from the Council's expert witness Dr Kwartz, dated 14 November 2023. Dr Kwartz's letter confirmed that she had reviewed the Registrant's written submissions on misconduct. In relation to the issue of whether the failings identified as below (but not seriously below) the standard expected could amount to misconduct, which was serious, Dr Kwartz responded that this was a matter for the Committee.

144. Ms Shah invited the Committee to find that the facts admitted and found proved amounted to misconduct, a statutory ground of impairment under section 13D(2)(a) of the Opticians Act 1989. She reminded the Committee that misconduct was a matter for the Committee's own judgement and that there was no standard or burden of proof to be applied at this stage.

145. Ms Shah referred the Committee to the case law on misconduct, including the case of *Roylance v General Medical Council (No.2)* [2000] 1 A.C. 311, where, at paragraph 35, Lord Clyde stated:

"*Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed in the particular circumstances*."

146. In determining those standards, Ms Shah referred the Committee to the "*Council's Standards of Practice for Optometrists and Dispensing Opticians*", effective from April 2016. Ms Shah submitted that the Registrant has departed from the following standards by virtue of his conduct:

- *Standard 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.*
- *Standard 8: Maintain adequate patient records.*
- *8.1 Maintain clear, legible and contemporaneous patient records which are accessible for all those involved in the patient's care.*
- *8.2.4 As a minimum, record the following information: The details and findings of any assessment or examination conducted.*

147. Ms Shah reminded the Committee of Dr Kwartz's evidence and the table in the appendix to her initial expert report, which set out a summary of her assessment of where conduct fell below or far below that of a reasonably competent Optometrist. Further, Dr Kwartz had concluded that in all of the instances of overwriting the IOPs, the Registrant's conduct fell far below, which Dr Kwartz had expanded upon in her oral evidence. Ms Shah submitted that when assessing seriousness, the Committee could take into account the Registrant's evidence in relation to reducing the IOP values was that it had become his practice, to avoid having to consider further investigations.

148. Ms Shah submitted that when considering misconduct the Committee ought to focus upon the risk of harm arising from the Registrant's conduct, rather than the fact that no patients actually suffered harm. Ms Shah invited the Committee to find that the Registrant's conduct, as found proved, amounts to misconduct.

149. Mr Mills submitted that whilst misconduct is a matter for the Committee's judgement, it was not disputed by the Registrant that his conduct amounted to misconduct. Mr Mills explained that his submissions, on behalf of the Registrant, which went into detail in relation to the expert evidence, were intended to set an approach the Committee should take in making its findings of misconduct.

150. Mr Mills further submitted that it was accepted by the Registrant that each instance of overwriting the IOP values amounts to misconduct and the purpose of his submissions was not to minimise that. However, when analysed, it was not clear on the evidence that each instance of overwriting would have had clinical consequences for the patient.

151. Mr Mills acknowledged that Dr Kwartz's assessment was that in relation to the clinical failings in respect of Patients C, E, G and U, the Registrant's conduct fell seriously below the expected standard. However, there was a category of particulars, as set out in a table within his written submissions, where Dr Kwartz's assessment was that the Registrant's actions fell only below, not seriously below, the required standard and as such, he submitted, those instances could not amount to misconduct.

152. In relation to the overwriting particulars, Mr Mills accepted that in respect of recordkeeping considerations, this conduct amounted to misconduct. However, from considering the objective clinical implications of the under recorded IOP values in respect of these specific patients, Dr Kwartz's evidence was more nuanced in her oral evidence. Mr Mills submitted that it was not the case that on every occasion there was a clinical significance to the reduction made to the IOP values. Further, there was no evidence of harm to the patients.

153. Mr Mills submitted that whilst the risk of harm is a significant factor, it is right to note that there was no evidence of harm in this case. Mr Mills submitted that the global comments made by Dr Kwartz in her report had to be seen in the context of her oral evidence in relation to specific patients and the primary concern was the recordkeeping and accuracy of the records, rather than the Registrant's clinical management of patients.

154. Mr Mills referred the Committee to examples in the evidence of Dr Kwartz where she had accepted that the Registrant's lowering of the IOP values was of no or little clinical significance in respect of those specific patients. He reminded the Committee that the focus of Dr Kwartz's evidence was on the average IOP value rather than individual values.

155. Mr Mills highlighted the letter from Dr Kwartz dated 14 November 2023, following her review of the Registrant's written submissions on misconduct. He submitted that there was nothing in Dr Kwartz's response to suggest that she disagreed with the points made in his submissions. Mr Mills suggested that this

may be because the Registrant was not seeking to go behind the evidence of Dr Kwartz.

156. Mr Mills referred the Committee to its findings at the facts stage, in particular when it found that some of the Registrant's overwriting, in relation to the denied particulars, was of clinical significance. Mr Mills submitted that he was not seeking to go behind the Committee's findings, however he observed that the Committee had not addressed Dr Kwartz's evidence and her opinion on whether the reductions were of clinical significance, and he invited the Committee to consider this further at stage two and to provide an explanation if its views differed to that of Dr Kwartz.

157. Mr Mills highlighted that there were only two patients (Patients A and H) where a referral may have been considered and only two patients (Patients Q and R) where there would be a change in management, in that there ought to have been a shorter review period.

158. Mr Mills accepted that the Committee could take into account the Registrant's reasons for reducing the IOPs, namely due to time pressure and that this would put patients at risk. However, it was not in respect of each patient that there was a clinical failing, falling far below the standard on Dr Kwartz's evidence. It was not contested that in relation to Patients C, E, G and U, the evidence of Dr Kwartz was that there was a failing far below and it was open to the Committee to make a finding of misconduct in relation to this conduct.

159. Mr Mills submitted in relation to the category of failings that were below, but not far below, this could not amount to misconduct, which was required, as per the case law on misconduct, to be serious. Mr Mills submitted that the Council had not sought to argue that these instances do amount to misconduct and had not put forward any argument for 'cumulating' them into a finding of serious misconduct. Mr Mills further indicated that should the Committee be considering the issue of cumulating instances of non-serious misconduct, into a finding of serious misconduct, of its own accord, he would wish to make further submissions on the relevant caselaw on that issue.

160. The Committee heard and accepted the advice of the Legal Adviser, who referred to the case of *Roylance v General Medical Council (no2)* [2000] 1 AC 311, regarding the two principal kinds of misconduct, either conduct linked to professional practice or conduct that otherwise brings the profession into disrepute. The Committee was advised that the threshold of serious misconduct has been described in the case of *Meadow v GMC* [2007] 2 QB 462 as being conduct which would be regarded as deplorable by fellow practitioners. However, it does not necessarily require moral turpitude; an elementary and grievous failure can also reach the threshold of serious misconduct, as held in the case of *Preiss v General Dental Council* [2001] 1 WLR 1296.

161. The Committee was reminded that misconduct was a matter for its own independent judgement and no burden or standard of proof applied at this stage. Further, that the Committee needed to consider whether the conduct was sufficiently serious to amount to professional misconduct.

162. The Legal Adviser gave advice on the issue of whether it was permissible for the Committee to take a cumulative approach to finding serious misconduct, given that the expert evidence in relation to several Patients was that the Registrant's failings fell below, but not seriously below, the standards expected. The Legal Adviser referred the Committee to the case of *Schodlok v GMC* [2015] EWCA Civ 769, which suggests that it may be permissible, in an appropriate but rare case, for a tribunal to undertake the exercise of cumulating findings of misconduct on some charges to make a determination of serious misconduct on others. However, that approach has to be taken with caution following the more recent case of *Ahmedsowida v The General Medical Council* [2021] EWHC 3466 (Admin), which set out that cumulation was only permissible, if at all, in limited circumstances.

The Committee's Findings on Misconduct

163. In making its findings on misconduct, the Committee had regard to the evidence it had received to date, the submissions made by the parties, the Hearings and Indicative Sanctions Guidance (revised November 2021), the legal advice given by the Legal Adviser and its earlier findings at the facts stage.

164. The Committee considered the "*Council's Standards of Practice for Optometrists and Dispensing Opticians*" and the standards which it had been referred to by the Council, namely 7 (conduct appropriate assessments) and 8 (adequate record-keeping), which the Committee was satisfied both applied in this case. The Committee noted that Mr Mills, on behalf of the Registrant, also agreed that standards 7 and 8 were the relevant Standards in this case.

165. The Committee noted that the Registrant's conduct, as admitted and/or found proved, related to inadequate recordkeeping, in relation to the series of overwriting allegations, which affected the adequacy, reliability and accuracy of the recordkeeping in respect of those patients. In addition, there were a wide range of clinical failings relating to the Registrant's failures in the assessment of patients. These included failures to appropriately assess the depth of the anterior chamber, and failures to record adequate information for example in relation to flashes, medical conditions (such as diabetes), whether there was any corneal staining present for patients who were using dry eye treatment, and failures to conduct visual field tests where indicated and/or to record the same.

166. In relation to all particulars of the Allegation which had been admitted and/or found proved, the Committee was satisfied that there was a falling short by the

Registrant of what was proper in the circumstances, with reference to Standards 7 and 8, set out above. All of the conduct in this case was related to the Registrant's clinical practice as an Optometrist. Accordingly, the Committee was satisfied that in respect of all of the Registrant's proved conduct, there were breaches of the expected standards, which amounted to misconduct.

167. The Committee was mindful that not every falling short of the standards was sufficient to amount to misconduct, as it must be serious. The Committee went on to consider whether the Registrant's failures were serious in relation to each particular of the Allegation admitted and/or found proved.

The overwriting particulars

168. The Committee had regard to the evidence of the Council's expert, Dr Kwartz, set out in her reports, dated 7 February 2022, supplementary report, dated 1 May 2023, and letter dated 14 November 2023. In addition, the Committee had regard to the oral evidence that Dr Kwartz gave to the Committee during the facts stage of the hearing.

169. The Committee had regard to the fact that Dr Kwartz's opinion was that in relation to all instances of the Registrant overwriting IOPs, this conduct fell far below the required standard. Dr Kwartz in her original report stated that:

> '*Rather than repeat the issue of altering IOPs multiple times within the appendix, I will state here once that I consider that the act is consistent with a standard far below that of a reasonably competent optometrist for several reasons: first, because the standards of the College of Optometrists' Guidance for Professional Practice, the General Optical Council's Standards of Practice and the General Optical Council's Competencies for Optometrists are not met; second, because there is a clinical significance to reducing patients' IOPs which could lead to ocular pathology not being detected; third, recording accurate data is an implicit part of an optometrist's duty of care to their patient; and, fourth because altering data may have implications for a patient's onward care*.'

170. Further, the Committee had regard to the oral evidence of Dr Kwartz at the facts stage. When Dr Kwartz was asked to explain the risks of altering IOPs, when they are raised, to lower values, she explained that:

> '*The risk of reducing an IOP is that a case of glaucoma may be missed, very simply. We know from the scientific literature the higher the pressure the higher the risk of developing glaucoma. So if a patient has a pressure of 26 today it does not necessarily mean that they are going to get glaucoma today. In fact, the process with which patients develop glaucoma can be quite*

long and drawn out over a number of years and that is well substantiated again in the scientific literature. So reducing a pressure first of all means we have not got good baseline data from which we can make subsequent comparison. It may mean that a referral of a patient today is not actually performed when it should be performed. It also means we cannot educate the patient appropriately so there may be some situations where we say to a patient, "Look I have measured your pressures today, they are on the high side. Your visual fields are normal and your discs look absolutely normal but we need to see you sooner than the normal two year interval. I therefore want you to come back in let us say six or 12 months". You can then explain to the patient the importance of doing so. Patients do not always attend for a sight test when they are called and many patients perhaps consider that the spectacle component of the sight test is the bit that they relate, so "if I can see okay I will not go for an eye test, I will not go back for that recall appointment". I think that is why it is very important to educate the patient and explain to them that their pressures are high and why they need to come back. I think another very important point here with regard to glaucoma in particular is that visual loss from glaucoma is not recoverable, so any visual function that is lost due to glaucoma cannot be regained.'

171. The Committee accepted the expert evidence of Dr Kwartz, given her expertise and balanced reasoning in assessing the Registrant's conduct in this case.

172. Further, the Committee noted that the Registrant accepted that all instances of overwriting amounted to misconduct, albeit observations were made by Mr Mills in respect of the degree of clinical risk arising from the reductions in the IOP figures that were made.

173. The Committee was of the view that by overwriting the IOP results, in order to lower the values, which the Registrant had admitted was when he was working under time pressure and to save further investigations from having to be carried out, was a fundamental failing and a significant breach of the standards required from a reasonably competent Optometrist and what patients would expect. In the Committee's view, the recording of accurate IOP measurements is particularly important, given the potential implications for patients should their IOP readings be raised and require further investigations, including potentially for glaucoma, which can lead to painless, irreversible sight loss.

174. The Committee had regard to and accepted the evidence of Dr Kwartz, that the actual reduction in IOPs made, did not have particular clinical significance for many of the specific patients concerned. Where the Committee had made reference in its earlier determination of the facts, to reductions in IOP values being clinically significant, this phrase was used by the Committee in lay terms and in the context of its independent analysis of whether the facts were found

proved or not. The Committee was not using this term to refer to the impact of the reduction on the individual patient's clinical management. The Committee's use of this term was not intended, and ought not to be interpreted, as the Committee taking a contrary position to Dr Kwartz's expert view from a clinical perspective.

175. Although the Committee accepts the submission of Mr Mills, that Dr Kwartz did not find in respect of many patients that there was clinical significance to the altered IOPs, this did not necessarily detract from the seriousness of the conduct in the Committee's view. Whilst there is no evidence of harm for the specific patients in this case, in the view of the Committee, if IOPs are not recorded accurately, this conduct puts patients at risk of harm. The Committee also took into account the Registrant's reasons for overwriting the IOPs values, which was due to time pressures and to avoid further investigations, which was not acting in the best interests of his patients. The Committee found that the practice of altering IOP values had become embedded in the Registrant's practice at the time in question. The Committee was satisfied that in the circumstances, the Registrant's actions in overwriting the IOPs was serious, would be considered wholly unacceptable and deplorable by fellow practitioners and amounted to misconduct.

Particulars 3(a)(i), 5(b), 7(a), and 21(a)(iii)

176. In relation to the particulars of the Allegation which related to clinical concerns, the Committee noted that there were four instances which in the view of Dr Kwartz the Registrant's conduct fell far below the standards to be expected of a reasonably competent Optometrist. These related to particulars 3(a)(i) (Patient C) and 5(b)(Patient E), both failures to adequately and/or appropriately assess the depth of the anterior chamber, which was necessary to determine the patients' risk factor for developing angle closure glaucoma and particulars 7(a)(Patient G) and 21(a)(iii)(Patient U), failures to record sufficient information about symptoms of flashes, which may be suggestive of retinal detachment. In her oral evidence, Dr Kwartz explained that these conditions (angle closure glaucoma and retinal detachment) were serious conditions with significant visual consequences if not managed appropriately. Further, in relation to glaucoma, Dr Kwartz stated that this can cause painless and irreversible visual loss.

177. The Committee noted that there was no evidence of actual harm to any of the patients in this case, as a result of the Registrant's conduct. However, there was in the Committee's view, a risk of harm to patients as a result of the Registrant's conduct, as explained by Dr Kwartz in her evidence. Further, the Committee noted the Registrant did not dispute that in relation to these four clinical instances, his conduct amounted to misconduct. The Committee was satisfied in relation to these four particulars (3(a)(i), 5(b), 7(a), and 21(a)(iii)), that the clinical concerns were serious, and the Registrant's conduct fell far below what was expected of him, so as to individually amount to misconduct.

Particulars 5/a, 5/c, 6/a, 8/a, 9/a/i, 12/a/i, 14/a/ii, iii, 16/a, 17/a, 21/a/i-ii, 22/a/iii-iv, 22/e, 23/a/i, 24/a/ii -iii

178. The Committee carefully considered the submission of Mr Mills in relation to the category of clinical concerns which, in the opinion of Dr Kwartz, the standard of the Registrant's conduct fell below, but not seriously below, the required standard. In relation to these particulars, the Registrant had admitted his failings and that his conduct was below the standard to be expected of a reasonably competent Optometrist. However, in respect of each failing, it was the expert view of Dr Kwartz, looking at all the circumstances of each individual patient, that the Registrant's conduct fell below but not far below the standards expected.

179. The Committee was mindful that it was not bound to accept expert opinion if there is reason to not do so. However, in this case, Dr Kwartz's evidence on her assessment of seriousness was unchallenged, there was no contrary expert view and it appeared to the Committee that there was no good reason to reject it.

180. In relation to these incidents, given the assessment of Dr Kwartz, which the Committee accepted, the Committee was of the view that the Registrant's conduct was not serious enough to meet the threshold of misconduct on an individual basis.

181. The Committee noted the issue of cumulation, which had been mentioned in Mr Mills' submissions and by the Legal Adviser. However, the Committee was mindful of the case of *Ahmedsowida v GMC* and the limited circumstances in which such an approach could be taken. Further, the Committee noted that the Council had not requested that the Committee cumulate these instances of non-serious misconduct into a finding of serious misconduct. In the circumstances of this case, the Committee was not satisfied that it was appropriate to take a cumulative approach.

182. Therefore, the Committee agreed with the submission of Mr Mills that these incidents of misconduct that fell below, but not far below, the standards expected, were not sufficiently serious to amount to misconduct.

183. Accordingly, the Committee found that the facts admitted and/or found proved do amount to misconduct, which was serious, in respect of all of the instances of overwriting the IOP values, and the clinical concerns in particulars 3(a)(i), 5(b), 7(a), and 21(a)(iii).

Clarification

184. The Committee, upon hearing Mr Mills' submissions on misconduct and in light of these, reviewed its findings at the facts stage, noted and acknowledged

that at paragraph 124, there was an inaccuracy when referring to the Registrant's evidence '*that he would ordinarily consider whether further investigations were required (at 22 mmHg and over)*'. This ought to read '*that he would ordinarily consider whether further investigations were required (at over 22 mmHg)*'. The Committee did not consider that this inaccuracy materially affected its earlier findings.

Impairment

185. The Committee next considered whether the fitness to practise of the Registrant was currently impaired, as a result of the misconduct found.

186. The Committee received a supplementary bundle of material on behalf of the Registrant, which contained further supervisor and audit reports, as well as written submissions from both parties on impairment.

187. The Registrant gave further evidence at this stage of the hearing, under affirmation. He was questioned on matters relevant to impairment by Mr Mills, Ms Shah, and the Committee.

188. The Registrant confirmed that the evidence in his statement dated 27 April 2023, and in his more recent reflective statement dated 5 November 2023, was correct. Mr Mills took the Registrant through his work history since leaving Boots Opticians and through the details of his workplace supervision, imposed as part of an interim order of conditions. The Registrant confirmed that he has had no issues complying with the interim order of conditions, which he has been subject to now for over two years.

189. The Registrant gave evidence in relation to his reflection and the remediation that he had undertaken since becoming subject to an interim order of conditions. The Registrant explained that prior to that point, he had not been taking full responsibility for his actions and this included lying in the local investigation and he also was untruthful about these matters to his wife. After the interim order of conditions was imposed, the Registrant explained that this made him realise that he needed to do something and he joined a course on Professional Boundaries and started Counselling. This helped him to start to realise the impact that his actions had on patients, staff, the whistle-blower, the profession, as well as himself.

190. The Registrant stated that he has tried to rectify his behaviour, by recognising how his emotional state can have an impact upon his actions and how he treats patients. He has worked on his development and restoration plan, a copy of which was before the Committee.

191. When questioned about how he would act differently today, the Registrant's evidence was that he would take time out, think about how he was feeling and

raise any issues, for example with time pressures, with his manager, who he described as being extremely supportive. He gave an example of patient lists being rearranged if necessary, if an emergency patient required further investigations.

192. In relation to assessing the depth of the anterior chamber in patients, he explained that he did not undertake any further training in respect of this, because he already knew the appropriate technique. The issue was that he had not undertaken the check when he ought to have done so. He confirmed that he now undertook this routinely. In relation to recordkeeping more generally, the Registrant gave evidence that the computer system that he now uses in his current role had tick boxes to complete, which acted as prompts to record information.

193. Ms Shah questioned the Registrant, including in relation to why he had lied in the local investigation. The Registrant explained that this was due to self-preservation and that he had not been taking responsibility for his actions at that time. When asked about the impact of doing so, the Registrant stated that it was extremely uncomfortable, and he was still deeply ashamed of it. He acknowledged that there were consequences of his lying for staff, patients and his integrity was in question. Ms Shah questioned the Registrant regarding why he had not accepted that the overwriting handwriting was his, in respect of the particulars of the Allegation found proved. The Registrant responded that he had not accepted these matters as the handwriting did not look like his.

194. Ms Shah questioned the Registrant regarding the pressures that he was under when the conduct occurred, why he had not taken steps at the time to address them and why it would be different now. The Registrant's evidence was that he did not realise at the time the pressure and issues until later on when he reflected upon his actions. He explained that the time pressure arose from COVID restrictions and insufficient time slots for patient examinations, which he mentioned to a supervisor but nothing was done about it. The Registrant also acknowledged that as it was a new job and role for him, he did not want to '*rock the boat or be seen as starting trouble'*.

195. In response to Ms Shah's questions on whether he had completed any courses on managing stress at work, the Registrant stated that he had not completed any specific courses on this but thought those issues were contained in some of the modules that he had undertaken.

196. In answer to the Committee's questions, the Registrant explained the information that he would seek to obtain from patients who had symptoms of flashes. In addition, he explained that changes to his practice because of COVID was part of the issue contributing to his actions, which he described as having multiple causes.

197. Ms Shah, in her submissions on impairment, referred the Committee to the paragraphs on determining impairment in the Council's '*Hearings and Indicative Sanctions Guidance (Revised November 2021)*' ('the Guidance'). She reminded the Committee that impairment was a forward looking exercise. When the Committee was considering the extent of the reflection and remediation undertaken by the Registrant, she invited the Committee to also consider to what extent the underlying concerns, leading to the misconduct, had been addressed.

198. Ms Shah highlighted as an example, that no course on stress at work had been undertaken by the Registrant, despite this being what led to the conduct. Furthermore, no courses had been undertaken on assessing the depth of the anterior chamber or flashes, which she suggested was due to a blase attitude on the part of the Registrant, to these very serious concerns.

199. In relation to insight, Ms Shah submitted that whilst the Registrant had referred to the risk of harm to patients, this was in a very cursory way, with no real detail. For example, the Registrant appeared to have no insight upon the impact of his lying in the investigation and how had he been open earlier, patients could have been contacted sooner, to check whether they had suffered any harm. Further, Ms Shah submitted that the Registrant's comments on insight appeared to focus primarily upon himself and he had not really reflected upon the reasons why his conduct occurred.

200. Ms Shah invited the Committee to consider the manner in which the Registrant had conducted himself in these proceedings, in that he had initially denied matters, made admissions and then resiled from some of those admissions. Furthermore, the Committee may find that the way he denied some of the instances of overwriting demonstrated that he was still seeking to avoid full responsibility for his actions. Ms Shah invited the Committee to consider if any remorse demonstrated was genuine and if the mitigation offered, such as the time pressure, was valid.

201. Ms Shah submitted that if the Committee were to find that the Registrant lacks insight, then a serious risk of repetition remains. Whilst there had been no repetition of the conduct, this would be unlikely whilst the Registrant was under significant workplace supervision.

202. In relation to the public interest considerations, Ms Shah submitted that this case involves a number of patients, over a period of time, and conduct which exposed patients to significant risk. The Registrant was an experienced Optometrist, which affects what weight can be placed on the mitigation. In those circumstances, there was a greater public interest for a finding of impairment, where an experienced Optometrist wilfully acts in a way to put patients at risk of harm.

203. In her written submissions, Ms Shah referred the Committee to the guidance in the case of *CHRE v (1) NMC and (2) Grant* [2011] EWHC 927 (admin) and the test that was formulated by Dame Janet Smith in the report to the Fifth Shipman Inquiry. Ms Shah submitted that limbs (a)-(c) of this test are engaged in this case, namely conduct which put patients at unwarranted risk of harm, brings the profession into disrepute, and conduct which breaches one of the fundamental tenets of the profession.

204. Mr Mills, on behalf of the Registrant, reminded the Committee that the Registrant has admitted that his fitness to practise is currently impaired since March 2023. Impairment was accepted on a public interest basis, rather than on the basis of there being a future risk of harm to the public. Mr Mills submitted that the public interest requirement for a finding of impairment arises from the overwriting misconduct, rather than the four discrete clinical concerns (particulars 3(a)(i), 5(b), 7(a), and 21(a)(iii)).

205. Mr Mills referred the Committee to the supervisors reports and clinical audits, which were before it, from the interim order of conditions, which the Registrant had fully complied with. As the interim order had been reviewed six times, over 2 years, this amounted to the review of hundreds of patient records, by three different supervisors. Mr Mills submitted that as the concerns in question had not been identified again, this was extremely strong evidence that the misconduct had been remediated by the Registrant.

206. Mr Mills drew the Committee's attention to the very positive references from the four practitioners who had worked with the Registrant since the events in question and their comments regarding the Registrant's excellent records, attitude, and improvements in his practice. Furthermore, the Registrant had prepared a detailed restoration plan, which had been updated for this hearing. Mr Mills submitted that if the Registrant's reflections coincided with the imposition of the interim order, this did not undermine his remediation efforts. Whilst the Registrant may not have developed insight straight away, the focus should be on the substance of what he had done, rather than the timing.

207. Turning to the issue of insight, Mr Mills highlighted the Registrant's evidence that he had identified a number of causes and explained how these had been dealt with. He had also addressed how he would avoid such pressures arising again in future. Mr Mills submitted that the Registrant has taken responsibility for his misconduct and the Council's submission that any reflection was purely cursory was plainly wrong.

208. In relation to the Registrant's lying in the local investigation, Mr Mills submitted that he had given a candid acceptance of his motivation for this, namely self-preservation. However, the local investigation was only in respect of Patient A at that time, as the wider concerns were raised later.

209. Mr Mills highlighted the letter from the Registrant's Counsellor, which details the Counsellor's perception of the Registrant having developed insight. Mr Mills invited the Committee to find that this was a useful source of information regarding the Registrant's perceived insight and understanding. Furthermore, if the Registrant had lacked insight, he would not have been able to maintain a high standard of practice, under the close scrutiny of workplace supervision.

210. Mr Mills referred the Committee to the letter from Dr Kwartz, dated 14 November 2023, which included her impression of the Registrant's insight and remediation. Whilst these were matters for the Committee's own judgement, it was akin to a reference and could be taken into account, particularly as Dr Kwartz had reviewed all of the case details in the course of giving her expert evidence.

211. Mr Mills submitted that whilst the Registrant had denied eight of the instances of overwriting (of which seven were found proved), this should not be held against the Registrant when considering his insight. Mr Mills referred to the case of *Sawati v GMC* [2022] EWHC 283 (Admin), a copy of which had been provided to the Committee and summarised the principles arising from a review of the caselaw on this issue.

212. Mr Mills stated that this was not a case where the facts had been entirely denied, as the Registrant had admitted eight of the overwriting incidents, some of which were the most serious. Further, he had admitted that he had developed a practice of overwriting and had already reflected upon that conduct. The overwriting instances that were denied were based upon circumstantial evidence, the Registrant did not recognise the handwriting as his, and in relation to one of these matters, the Committee found the facts not proved. Further, it was not a case of blatant dishonesty. In the circumstances, Mr Mills invited the Committee to find that it was not fair nor appropriate to use the denials against the Registrant.

213. Mr Mills submitted that the misconduct in this case was remediable, had been remediated by the Registrant, as demonstrated by the objective evidence produced and was highly unlikely to be repeated.

214. In relation to the other clinical concerns which amounted to misconduct (particulars 3(a)(i), 5(b), 7(a), and 21(a)(iii)), the Registrant has given an explanation as to why he felt that no further training on these areas was necessary. Further, the Registrant now uses a computer system that has prompts, so a fuller history is recorded. Mr Mills stated that these are issues which have not come up in the supervisors' reports, which show that the Registrant's attitude to his standard of patient care has improved. Mr Mills submitted that the Committee can be reassured that these discrete areas of misconduct have also been remediated by the Registrant.

215. In conclusion, Mr Mills invited the Committee to find that the Registrant's current fitness to practise was impaired, however only in relation to the overwriting incidents, and on public interest grounds. Mr Mills submitted that given the Registrant's remediation since the misconduct, there was no basis for a finding of current impairment on public protection grounds, as there was no future risk to patients .

216. The Committee heard and accepted the advice of the Legal Adviser who advised the Committee that the question of impairment was a matter for its independent judgement taking into account all of the evidence it has seen and heard so far. She reminded the Committee that a finding of impairment does not automatically follow a finding of misconduct and outlined the relevant principles set out in the case of *Cohen v GMC* [2008] EWHC 581 (Admin). The Legal Adviser confirmed that she agreed with Mr Mills' summary of the case law on the issue of insight and rejected defences.

217. The Legal Adviser referred the Committee to the test for considering impairment as set out by Dame Janet Smith in the fifth report of the Shipman Inquiry (para 25.67), and cited with approval in the case of *CHRE v NMC & Paula Grant* [2011] EWHC 927 (Admin), para 76, by Mrs Justice Cox, which is:

"Do our findings of fact in respect of the…misconduct, show that his fitness to practise is impaired in the sense that he:

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

The Committee's findings on impairment

218. In making its findings on current impairment, the Committee had regard to the evidence it had received to date, the submissions made by the parties, the Hearings and Indicative Sanctions Guidance (revised November 2021) ('the Guidance'), the Council's Standards, the legal advice given by the Legal Adviser and its earlier findings.

219. The Committee firstly considered whether the Registrant's conduct was remediable, whether it had been remedied and whether the conduct is likely to be repeated in future.

220. The Committee noted that the misconduct which it had found related to issues of record-keeping and clinical issues relating to the assessment of patients. The Committee had regard to the Guidance, which at paragraph 16.1, states that:

> '*Certain types of misconduct (for example, cases involving clinical issues) may be more capable of being remedied than others*.'

221. The Committee was of the view that the nature of the misconduct in this case, which involved clinical issues, was such that it was capable of being remedied.

222. The Committee turned to consider whether this conduct had been remedied by the Registrant since the events took place in 2020. The Committee noted the particular set of circumstances in which the misconduct arose, as set out in the Registrant's statement, including time pressures of reduced appointment times following COVID, working in a new position, which was a very different role than his previous one, and also the [redacted] circumstances of the Registrant. Whilst the Registrant had not appreciated the impact of the pressures that he was under at the time, it was apparent to the Committee that the Registrant subsequently developed an understanding of the causes of his actions and has sought to address them.

223. The Committee noted the steps that the Registrant has taken in order to remediate, which include his detailed development and restoration plan, his reflective statements, the CPD undertaken, including the course on professional boundaries and the extensive Counselling that he has undertaken.

224. In relation to the courses undertaken by the Registrant, the Committee noted that he had not completed specific courses on the issues arising from the four discrete clinical concerns, namely assessing the depth of the anterior chamber or the adequate recording of information relating to flashes (particulars 3(a)(i), 5(b), 7(a), and 21(a)(iii)). However, the Committee noted that the Registrant had undertaken a volk lens assessment course, which would have likely involved looking at the back of the eye. Furthermore, the CPD that had been undertaken by the Registrant was wide ranging and practical in nature, including a course involving reflection and supervisor feedback.

225. The Committee considered that the Registrant had engaged with the Optometry community, undertaken peer learning, and had consistently received positive supervisory reports during the course of his workplace supervision. Overall, the Committee found that the remediation undertaken by the Registrant does address the misconduct and was adequate.

226. The Committee considered the level of insight demonstrated by the Registrant, in his written reflective statements and the oral evidence that he has given during this hearing. The Committee was of the view that the Registrant had given a sincere account of his actions and had demonstrated remorse for

his misconduct, stating that he was appalled at how he behaved. He was able to reflect in his evidence, particularly in his written reflective statements, upon why the misconduct occurred and he gave specific examples of how he would do matters differently, should he find himself facing similar circumstances again.

227. Although the Registrant did not immediately take responsibility for his actions, in that his initial response in the local investigation was to deny the overwriting in respect of Patient A, in the Committee's view he has been on a journey of remediation since the events in question occurred, both personally and professionally, and has over the past two years taken significant steps to reflect, develop insight and address the misconduct.

228. In relation to the issue of rejected defences, the Committee considered the principles summarised in the case of *Sawati v GMC* [2022] EWHC 283 (Admin). The Committee noted that the Registrant had admitted eight instances of overwriting, some of which were the most serious. Of the eight that he had denied, this was on the basis that he was unsure that it was his handwriting. The Committee noted from the agreed facts, that a handwriting expert had been instructed, however they were unable to give an opinion upon it. The Committee was of the view that it was reasonable for the Registrant to put the Council to proof, when he was unsure that he had done it and indeed one of the instances was found not proven (particular 10(a) in relation to Patient J). In these circumstances, the Committee determined that it would not be fair nor appropriate to hold the fact that the Registrant had denied some of the instances of overwriting against him, when assessing his insight and did not do so.

229. The Committee turned to consider the likelihood of repetition. The Committee bore in mind that the Registrant has practised as an Optometrist for over three decades, has no prior fitness to practise history and there has been no repetition since these events in 2020, albeit he has worked under conditions, including supervision, since the interim order was imposed. The Committee noted that only minor issues had been identified by the Registrant's supervisors, which had been addressed and he had made positive changes in his practice.

230. The Committee was further reassured by the excellent references from the Registrant's two work colleagues (practice manager and line manager) and two of his workplace supervisors. In addition, as set out above, the Committee was of the view that the Registrant has reflected, developed insight, and remediated his misconduct appropriately. Accordingly, the Committee determined that the Registrant's risk of repetition, in relation to both the overwriting conduct and the clinical failings, is very low.

231. Having regard to all of the above, the Committee determined that the Registrant's fitness to practice was not impaired on public protection grounds.

232. The Committee next had regard to public interest considerations and to the case of *CHRE v (1) NMC and (2) Grant* [2011] EWHC 927 (admin), particularly the test that was formulated by Dame Janet Smith in the report to the Fifth Shipman Inquiry. The Committee agreed with the submission of Ms Shah that limbs (a)-(c) of this test are engaged in this case, namely conduct which put patients at unwarranted risk of harm, brings the profession into disrepute and breaches a fundamental tenet of the profession. The Committee considered that these limbs of the test were engaged on the Registrant's past conduct in relation to the misconduct found proved, rather than on the basis of being '*liable in the future to so act*', given the very low risk of repetition found.

233. Although the Committee was of the view that the Registrant does not continue to present a risk to members of the public, the Committee went on to consider whether, nonetheless, a finding of impairment was necessary in order to uphold proper professional standards and public confidence in the profession.

234. The Committee considered the serious nature of the overwriting misconduct, which the Registrant had admitted was a practice he had developed at that time, in order to avoid considering further investigations, which was not acting in the best interests of his patients. The Committee was mindful of Standards 7 and 8 and also the preamble to the Standards, which states:

> '***Standards of Practice***
> *Our Standards of Practice define the standards of behaviour and performance we expect of all registered optometrists and dispensing opticians.*
>
> ***Your role as a professional***
> *As a healthcare professional you have a responsibility to ensure the care and safety of your patients and the public and to uphold professional standards. You are professionally accountable and personally responsible for your practice and for what you do or do not do, no matter what direction or guidance you are given by an employer or colleague. This means you must always be able to justify your decisions and actions.*
>
> ***Making the care of your patients your first and overriding concern***
> *The care, well-being and safety of patients must always be your first concern. This is at the heart of being a healthcare professional. Even if you do not have direct contact with patients, your decisions or behaviour can still affect their care and safety*'.

235. The Committee was of the view that the Standards and particularly the requirement for Optometrists to put patients first, was at the heart of being a healthcare professional. These standards were equally, if not more, important during the COVID pandemic, as patients may not have attended for an eye appointment for some time and may have been apprehensive about doing so. For the Registrant to develop a practice of overwriting IOPs, and knowingly risk

patient safety, in order to avoid the consideration of further investigations (for potentially serious eye conditions such as glaucoma) was wholly unacceptable conduct that was serious, and more so in the context of COVID.

236. The Registrant's conduct in respect of the instances of overwriting was a significant departure from the fundamental principle of putting patients first. Further, patients put trust in Optometrists to accurately record their measurements when tests are undertaken. The Committee was of the view that despite the remediation undertaken by the Registrant, the public would be concerned and public confidence in the profession would be undermined, if a finding of impairment was not made, in respect of the Registrant's overwriting misconduct. The Committee determined that it was necessary to make a finding of impairment in this case in order to maintain confidence in the profession and in order to uphold proper professional standards.

237. Accordingly, the Committee found that the Registrant's fitness of to practise as an Optometrist is currently impaired.

Sanction

238. The Committee reconvened on 15 April 2024 (day nine of the hearing) to consider what would be the appropriate and proportionate sanction, if any, to impose in this case. It heard submissions on sanction from Ms Shah, on behalf of the Council, and from Mr Mills, on behalf of the Registrant.

239. Ms Shah reminded the Committee that the appropriate sanction was a matter for the Committee's professional judgement and that it had made a finding of impairment on public interest grounds only, having found no outstanding clinical concerns.

240. Ms Shah emphasised that the purpose of imposing a sanction was not to punish the Registrant, although it may have that effect. The primary purpose of sanctions was to protect the public and to meet the overarching objective. She invited the Committee to consider the least restrictive sanction first, with regard to the GOC's '*Hearings and Indicative Sanctions Guidance*' (updated November 2021) ('the Guidance').

241. Ms Shah submitted that the Committee was entitled to take into account, as aggravating factors, that the misconduct amounted to a pattern of behaviour, which put patients at risk of harm and also that the Registrant told lies during the initial employer investigation. She submitted that, although she had referred to conditions potentially being appropriate in her earlier written submissions, in light of the Committee's findings at the impairment stage, suspension is the only appropriate sanction. Furthermore, almost all of the factors set out at paragraph 21.29 of the Guidance, which indicate when a suspension order might be appropriate, were met.

242. Ms Shah submitted that the length of suspension was a matter for the Committee, however she suggested that a six month period of suspension would send the right message to the public and the profession that the conduct in question was not appropriate and should not be repeated.

243. Mr Mills, on behalf of the Registrant, expanded upon his written submissions on sanction, which were before the Committee. He submitted that repetition of the overwriting should not be regarded as a separate aggravating factor, as it is inherent in the finding of a practice occurring at the time, which the Committee found to be misconduct. Mr Mills submitted that the only separate aggravating factor was the lies told initially by the Registrant in the investigation, in relation to Patient A.

244. Turning to mitigation, Mr Mills submitted that the key points of mitigation were that:

a. The well-informed, relevant, and universally positive references from a range of persons over an extended period of time.

b. The evidence in (a) of positive feedback from patients, and the Registrant's commitment to them, and to his own training and development.

c. The positive clinical audits and supervisor reports over an extended period, with a brief pause at the end of 2021 which are otherwise from August 2021 to April 2024.

d. The evidence of the Registrant orally and on paper as to an extensive period of reflection, and the demonstration of significant insight.

e. The "very low" risk of repetition, in the judgement of the Committee, and the absence of any repetition in the audited practice from 2021 to date.

f. Remorse.

g. Substantial admissions at an early stage in proceedings.

h. The unique circumstances in which the misconduct arose: personal, workplace, COVID.

i. The Registrant's otherwise long career without a fitness to practise history, up to 2020.

j. The passage of time since the events and chronology of proceedings: a self-referral from to the GOC in December 2020, a referral to a hearing by the case examiners in July 2022, service of the case in November 2022, a hearing in May 2023, which did not conclude until April 2024, nearly 3 and a half years after the GOC was first contacted by the Registrant.

k. The period of time spent subject to an interim order of conditions (in terms of being subject to a restriction on practice, rather than in respect of the outcome of the clinical audits and supervision).

245. Mr Mills referred the Committee to the Guidance and that the starting point was to consider taking no further action, which he submitted was the appropriate outcome in this case. Mr Mills submitted that this was a case where exceptional

circumstances could be found, particularly when the factors were considered in combination. Mr Mills highlighted in particular the universally positive reports from the Registrant's supervisors over the past 2 and a half years of supervision, the passage of time for this case to conclude, the Registrant's insight, remorse, candour and remediation, hitherto good character and references. In light of these factors, Mr Mills queried whether a restrictive sanction could be justified at this stage.

246. Turning to conditions, Mr Mills submitted that whilst the Guidance refers to conditions being most appropriate in cases of health or performance, or where there is evidence of shortcomings in specific areas of a registrant's practice, this should not be interpreted as limiting the sanction to only those cases and there is no reason why in principle conditions cannot be imposed in this case. Mr Mills referred the Committee to the interim order of conditions that had been in place for approximately two and a half years and suggested that the same or similar conditions could be imposed as an appropriate and proportionate sanction.

247. Considering the factors which indicate that conditions may be appropriate, at paragraph 21.25 of the Guidance, Mr Mills submitted that these mostly applied, with some factors not being relevant. Mr Mills submitted that if the Committee excluded conditions in principle, because it was a public interest case, then it should look again at taking no action, as otherwise the stark choice was to consider suspension.

248. Mr Mills submitted that his primary position was that no order should be made, failing that conditions would be the most appropriate and proportionate sanction. However, if the Committee was considering a suspension, neither a member of the public, nor the profession, would consider a lengthy suspension necessary. Mr Mills submitted that there was no minimum period for a suspension and its length should be no more than was necessary. Mr Mills suggested that if the Committee was considering a suspension, a period of one month would be appropriate and proportionate.

249. Mr Mills submitted that erasure would be wholly disproportionate given the mitigation in the case and it was not necessary, as it was not the only sanction that would meet the public interest. Mr Mills submitted that erasure would remove a useful and competent Optometrist from practice, and this was clearly not an erasure case.

250. The Committee accepted the advice of the Legal Adviser, which was for the Committee to take into account the factors on sanction as set out in the Guidance; to assess the seriousness of the misconduct; to consider and balance any aggravating and mitigating factors; and to consider the range of available sanctions in ascending order of seriousness. Further, the Committee is required to act proportionately by weighing the interests of the registrant against the public interest.

251. On the issue of exceptional circumstances, which are required to be found if no further action was taken, the Legal Adviser referred to the case of *GMC v Rezk* [2023] EWHC 3228 (Admin), which reiterated that exceptional circumstances are unusual, special and uncommon.

The Committee's findings on sanction

252. When considering the most appropriate sanction, if any, to impose in this case, the Committee had regard to all of the evidence and submissions it had heard, which included the recent patient records audit and supervisor reports. The Committee also had regard to its previous findings at the misconduct and impairment stages.

253. The Committee considered the aggravating and mitigating factors. In the Committee's view, the aggravating factors in this case are as follows:

i) The misconduct in relation to overwriting of IOPs formed a pattern of behaviour, which was repeated over a sustained period of time and put multiple patients at risk of harm;

ii) The Registrant initially denied responsibility in the early stages of the employer investigation.

254. The Committee considered the submission made by Mr Mills regarding the first aggravating factor listed above. It was mindful of the point made by Mr Mills regarding ensuring it was not in effect counting the misconduct more than once. The Committee was satisfied in its determination it did not do so.

255. The Committee considered that the following were mitigating factors:

a. The positive references from a wide range of people who had worked closely with the Registrant over an extended period of time.

b. The evidence of positive feedback from patients provided within the references.

c. The positive clinical audits and supervisor reports, which showed consistent and impressive results sustained over an extended period.

d. The evidence of the Registrant's extensive reflection, and the demonstration of significant insight.

e. The very low risk of repetition, and no reoccurrence of the misconduct.

f. Remorse, which the Committee accepted was genuine.

g. Substantial admissions at an early stage in proceedings.

h. The circumstances in which the misconduct arose: the Committee noted the difficult [redacted] and work circumstances of the Registrant, as set out in its earlier determinations.

i. The Registrant's otherwise long career without any fitness to practise history.

j. The passage of time since the events and the chronology of proceedings, during which time the Registrant has fully engaged with these proceedings.

k. The period of time spent subject to an interim order of conditions (in terms of being subject to a restriction on practice, rather than in respect of the outcome of the clinical audits and supervision).

256. The Committee next considered the sanctions available to it from the least restrictive to the most severe, starting with no further action.

257. The Committee considered taking no further action as set out in paragraphs 21.3 to 21.8 of the Guidance. The Committee noted that the Guidance states at paragraph 21.3 that,

'*Where a registrant's fitness to practise is impaired, the FtPC would usually take action to protect patients, maintain public confidence in the profession and uphold proper standards of conduct and behaviour*.'

258. The Committee was mindful that exceptional circumstances are required to justify taking no further action. It had regard to the cases of *R v Kelly (Edward)* [2000] QB 198 (as referred to in the Guidance) and *GMC v Rezk*, on the meaning of exceptional. It noted that in *R v Kelly*, Lord Bingham said:

"*We must construe 'exceptional' as an ordinary, familiar English adjective, and not as a term of art. It describes a circumstance which is such as to form an exception, which is out of the ordinary course, or unusual, or special, or uncommon. To be exceptional a circumstance need not be unique or unprecedented, or very rare; but it cannot be one that is regularly, or routinely, or normally encountered."*

259. The Committee was of the view that there was considerable mitigation, including that the Registrant had been subject to an interim order of conditions for a significant period. However, when balanced against the seriousness of the misconduct and its earlier findings, it was the Committee's view that a restrictive sanction was required in the public interest. It concluded that the mitigating circumstances, either alone or in combination, fell short of being unusual, special or uncommon.

260. The Committee therefore determined that there were no exceptional circumstances present that could justify taking no action in this case. It further considered that taking no further action would not be a proportionate, nor a sufficient outcome, given the seriousness of the case and the public interest concerns.

261. The Committee considered the issue of a financial penalty order, however it was of the view that such an order was not appropriate, given that the

Registrant's conduct was not financially motivated and had not resulted in financial gain.

262. The Committee next considered the GOC Indicative Sanctions Guidance in relation to the imposition of conditions. It noted in particular that at paragraph 21.17 of the guidance it states,

> "*Conditions might be most appropriate in cases involving a registrant's health, performance, or where there is evidence of shortcomings in a specific area or areas of the registrant's practice."*

263. The Committee considered that this paragraph did not necessarily limit the imposition of conditions to such cases, however any appropriate conditions would need to address the misconduct and any risks in the case. The Committee was mindful that impairment had only been found on public interest grounds and that there were no outstanding patient safety concerns.

264. The Committee considered the factors in the Guidance set out at paragraph 21.25, which indicated when conditions may be appropriate:

Conditional registration may be appropriate when most, or all, of the following factors are apparent (this list is not exhaustive):

a. No evidence of harmful deep-seated personality or attitudinal problems.

b. Identifiable areas of registrant's practise in need of assessment or retraining.

c. Evidence that registrant has insight into any health problems and is prepared to agree to abide by conditions regarding medical condition, treatment, and supervision.

d. Potential and willingness to respond positively to retraining.

e. Patients will not be put in danger either directly or indirectly as a result of conditional registration itself.

f. The conditions will protect patients during the period they are in force.

g. It is possible to formulate appropriate and practical conditions to impose on registration and make provision as to how conditions will be monitored.

265. The Committee did not consider that the Registrant held deep-seated personality or attitudinal problems and noted that the Registrant had been complying well with his interim order of conditions. However, the Committee was of the view that there were no identifiable areas in the Registrant's current practice in need of assessment or retraining.

266. The Committee considered that most of the factors in paragraph 21.25 linked to retraining and the protection of patients and were not particularly relevant to

the public interest. The Committee also had regard to the interim conditions that the Registrant had been subject to during these proceedings and noted that most of those also were relevant to the clinical concerns (such as working under supervision with records being audited). The Committee had regard to the template for conditions of practice in the conditions bank (included at the end of the Guidance) and found no other conditions that would be relevant and/or appropriate.

267. The Committee considered whether it would be possible to formulate appropriate and practical conditions in this case. The Committee noted that at paragraph 21.19 of the Guidance, it states that,

"*The objectives of any conditions placed on the registrant must be relevant to the conduct in question and any risk it presents*."

268. The Committee was of the view that it would not be possible to formulate appropriate and practical conditions in this case, relevant to the misconduct. In addition, the Committee was mindful that there was not a particular risk to be addressed with conditions, as it had found the risk of repetition to be very low.

269. Furthermore, the Committee balanced the aggravating and mitigating factors in the case. It concluded that despite the mitigation, and the Registrant's insight and remediation, having regard to the seriousness of the misconduct in overwriting IOP readings, involving multiple patients over several months, who were exposed to the risk of harm, an order of conditions would not sufficiently meet the public interest.

270. Considering all of the above, the Committee determined that a conditions of practice order would not sufficiently mark the serious nature of the misconduct, nor address the public interest concerns identified when making a finding of impairment. The Committee was also not satisfied that adequate conditions could be devised which would be appropriate, proportionate, workable or measurable in this case.

271. The Committee next considered suspension and had regard to paragraphs 21.29 to 21.31 of the Guidance. In particular, the Committee considered the list of factors contained within paragraph 21.29, which indicate that a suspension may be appropriate, as follows:

Suspension (maximum 12 months)

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

272. The Committee was of the view that all of the factors listed in paragraph 21.29 were applicable, apart from factor e) which was not relevant in this case. In relation to factor a), this was serious misconduct, where a lesser sanction was not sufficient, as set out above.

273. In relation to b), the Committee was of the view that there was no evidence of harmful deep-seated personality or attitudinal problems. In relation to c), there was no evidence of repetition of the behaviour since the incidents.

274. In relation to d), the Committee was satisfied that the Registrant has developed insight and does not pose a significant risk of repeating behaviour.

275. The Committee balanced the mitigating and aggravating factors in the case and considered the principle of proportionality. It concluded that a suspension order was appropriate in order to address the public interest concerns that it had identified. A period of suspension would send a clear signal to the public and profession that such conduct was not acceptable. The Committee concluded that a suspension order would adequately mark the seriousness of the Registrant's conduct, promote and maintain public confidence in the profession and promote and maintain proper professional standards and conduct.

276. The Committee was mindful of the impact of a suspension upon the Registrant, however it was satisfied that it struck the balance correctly between the public interest and the Registrant's interests.

277. The Committee did not go on to consider the relevant part of the Guidance in relation to erasure, as it was satisfied that an order of suspension was the appropriate and proportionate sanction to impose in this case and given the extent of the mitigation, erasure would be a disproportionate outcome.

278. In relation to the length of suspension, the Committee gave consideration to the appropriate length of the order of suspension and determined that, having balanced the mitigating and aggravating factors against the public interest, it would be proportionate to suspend the Registrant for a period of two months. When considering the appropriate length of order, the Committee had regard to the considerable mitigation, the impact upon the Registrant and the fact that he had been subject to an interim order of conditions for a lengthy period. Had these factors not been present, the Committee would have been minded to impose a longer period of suspension. In the circumstances, the Committee was of the view that two months was an appropriate and proportionate period of suspension to sufficiently mark the seriousness of the Registrant's conduct, to

send a message to the public and the profession that such conduct was not acceptable and to address the public interest concerns it had identified.

279. The Committee considered whether to direct that a review hearing should take place before the end of the period of suspension. The Committee noted that at paragraph 21.32 of the Guidance, it states that a review should normally be directed before an order of suspension is lifted, because the Committee will need to be reassured that the registrant is fit to resume unrestricted practice.

280. The Committee bore in mind that it had found that there was a very low risk of repetition of the conduct, as the Registrant had insight and had significantly remediated. Furthermore, that the finding of impairment had been made only to maintain public confidence in the profession and uphold proper professional standards and conduct. The Committee considered that in the circumstances, and given the relatively short period of suspension, a review hearing was neither necessary nor proportionate.

281. The Committee therefore imposed a suspension order for a period of two months, with no review hearing.

Immediate Order

282. Ms Shah, on behalf of the Council, invited the Committee to consider whether to impose an immediate order of suspension under Section 13I of the Opticians Act 1989. Ms Shah submitted that the only applicable ground based upon the Committee's findings was if an immediate order would be in the public interest. She referred the Committee to paragraph 23 of the Guidance.

283. Mr Mills, on behalf of the Registrant, opposed the imposition of an immediate suspension order. He submitted that the grounds of public protection and the Registrant's own interests were plainly inapplicable and in respect of the public interest, the appropriate yardstick was "necessity". Mr Mills submitted that it would not be necessary nor proportionate to impose an immediate order, which would have the effect of increasing the suspension by approximately a third. Mr Mills submitted that a signal was sent to the profession by the suspension order itself. Furthermore, an immediate order would have a negative impact on the Registrant who would need time to fulfil existing professional commitments and earn a living over the next few weeks.

284. The Committee accepted the advice of the Legal Adviser, which was that to make an immediate order, the Committee must be satisfied that the statutory test in section 13I of the Opticians Act 1989 is met, i.e., that the making of an order is necessary for the protection of members of the public, otherwise in the public interest or in the best interests of the Registrant.

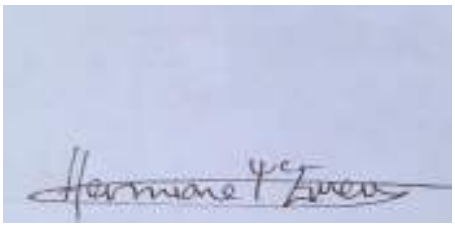
285. The Committee had regard to the statutory test, which required that an immediate order had to be necessary to protect members of the public, otherwise in the public interest or in the best interests of the Registrant. The Committee was mindful that on public interest grounds the requirement of necessity was an appropriate yardstick, and that being desirable to make an order was not sufficient.

286. The Committee was not satisfied that there was any necessity for an immediate order in the public interest. It considered that the public interest had been adequately marked by the two month suspension order itself. Furthermore, an immediate order would have a negative impact on the Registrant and be disproportionate. Therefore, the Committee was not satisfied that the statutory test had been met and decided in the circumstances not to impose an immediate suspension order.

Revocation of an interim order

287. The Committee directed that the current interim order that has been in place be revoked.

Chair of the Committee: Hermione McEwen

Signature  **Date: 16 April 2024**

Registrant: John Watson

Signature Present via MS Teams **Date: 16 April 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.