

**BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL**

GENERAL OPTICAL COUNCIL

F(23)10

AND

BEN BURNAGE (D-17008)

**DETERMINATION OF A SUBSTANTIVE HEARING
03 July - 11 July 2023**

Committee Members:	Ms Jayne Wheat (Chair/Lay) Ms Ann McKechin (Lay) Mr Ben Summerskill (Lay) Mr Philip Cross (Dispensing Optician) Mr Ian Taylor (Dispensing Optician)
Clinical adviser:	N/A
Legal adviser:	Mr Jayesh Jotangia
GOC Presenting Officer:	Ms Zahra Ahmed
Registrant present/represented:	No and not represented
Registrant representative:	No
Hearings Officer:	Ms Arjeta Shabani Ms Abby Strong-Perrin (11 th July only)
Facts found proved:	All
Facts not found proved:	None
Misconduct:	Found
Impairment:	Impaired
Sanction:	Erasure
Immediate order:	Yes

Proof of service

1. The Committee heard an application from Ms Zara Ahmed, Counsel for the General Optical Council ('the Council'), for the matter to proceed in the Registrant's absence. First, the Council was required to satisfy the Committee that the documents had been served in accordance with Section 23A of the Act and Rules 28 and 61 of The General Optical Council (Fitness to Practise) Rules Order of Council 2013 ("the Rules").
2. The Registrant had confirmed via an email to the Council on 28 January 2022 that he accepted service by email stating "sending correspondence by email is acceptable and this current email is fine to use", thus providing e-consent in writing.
3. The Committee accepted the advice of the Legal Adviser. The notice had been sent on 17 May 2023 to the email address notified by the Registrant to the Council. He advised that this was more than the 28 days' notice required by Rule 34(2).
4. The Legal Adviser advised that the Committee ought to be satisfied that the notice given to the Registrant of the hearing accorded with the Rules and should note, that pursuant to Section 23A of The Opticians Act 1989, effective service may now be completed via email.
5. The Committee made the decision that it is satisfied that all reasonable efforts have been made to notify the Registrant of the hearing, and that notice was served in accordance with the Rules.

Proceeding in the absence of the Registrant

6. Thereafter, Ms Ahmed made an application to proceed in the absence of the Registrant.
7. The Committee considered whether all reasonable efforts had been made to notify the Registrant of the hearing in accordance with Section 23A and Rule 61, and whether it would be in the public interest to proceed in the Registrant's absence in accordance with Rule 22.
8. The Committee accepted the advice of the Legal Adviser. He informed the Committee that the test to apply was set out in paragraphs 23 and 63 of **General Medical Council v Adeogba [2016] EWCA Civ 162**, which was whether all reasonable efforts had been taken to serve appropriate notice of the proceedings to the Registrant and whether the Registrant had deliberately chosen not to attend or be represented.
9. It was noted by the Committee that the Registrant had not made an application for an adjournment nor provided any reasons for his non-attendance on any grounds whatsoever. The Committee was mindful that the Council had made reasonable efforts to communicate with the Registrant. The Committee also noted the regulatory requirement for the Registrant to engage with the Council and that no

attempt had been made by the Registrant to offer an alternative address for communications or correspondence. Indeed, the Committee was satisfied there was no reason that an adjournment would achieve anything to further the public interest.

10. The Committee were also mindful that witnesses had been warned and were available to give evidence. As the matters alleged against the Registrant dated back to 2021, the Committee took into account the need for expediency and that further delay could affect the recollection of the witnesses.
11. The Committee therefore determined that it would be fair, proportionate and in the public interest for the hearing to proceed in the Registrant's absence.

ALLEGATION

The Council alleges that you, Ben Burnage (D-17008), a registered Dispensing Optician whilst employed at Specsavers Opticians [redacted]:

1. *On or around 25 March 2021, you falsified the visual field results for Patient A in that:*
 - a. *you repeated the field test for Patient A's left eye without the patient present;*
 - b. *you replaced the original results for Patient A's left eye with the new results in that you printed out the 'new' result for the left eye, reversed the paper record and printed the original result for Patient A's right eye;*
 - c. *you disposed of Patient A's original results card in a 'Shred-It' bin;*
 - d. *When asked about Patient A's field test results by a colleague you advised that the field test machine was 'playing up' and you were 'checking to see if the machine was working ok' or words to that effect;*
2. *Your actions as set out at 1 above were dishonest in that you withheld clinical data that showed a potentially pathological result in Patient A and instead showed your colleague a simulated 'normal' outcome;*

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

DETERMINATION

Background to the Allegation

12. The Registrant is a registered Dispensing Optician and was employed at Specsavers Opticians, [redacted].
13. It is alleged that on 25 March 2021, whilst working at Specsavers Opticians, the Registrant was asked by Witness A, a locum Optometrist, to carry out a visual field test on Patient A, whilst Witness A attended to another patient.
14. On completion of that visual field test and after Patient A had left the premises, the Registrant is alleged to have repeated the field test for Patient A's left eye without Patient A being present. A bleeping sound from the performance of the repeated test was said to have been heard by a colleague.
15. It is said that the Registrant disposed of the original test result and replaced it with the result of a repeated field test performed by the Registrant in the absence of Patient A, which was presented by him to Witness A.

Findings in relation to the facts

16. The Committee carefully considered the Council's Bundle which consisted of 154 pages and a Service Bundle consisting of 18 pages. The Bundle included but was not limited to, the witness statements and exhibits of Witness A, Witness B, Witness C and Witness D and an Expert Report of Dr Anna Kwartz dated 22 October 2022.
17. In addition, the Committee had sight of the CCTV footage which it viewed at the outset of the hearing and again when Witness B gave oral evidence.
18. All witnesses attended the hearing and provided oral testimony, with the exception of Dr Anna Kwartz. The Committee accepted her Expert Report as read as it had no questions for her and therefore, she was not called to give oral evidence.
19. As noted above, the Registrant did not attend and was not represented having been made aware of the hearing date via the Council's Notice of Inquiry dated 17 May 2023. The Registrant did not provide the Committee with a witness statement or any written representations.
20. Ms Ahmed made closing submissions on the facts stage of the hearing, on behalf of the Council.
21. The Committee accepted the advice of the Legal Adviser who reminded the Committee that the burden of proof is on the Council in respect of the facts and that the standard of proof is the balance of probabilities pursuant to Rules 39 and 38 respectively. The Committee was reminded to consider each of the particulars of the Allegation separately and all the evidence in relation to each. The Legal

Adviser informed the Committee of the test for dishonesty as laid out in the case of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords [2017] UKSC 76*.

22. In considering each particular of the Allegation in turn, which involved assessing the evidence of each of the relevant witnesses, the Committee found all the witnesses to be credible and reliable and accepted their evidence which was corroborated by the documents and the CCTV footage. A summary of their evidence is as follows:
23. Witness A, a locum Optometrist at Specsavers in [redacted], informed the Committee that the visual fields machine was located downstairs and the testing rooms were upstairs. It was her usual practice to ask for visual field test results to be brought back to her when someone else had undertaken them. She said she had worked with the Registrant before, that he had performed these tests before and there had been no cause for concern previously.
24. Witness A explained to the Committee what a visual fields test was and explained the interpretation of results. With regards to Patient A, she explained that when the field test results were brought back to her by the Registrant, both agreed to the unreliability of the result for the patient's left eye, as the test had a high threshold and 100% false positives and that the test needed to be repeated. Witness A said in her evidence that the Registrant had stated that Patient A wanted to go but that he would repeat the test when Patient A came back to collect her glasses. She told the Committee that the Registrant had stated that Patient A was "trigger happy" and Witness A explained that this phrase was commonly used for results with a high number of false positives.
25. In her evidence, Witness C, who at the time was an Optical Assistant at Specsavers [redacted], explained the process involved during a visual field test and that on the results, a white square would signify that a patient had seen a light and clicked the button to confirm, and a black square would signify what a patient had not seen.
26. Witness C explained that she had seen the Registrant on the field machine via the laptop and explained the close proximity of where he was sitting to where she was working when she heard the constant bleeping sound of the visual field test. She told the Committee that she had never seen, in her two and half years of being employed at Specsavers, unless on training, a member of staff using the field machine by themselves. She felt this was "strange, odd and unnecessary" and "did not feel right". She confirmed that she had never seen a field test being carried out without a patient present. In her statement, Witness C stated that she printed off the field test result after the Registrant had left the machine without logging off. Some 15-20 minutes later she presented the results to Witness D. She said that she had seen the Registrant on the field test machine when there had been no reason for him to be there.
27. Witness C confirmed that there had been no fault reported with the field machine with no conversation of that nature and that any reporting of a fault would have been to a manager. Witness C informed the Committee that if there had been a fault, word of that fault would have quickly got around to staff members as it was

a machine which was used frequently. In fact, Witness C went on further to state that in the event of a fault, “people would have panicked” as most optometrists would ask for field tests regularly and it would have been “a messy situation”.

28. Witness C confirmed in evidence that she did not know how to “calibrate” the machine and had not seen it being done. She informed the Committee that the only machine she ever saw being repaired was the printer.
29. Witness D, Dispensing Optician at Specsavers [redacted], gave evidence that on 25 March 2021, she had been working on a different floor to where the fields machine was when Witness C approached her. She stated that she could not recall what she first thought of the concerns being put by Witness C but did not think the Registrant was doing anything untoward, and she said that she would look into it. She felt it her duty to do so to make sure what Witness C had informed her was true.
30. Witness D confirmed that Witness C had provided her with a copy of the field test that she had printed from the laptop after the Registrant had used it which was presented as Exhibit GC/01. Witness D confirmed that the handwriting on it was that of Witness B. Witness D said she went to the field machine and saw that there were three results. Two of the results were for Patient A’s left eye, one of which was the same as the printed copy she had been given by Witness C, and another, which showed potential field losses in the periphery. These results were exhibited as MA/02. Witness D informed the Store Manager, Witness B, who subsequently viewed the CCTV footage the next day. Witness D said that as a result of Witness B informing her that the CCTV showed the Registrant putting something in the Shred-it cabinet, she took her keys and opened that cabinet. She confirmed that Exhibit GC/03 had been recovered by her from the Shred-it bin, which she said was the original visual field test results for Patient A’s eyes.
31. Witness D confirmed that the Shred-it bin was a locked cabinet, like a post box. She said documents were not shredded at the premises but taken away by a secure company to be shredded off-site.
32. Witness D said in her oral evidence that it was not normal to find field test results in the Shred-it bin as they would usually have been handed to the optometrist who requested the original test.
33. Witness D explained her understanding of the field test results and informed the Committee that there had not been faults with the machine, none reported nor any calibration carried out. She also confirmed that in the absence of a patient that a field test machine or laptop would not be used.
34. It was also confirmed by this witness that the location of the printer was under the desk where the Registrant had been seen on CCTV to be sat when using the field test machine. Witness D recalled that the Shred-it bin had been located towards the back of the room at the time, but could not remember exactly as it had been moved subsequently.

35. Turning to the evidence of Witness B, a Dispensing Optician and Store Manager at Specsavers [redacted], the Committee re-viewed the CCTV footage, which the witness was examined on by Ms Ahmed, at the same time explaining what she saw and any persons identified.
36. Witness B explained that the CCTV showed the Registrant printing off the field test results after Patient A had completed her test. He folded the same, placing the results on the clipboard after Patient A had left. Thereafter, Witness B confirmed that she could see the Registrant at the laptop clicking the button of the field machine with his right hand whilst wearing a blue glove. She identified two colleagues at the store, who both appeared on the CCTV footage at different times whilst the Registrant was present in the room. She confirmed they were Person A, a store supervisor and Person B, an Optical Assistant at the store, whom Witness B said she later interviewed. Witness B confirmed that she had made a contemporaneous note of her interview with Person B. Person B told Witness B that the Registrant had told her he was 'just calibrating the fields machine', when she asked him what he was doing. Witness B told the Committee that the Registrant could subsequently be seen on the CCTV printing off another test result, folding the paper, adding it to the clipboard and writing something on it.
37. Witness B explained where the Shred-it bin was located, at the back of the room, and that the printer was underneath the desk of the laptop for the fields machine. Witness B stated that it could be seen from the CCTV footage that the Registrant had removed the original test result and placed it where the "dark area" on the video was, at the back of the room and where the Shred-it bin was located.
38. Witness B stated that the Registrant could be seen placing the other print out of the field test result he had undertaken on the clipboard and writing on it. This document was identified as Exhibit JH/02. The Registrant's handwriting was of Patient A's TR number but the handwriting stating "Ben's Handwriting" was of Person C, the Director of Specsavers.
39. Exhibit JH/03 was confirmed by Witness B to be the original field test. She said that she had made a note of what she had observed on the CCTV footage on 26 March 2021 at Exhibit JH/04. Witness B also made a note of the interview with the Registrant on the same date which appeared as Exhibit JH/05.
40. Witness B confirmed no faults had been reported with the field test machine by others. She confirmed that to her knowledge, there had been no fault on the day in question nor the day after. As far as she was aware, faults had only been reported with the printer previously but not with the field test machine. If there had been faults with the field test machine, the matter would have been brought to her attention, or Witness D. Further, Witness B informed the Committee that the field test machine could not be calibrated.

Allegation 1(a) - you falsified the visual field results for Patient A in that: you repeated the field test for Patient A's left eye without the patient present - proved

41. The Committee found this allegation proved.
42. The Committee found that Witness A had been brought a field test result for Patient A by the Registrant himself and that a discussion had occurred as to the unreliability of the left eye result, as it had a high threshold and 100% false positives. As the conversation unfolded, the Registrant stated that Patient A was "trigger happy" and a test would need to be repeated.
43. The CCTV footage was consistent with the documentary evidence of an earlier field test result for Patient A's left eye, timed at 15.31, the right eye result timed at 15.29 and a further test result for the left eye timed at 15.42, which the Committee found was the result shown by the Registrant to Witness A. The CCTV footage showed the pressing of the button by the Registrant without Patient A present and without looking at a screen. It was evident to the Committee that this was a repeat test for the left eye.
44. The Committee considered the notes taken by Witness B at Exhibit JH/05, of a conversation she held with the Registrant, on 26 March 2021, at which he said, "*I may have shown the wrong record to the optom so if I have done that, I'm sorry that must have been a genuine mistake.*"
45. However, in the view of the Committee, the CCTV footage showed that the Registrant carried out a further test without Patient A present, and that this test result of the left eye was the one presented to Witness A. Witness A's evidence as to what was presented to her by the Registrant, and the documentary evidence of an earlier result discovered by Witness D on the laptop, as well as the evidence obtained by Witness D of the original printed results from the Shred-it bin, all demonstrated that the Registrant had repeated the field test for Patient A's left eye in her absence.

Allegation 1(b) you falsified the visual field results for Patient A in that: you replaced the original results for Patient A's left eye with the new results in that you printed out the 'new' result for the left eye, reversed the paper record and printed the original result for Patient A's right eye; – proved

46. The Committee took the view that the CCTV footage evidenced an active decision-making process by the Registrant, in that he can be seen using the fields test buzzer and laptop, subsequently replacing the original test results of Patient A's left eye with the 'new' results on the clipboard. It was clearly visible on the CCTV that the Registrant took the paper out of the printer, reversed it and, placed it back into the printer for it to be printed out, which then evidenced both eyes together as one printed result. The documentary evidence before the Committee of this set of results showed a disproportionate amount of time between the results of the right eye (15.29) and the left eye (15.42). The Committee would have expected the

test results for each eye to be within a close time frame if actually carried out at the time of Patient A being tested at her appointment, but they were not.

47. Further, the Committee took into account Witness A's evidence of the results she had been presented with by the Registrant, showing as unreliable.

Allegation 1(c) - you falsified the visual field results for Patient A in that: you disposed of Patient A's original results card in a 'Shred-It' bin – **proved**

48. The Committee found this particular of the Allegation proved. It found that Witness D discovered Patient A's original results in the Shred-it bin after being notified by Witness B that she had viewed the Registrant seemingly placing them in the Shred-It bin on the CCTV footage.
49. Firstly, the Committee took the view that the CCTV footage showed the Registrant originally placing the first set of results onto the clipboard for Patient A and subsequently removing them and putting them in the area of the room where the Shred-it bin was located. The Committee was provided with a copy of the document Witness D removed, which showed left and right eye field test results for Patient A, timed at 15.31 and 15.29 respectively, which the Committee considered demonstrated the authenticity of the original test results.
50. Having determined that as a matter of fact, it was noted by the Committee that although it could not clearly be seen that the Registrant had disposed of Patient A's original test results in a Shred-it bin, it was confirmed by both Witness D and Witness B as to where the Shred-it bin would have been located in or around 25 March 2021 and that the CCTV footage shows the Registrant taking the test result to a "dark area" of the footage. It disappears thereafter when his hand can be re-seen without the test result paper.
51. The Committee considered the possibility of anyone else placing the test result into the Shred-it bin, but from the CCTV footage, this does not appear to be the case as there is no lapse on time in the CCTV footage.
52. The Committee drew a reasonable inference based upon the evidence before it, that the Registrant did place the original results in the Shred-it bin, and found the matter proved on the balance of probabilities.

Allegation 1(d): you falsified the visual field results for Patient A in that: A when asked about Patient A's field test results by a colleague you advised that the field test machine was 'playing up' and you were 'checking to see if the machine was working ok' or words to that effect - **proved**

53. The Committee noted that this particular appeared to have an inadvertently placed letter "A" at the beginning of it. It took the view it should amend this particular of its own volition under Rule 46 of the Rules, by removing the letter "A" from the rest of the wording as it made no sense and would not prejudice the Registrant or the Council or cause injustice in any way. The Committee took the view that the addition of the letter "A" had been by mistake as a typographical error.

54. With regards to this particular, the Committee firstly considered what had been documented to have been said by the Registrant. This appeared at Exhibit JH/05 which was a note made contemporaneously by Witness B, of an interview between the Registrant and Witness B on 26 March 2021.
55. The Committee, having determined that Witness B was a reliable witness, found as a matter of fact and on a balance of probabilities that what had been noted contemporaneously at JH/05 was an accurate recording of the words said by the Registrant.
56. It is noted at Exhibit JH/05 that the Registrant stated, "*I was probably just checking it was working ok. I may have shown the wrong record to the optom so if I have done that, I'm sorry, that must have been a genuine mistake.*"
57. Furthermore, Witness B writes in her note that the Registrant used the words "playing up".
58. The Committee accepted Witness B's evidence as to what had been said via these notes on 26 March 2021.
59. The Registrant has not given an account in these proceedings as to what was actually said or not.

*Paragraph 2: Your actions as set out at 1 above were dishonest in that you withheld clinical data that showed a potentially pathological result in Patient A and instead showed your colleague a simulated 'normal' outcome - **proved***

60. The Committee found this paragraph proved in relation to sub-paragraphs 1(a) to (d). The Committee had regard to the two-stage test laid out in ***Ivey v Genting Casinos (UK) Ltd t/a Crockfords [2017] UKSC 76***. The Committee determined that in relation to its factual findings in 1(a) to 1(d), the Registrant subjectively knew in his mind that his actions in falsifying Patient A's visual field results by repeating the test of Patient A in absenteeism, replacing the original result and disposing of the original result were wrong and dishonest. In addition, the Committee was not satisfied by the Registrant's explanation that he was checking the machine and that it was 'playing up'. The findings of the Committee were of a deliberate course of action in repeating, replacing and disposing of the original test result and presenting a different result to Witness A. The Committee considered he was aware Witness A was expecting the results. To provide her with a different result to the one Patient A had taken, and discuss that replaced result with her, cannot have been a mistake, nor was it consistent with simply checking the machine was working.
61. With that in mind, the Committee went on to consider the second limb of the dishonesty test in ***Ivey***; would the Registrant's conduct be considered dishonest by the standards of ordinary decent people?
62. The Committee determined that for each paragraph 1(a) to 1(d), an ordinary, decent person would consider the Registrant's actions to be dishonest.

63. Furthermore, the Committee considered that the dishonest actions set out in paragraph 1 amounted to withholding clinical data that showed a potentially pathological result in Patient A. Instead, the Registrant showed his colleague a simulated outcome. In reaching this conclusion, the Committee took into account the written evidence of Witness A, in which she explained that the original test result for Patient A's left eye revealed a field defect and it had missing points, showing either a potential pathology, or a lens artefact, meaning the test needed to be repeated. The Committee had regard to Dr Anna Kwartz's expert opinion at paragraph 6.2.1 of her report, which stated:

"The simulated visual field results for Patient A's left eye (the examination of 15:42) showed that there was no clinically significant defect. For avoidance of doubt, the initial test on the left eye (the examination of 15:31) showed a curved defect across the upper part of the plot. The pattern of the 'loss' can be described as superior arcuate defect that can occur in glaucoma, so could very reasonably have been a manifestation of the condition."

In making its findings at 1(a) to 1(d), the Committee had already found that the Registrant showed Witness A a falsified result.

Misconduct

64. Having found the facts alleged proved, the Committee next considered whether the facts found proved amounted to the statutory ground of misconduct.
65. The Committee heard submissions on misconduct, on behalf of the Council, from Ms Ahmed. She also provided the Committee with written submissions. She referred the Committee to Section 13D of The Opticians Act 1989, that misconduct was the ground of impairment relied upon by the Council.
66. Ms Ahmed highlighted the definitions of misconduct in case law in the absence of a statutory definition. In particular, Ms Ahmed cited ***Remedy UK Ltd v General Medical Council [2010] EWHC 1245 (Admin)***, ***Meadow v General Medical Council [2006] EWCA Civ. 1390*** and ***Roylance v General Medical Council (No.2) [2000] 1 A.C. 311***.
67. She referred the Committee to a number of provisions in the GOC's 2016 Standards of Practice for Optometrists and Dispensing Opticians and references to those Standards in Dr Anna Kwartz's Expert Report. Ms Ahmed submitted that these standards had been breached and that the facts found proved were sufficiently serious to amount to misconduct.
68. The Committee received and accepted advice from the Legal Adviser. This included the following guidance on misconduct from the judgment in the case of ***Roylance v GMC [2000] 1 AC 311***:

"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 by a practitioner in the particular circumstances. The misconduct is qualified in two respects. First, it is qualified by the word 'professional' which links the misconduct to the profession Secondly, the misconduct is qualified by the word 'serious'. It is not any professional misconduct which will qualify. The professional misconduct must be serious."

69. The Legal Adviser also referenced ***Nandi v GMC [2004] EWHC 2317 (Admin)*** where the Court referred to Roylance and described misconduct as:

"a falling short by omission or commission of the standards of conduct expected among medical practitioners, and such falling short must be serious" such that it would be "regarded as deplorable by fellow practitioners".

The Committee's Decision on Misconduct

70. The Registrant's conduct, as proved, involved him dishonestly repeating Patient A's field test in her absence, replacing and disposing of the original results and presenting the falsified test result to an optometrist colleague. The Committee agreed that the standards identified by Ms Ahmed in her submissions, as set out in Dr Kwartz's expert report, were engaged. They were the following Council's Standards of Practise 2016:

8.1 Maintain clear, legible and contemporaneous patient records which are accessible for all those involved in the patient's care.

16.1 Act with honesty and integrity to maintain public trust and confidence in your profession.

17.1 Ensure your conduct, whether or not connected to your professional practice, does not damage public confidence in you or your profession.

17.3 Be aware of and comply with the law and regulations that affect your practice, and all the requirements of the General Optical Council.

19.2 Be open and honest with your colleagues, employers and relevant organisations, and take part in reviews and investigations when requested and with the General Optical Council, raising concerns where appropriate. Support and encourage your colleagues to be open and honest, and not stop someone from raising concerns.

71. The Committee determined that each of these standards had been breached by the Registrant. The Committee found that the Registrant had breached his duty of trust towards another colleague in deliberately handing over a false field test result as opposed to the correct field test result. By so doing, the Registrant's standards of accurate record-keeping fell far below what would be expected of him as a registered professional. Not having accurate information of Patient A's test results had the potential to undermine the care she was given and put her at risk. It was the Committee's view that acting dishonestly and without integrity would be conduct regarded as deplorable by fellow practitioners.

72. The Committee was of the view that the Registrant's conduct was serious and occurred during the exercise of his professional practice.
73. The Committee consequently determined that the facts found proved amounted to misconduct.

Impairment

74. Having determined that the facts found proved amounted to misconduct, the Committee went on to hear submissions on impairment from Ms Ahmed, who also provided written submissions.
75. Ms Ahmed cited the principles in the cases of ***Cheatle v General Medical Council [2009] EWHC 645***, ***Meadows v General Medical Council [2006] EWCA Cave 1390 [2007] 1 QB 462*** and ***CHRE v NMC and Grant EWHC 927 (Admin)*** relevant to impairment.
76. Ms Ahmed reminded the Committee of the factors to be taken into consideration regarding impairment *from* ***Cohen v General Medical Council [2008] EWHC 581 (Admin)***.
77. Ms Ahmed submitted that in this particular case, the Registrant had not provided any reflection on the gravity of the allegations having been found proved, nor had he provided any evidence of remedial action or of insight into his misconduct. She submitted that it could not be said that past conduct would be highly unlikely to be repeated again in the absence of such evidence as the Registrant had not engaged with the process.
78. The Committee accepted the advice of the Legal Adviser where the established principles laid out in the above-mentioned cases were repeated.
79. The Legal Adviser summarised for the Committee's benefit the approach formulated by Dame Janet Smith in her Fifth Report from the Shipman case, cited with approval in Grant, namely whether the Registrant:
 - a. *Has in the past acted and/or is liable in the future to act so as to put a patient(s) at unwarranted risk of harm; and/or*
 - b. *Has in the past and/or is liable in the future to bring the 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 profession; and/or*
 - d. *Has in the past acted dishonestly and/or is liable to act dishonestly in the future.*

The Committee's decision on Impairment

80. The Committee bore in mind the Council's overarching objective and gave equal consideration to each of its limbs as set out below:

“To protect, promote and maintain the health, safety and well-being of the public, the protection of the public by promoting and maintaining public confidence in the profession and promoting and maintaining proper professional standards and conduct.”

81. The Committee first considered the questions endorsed in *Grant* in relation to past behaviour. It concluded that in repeating, replacing, and disposing of the original field test result for Patient A, the Registrant had in the past put a patient at risk of harm. The Committee considered that acting dishonestly in this way had in the past brought the profession into disrepute. The Committee considered that falsifying information which was then given to a professional colleague and not ensuring a patient’s records were accurate had breached fundamental tenets of the profession, as demonstrated by the breaches of professional standards outlined above. The Committee has made findings of dishonesty and therefore the last question was also answered in the affirmative in relation to past behaviour.
82. Following on from the consideration of past behaviour, the Committee went on to consider the questions to be asked from the case of Cohen as follows:
 - a. whether the conduct leading to the charges is easily remediable?
 - b. If it is, whether it has been remedied, and then,
 - c. whether it is likely to be repeated?
83. The Committee considered that dishonest conduct is difficult, but not impossible, to remediate. However, the lack of engagement from the Registrant in this case meant that the Committee had to conclude that this particular misconduct was not easily remediable. In the absence of any evidence of remedial activity - for example, courses undertaken, reflection on the effect of the misconduct on colleagues or the reputation of the profession, remorse or apology - the Committee was not satisfied that the Registrant had any insight into his misconduct. It was regrettable that the Registrant had not engaged with the regulatory process as it meant that the Committee had to conclude that the conduct had not been remedied. The Committee then returned to the questions posed by Dame Janet Smith above, and concluded, in light of the conduct not being remedied, that there was a future risk that patients would be placed at an unwarranted risk of harm. Furthermore, that the profession would be brought into disrepute, that fundamental tenets of the profession may be breached in future and that the dishonesty might recur. It determined, in the circumstances, that the risk of repetition was high.
84. On the basis that there remained a risk to the health, safety and wellbeing of patients, the Committee concluded that the Registrant’s fitness to practise is impaired. The Committee then considered the wider public interest in maintaining public confidence in the profession and in promoting and maintaining proper professional standards and conduct. It determined that in circumstances where the Registrant had acted dishonestly, produced falsified results to a colleague and put a patient at risk of harm, public confidence in the profession would be undermined if a finding of impairment were not made. The Committee concluded that all three limbs of the overarching objective were engaged.

85. The Committee concluded that the Registrant's fitness to practise is currently impaired.

Sanction

86. The Committee heard oral submissions and considered the written submissions of Ms Ahmed on behalf of the Council. Ms Ahmed referred to the Hearings and Indicative Sanctions Guidance ('the HISG') throughout her submissions and in particular to paragraphs 22.4 – 22.5, in relation to the approach to be taken by the Committee in its assessment of the dishonest conduct.

87. Ms Ahmed invited the Committee to consider the aggravating and mitigating factors in this case and reminded the Committee to consider the sanctions available to it in ascending order, taking into account the Council's overarching objective and the principle of proportionality. Ms Ahmed submitted that in line with the case of ***Bolton v Law Society (1994) 1 WLR 512 CA (Civ Div)***, the reputation of the profession is more important than the fortunes of an individual member.

88. Ms Ahmed submitted that the Committee could consider a lengthy suspension as an alternative to erasure. However, she stressed that the matter of sanction was entirely for the Committee to determine, exercising its independent judgment, and that the Committee may conclude that only erasure was appropriate.

89. The Committee accepted the advice of the Legal Adviser. He referred the Committee to the HISG and reminded the Committee that it did not necessarily follow that a sanction must be imposed on findings of fact, misconduct and impairment, but that the Committee must come to its own independent view. The Council had no burden or standard of proof at this stage of the proceedings.

90. The Legal Adviser advised the Committee that the purpose of imposing a sanction was not punishment, but that the appropriate sanction may have a punitive effect. The Legal Adviser reminded the Committee to have regard to the principle of proportionality, balancing the Registrant's interests with the public interest. In addition to identifying the aggravating and mitigating factors, the Committee was advised to assess its conclusions on the act of dishonesty itself, then, to consider the extent of the dishonesty and its impact on the Registrant's character and most importantly, its impact on the wider reputation of the profession and public perception of the profession.

91. The Committee was advised that imposing a sanction would require consideration of the need to protect the public and the wider public interest. Further the Committee ought to consider the least restrictive sanction first and, if not appropriate or proportionate, move to the next available sanction in ascending order.

The Committee's decision on Sanction

92. In reaching its decision, the Committee took into account the submissions on behalf of the Council by Ms Ahmed, the facts found proved and its previous decisions on misconduct and impairment.
93. Throughout its deliberations the Committee had regard to the overarching objective, giving equal consideration to each of its limbs.
94. The Committee considered the following to be aggravating factors:
 - a. The misconduct occurred whilst the Registrant was undertaking his professional duties at work. It involved withholding clinical data (the original test result), which put Patient A at risk of harm and which had implications for monitoring a potential pathology.
 - b. The dishonesty was covered up by the Registrant and on repeated occasions he gave varying accounts to colleagues when questioned.
 - c. The Registrant breached a number of professional standards as outlined in the Impairment determination. His conduct breached the trust of both his optometrist colleague, who was entitled to rely upon receiving accurate clinical information from him, and Patient A, who would have expected the correct test results to have been communicated by the Registrant.
 - d. No evidence of insight, remorse, reflection or remediation was provided by the Registrant.
95. In mitigation, the Committee found that the findings related to one incident, albeit a grave and serious occurrence, which concerned one patient. There had been no previous fitness to practise history. There was no evidence of repetition.
96. It was the Committee's assessment that, on a scale of dishonest conduct, the Registrant's actions were at a high level of seriousness, when considering the aggravating factors identified. It took the view that informed and reasonable members of the public would be deeply concerned by the actions of the Registrant, and that the impact on the reputation of the profession was significant, particularly in circumstances where the Committee had determined that there remained a risk to public safety and where the risk of repetition was high.
97. The Committee first considered taking no action. It determined that there were no exceptional circumstances to justify so doing. Taking no action would not protect the public or be in the wider public interest and did not meet the seriousness of the findings.
98. The Committee decided that imposition of a financial penalty was not appropriate and was disproportionate. This sanction would not be sufficient in protecting the public against the risk of repetition and not appropriate in the wider public interest because of the seriousness of the actions found proved.
99. The Committee next considered a period of conditional registration. It took into account the relevant sections of paragraph 21.25 of the HISG as follows:

“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. ...*
- 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. “*

100. The Committee determined that the Registrant’s lack of engagement and the seriousness of his dishonest conduct meant that conditional registration was not appropriate and was disproportionate when considering the aggravating features identified. It was not possible to formulate conditions to protect patients against the risk of a repetition of dishonest behaviour, and there was no indication that the Registrant would comply with any conditions imposed.

101. The Committee next considered a suspension order and the relevant sections of the guidance contained within paragraph 21.29 of the IHSG namely:

“This sanction may be appropriate when some, or all, of the following factors are apparent (this list is not exhaustive):

- 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. ...”*

102. The Committee considered 21.29 a) was engaged, given the aggravating factors identified. In considering the limbs at b), c) and d), the Committee had regard to the Registrant’s non engagement, which it considered highly regrettable. He has not provided the Committee with evidence of any reflection, insight or remediation. Nor has he shown any remorse. Therefore, the Committee could not rule out deep-seated personality or attitudinal problems. The Committee could not be satisfied that the Registrant has insight. It has already determined that there is a high risk of repetition, albeit accepting as a mitigating factor, that there is no evidence before the Committee of a repetition of the misconduct since the incident, to date.

103. In order to properly assess the proportionate and appropriate sanction, the Committee went on to consider the sanction of erasure and were guided by the relevant section of paragraph 21.35 of the HISG, which state the following:

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

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

104. The Committee formed the view that 21.35 a) was engaged. The Committee has highlighted the standards it found to be breached in its earlier determination on misconduct and impairment. In relation to 21.35 b), the Committee found there was a risk of harm to Patient A, and that there remains a risk to the public in the absence of any insight, remorse and remediation. The Committee considered the aggravating factor of breaching Patient A's trust to be relevant to 21.35 c). Whilst the Committee has found the dishonest conduct to have been in relation to one incident rather than a pattern of repeatedly dishonest behaviour, the Registrant did repeatedly give differing accounts of his actions to colleagues. Therefore, the Committee determined that 21.35 f) and g) were relevant considerations. In relation to 21.35 h), the Committee has no evidence from the Registrant of any insight into the seriousness of his actions or their consequences.

105. In considering the many factors in the guidance in relation to erasure identified above as being relevant to the Committee's deliberations, the Committee determined that it had no option but to conclude that the Registrant's behaviour was fundamentally incompatible with continued registration. The Registrant's lack of engagement with the hearing process has meant there is no information before the Committee upon which it could conclude that a lesser sanction would be effective in upholding the overarching objective. The lack of information from the Registrant about any aspect of his misconduct, including his current circumstances, made it difficult to properly take account of his interests when balanced with the public interest. In circumstances where a high risk of repetition remained, where the public required protection and where public confidence and proper professional standards must be maintained, the Committee concluded that erasure was the appropriate and proportionate sanction.

106. The Committee therefore directs that the Registrant's name is erased from the register of dispensing opticians.

Immediate Order

107. Having determined an order for erasure, the Committee heard an application by Ms Ahmed on behalf of the General Optical Council for an immediate order of suspension.
108. Ms Ahmed invited the Committee to re-consider its findings on the need to protect the public and the wider public interest contained in the previous determination on impairment. She referred the Committee to Paragraph 23.3 of the HISG and submitted that the Committee had the power to impose an immediate order if it was satisfied the criteria laid out at Section 13 I of the Opticians Act 1989 were met.
109. The Committee accepted the advice of the Legal Adviser who stated that this decision was a matter for the Committee's own professional judgment.
110. The Committee decided to impose an immediate order of suspension. Taking into account its prior findings it was necessary for the protection of the public and in the wider public interest.

Chair of the Committee: Ms Jayne Wheat

Signature

A handwritten signature in black ink, appearing to read "Jayne Wheat", enclosed in a thin black rectangular border.

Date: 11 July 2023

FURTHER INFORMATION
Transcript
A full transcript of the hearing will be made available for purchase in due course.
Appeal
Any appeal against an order of the Committee must be lodged with the relevant court within 28 days of the service of this notification. If no appeal is lodged, the order will take effect at the end of that period. The relevant court is shown at section 23G(4)(a)-(c) of the Opticians Act 1989 (as amended).
Professional Standards Authority
<p>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.</p> <p>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).</p> <p>Further information about the PSA can be obtained from its website at www.professionalstandards.org.uk or by telephone on 020 7389 8030.</p>
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.