

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

GENERAL OPTICAL COUNCIL

F(10)15

AND

STEPHEN JAMES BROWN (D-8305)

DETERMINATION OF THE INQUIRY: 14-17 MARCH 2011

On 14-17 March 2011, the Fitness to Practise Committee of the General Optical Council met to consider allegations against Stephen James Brown.

ALLEGATION

(The Committee's findings in relation to the particulars of the allegation are shown after each stem in bold text)

The Council alleges that in relation to you, Stephen Brown (a registered dispensing optician)

1. On 12 August 2008 at a consultation with Patient A you did not fully investigate the cause of Patient A's symptoms in that you:
 - i) Did not ask basic, routine history and symptom questions;
 - ii) Did not ask thorough questions relating to the patient's wearing of contact lenses.

Both allegations are denied in full

The Committee finds as a fact that the patient's evidence is to be preferred to that of the Registrant in respect of the reporting of her pregnancy. It found the patient to be convincing and consistent in her testimony. It finds that the reason for the appointment was the pregnancy and her main concern was the risk of pre-eclampsia, and not a routine appointment. It is unrealistic to suggest that she would not have mentioned her condition and concerns at this appointment. In the opinion of the Committee, Mr Brown clearly failed to record the fact of the pregnancy or her other concerns. It follows from this that the Committee finds that he failed to ask appropriate history and symptom questions at the appointment, and did not thoroughly investigate her wearing of contact lenses.

2. On 9 December 2008 at a consultation with Patient A you did not fully investigate the cause of Patient A's symptoms in that you:

- i) Did not obtain information about the conditions, environments or tasks that the contact lenses are used for;

This allegation is denied in full

- ii) Did not conduct a +1.00d blur test or pinhole test to check accommodation or best possible visual acuity;

This allegation is denied in relation to the blur test, and admitted in relation to the pinhole test

- iii) Did not ask how long the patient had noticed the drop in vision in her right eye, any patterns that made it worse or better or if it was getting worse;

Allegation admitted

- iv) Did not check the visual performance of the patient's spectacle prescription and compare this with her contact lenses;

Allegation admitted

- v) Did not conduct a full assessment of the patient's level of near vision despite the records indicating that her near vision had deteriorated;

Allegation admitted

- vi) Did not conduct a visual acuity or fit assessment on the patient's new lenses;

Fact admitted but failure to investigate symptoms denied

- vii) Did not conduct an adnexa check to ascertain why the patient's vision had deteriorated;

This allegation is denied in full

- viii) Did not conduct keratometry.

Fact admitted but failure to investigate symptoms denied

The Committee finds as a fact that the Registrant did not ask sufficient and thorough questions concerning the conditions, environments or tasks that the CLs were used for, because had he done so further investigations would certainly have been performed, such as possible variation of the cleaning and disinfecting regime.

The Committee finds that a Blur Test should have been conducted. The Committee accepts Mr Forrest's evidence that the calibration possibly should have been +1.50D to give maximum visual effect, however, there is still merit in using the +1.00D Blur test even in a reduced room size.

Both parties accept that the pinhole test should have been carried out, and the Committee finds this as a fact.

The Registrant admits that he did not ask how long the patient had noticed the drop in vision in her right eye, any patterns that made it worse or better or if it was getting worse; did not check the visual performance of the patient's spectacle prescription and compare this with her contact lenses, and did not conduct a full assessment of the patient's level of near vision. The Committee finds these as facts.

The Committee finds that given the report of a problem, and given the presence of the patient in the room, the Registrant should have carried out a visual acuity and fit assessment on the new lenses.

The Committee finds that the Registrant did carry out an adnexa check on this occasion.

Both expert witnesses agreed that keratometry should have been carried out, and the Committee finds that it should have been conducted at this time.

3. On 16 December 2008 at a consultation with Patient A you did not fully investigate the cause of Patient A's symptoms in that you:
- i) Did not conduct a +1.00d blur test or pinhole test to check accommodation or best possible visual acuity;

Re pinhole test - admitted

Re Blur Test - Fact admitted but failure to investigate symptoms denied

- ii) Did not conduct a full assessment of the patient's level of near vision despite the records indicating that her near vision had deteriorated;

This allegation is denied in full

- iii) Did not check the visual performance of the patient's spectacle prescription and compare this with her contact lenses;

Allegation admitted

- iv) Did not conduct an adnexa check to ascertain why the patient's vision had deteriorated.

This allegation is denied in full

The Committee finds that, given this was a young patient with no prior ocular disorders, presenting for a third appointment in a short period, this should have alerted the Registrant to potentially serious problems.

The Committee finds that a Blur test should have been carried out at this stage, subject to the observations already made. The Registrant accepts that a pinhole test should have occurred and the Committee finds this as a fact.

The Committee finds that the Registrant did not conduct a full assessment of the patient's near vision. The Committee accepts that a full investigation was not necessary, but that some inquiry was called for.

The Registrant accepts he did not check the visual performance of the patient's spectacle prescription and compare this with her contact lenses; the Committee finds this as a fact.

The Committee finds that an adnexa check was carried out.

Overall the Committee finds that the quality of this examination was sub-standard.

4. On 9 December 2008 at a consultation with Patient A you did not refer the patient to an Optometrist for further assessment, despite the patient being six months pregnant and presenting with the following symptoms/conditions:
- i) A significant drop in the patient's right eye vision;
 - ii) A deterioration to -6.00d myope in the patient's near vision.

This allegation is denied in full

The Committee finds that the Registrant should have made a referral to an Optometrist on this occasion, and that there was a failure to do so despite a significant deterioration in vision which Mr Brown could not correct, and which should have alerted him to the need to refer her.

5. On 16 December 2008 at a consultation with Patient A you did not refer the patient to an Optometrist for further assessment, despite the patient being six months pregnant and presenting with the following symptoms/conditions:
- i) No improvement in the patient's right eye vision;
 - ii) A deterioration in the patient's left eye vision;
 - iii) A deterioration in the patient's binocular vision.

This allegation is denied in full

The Committee finds that the recommendation to undergo an eye test on this occasion was seriously undermined by the failure of Mr Brown to properly explain the nature of the tests carried out already, and that what was required lay beyond his expertise or qualifications. This meant that the patient was not able to make an informed choice. On this basis the Committee finds that an offer was made but not a referral. The Registrant failed to even mention the matter to an Optometrist, when further investigation by an optometrist was clearly called for.

6. During your management of Patient A you did not maintain adequate records on the following dates:
- i) On 11 October 2005 you:
 - a) Did not record the patient's name; **[Stem denied]**
 - b) Did not record visual acuity; **[Admitted]**
 - c) Did not record specific symptoms; **[Denied in full]**
 - d) Did not record a full patient history; **[Denied in full]**
 - e) Did not record the age of the contact lenses; **[Stem denied]**
 - f) Did not record how long the patient had been wearing the contact lenses on 11 October 2005; **[Stem denied]**
 - g) Did not record a tear assessment. **[Denied in full]**

The Committee finds that there was a failure to record the patient's name, or a full patient history. The Registrant admits a failure to record visual acuity, and the Committee finds this as a fact.

The Committee finds as a fact that he should have recorded the age of the lenses, the period for which they had been worn on the day, and a tear assessment.

The Committee finds that he did record specific symptoms.

- ii) On 25 November 2005 you:
 - a) Did not record the patient's name; **[Stem denied]**
 - b) Did not record the age of the contact lenses; **[Stem denied]**
 - c) Did not record any information about which contact lens solution the patient was using; **[Stem denied]**

- d) Recorded insufficient detail in relation to the contact lens fit; **[Denied in full]**
- e) Did not record if the palpebral or bulbar conjunctiva was checked; **[Admitted]**
- f) Did not record if the limbus was checked; **[Admitted]**
- g) Did not record a tear assessment; **[Stem denied]**
- h) Did not record if lid margins or vessels were checked. **[Admitted]**

The Committee finds that there was a failure to record the patient's name and the age of the contact lenses, which should have been done. The Committee finds that he should have recorded which contact lens solution the patient was using to verify compliance.

The Committee finds that insufficient detail in relation to the contact lens fit was recorded.

The Committee finds a stain test was performed. The record of that was sufficient and a tear assessment would have been of minimal use.

The Registrant admits a failure to record whether the palpebral or bulbar conjunctiva was checked; whether the limbus was checked, and whether lid margins or vessels were checked and the Committee finds these as facts.

- iii) On 17 October 2006 you:
 - a) Did not make a full record of the patient's history and symptoms; **[Denied in full]**
 - b) Recorded insufficient information in relation to the entry, "v. light old sterile scar". **[Denied in full]**

The Committee finds that there was a failure to record the patient's history and symptoms when this should have been done. The Committee finds that having made an observation of the "scar" there is an insufficient recording of the management of it.

- iv) On 12 August 2008 you:
 - a) Did not record anything in relation to an arcus which was noted on the previous entry for 21 September 2007; **[Stem denied]**
 - b) Did not record a tear assessment. **[Stem denied]**

The Committee finds that the previous record of an arcus should have given rise to a further enquiry, which should in turn have been recorded. The Committee finds that he should have conducted a tear assessment and recorded it.

- v) On 9 December 2008 you:
 - a) Did not record the patient's forename or date of birth; **[Stem denied]**
 - b) Recorded a name and mobile telephone number on this page which do not relate to this patient; **[Denied in full]**
 - c) Did not record the age of the contact lenses; **[Stem denied]**
 - d) Did not make a full record of the patient's history and symptoms; **[Denied in full]**
 - e) Did not record the level of visual performance of the patient's spectacle prescription. **[Admitted]**

The Committee finds that he should have recorded the patient's forename and date of birth, and the age of the contact lenses.

The Committee finds that he failed to make a full record of the patient's history and symptoms, and that this should have been done.

The Registrant admits he did not record the level of visual performance of the patient's spectacle prescription and the Committee finds this proven.

The Committee finds there is no evidence that he recorded the name and telephone number of a third party, or when it was added to the record; this allegation is not proven. However it troubles the Committee that it remained on the notes.

- vi) On 16 December 2008 you:
- a) Did not record the patient's forename or date of birth; **[Stem denied]**
 - b) Did not record the age of the contact lenses; **[Stem denied]**
 - c) Did not make a full record of the patient's history and symptoms; **[Denied in full]**

The Committee finds that he should have recorded the patient's forename and date of birth, and the age of the contact lenses.

The Committee finds that he failed to make a full record of the patient's history and symptoms, and that this should have been done.

By virtue of the matters set out above your fitness to practise is impaired by reason of your deficient professional performance and/or misconduct.

DETERMINATION

Findings in relation to deficient professional performance and/or misconduct

Evidence of Deficient Professional Performance:

There was a pattern of failures to carry out sufficient or appropriate tests on the patient, amounting to DPP, as evidenced by the facts found in relation to:

- Allegation 1 (Failure to ask questions re history/symptoms/ CL wear on 12 August 2008).
- Allegation 2 (Failure to ask sufficient questions/conduct tests etc on 9 December 2008).
- Allegation 3 (Failure to conduct sufficient tests/checks etc on 16 December 2008)

Evidence of Misconduct:

There was a failure to refer the patient to an Optometrist, which amounted to Misconduct, as evidenced by the facts found in relation to both:

- Allegation 4 (Failure to refer the patient to an Optometrist on 9th December 2008) and
- Allegation 5 (Failure to refer the patient to an Optometrist on 16th December 2008)

Evidence of Deficient Professional Performance:

There was a pattern of failures to keep proper records, amounting to DPP, as evidenced by the facts found in relation to:

- Allegation 6 (i) Failure to keep records on 11 October 2005
- Allegation 6 (ii) Failure to keep records on 25 November 2005
- Allegation 6 (iii) Failure to keep records on 17 October 2006
- Allegation 6 (iv) Failure to keep records on 12 August 2008
- Allegation 6 (v) Failure to keep records on 9 December 2008
- Allegation 6 (vi) Failure to keep records on 16 December 2008

In coming to the above decision in relation to record keeping the Committee noted the evidence of Mr Forrest at p120 of the bundle to the effect that:

“...the standard of Mr Brown’s record keeping is no different in quality from that of his peers who are or have worked in that particular practice, as can be seen from the record bundle. While these records may be towards the lower end of average, my experience of high street practice is that there are many practices in the UK which are of a similar standard”

The Committee does not accept that this is the general standard of record keeping amongst the wider community of opticians in the UK and we reject the contention that it is the standard against which registered opticians are judged.

Findings regarding impairment

The Committee has considered the submissions and evidence presented in relation to the question of impairment.

- The Committee bears in mind the 30 year unblemished record of the Registrant and takes into account the stress of the disciplinary process which inevitably falls upon an accused Registrant.
- The Committee accepts that his integrity has not been called into question in the course of these proceedings.
- The Committee accepts that he has expressed genuine remorse and a sincere apology to the patient, and the Committee accepts that he has been chastised by these proceedings.
- The Committee is satisfied that he has reflected upon the shortcomings in his former practices and has taken some steps to rectify the situation, including the use of a template for recording clinical findings.
- The Committee was reassured by the written references from Optometrists which evidence a greater awareness on the part of the Registrant of the need to refer cases to them.
- The Committee notes with approval that he has negotiated additional time for his appointments.

Conclusion: The Committee concludes that Mr Brown’s fitness to practise as a dispensing optician is not currently impaired. The Committee is minded to issue a warning to Mr Brown which will be placed upon the GOC website, and will remain there for five years.

Warning: The Committee warns Mr Brown that he must be aware of his own limitations; that his record keeping should not fall below ABDO standards, and that he should bear in mind that his primary duty of care is to the patient. The Committee strongly recommends that he undertakes more practical aspects within the CET programme.

Chairman of the Committee: Francesca Jones

Signed _____ Date 17 March 2011

Registrant: Stephen James Brown

Signed _____ Date 17 March 2011

FURTHER INFORMATION
<p>Transcript</p> <p>A full transcript of the hearing will be made available via the GOC website in due course.</p>
<p>Appeal</p> <p>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).</p>
<p>Council for Healthcare Regulatory Excellence</p> <p>This decision will be reported to the Council for Healthcare Regulatory Excellence (CHRE) under the provisions of section 29 of the NHS Reform and Healthcare Professions Act 2002. CHRE 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 unduly lenient and/or should not have been made, and if they consider that referral is desirable for the protection of the public. CHRE is required to make its decision within 40 days of the hearing (or 40 days from the last day on which a registrant can appeal against the decision, if applicable) and will send written confirmation of a decision to refer to registrants on the first working day following a hearing. CHRE will notify you promptly of a decision to refer. A letter will be sent by recorded delivery to your registered address (unless CHRE has been notified by the GOC of a change of address).</p> <p>Further information about the CHRE can be obtained from its website at www.chre.org.uk or by telephone on 020 7389 8030.</p>
<p>Effect of orders for suspension or erasure</p> <p>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.</p>
<p>Contact</p> <p>If you require any further information, please contact the Council's Hearings Manager at 41 Harley Street, London, W1G 8DJ or, by telephone, on 020 7580 3898.</p>