

**F(10)19**

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

**GENERAL OPTICAL COUNCIL  
AND  
JONATHAN SIMON POINTER (01-9650)**

**SUBSTANTIVE HEARING: Thursday, 16 June 2011**

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Committee Members: Ms Corinna Kershaw (Lay, Chair)  
Mr Arif Khan (Lay)  
Mr Rod Varley (Lay)  
Ms Alison Hudson (Optometrist)  
Miss Janice McCrudden (Optometrist)

Legal Adviser: Mr Mark Lucraft QC

For the GOC: Ms Katrina Wingfield

For the Registrant: Mr Ian Stern QC

Hearings Manager: Mr David Henley BEM

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*[Hearing commenced at 09.37]*

**Ms Kershaw:** Good morning. I am Corinna Kershaw, a lay member of the hearings panel, and I have been elected to chair today's hearing. The Committee today is made up of two optometrists and three lay members. I will ask the members of the Committee to introduce themselves and the capacity in which they sit. *[Introductions]*

To my right is Mr Mark Lucraft QC, the Committee's Legal Adviser, who will provide legal advice and assistance to the Committee and ensure that the proceedings are conducted in accordance with the Rules of Procedure, so as to arrive at a result which is fair and just. The Legal Adviser may accompany the Committee should it sit in private to deliberate. In the event that any matter arises during the course of the Committee's deliberations, upon which the Committee seeks advice, the parties will be invited to return to hear the matter which the Committee has raised and the advice to the Committee. Where advice on any issue is not accepted by the Committee, this will be indicated in the course of its decision on that issue.

To your right is David Henley, the Hearings Manager, who will provide administrative support to the Committee. Next to Mr Henley is the transcriber, Mr Charles Nisbet, who will be keeping an official record of all that is said today during the sessions of the hearing at which the parties are present. The remaining persons sitting in the hearing room, rather than in the public and press areas, are members of the respective legal teams. All parties are reminded that where details of the patient are to be discussed that the patient

has been allocated the letter 'A' in the allegation, and should only be referred to by that letter. Where the patient's name is mentioned in the course of the hearing, the transcriber will delete the name from the transcript and replace with the words "Patient A" or "the patient". It is the Council's policy for the determination of the Committee and a transcript of the proceedings to be displayed on the Council's website for public viewing, but where matters of health have been discussed the determination and the transcript will be redacted accordingly. Are there any applications? [No]

At this point I will ask the Hearings Manager to read out the allegation, and I gather that, Mr Stern, you would be happy to make any admissions should there be any, as we go through, so I will ask Mr Henley to hesitate between each one, so that you can say what you want to say.

**Mr Henley:**

### **ALLEGATION**

"The Council alleges that in relation to you, Jonathan Simon Pointer (a registered optometrist):

1. Patient A attended an examination with you on 12 October 2009."

**Mr Stern:** Yes, that is agreed and admitted.

**Mr Henley:**

"2. When assessing Patient A's vision, you failed to use a test suitable for the age of patient being assessed in that you undertook a Sheridan Gardiner single letter test."

**Mr Stern:** That is not admitted.

**Mr Henley:**

"3. You incorrectly concluded that a visual acuity of 3/9 (which you recorded as "approximately equivalent to 6/18") was an acceptable visual acuity for this patient."

**Mr Stern:** That is also not admitted.

**Mr Henley:**

"4. You did not undertake retinoscopy with a cycloplegic agent in circumstances where your examination indicated:

a. visual acuity of 3/9;"

**Mr Stern:** None of them are admitted.

**Mr Henley:**

- b. stereo acuity was 200 seconds of arc;
- c. there was limited co-operation from the patient;
- d. the reason for the visit was that Patient A, for around 12 weeks, had been squinting and closing her eyes when watching television and reading.

5. You advised the mother of Patient A that:

- a. Patient A was squinting out of habit and there was no problem with her eyes, or words to that effect;”

**Mr Stern:** Admitted.

**Mr Henley:**

“and

- b. Patient A attend for a return appointment in 12 months in circumstances where you had not undertaken a complete examination.”

**Mr Stern:** Admitted.

**Mr Henley:**

“6. On 20 October 2009 you repeated your advice to the mother of Patient A that Patient A should attend for a return appointment in 12 months.”

**Mr Stern:** Admitted.

**Mr Henley:**

“7. You did not

- a. request that Patient A return for a further appointment in the near future to allow you to complete your examination of Patient A;”

**Mr Stern:** Admitted.

**Mr Henley:**

“or

- b. refer patient A for specialist examination by an optometrist competent in examining paediatric patients or the Hospital Eye Service.”

**Mr Stern:** With the deletion of the words “by an optometrist competent in examining paediatric patients or” and with the insertion of the word “to” before

“the Hospital Eye Service”, that is admitted, so it will read “refer patient A for specialist examination to the Hospital Eye Service.”

**Ms Wingfield:** Madam, I am content with the amendment to that on the basis of the admission, save to say I think you don’t need to change the “by” to a “to”.

**Mrs Kershaw:** Thank you. Do you have any comments to make on the amendment?

**Mr Lucraft:** In terms of “by” or “to” I don’t think it makes very much difference, but if the rest of it is agreed between the parties, then I think the sensible thing is to note the amendment to 7(b) in the way in which Mr Stern has invited you to, and to put a line through the words “by an optometrist competent in examining paediatric patients” and to mark it as omitted.

**Ms Wingfield:** Do any of the panel have any concerns? [*No*]

**Mr Henley:**

“And by virtue of the matters set out above your fitness to practise is impaired by reason of your misconduct.”

**Mr Stern:** That is not admitted.

**Ms Kershaw:** Thank you. We have noted the admissions, so under our Rules, a decision as to whether something is found proved comes later. We now move on to ask the presenting officer to make the opening statement.

**Ms Wingfield:** Madam, if I could indicate, I have prepared some opening submissions and I have copies available for circulation [*C2 is distributed*] and what I propose to do, Madam, is to read those out, and I then propose to call my expert witness. I will also have available, I understand, the patient’s mother should there be any questions from the Committee on the basis of the admissions and on the basis of the package. You have read the bundle, including her statement. I was not intending to call her to give evidence, and I understand from Mr Stern that he has no questions for her, but it may be that there will be questions from you.

**Mr Stern:** Madam, all I was going to say was this, that we informed the Optical Council last week that we would not require the witness to give evidence, and her statement could be read. We have a statement, so that in fact has been done, so if you do not have questions for her then obviously when she attends she can be informed rather than having to wait around. That is my only point that I might invite you to think about.

**Mr Henley:** Can I just say that the Council’s bundle can be called C1 and the submissions, C2?

**Ms Kershaw:** Thank you. On the subject of the bundle, can I just say that page 96 contains a clinical practice survey dated 1998 by a person called Ronnie Stevenson, who was one of our fellow panellists. In 1998 none of us were panellists here. We weren't appointed until 2005, so it pre-dates our involvement in the GOC as panellists, but also he is no longer in that post, but provisions over. For clarity we wished you to know about that.

**Ms Wingfield:** Madam, if I could then please read out the opening submissions. Madam, in relation to the facts; [*Reads from C2*]

“On 12 October 2009, Ms KG brought her daughter AG to the Respondent's practice in Higham Ferrers in Northamptonshire. AG was at that time approximately six weeks short of her third birthday (her date of birth was 23 November 2006). The Respondent, a registered optometrist, took a history from KG, who explained she was concerned as her daughter had been squinting while watching television and reading over the past twelve weeks. KG also explained that she was concerned as she herself had worn glasses as a child and her own mother (ie the patient's maternal grandmother) had told her that KG had demonstrated similar behaviour as a child. KG further reported that her mother had glaucoma.

The Registrant undertook a number of tests as part of what purported to be an eye examination of AG. The Council alleges that this was not a full or sufficient eye examination and the alleged deficiencies in the test are set out in the Notice of Hearing and dealt with more fully below. AG became rather fidgety during the course of the examination, and at one point closed her eyes tightly and refused to open them again, and so the Registrant stopped the examination.

When he stopped the examination, the Registrant told KG that AG was squinting out of habit and that there was no problem with her eyes. He told her that she should bring AG back in 12 months' time, that it was very young to be undertaking an eye test and that it was normal for a child that age to be fidgety.

AG continued to squint while watching television and reading and her parents decided to take her for a second opinion. KG visited the Registrant's surgery to obtain a copy of the eye test report. The Registrant continued to maintain that AG did not need to be re-checked for another year and that she was squinting out of habit. He nonetheless gave KG a copy of the report and she took it, with AG, to Specsavers in Wellingborough. The optometrist at Specsavers concluded that AG was long-sighted but was not able to examine the back of her eye; and so suggested she be referred to hospital.

KG duly took AG to a hospital appointment at the Woodland Hospital in Kettering where she was diagnosed as needing a prescription of +6 in both eyes. AG was given glasses with a prescription of +4 lenses (to begin with).”

So I then move on to the issues between the parties:

“The Council has obtained the expert opinion of an optometrist in private practice, Mr Andrew Keirl. The Registrant has instructed his own expert, Professor Bruce Evans. Both experts have met and discussed the allegations and provided a joint report for the Committee (pp76-77). The joint report sets out the points about which there is agreement and dispute between the experts.

One of the main factual issues to be determined is whether the examination was, as far as KG and the Registrant were concerned, finished; or whether there was any expectation that KG would bring AG back to the practice to complete the examination in the near future.”

That is, of course, now admitted as part of the admissions in relation to the allegations.

“The Council will allege that KG and the Registrant both believed the examination to be over, and that the next appointment for AG would be in a year’s time. The Council relies on the following evidence in support of this proposition:

- KG’s evidence is that the Registrant advised her that AG’s eyesight was normal and that she should come back in a year’s time;
- the Registrant’s clinical record card for AG states “*Appears OK but poor test: Mother to monitor and suggest R/C – 1 year*”. There is nothing about returning in the near future to complete the test (p32/33)
- the GOS2 form completed by the registrant (p69) indicates that no prescription was required and “*advise review in 1 year*”. There is no mention of a follow-up appointment sooner to finish the examination;
- KG’s evidence is that when she went to the practice to collect the GOS2, the Registrant again said that there was no need for another appointment until twelve months had passed.
- The Registrant submitted the GOS1 form to Northamptonshire PCT to make a claim for payment for

the test on AG – something which should not have been done if the test had genuinely not been completed (p14).”

### The allegations regarding the Registrant’s test

This is allegation 2 of the allegations:

*“2. when assessing patient A’s vision you failed to use a test suitable for the age of the patient being assessed in that you undertook a Sheridan Gardiner single letter test”.*

The Registrant undertook a Sheridan Gardiner single letter test in order to assess AG’s vision. This is a test whereby the optometrist holds up a card with a single letter on it and asks the patient to point to the same letter on a card which she has in front of her. The Council alleges that, for a child of this age, the Registrant should have used a test with a number of symbols shown on a card (“crowded optotypes”) to assess AG’s vision; and that the Sheridan Gardiner test alone was insufficient.

Mr Keirl has concluded in his report that in his view the College of Optometrists’ Code of Ethics and Guidelines to Professional Conduct (p72) should have been followed. This provides in relation to paediatric examinations:

*“When examining a younger child, the optometrist has a duty to use a range of test suitable for the age of the patient being assessed and in all cases to obtain as much information about vision and/or visual acuity, oculomotor balance, refractive error and the health of the eyes.”*

The College of Optometrists’ Code gives further guidance in relation to the choice of optotype when examining a young child:

*“Single letter (angular) acuities are frequently an overestimate due to the crowding phenomenon that exists in some amblyopias. Wherever possible, acuities should be measured using a line of letters (morphoscopic acuity) or some other method that induces “crowding”.*

Dr Keirl is of the view that the Registrant should have used a crowded optotype rather than simple single letter test (p19 to 20). He agrees with Professor Evans that if the test had *started* with a Sheridan Gardiner and then developed to use the more crowded test this would have been acceptable (supplementary report p76); but that if, as the Council allege, the Registrant had in effect completed his examination, it was not sufficient.”

And as you have heard, the Registrant now accepts he had in fact completed his examination.

The third allegation is:

*“3. When assessing Patient A, ...you concluded that a visual acuity of 3/9 (which you recorded as “approximately equivalent to 6/18”) was an acceptable visual acuity for this patient when it was not so acceptable;*

Dr Keirl takes the view that 3/9 was not an acceptable visual acuity for a three year old. He would expect a normal child at 2 years to achieve an acuity of 6/12 to 6/9 and at 3 years 6/9 to 6/6 using logMAR single letters (pp20;25;77). In the joint expert report, Professor Evans states that he believes 3/9 to be below average but not necessarily unacceptable *“if other test results are normal”*. Mr Keirl takes the view that, in the absence of a reliable retinoscopy result, 3/9 should be considered abnormal until the contrary is proved (p77).”

Then the fourth allegation is:

*“4. you failed to undertake retinoscopy with a cycloplegic agent in circumstances when you should have done as:*

- (i) your examination indicated visual acuity of 3/9;*
- (ii) your examination indicated stereo acuity was 200 seconds or arc;*
- (iii) there was limited co-operation from the patient;*
- (iv) the reason for the visit was that Patient A, for approximately the previous 12 weeks, had been squinting and closing her eyes when watching television and reading.*

Mr Keirl is of the view that, given the particular circumstances of this examination, namely that visual acuity had been recorded as 3/9, stereo acuity at 200 seconds of arc; and further given the limited cooperation from the patient and the history by the patient’s mother, it would have been important for the examiner to undertake retinoscopy with a cycloplegic agent (21, 25, 26, 28, 76). Professor Evans takes the view that it would be *“very likely but not definite that Patient A would need cycloplegic refraction at an appointment to finish the sight test”*. The Council would say that this pre-supposes that it was within the anticipation of the parties that there would be an appointment to finish the test – ”

And as I have said, as is now admitted “– the Council alleges that there was not.

5. you failed to undertake the following in circumstances when you should have done so, namely either:

- (i) request that Patient A return for a further appointment in the near future to allow you to complete your examination of Patient A; or
- (ii) refer Patient A for specialist examination by the Hospital Eye Service

The Council relies on the factors set out above in support of the contention that the Registrant did not suggest that AG return in the near future. The Registrant accepts that he did not refer AG to another optometrist or hospital eye service. Mr Keirl expresses the view that he should have either asked her to return for further tests or referred her on (pp22, 23, 28, 77).

The Registrant acknowledged (p15) that it would have been better to have booked a firm appointment for a re-check rather than leaving it for the mother to re-arrange this at a later date; and a further error to allow the GOS2 to be handed out when the sight test was incomplete (p15); and for the GOS1 to be sent to the PCT (p14).

It is the Council's case that these were not errors; that in fact the Registrant gave the GOS2 form to KG and submitted the GOS1 to the PCT because, as he had indicated in the notes, he was not expecting to do anything further with the patient until a year had passed.

The Council alleges that in all the circumstances, given the deficiencies identified in the Registrant's test of a two year old child, his conduct fell below the standard to be expected of a registered optometrist."

That is my opening in relation to these matters. You have, however, indicated that you have had the opportunity of reading the bundle, and in particular, of seeing the reports of the two experts and the joint report and the patient's mother's statement. What I propose to do now is to call evidence from Andrew Keirl.

**Mr Stern:** Just before that is done, may I raise a particular matter in relation to Head 2; Head 2 alleges that, as you can see:

*"2. when assessing patient A's vision you failed to use a test suitable for the age of the patient being assessed in that you undertook a Sheridan Gardiner single letter test".*

In my submission that allegation is crystal clear. What is certain is that the Sheridan Gardiner test is not a test suitable for the age of the patient. That is now not the case for the Council as is set out in this opening. What is alleged

if you look at page 2, paragraph 9 of what is described as opening submissions, is this:

“The Registrant undertook a Sheridan Gardiner single letter test in order to assess AG’s vision. This is a test whereby the optometrist holds up a card with a single letter on it and asks the patient to point to the same letter on a card which she has in front of her. The Council alleges that, for a child of this age, the Registrant should have used a test with a number of symbols shown on a card (“crowded optotypes”) to assess AG’s vision; and that the Sheridan Gardiner test alone was insufficient.”

That is not the allegation. The word ‘alone’ does not feature anywhere in the allegation, so what we have at the moment is an alteration of the case by the Council. That is to say they are not saying that the Sheridan Gardiner test is not a suitable test, but what they are saying is that the Sheridan Gardiner test should have been accompanied by a second test. That is not the allegation. It is quite wrong at this stage – I pointed this out to my learned friend this morning, and there was then a discussion as to whether or not there was going to be an application to amend. That has not been forthcoming, and the position now is that what the Council are seeking to do is to fit a new version within an old wording, and so in my submission they should not be allowed to do that, and it is absolutely critical that we get this hearing off the ground on the correct footing so that everybody knows where they are. A registrant comes before you entitled to know what the allegation is, having had the allegation over a considerable period of time, and it is not within the purview, in my submission, of the Council to turn up at the hearing and to create an entirely different allegation without applying to amend, which clearly they recognise is far too late at this stage in the case, so in my submission, we need to be crystal clear about this before we start.

**Ms Wingfield:** Madam, I was not aware that I had suggested that I was going to amend the allegation. That was not the discussion that as far as I was concerned was being had. It was whether or not I amended my opening submissions.

Madam, the allegation is quite clear as I said, and the case has been quite clearly put by the Council on the basis that this was a completed test, namely that the only test that had been undertaken as far as the patient was concerned was the Sheridan Gardner test, and that is the basis on which I put this case; that there was challenge, as you will have seen from reading the papers, as to whether or not this test had been completed or whether or not it was expected that the mother was going to bring the child back shortly. That matter was not made clear until the beginning of this week when the admissions were made by the respondent. Madam, it is in the context of that particular framework that this allegation is made; namely, that there was only one test undertaken, and that was unsuitable for the child, and it was a completed test. Madam, the evidence has been with the Registrant, in the

same way the allegations have been with the Registrant, for many months, and the evidence quite clearly supports the allegation being made and which is brought by the Council.

**Mr Stern:** I don't, with respect, accept that. The evidence is pretty unclear. If you look at the first report you will have seen it was so unclear that the Optical Council then had to have a telephone conference with the expert because at that stage he wasn't saying that there was anything that actually was below the standard of a reasonable optometrist. We then had a telephone conversation with him, of which you have the note at page 25. Having had that discussion with him, the supplementary report then at page 27 comes about, and that deals with cycloplegic agent, and it is still not very clear even at the end of that supplementary call at the end of the first part at page 10:

“fell below the standard of a reasonably competent optometrist using up to date techniques and methodology.”

So it has never been entirely clear what the position was.

**Ms Kershaw:** Forgive me, it is not on page 10 of our bundle.

**Mr Stern:** Page 27. I have two page numbers on mine. I beg your pardon. It is page 27. Over the page, having had this conversation, Mr Keirl has put what he says was undertaken and what was not undertaken. That is all. So the position is this; it really doesn't matter if the test is complete or not complete. That is an irrelevant consideration. The consideration is this; on the wording that you have before you in Head 2 that is the allegation and the Registrant is entitled to know absolutely what allegation it is that he has to meet, and the allegation is clear; that he failed to use a test suitable for the age of a patient. That is the allegation, and the Sheridan Gardiner test, as I understand it, is now accepted to not be a test that is not suitable for that age, but what they are saying is another test should have been done. That is it simply. I can't keep repeating the same thing, but I think you have the point, at least, I hope.

**Ms Kershaw:** I think we do. I turn to our Legal Adviser.

**Mr Lucraft:** There has been no application to amend the allegations, and my advice to you is that you should stick to the wording that is set out in the allegation. The question you will have to determine on the facts is whether that allegation is made out. To that extent, it is clear in what Mr Stern has put on behalf of the Registrant, he is entitled to know exactly the allegation that he has to face and the facts that he has to deal with. It seems to me on the reading of allegation 2, the wording is very clear as to what it is that is alleged to have taken place, and I would suggest that – I have to say, there has been no application to amend it – the Committee, in considering allegation 2, looks very closely at the facts as they are placed before it in support of that allegation.

**Ms Kershaw:** Thank you. We are an experienced panel.

**Mr Stern:** I know you are, but you will appreciate that the Registrant is not experienced in these matters, and needs to understand what it is that is happening because, clearly, you look at the wording of the allegations – and he has had to live with this for some considerable time; we are now talking about 2009, and we attend in 2011 – and having looked at and considered on a number of occasions the allegations, he finds that the assertion is now moving, and that is not fair. He needs to understand what it is that is happening.

**Ms Kershaw:** Thank you.

**Ms Wingfield:** Thank you, Madam. If I could call Mr Keirl.

**ANDREW KEIRL, called and sworn  
Examined-in-Chief by MS WINGFIELD**

**Q.** Good morning, Mr Keirl.

**A.** Good morning.

**Q.** If I could ask you to direct your answers towards the Committee although in this shaped room, it is actually not that difficult. Could I ask you, please, to confirm your full name is Andrew William Keirl?

**A.** It is.

**Q.** And could you please confirm your current practice address?

**A.** The Parade, Liskeard, Cornwall.

**Q.** You should have a copy of the bundle in front of you there; if I could ask you, please, to turn to page 16, and if you could confirm, please, that pages 16 to 24, does that comprise your first report in relation to these matters today?

**A.** Yes, it does.

**Q.** And is that your signature on page 24?

**A.** It is.

**Q.** Above the date of 20 July 2010?

**A.** It is.

**Q.** Thank you. If I could ask you then to look at pages 25 and 26; you may not have seen this note before, but if you could just have a quick look at that, and I will ask you then to confirm whether you recall this particular telephone conversation. [*Pause to read note*]

**A.** This is the first time I have seen this document, but I can confirm the telephone conversation took place between myself and the Council based on the content of the document.

**Q.** Thank you, and if you could then turn to the next pages, pages 27 to 28; is that a supplementary report that you prepared for the Council?

**A.** Yes, it is, following the telephone conversation.

**Q.** Then if we turn to pages 76 to 77 in the bundle; is that a joint report following a telephone conference that you had with the respondent's expert, Professor Bruce Evans?

**A.** It is.

**Q.** I just wanted to ask you then a few specific questions. You will have heard this morning that Dr Pointer now admits in effect that the examination had been completed on 12 October 2009, and on that basis, there are a number of issues that arise in relation to what I would describe as the test itself. Could I ask you, please, looking at the joint supplementary report, and if I could take you through then the allegations specifically, the first question of the joint supplementary report was "Was Dr Pointer's sight test completed on 12<sup>th</sup> October 2009?" You have said in the joint report that both you and Professor Evans agreed that it was not completed?

**A.** That's right. That is correct.

**Q.** And that the best way of ensuring that Mrs KG returned would have been to actually arrange a continuation appointment?

**A.** That is correct.

**Q.** You have heard this morning, as I have indicated, that in fact it is accepted now that so far as Dr Pointer was concerned, he had completed his examination on that day. Bearing that in mind, what do you say about the issue of the Sheridan Gardiner single letter test?

**A.** The Sheridan Gardiner test has been used for some considerable time. Both Professor Evans and I agreed in our conference, and as outlined in the joint report, it is a reasonable starting point. There is evidence in literature that the results obtained with the single letter Sheridan Gardiner test may be different to those obtained using a crowded letter test. A crowded letter test could be a target with a series of letters, typically five letters in a row as opposed to a single letter, or, a single letter with what I refer to as contour interaction lines, top, bottom, left and right to induce the crowding phenomenon, and the single tests are available in the form of letters or pictures, so you have symbols or pictures with lines top, bottom, left and right to induce the crowding effect.

As I say, the evidence suggests that an examination conducted using a crowded target, be it pictures or letters, may produce a different visual acuity result compared to a test using an uncrowded target. Professor Evans and I agreed the use of an uncrowded target would be a good place to start, but in this particular case, it would have been useful and the test would have, indeed, provided more information if a crowded test had been used to follow that up. I understand that Dr Pointer does have a crowded test available in

his practice, but there was no indication on the clinical record card or Dr Pointer's statement that that test was used or there was any intention of using it at a later date.

- Q.** So far as the suitability of a Sheridan Gardiner single letter test is concerned, if used on its own, is it a test suitable for a child aged under three?
- A.** I think it depends on circumstances. If the child had produced a reasonable level of acuity using the Sheridan Gardiner single letter uncrowded test, for example, 6/6, then an argument could be made that that was acceptable. In this particular case, the acuity was approximately 6/18 with an uncrowded test. The chances are that if a crowded test had been used, that level of acuity would have been less than 6/18, so I am sorry I am not giving a direct answer to the question, but I think in this case, if I had been examining Patient A and I had come up with 6/18 on an uncrowded test, I would have wanted the rest of the picture. I don't think the picture was complete at that point. As the College of Optometrists' guidelines state we should be using tests to give as much information as possible. I don't think, in this case, the Sheridan Gardiner test gave the whole story.
- Q.** You have talked about the visual acuity as being the equivalent of 6/18; do you believe that that was acceptable in these particular circumstances?
- A.** I wouldn't be comfortable with an acuity of 6/18 with a child of this age. I have spoken to colleagues both in hospital eye service and in primary care optometry to get a feel of what a reasonable competent optometrist might expect, and the general opinion is that 6/18 would be a cause for concern, particularly using an uncrowded chart. I know there is some evidence in literature that 6/18 may be acceptable, and in our joint report, Professor Evans also alludes to that fact, but he also alludes to the fact that he would expect an acuity better than 6/18 for a child of this age. As I said, there is much evidence and many facts in the literature to give optometrists guidelines to levels of expected acuity. One of the more recent ones was produced by DOCET, produced by optometrists for optometrists in 2006, and that gives some useful guidance in terms of visual acuity levels. I have quoted those in my reports and they are better than the 6/18 produced in this case.
- Q.** I am going to take you through the specifics of the allegation at number 4 of the allegations, and I don't think you have a copy of the allegations in front of you, so I will ask you these in separate bits if I may? [*Mr Keirl is handed a copy*] If you could have a look at the allegation at number 4, and in relation to the retinoscopy with a cycloplegic agent, it is alleged that Dr Pointer didn't undertake that in particular circumstances, and a, b, c, and d are set out there. Could I ask you to comment on those specific issues please?
- A.** There are a number of reasons stated in the literature why and when a cycloplegic refraction should be carried out. Certainly one of them is an unexpected or unaccepted level of visual acuity. A visual acuity of 3/9 or 6/18, in my opinion, would be an indication of carrying out a cycloplegic refraction. Stereoacuity of 20 seconds of arc with the test used, that is an acceptable level of acuity, and the Lang II test which Dr Pointer used is a common test in

practice. There are other stereoacuity tests available that assess stereoacuity in different ways, and you can't really transfer results from one test to another, so using the tests or talking about the tests that Dr Pointer used, 200 seconds of arc is fine.

There was limited cooperation from the patient. Again, that is listed in the literature as a reason for undertaking a cycloplegic refraction, along with concerns from the patient or unusual presenting symptoms. Of course we have both of those in this case; concerns from the parent, symptoms of squinting – I think it is important to clarify what we mean by the word 'squinting' in this case, squinting is a reduction in the size of palpebral aperture; the distance between the upper lid and the lower lid as opposed to a turn in the eye. The word 'squint' can be used in different ways here. So there are presenting symptoms. There are presenting concerns from the parent. That, in my opinion, is a reason to conduct a cycloplegic refraction. We wouldn't have had the complete picture otherwise.

**Q.** In terms of someone who works in a community practice, what would your expectation be of the frequency that you would be faced with for a child of this age for examination?

**A.** I think it depends on the location of the practice. In a community practice such as, I guess, Higham Ferrers and my own practice, we see children every day, and it is not uncommon to test pre-school children. In fact, it is often encouraged, particularly if an area doesn't have a screen programme set up by the local hospital or PCT to encourage parents to bring children into a practice before school to have their first eye examination. So examination of a three year old is a relatively common event in a community practice.

**Q.** And, again, a simple question; as far as the final outcome was concerned for this child, is the prescription required significant?

**A.** Can you clarify which prescription you mean?

**Q.** Well the hospital prescription was eventually that she needed +6 in each eye. Is that significant?

**A.** Yes.

**Q.** And I think that the initial prescription that was provided was actually +4; a reason being?

**A.** It is quite shock to the patient and the patient's visual system to give the full prescription straight away, and again, in the literature there are various figures quoted for reducing the retinoscopy, the cycloplegic prescription, in other words the full prescription, by a certain amount for the initial pair of spectacles. The hospital eye service reduced it by two dioptres, I believe, from 6 to 4, which as a starting point, I think would have been reasonable. At that particular point in time, a strabismus had been ruled out. If there was a strabismus present, a different approach might have been taken, and the full

prescription may well have been given, but I think in this case, knowing a strabismus had been ruled out, that reduction is acceptable.

- Q.** I think the only additional question that I want to ask you is in relation to your report and your supplementary report and your subsequent joint report, as far as the basis upon which you were dealing with this matter was concerned, is it right that that was on the basis that it was not accepted by Dr Pointer that he had completed his examination on 12 October?
- A.** Sorry, can you just rephrase the question so that I am completely clear?
- Q.** Yes. When you produced your first report and your supplementary report, and then again at the time that you had your discussions with Professor Evans, is it right that you were working on the assumption that Dr Pointer had said that he had not completed his examination?
- A.** There were aspects of the documentation provided that lead you to believe that Dr Pointer had not completed, or thought he had not completed, or confirmed that he had not completed the examination, but by issuing the prescription, the GOS2 and submitting the GOS1 to the PCT, that gives the impression that the examination had been completed. In the absence of several factors, for example, an accurate retinoscopy result and a cycloplegia, the examination obviously hadn't been completed, but the submission of the GOS forms to the PCT leads you to believe that the examination had been completed.
- Q.** Thank you. I have no further questions. There may be questions from Mr Stern.

#### **Cross-examined by MR STERN**

- Q.** Mr Keirl, in your report at page 16, you can see that the first paragraph relates to Curriculum Vitae, and it says it is appended to the document, but for reasons that I am not quite clear about, that doesn't seem to have found its way into the panel's bundle. You may not know what the panel have and what they do not have, so I am afraid a copy has not been forthcoming in that document, but obviously let me then try and deal with that, so that the panel have an idea of who you are because, obviously, as yet, they don't know anything about you. You qualified as an optometrist I think at the age of 42 in 2003.
- A.** That is correct.
- Q.** Having done, I think, a degree in optometry at Anglia Polytechnic in 2002, was it?
- A.** That is correct.
- Q.** You registered in 2003, and then, forgive me if I do not have the exact details clear of your Curriculum Vitae, but do you have a copy with you?
- A.** No.

- Q.** As I understand it, in July 2003 to October 2003, you then worked for three months in Specsavers in Peterborough?
- A.** Yes, that is correct.
- Q.** Then from November 03 to March 04 – that is a period of four months or so – you worked at Specsavers in Plymouth?
- A.** That is correct.
- Q.** And then at Noakes and Habermehl in Cornwall from March 04 to May 08?
- A.** That is correct.
- Q.** What I haven't quite understood is that you also describe yourself as a visiting optometrist at that time at the Royal Eye Infirmary, so how often were you visiting the Royal Eye Infirmary?
- A.** Weekly.
- Q.** Yes, but once a week?
- A.** Once a week.
- Q.** So you were effectively working four days a week at the Cornwall optometrist?
- A.** It was half a day session at the Royal Eye Infirmary, so four and a half days in community practice and half a day at the hospital.
- Q.** And since May 2008 you, I think, have set up your own practice?
- A.** That is correct.
- Q.** You describe yourself as an expert, but have you given expert evidence before?
- A.** Yes, I have.
- Q.** At the General Optical Council?
- A.** Yes, I have.
- Q.** On how many occasions?
- A.** Once before today.
- Q.** And anywhere else?
- A.** No.
- Q.** Have you written expert reports for the High Court or anything like that?
- A.** No, I haven't.
- Q.** Your external examining – and I am going through this because as you will appreciate the panel don't have a copy of your CV so I am going into it in a little more detail than I might otherwise have done – your external examining has been as a dispensing optician?
- A.** Yes.

- Q.** And your publications are as a dispensing optician?  
**A.** Dispensing optician and an optometrist.
- Q.** Which is the optometrist one?  
**A.** It is difficult to separate them. When you write an article you are often aiming at multiple target readers, for example, optometrists and dispensing opticians.
- Q.** I am assuming you couldn't have done that before 2003 because you weren't qualified.  
**A.** Well, if we looked at the GOC core competencies, albeit they were after 2003, they were similar core competencies both for optometrists and dispensing opticians, so if I was to write an article aimed at a particular core competency, that could be targeted at both optometrists and dispensing opticians.
- Q.** Yes, but the point is, as I understand the distinction, you had never carried out a sight test before 2003?  
**A.** It would have been illegal for me to do so.
- Q.** Exactly, so your very first eye test was only something like seven years ago?  
**A.** That is obviously correct.
- Q.** Madam, we can see if we can obtain copies if you would like to have a copy given to you. I think I have gone through most of the important matters. It is not necessary to do any expert training, but perhaps you ought to disclose whether or not you have done some expert training.  
**A.** Is that a question or a statement?
- Q.** It is a question for you to disclose to us, please, if you have done expert training?  
**A.** I haven't.
- Q.** It is not a criticism, but we are entitled to know that. That is the point. When you wrote your report – well, perhaps I should just ask you this – when did you give evidence to the General Optical Council as an expert? How long ago?  
**A.** Approximately two years ago.
- Q.** And that was for the Council, was it?  
**A.** It was.
- Q.** Because in your report at page 16, at paragraph two, there is set out there what you describe helpfully as the 'summary of instructions', and you were asked to deal with the standard of a reasonably competent optometrist. Correct?  
**A.** Correct.
- Q.** I think in that report, which was in July, you don't actually come to any conclusions in that regard. Is that right? You say certain things might have

been more appropriate or certain things might be of the gold standard, that sort of thing, but that is as far as it goes, isn't it?

**A.** Yes, you're correct. I have listed several things, and I have put a list there of what a reasonable competent optometrist may perform when examining a child of that age, so I think I probably have addressed most of the issues.

**Q.** What you say is that his examination does not entirely reflect the above points. That is what your conclusion is. You then have this telephone call. Who did you have a telephone call with?

**A.** With Kisha.

**Q.** I am sorry. You will have to tell me who Kisha is because that is not someone I am familiar with.

**A.** She is, I think, the Director of Fitness to Practise who asked me to do the report.

**Q.** She is the person who instructed you in the first place?

**A.** She is indeed.

**Q.** So she then came back to you on the telephone call, and unfortunately, this is the first time you have seen this telephone call log.

**A.** It is.

**Q.** And as a result of that, you then wrote a supplementary report. Is that right?

**A.** That is correct.

**Q.** Presumably she told you what to include in it because the reason she had phoned you is that you hadn't dealt with the issue of the reasonably competent optometrist?

**A.** I don't recall that specific instruction being the case.

**Q.** Right, because you will appreciate that there is obviously a difference between the reasonably competent optometrist and the gold standard.

**A.** I do, yes.

**Q.** Because what we are not having is an academic discussion about whether something should or should not be done, whether something is a better course of action. You understand that?

**A.** I do indeed.

**Q.** Can I invite you to look, please, at Dr Pointer's Curriculum Vitae because I don't know if you have seen that?

**A.** No, I haven't.

**Q.** Right. It might be helpful if you have a look at that. Madam, again, perhaps that could be handed to you. We do have copies, and I apologise to your member who will obviously find this harder, but I will endeavour to deal with it

more fully when I call Dr Pointer, but for the moment, perhaps I can just deal with the highlights. So I hope that is acceptable to the member.

**Mr Lucraft:** It is actually in our bundle. His CV starts on page 109 of the bundle.

**Q.** With respect I think you will find that is Professor Evans' one. We have copies of Dr Pointer's CV.

**Ms Kershaw:** Are you going to give copies to us now?

**Q.** Yes. It would just make sense and be easier if we look at that at this stage. I am coming on to Professor Evans' CV in a moment, which you do have in the bundle.

*[R1 is distributed]*

**Ms Kershaw:** We will identify this one as R1.

**Q.** I hope everyone has a copy, and as I say, I will do the highlights of this point and then come back to it in more detail with Dr Pointer so that all of your Committee can follow it.

**Ms Kershaw:** That's fine, and should we need to, we will take a break if it is necessary to.

**Q.** If we could, could we start at page 4, so that we can, as it were, work backwards. So you can see at page 4 that in 1973 to 1976 Dr Pointer obtained a 2:1 degree in Ophthalmic Optics (now termed 'Optometry') in July 1976 from Aston University. *[Query on page numbers]* Mr Varley has pointed out quite correctly that the publications of Dr Pointer start again at page 1, so if you go to page 5, then beyond that the pages then go from pages 1 through to 11 with his publications, so what I am asking you to look at, and thank you for pointing that out, is the first excerpt of the page numbering which is page 4, and you can see the degree which he obtained. Turning as it were backwards then, and looking at page 3; pre-registration year; 76 to 77, contact lens research project at Aston University; 77 to 78, PhD research at Aston University; 1978 to 1982. Then on page 2, 1986 to 1988; Senior Refractionist at the Infant Visual Development Unit, Department of Psychology, University of Cambridge. I will just go into this in a little more detail. At that time:

"During some of my time at Cambridge I worked part-time in the paediatric vision unit with Professors O Braddick and J Atkinson."

I don't know if those names are familiar to you, Mr Keirl? Do you know them?

**A.** I do. Well, the names are familiar.

**Q.** Yes.

“Their research group were undertaking a large project assessing a video-photorefracton technique to determine the refractive error of infants and pre-school children, along with an evaluation of the types and distribution of refractive error in that age group. My role was to provide an objective assessment of refractive error using retinoscopy. This was the standard against which the accuracy of the new technique was to be assessed. My involvement in this study meant that I tested in excess of five hundred babies, toddlers and pre-school children over the period.

...Throughout my six years at Cambridge I also undertook a regular weekly locum session at the Medical Eye Centre.”

Moving further up the page then, 1982 to 1988, he was a Senior Research Associate at the University of Cambridge:

“Vision research Fellowship supported by grants from the UK Medical Research Council. The projects investigated the nature and extent of the amblyopic visual deficit (unilateral poor sight present from childhood, usually as a consequence of a squint or excessive longsight) in strabismic and anisometropic adult subjects. This work utilised my optometric expertise as well as my academic qualifications.”

Then at the top of page 2, we have “extensive locum sessions”. Coming on to page 1, from 1989 to present; managing his own independent optometric practice. He is a sole practitioner, does not employ locums, and is supported by two long-term reception staff, who both live locally. He doesn’t advertise, but involves himself in family eye care, so he is clearly, on any view, a very experienced practitioner.

- A.** He is, and I alluded to that fact in my initial report.
- Q.** I am sorry, I thought you hadn’t seen his Curriculum Vitae.
- A.** I know Dr Pointer by reputation, so in my initial report I alluded to the fact he is very experienced, has examined, obviously, countless children and is respected within the profession.
- Q.** Right. The reason I am drawing this to your attention is because, obviously, an individual optometrist has to assess the child or any patient who is in front of that optometrist.
- A.** Yes. If that is a question, the answer is yes.
- Q.** And the level of cooperation of a child is very often one of the important factors in what tests you can carry out.
- A.** It is.

- Q.** We know in this case that ultimately this child, who was just under three, decided at one point to firmly shut her eyes and not re-open them despite coaxing by the mother and the optometrist.
- A.** That happened according to the documentation provided.
- Q.** In those circumstances it is impossible to carry out a further test. You cannot carry out retinoscopy on a child who will not open their eyes, can you?
- A.** Looking at the CV that you just provided, Dr Pointer has examined countless youngsters; babies, toddlers. I would be very surprised if he hadn't come across a patient such as Patient A before. Okay, these things happen, so I would be very surprised if he hadn't come across it before, and with his experience, I would be very surprised if he didn't know how to deal with that situation adequately. My concern is not about PhDs. It is very interesting, but not really relevant – some of it isn't relevant to this case – but very interesting research and publications. My concern is what a reasonably competent optometrist would have done, not somebody with a PhD, research posts, etc.
- Q.** Yes, but you are here as an expert. You are not advancing a case. Do you understand the difference?
- A.** Yes, I am assuming I was asked because I am a reasonably competent optometrist.
- Q.** I don't know why you were asked. I haven't seen the letter of instruction, but what I am asking you is not about what your evaluation of PhDs are or the like. You may not approve of them. I don't know. That is a matter for the panel, but what I am asking you is a very simple question, which is as a reasonably competent optometrist is it possible to carry out retinoscopy if the patient won't open his/her, child/adult eyes?
- A.** You have asked a closed question, and the answer to that closed question is no, but my point is that that situation should then have been handled correctly.
- Q.** It is not really your job to say what you think should have happened. Do you understand the difference?
- A.** I have answered the question. I answered the question with 'no'.

**Ms Wingfield:** He is an expert witness.

- Q.** Yes. You are entitled to give your opinion.
- A.** My opinion is that that happened, but then you have to take that forward and decide what the next course of action is.
- Q.** I absolutely accept that. That must be right, but what I am saying to you is at that session it is not possible to carry out retinoscopy if the child has the eyes shut?
- A.** And I answered the question 'no'.
- Q.** Much less is it possible to put drops into the eyes of child if the child won't even allow you to carry out retinoscopy? It follows, doesn't it?

- A.** Some practitioners will advocate putting the drops on the lashes. The eyes are closed so the drops can be placed on the lashes. Eventually the child will have to open their eyes and some of those drops will go into the eyes. That is the view of some practitioners. Obviously in this case the optometrist who Patient A was taken to for a second opinion managed to get eye drops into the eyes, as did the practitioner at the eye infirmary.
- Q.** What is your point; the fact that the practitioner was able to do that on another occasion, what is the point that you are making?
- A.** The point I am making is that in this case Dr Pointer could have used another occasion to attempt this.
- Q.** But that other optometrist wasn't able to carry out ophthalmoscopy, was he?
- A.** No.
- Q.** So that wasn't a full sight test either, was it?
- A.** No, and that information is obviously in the documentation.
- Q.** So that practitioner, who decided that they couldn't carry out ophthalmoscopy, didn't prise the child's eyes open?
- A.** But the decision was taken at the end of that examination as to what to do with that patient; to refer onwards.
- Q.** Exactly. That was the error that Dr Pointer has accepted, obviously. I was going to ask you about the publication, but as you dismissed all of this as being irrelevant –
- A.** No, I didn't dismiss all of it as being irrelevant.
- Q.** Well there are a considerable number of publications, are there not, starting in the second section of the CV, page 1 through to page 11?
- A.** Yes.
- Q.** I don't know if you are familiar with any of Dr Pointer's articles or books or any of the publications that you see set out there?
- A.** I have read one or two over the years, and I am familiar with Dr Pointer's standing in the profession.
- Q.** Well, again, I don't suppose it is worth going through them with you, but I will certainly, Madam, deal with it with Dr Pointer in due course, so no-one fear that it won't come out, as it were. That will be heard about later.
- A.** My only point is to finish off on that final point, Madam Chairman, is that what we are trying to do here is to decide what a reasonably competent optometrist would do. There are many average, if you like, reasonably competent optometrists who would spend a great deal of time ploughing through the literature. What they would do, hopefully, is to spend time looking at CET and CBT material produced by the profession for the profession as opposed to research papers like some of these.

**Q.** Yes. Well, as I say, I think you need to understand your role. Your role is not we are deciding. You are not deciding.

**A.** Sorry, I apologise.

**Q.** I think you seem to have misunderstood, if I may so with respect, your role. Can we look just so, again, the panel have it, but I think I can deal with this considerably more swiftly because the panel have already seen it – if you look, please, at page 109, as has already been pointed out, there is a Curriculum Vitae there of Professor Evans, and, again, it may be that you are familiar with Professor Evans.

**A.** I am indeed.

**Q.** I think he has actually done one of the documents that relate to DOCET. Is that right?

**A.** Professor Evans has been involved in DOCET on numerous occasions over the years. Yes.

**Q.** So we can take it he knows about it. You can see that he attended City University. As I say I will just take the highlights because you have had copies of this before. He attended City University between 1980 and 1983, and his postgraduate qualifications are set out there, and he specialises in children's visual problems and contact lenses from 1996 we can see. 1998 to 1991 he did a PhD in "Ophthalmic Factors in Dyslexia". He was between 1993 and 1997 Head of Orthoptic & Paediatric Clinics at the Institute of Optometry, and from 1996 to the present is a Principal Optometrist, as you can see, at Cole Martin Tregaskis Optometrists. Over the page, at page 110, just taking the most recent appointment, 2009 to present, he is a Visiting Professor of Optometry in Faculty of Health & Social Care at the London South Bank University, and author of a number of books and also involved as an expert witness over a considerable period of time as we can see. That is, as it were, are the people involved so that the panel can understand that?

Can I, please, ask you about Sheridan Gardiner test? Madam, I am going to Head 2. It is, as I understand it, designed for patients of the age of this child?

**A.** It is.

**Q.** And therefore, it is clearly a suitable test for the age of such patients?

**A.** It is.

**Q.** Indeed, in the Buckingham textbook, a book which I am sure you are familiar with – again, you have to answer rather than just nod.

**A.** Yes.

**Q.** Which is in your bundle, Madam, at page 103. I don't ask you to look it up. That is just for reference so that you have it. About five lines up, you will see it says:

“The test most commonly used is the Sheridan Gardiner test, in which symmetrical letters are printed on a keycard. This is held by the child, who points to the letters matching those indicated by the practitioner on an internally illuminated chart or ring-bound booklet.”

So that is essentially it. The child points and recognises or identifies the letter that is being held up at a distance by the optometrist, and points to the letter on the lap of the child. Correct?

A. Correct.

Q. Now the advantage of carrying out such a test is that the child, initially – and this is a young child as we know – is not faced with the difficulty of understanding exactly what is required because obviously a crowded test, that is to say, a series of letters together on a block, might be difficult for the child to follow.

A. Agreed.

Q. So what you want to do is to set the child at its ease early on in the sight test.

A. Agreed.

Q. So do I take it that you do agree that carrying out the Sheridan Gardiner test with the possibility of carrying out the crowded test, if you like, afterwards if necessary, is best practice?

A. Yes.

Q. So, if the child is assessed by the optometrist as being cooperative, then a crowded test can follow?

A. Yes, and also if the level of acuity with the uncrowded test was reasonable.

Q. Yes, in fairness, you have made that point. Thank you. If the child is not cooperative in the assessment of the optometrist then, do you agree, it makes sense to move on?

A. Yes, I do.

Q. Do you agree – and now I am dealing with Head 3 – that different authors give differing values for normal results?

A. I do.

Q. And you have already alluded to a textbook put into the report of Professor Evans, which, Madam, you will find the relevant part of at page 106. The table which you can see at 9.1; ‘Development of visual acuity with age’ has a two year old child as 6/18. Correct?

A. Correct.

Q. And 3/9, which is the way in which the test was done by Dr Pointer, translates at 6/18?

A. It does.

- Q.** So on the basis of that, some might consider 6/18 to be reasonable?  
**A.** Some might.
- Q.** Well some optometrists might consider that to be reasonable?  
**A.** Agreed.
- Q.** I just want to take up with you one point you made. If a child is not particularly cooperative, do you agree it would be fair to assume that the child would do better than 6/18 if the child had been cooperative?  
**A.** Sorry, can you repeat that?
- Q.** Where you have an uncooperative child – I don't mean running around all over the place, but you know what I mean – would it be fair to say that a child in that position might give a worse performance than if they were cooperative?  
**A.** Yes, a worse performance and an unreliable performance.
- Q.** It is right that you need to take into account other tests as well?  
**A.** You do.
- Q.** In coming to a conclusion about that?  
**A.** You do.
- Q.** Can we look at the cover test; just explain, if you would, what that is?  
**A.** The cover test is part of a binocular vision assessment to check the alignment of the eyes; both the distance vision and the near vision.
- Q.** Right, and in this instance, the child is asked to fix its eye or eyes, depending on the process that is being carried out, on a red or green light?  
**A.** That was the case that was used.
- Q.** And what you do – forgive my simplistic view of it, but I know there are other people who probably know a lot more than me – is look at the eye that is covered and uncovered of the child and you repeat it for each eye several times?  
**A.** Yes, there are two basic components of the test. It does involve covering and uncovering the eye.
- Q.** And if, in simple terms, the eye does not fix, in other words it wanders, that gives you an indication that the patient has strabismus.  
**A.** Certainly an anomaly of binocular vision.
- Q.** So we are clear about it, strabismus is the proper title for what optometrists call a squint?  
**A.** Strabismus is the proper title of what most patients refer to as a squint. Sorry, no, strabismus is the proper title optometrists use for something that can be termed as a squint. Patients use this word 'squint' incorrectly.

- Q.** Exactly. Patients use the word incorrectly because patients use the word fairly commonly for their children. Do you agree?
- A.** I do.
- Q.** And they use the word squint to cover a wide range of eye movements by the child?
- A.** No. It is usually when a child is reducing the distance between the upper and lower lids.
- Q.** You mean when they are scrunching their eyes up?
- A.** When they are doing that - [*Mr Keirl demonstrates*]; squinting.
- Q.** So they call that squinting. That is not the medical term.
- A.** That is not strabismus.
- Q.** Right. Okay. Can I ask you about the Lang Stereoacuity Test; just again, it has a very smart name, but what is that actually? What is the Stereoacuity Test?
- A.** Stereopsis is the highest grade of binocular vision. Essentially it is a test to ensure that the eyes are working together, and the child can see in 3D. There are various tests available, and the Lang test is one of them.
- Q.** And that is essentially – just so I understand how it translates into the practicalities – you ask the child to look at a block which has hidden images within the dots or spots or whatever it is?
- A.** That is correct.
- Q.** So it is find the picture in the dots, put in my inappropriate but nevertheless helpful way?
- A.** Find the magic picture.
- Q.** Find the magic picture. All right, and there are three magic pictures, I think, in the Lang test or certainly three that I have managed to find. As you say, what is important about it and what is helpful about it is that it shows that both eyes are working together?
- A.** It does.
- Q.** And that is, again, important in relation to the question of whether or not the child has a strabismus?
- A.** It is.
- Q.** This patient found all of the items easily.
- A.** Yes.
- Q.** And therefore this patient achieved good results, and 200 seconds of arc is the best possible result, is it not?
- A.** On that particular test.

- Q.** On that test, yes. Now as you know, Dr Pointer managed to carry out ophthalmoscopy.
- A.** In a brief form.
- Q.** In a form that I think is acceptable on the patient record?
- A.** Yes, agreed.
- Q.** That, as we know, was not something that the following optometrist was able to carry out?
- A.** Correct.
- Q.** Having done that and concluded that, then the next test to be carried out was retinoscopy. Again, just help with what retinoscopy is?
- A.** Retinoscopy is an objective assessment of a patient's refractive error or potential refractive error.
- Q.** Now can we look at page 21 in the bundle, please? This is part of your report dealing with this aspect, Madam, this is Head 4 we are now dealing with. At the conclusion of the top paragraph, you say "Most practitioners tend to use cycloplegics..." That is the drops, yes?
- A.** Yes.
- Q.** "when..." and then you set out a number of points there, but can I ask you about the sixth bullet point down, which reads "When retinoscopy suggests that accommodating is fluctuating significantly" and the next bullet point reads "When the retinoscopy findings differ significantly from the subjective findings." Correct?
- A.** Correct.
- Q.** So does it follow that you visit a situation where retinoscopy could be carried out first of all without using a cycloplegic?
- A.** Retinoscopy, in most cases, is carried out prior to the installation of a cycloplegic in community practice.
- Q.** Right. So there is no criticism if Dr Pointer was going to attempt to carry out retinoscopy first of all without cycloplegic agent?
- A.** None at all.
- Q.** The reason I ask you about that is because if you look at page 27, which is your supplementary report, you set out on page 27 "when a cycloplegic agent should be used", you said, and in the first bullet point you say "When a child presents for his/her first eye examination."
- A.** That is not advocated by all practitioners.
- Q.** Sorry, where do you say that?
- A.** I haven't. I am attempting to answer your question.

**Q.** Yes, but the point is, in your report, if you have anything which you are saying is not the view of other individuals, then you need to make that clear.

**A.** I think the word there “should”, might be better with “could”.

**Q.** Yes. That is why I am asking you about this because you have written “should be used” and so the impression one might get if you weren’t here to give evidence, would be when a child presented for his or her first eye examination, then an optometrist would be failing in their duty not to carry out retinoscopy with a cycloplegic agent, but you are not saying that?

**A.** I am not saying that.

**Q.** Right. I want to be clear on that. If we look, please, at page 90 of the bundle, you will see in the full second paragraph down Professor Evans deals with your supplementary report. The first point you have already dealt with. Then about five lines down Professor Evans says:

“Mr Keirl’s fourth point is that a cycloplegic refraction is required if the results of non-cycloplegic retinoscopy are inconclusive. I agree with this reason but, if a child won’t open their eyes for non-cycloplegic retinoscopy then it is unlikely that they will open them for cycloplegic drops let alone cycloplegic retinoscopy after drops had been forced upon the child. In my view, this would be a reason for continuing the sight test on a different day”

Is there anything in that which you disagree with?

**A.** No.

**Q.** The fifth point, he continues, which he disagrees with you about, is:

“that stereoscopic acuity was unsatisfactory. In my view, Dr Pointer used an appropriate stereoacuity test and the child achieved the best possible result with this test. Such a finding would reduce the likelihood of a child requiring a cycloplegic refraction.”

Do you agree with that?

**A.** I have already said this morning that the 200 seconds of arc on the Lang test that was used was a good level of stereopsis.

**Q.** Yes. Do you disagree with anything that I have just read to you?

**A.** No.

**Q.** Just so people are clear in case they don’t know – the lay members may not know – drops, in fact, put into the child’s eye can sting.

**A.** They can.

**Q.** And it can make the eyes blurry for a few hours.

**A.** It can.

**Q.** And then obviously the child feels slightly dazzled by the light?

**A.** That is correct.

**Q.** I think that was all. Thank you very much, Madam.

**Re-examined by MS WINGFIELD**

**Q.** If I can come back just on a couple of points; in relation to the points that you have had put to you and where you have confirmed that you do not disagree with Professor Evans' comments, can I ask you is that in isolation in relation to each point or is that cumulatively in relation to the whole process of testing?

**A.** I think in isolation.

**Q.** Thank you. No further questions.

**Questions from the Committee**

**Mr Khan:** Mr Keirl, I am a lay member, and I will be using my ordinary English to ask this question because I am not familiar with all the terminology. I have tried to learn it over the last two days, but do forgive me, and if you don't understand my question, would you please come back?

**A.** Of course.

**Q.** In so far as the facts are concerned, and I am sure representatives will correct me if I have this wrong; on 12 October, the mother took her child A, and the test was concluded.

**A.** Correct.

**Q.** She was not happy. She went back on 20 October and it was repeated that she need not come back for another appointment for 12 months.

**A.** That appears to be correct.

**Q.** She then takes a second opinion with Specsavers who then send the child A to an eye specialist, who prescribes glasses. I think the strength was 4 or something, which doesn't really mean much.

**A.** In this case, the initial spectacles were prescribed by the Hospital Eye Service in Northamptonshire.

**Q.** My question is this. If she hadn't taken the second opinion, if she hadn't gone to the eye specialist, what consequences might have followed for the child's eyesight?

**A.** The patient's symptoms would have probably continued in terms of squinting. There may well be other associated symptoms such as headaches, eye strain. Sometimes it is difficult for a youngster to communicate those symptoms, but, generally speaking, the patient's vision could be described as being unhappy because of that. It is unlikely that there would be any long-term physical effects to the eyes. The stereopsis level indicated there was no

strabismus at that particular time. If there had been a difference in acuities in both eyes, there could well have been a development of something called amblyopia or a lazy eye, particularly if the eyes weren't in alignment, but assuming that the prescriptions were the same in both eyes, and there was no involvement of a strabismus, the eyes were pointing in the same place at the same time for all distances, there could well have been symptoms for the patient but unlikely to be lasting physical damage.

**Q.** So there could have been some damage to the eyes?

**A.** There would, I think, certainly have been symptoms, and possibly, a reduction in the normal development of acuity because for the normal development of vision, the brain requires a clear image to be formed on the retina. In this particular case, there weren't clear images being formed on the retina so there is a possibility that visual development could have been restricted.

**Q.** I am aware of the child being two years and 10 and a half months old, and the gap was a whole 12 months.

**A.** Yes. During this age the visual system is still developing, so it is important that clear images are being formed on the retina for the visual system to develop.

**Mr Stern:** Can I just correct one matter, if I may, in relation to the synopsis of the facts because at paragraph 10 of the witness' statement, Mrs A, page 2 of your bundle; in fact, the mother visited the surgery on 20 October as Mr Khan rightly said, but it was to obtain a copy of the eye test report to take to the second optometrist, so it wasn't dissatisfaction on that second occasion, it was dissatisfaction on the first occasion, which then led to her wanting a second opinion.

**Mr Khan:** Thank you.

**Ms Kershaw:** There are no more questions.

**Ms Wingfield:** Sorry, you said there are no more questions. Thank you very much, Mr Keirl.

*[The witness stood down]*

**Ms Wingfield:** Madam, I wonder if we can break for a few moments at this stage so I can just see whether or not Mrs G is actually here, should we wish to ask any questions of her.

**Ms Kershaw:** Thank you. I was just going to suggest that we take a short break anyway at this point in the morning, and if we reconvene at 11.35, that will give you a chance to speak to her.

**Ms Wingfield:** Thank you very much, Madam

**Mr Lucraft:** It may be whilst we are doing that, the Committee can make it known whether they do actually want to ask any questions because it may be that Mrs G can then be told 'yes' or 'no', and either sit in if she wishes to or go if she wishes to.

**Ms Wingfield:** That is very helpful.

*[Hearing adjourned at 11.18]*

*[Hearing resumed at 11.38]*

**Ms Kershaw:** The Committee would like to ask questions of the mother.

**Ms Wingfield:** Thank you, Madam. She is here. She will be brought in and sworn in.

**Mr Lucraft:** Ms Wingfield, just so you know what I have suggested is that the Committee should ask their questions first of all, and if you or Mr Stern have any supplementary questions to deal with it that way.

**MRS G, called and sworn  
Examined-in-Chief by MS WINGFIELD**

**Q.** There is a bundle of documents in front of you with a plastic cover. If you just have a little look at page 1 inside that bundle; 1, 2 and 3, could I ask you to confirm that that is your statement?

**A.** It is, yes.

**Q.** And we will refer to you today as Mrs G, but if you could confirm that that is your full name set up at the top of the statement.

**A.** It is, yes.

**Q.** Thank you very much.

**Ms Kershaw:** Thank you. The Committee would like to ask you some questions, so I will let my fellow Committee members ask you questions, but if you can just address all your answers to us, that would be very helpful.

**Questions from the Committee**

**Ms Hudson:** My name is Alison Hudson. I am an optometrist panel member and I am also a dispensing optician. I just really would like to ask you a few questions. In order to protect your daughter's anonymity, if we do use her full name, which I appreciate may happen, she will be referred to as A in the published documentation. So, there are couple of things that I would really like to ask you, but I think first of all, the most important is; how is your daughter?

- A. She is doing okay.
- Q. Good and she wears glasses?  
A. She does.
- Q. Does she wear them full time?  
A. Full time, yes.
- Q. Is she under the care of the eye department at the hospital?  
A. She is.
- Q. Who does she see in the eye department?  
A. She sees Miss Lucas and Miss Menon.
- Q. And can you tell us what their occupations are?  
A. Julie Lucas is an optometrist and Miss Menon is the doctor who we see, but also she is the one who tests her eyes.
- Q. Okay. While she has been under the care of the eye department, has she had any patching or any treatment or purely using glasses?  
A. She has had no patching because both eyes have been working equally so she hasn't needed any patching. She did have treatment for sticky eye. That was just clearing out the tear ducts of her eye, which I think she would have needed anyway, and that is nothing to do with her eyesight.
- Q. And she wears her glasses –  
A. Full time.
- Q. And she wears them full time?  
A. Yes, happily most of the time.
- Q. How did she cope when she first got glasses?  
A. It was like watching a different child, and the day she got them all the mothers at the school commented at how she was looking at things as if it was the first time she had seen them. It was really quite sweet and quite emotional to see her just looking at a tree or something like that.
- Q. Obviously it looked different to the way it had done previously. What I would just like to understand for both myself and my fellow panel members is exactly, in your words, what the symptoms were that made you decide to take your daughter for an eye examination?  
A. We noticed that she was sat screwing her eyes up a bit like this [*Mrs G demonstrates*] and she was stood right next to the television. We kept telling her to move back from the television, but she would move forward to the television, and she would do that while she was reading; she would be screwing her eyes up as well.

- Q.** Did she ever appear to be unwell or other symptoms like headaches?  
**A.** She never complained about having a headache, but then she was only young so I don't think she would have known what a headache was.
- Q.** She didn't appear to be unwell at any time?  
**A.** No.
- Q.** Okay, thank you. I would just like to clarify your own history because I understand that you wear spectacles, so what age were you first prescribed spectacles?  
**A.** My mum said she remembers me being between three and four. She said she can't remember exactly how old, but she remembers me being young.
- Q.** Do you wear spectacles now?  
**A.** Only for reading.
- Q.** Do you wear contact lenses?  
**A.** No.
- Q.** So were you given glasses as a child?  
**A.** Yes.
- Q.** And what length of time was your mother advised that you should be wearing them for at that stage? What was she encouraged to get you to wear them for; all the time?  
**A.** All the time, yes. I do remember having a patch as a child as well. My mum said I had to have one. I don't know which eye. She just remembers me having to have a patch at one stage as well.
- Q.** So what sort of age did you wear glasses to because I know a lot of children reach a point where they abandon it?  
**A.** Probably about 12.
- Q.** Do your two eyes see equally well now?  
**A.** Yes.
- Q.** They do, and you purely, at the moment, wear glasses for –  
**A.** Yes, the prescription at the moment, I think, is a +1.5 so it is not very significant, but the optician said it is fine to wear them just for reading.
- Q.** Okay. Thank you very much. I think that is all I wanted to ask. Thank you.
- Ms McCrudden:** My name is Janice McCrudden, and I am an optometrist. There are just a few things. When your daughter was younger how was her development? Was she a normal, active child?  
**A.** Yes, she seemed to be.
- Q.** Was she a full-term birth?

**A.** She was overdue, yes.

**Q.** And there were no complications?

**A.** No complications, no. Everything was normal.

**Q.** Okay. That is fine. Thank you.

**Ms Kershaw:** That is all the questions from the Committee, but it may be the lawyers want clarification on anything asked by us.

**Ms Wingfield:** I just have one question, if I may. Currently you said that your daughter is still under the eye hospital. How frequently are her eyes being tested currently?

**A.** Every six months.

**Q.** That was the only question I wanted to ask, Madam. If that is everything, I wonder whether Mrs G could actually be released.

**Ms Kershaw:** Yes, you are now released. If you would like to stay and listen to the proceedings, you are very welcome to sit at the back or, alternatively, you are free to go.

**A.** Okay. Thank you very much.

*[The witness stood down]*

**Ms Wingfield:** Madam, that is all the evidence that I would propose calling.

**Ms Kershaw:** Thank you. I now turn to Mr Stern.

**Mr Stern:** Madam, I seek to submit there is insufficient evidence for you to consider Heads 2, 3 and 4 bearing in mind the evidence that you have heard. In relation to Head 2, the evidence that you have heard contradicts the wording that is set out in Head 2. In fact it is asserted that best practice is to undertake a Sheridan Gardiner single letter test prior to the crowded test. If you can, then carry that out. That is a suitable test for the age of the patient as is accepted by Mr Keirl, and indeed, accepted in opening, so there can be no evidence in that regard.

Head 3 is asserted that the practitioner incorrectly concluded that the vision with an acuity of 3/9 was an acceptable visual acuity for this patient. It is the case that some practitioners would have considered 3/9 acceptable or reasonable. Again, bearing that in mind, there is no evidence upon which you could conclude that no reasonable optometrist would have concluded that.

Head 4; you did not undertake retinoscopy with a cycloplegic agent, so the allegation is not that he failed to carry out retinoscopy but that he failed to carry it out with a cycloplegic agent. You have heard that it is perhaps

common, and indeed, the most common method is to carry out retinoscopy without a cycloplegic agent first of all to see whether or not it is necessary to carry out a test with a cycloplegic agent, in other words whether to put the drops in after you have carried out the initial testing, so again, that cannot be made out.

I would add this; that in any event, one has to have a grasp of the facts in relation to this case. This is a child with the eyes screwed up – for want of a better word – at the time the retinoscopy was about to be carried out, so it is not clear how it can be asserted that no reasonable optometrist would have ceased the examination at that stage or no reasonable optometrist would not have undertaken retinoscopy with a cycloplegic agent at that point. I am not clear how it is put in that regard. So, the short point is there is no evidence in relation to 2, 3 and 4. The gravamen or the most important part of the case has been admitted, and you know what happened at the actual examination. Those are my submissions, Madam.

**Ms Kershaw:** Thank you. Ms Wingfield, would you like to comment.

**Ms Wingfield:** In brief, Madam, the basis upon which the case is put, and Mr Keirl confirmed that, in effect, each of these items may on their own be appropriate separately, but the concern here was that they were not added together, and a complete examination was not carried out as far as the patient was concerned, and in relation to the Sheridan Gardiner test, it may be suitable as a starting point but not as an end point. On that basis there is evidence, in my submission, that an optometrist should proceed to the next stage of the proceedings, and the same in relation to each of the other steps that are alleged. If you have an inappropriate or incomplete result as a result of the first part, then you have to carry on to do the other parts of the relevant tests before you are in a position to provide the advice, which it is quite clear is admitted, that as far as Dr Pointer was concerned there was no problem, and clearly there was.

**Ms Kershaw:** Thank you. I turn to our Legal Adviser for advice on the matter.

**Mr Lucraft:** Certainly. The advice I give you at this stage is, clearly, what you have set out on the allegations are separate allegations of fact, and of course, at this stage this Committee is engaged in a fact finding exercise, and so when you look at each of the allegations 2, 3 and 4 on which Mr Stern makes his submission, you have to look at whether there is evidence that supports 2, 3 and/or 4. You should look at what you have heard in relation to 2, 3 and 4 with the wording of the allegations set out. What Mr Stern is not saying is that there isn't other evidence which goes on the other heads of the allegation which have been conceded. He limits this to simply those parts of the allegation 2, 3 and 4.

The law is very clear. If you are of the view that there is no evidence on any of the heads, then your obligation is to strike it out from the allegation.

Equally, the law is clear that if there is some evidence, and the issue on that evidence is your assessment of it in the round, then the appropriate course at this stage is not to dismiss it, but to then go on in due course to consider whether that is sufficient in the realm of all the evidence you then hear for the other matters that you then have to consider.

This stage is simply that if you look at what you have heard from the evidence that has been given in this room today, in relation to allegation 2, 3 and 4, is there any evidence to support those allegations made? The submission made is that there is not, and so my advice to you is that you have to consider what is said and come to the view of whether there is evidence. If not, then Mr Stern's submission succeeds. If there is some evidence, then at this stage his submission would be unsuccessful and the Committee would then go on to consider that in the round as you then go on to the next stage of the process.

**Ms Kershaw:** Thank you. Do either of you have any comments about the legal advice? [No] We will then go to consider your half time submission.

*[Hearing adjourned at 11.52]*

*[Hearing resumed at 12.35]*

**Ms Kershaw:**

### **Findings in relation to the facts of the allegation**

At the conclusion of the evidence called on behalf of the Council, Mr Stern QC on behalf of Jonathan Pointer made a submission that there was no evidence to support paragraphs 2, 3 and 4 of the allegation. The Committee accepted the advice of its Legal Adviser.

The Committee considered each of the paragraphs of the allegation separately, and the evidence set out in the papers before it as well as the evidence given by Mr Kierl to the Committee today.

In relation to paragraph 2 the Committee found that there was no evidence to prove that Dr Pointer did not use a test suitable for the age of the patient. A Sheridan Gardiner test is frequently considered as a suitable test for a patient of this age.

In relation to paragraph 3, the Committee found that there was no evidence to support the allegation that Dr Pointer came to a conclusion that a visual acuity of 6/18 was acceptable for this patient.

Equally the Committee found that there was no evidence to support the allegation in paragraph 4. In the light of the patient's non-cooperation at this stage of the examination, no retinoscopy – either cycloplegic or

non-cycloplegic – would have been possible so this part of the allegation must fail.

In the light of the admissions made as to allegations at paragraphs 1, 5, 6 and 7 (as amended), the Committee formally finds those matters proved.

We, therefore, move on to consider impairment, but I would suggest that lunch first might be a good idea.

**Ms Wingfield:** Madam, what time would you want to resume?

**Ms Kershaw:** If we resume at 1.30, would that be long enough for you to do what you need to do?

**Mr Lucraft:** Madam, just to correct one thing; the next stage obviously is to consider misconduct and then impairment, and just for the record, perhaps I should also say that the parties were content that as well as considering 2, 3 and 4, the Committee formally dealt with the matters which had been admitted earlier on without the need for the parties to come back in and go out again.

**Ms Kershaw:** Thank you very much.

*[Hearing adjourned at 12.37]*

*[Hearing resumed at 13.29]*

**Ms Kershaw:** We have reached the stage where you may wish to address us on whether the facts found proved amount to misconduct.

**Ms Wingfield:** Yes, Madam.

**Mr Lucraft:** May I ask at this stage whether Mr Stern wants to call any evidence before we move on to that stage. Ordinarily, one would hear the evidence on the facts. As the facts have been agreed, I don't know whether Mr Stern might be proposing to call evidence regarding the question of misconduct.

**Mr Stern:** I was proposing to call Dr Pointer in relation to the next stage.

**Mr Lucraft:** Are you intending to deal with the misconduct as part of that?

**Mr Stern:** Yes, I was going to deal with the misconduct and the question of impairment in one go so obviously we wouldn't be coming backwards and forwards, but may I say this, that if you are of the view – and I think the Rules are silent in this regard, but they are not at the General Medical Council – at this stage, the facts as admitted and found proved were insufficient to amount to misconduct and could not amount to misconduct, then on that basis, that obviously is a matter that could be raised at this stage. Certainly with the

General Medical Council itself, the Rules are perhaps not as full as they might be.

**Ms Kershaw:** They are different at the GMC.

**Mr Stern:** Yes, I think 'different' is the polite way of putting it.

**Mr Lucraft:** Ordinarily, for the General Optical council, the question arises as to whether the facts amount to misconduct and then one goes on to look at impairment. I was just thinking, and watching Ms Wingfield, it may be that if in fact there is going to be evidence which straddles both of those issues, that before Ms Wingfield makes any submissions as to whether the facts amount to misconduct, it might be better to hear the evidence first of all, and then for the Committee to hear the submissions after that on behalf of the Council as to whether the facts amount to misconduct, first of all, and then if they do, the issues about impairment.

**Mr Stern:** That is correct, but there is a stage in between whereby you are entitled to argue the fact, rather like the submission of no case effectively, on misconduct. So you are entitled to argue, as it were, twice if you are unsuccessful at the first hurdle first of all whether as a matter of law –

**Mr Lucraft:** Taking the facts as they are.

**Mr Stern:** Exactly.

**Mr Lucraft:** It may well be that Ms Wingfield is happy to say what the Council's case on the facts is.

**Ms Wingfield:** It seems to me that if there is going to be a submission that the facts do not amount to misconduct, then that should be a submission made by Mr Stern at this stage, and I can have an opportunity of answering it. It seems to me that if that is the way he wants to proceed, then he must make that submission, and I would then respond accordingly. In the same way as the half time submission, it would be open for the Committee to make that decision or alternatively to proceed, and if they wish to proceed then they can hear evidence and/or submissions in relation to the issue of misconduct.

**Mr Lucraft:** The Rules are slightly opaque on the issue. The stage is to consider whether the facts do amount to misconduct in those circumstances. It may be best that Mr Stern sets out why he says they don't amount to misconduct and you answer or the other way round. It really makes very little difference. The Committee then considers that at this stage, and whatever the finding is, we then move on to the next stage if that is necessary because, obviously, on your submission you will be saying that if they don't amount to misconduct, we don't need to go further.

**Mr Stern:** Obviously that is correct, yes. Perhaps I am not making myself clear, but there is a difference in stage, which is that whether or not the facts are capable, even taken as they are, whether they are capable as a matter of law, not whether or not, in fact, they amount to misconduct in this case, but whether they are capable of amounting, and that is the distinction that I am drawing.

**Mr Lucraft:** Yes, on that legal issue, it is probably sensible to take that now.

**Mr Stern:** That is what I am saying.

**Mr Lucraft:** Then see what the conclusion on that is, and deal with the facts afterwards.

**Mr Stern:** Yes, I would respectfully agree, so in other words, even if you were against me on this, I would then wish to call Dr Pointer on the issue of the ultimate determination of whether it does in fact amount to misconduct.

**Ms Kershaw:** So please address us.

**Mr Stern:** So I am on the simple question, simple to express, of whether or not the facts as admitted and found proved, that is to say Heads 5, 6 and 7 are not equal in amounting to misconduct in relation to a practitioner. Helpfully, there is no definition of misconduct, so one is thrown back to the decisions of the High Court in relation to various regulatory bodies, and the case that is most often cited – and I know that your learned Legal Adviser has a copy of it. It may be my learned friend does not – is the case of *Calhaem v General Medical Council* [2007] EWHC 2606 (Admin).

**Ms Kershaw:** I am familiar with it, but I don't have a copy with me.

**Mr Stern:** Well it is a case that is most often cited, and perhaps it is a case that you are familiar with, or at least, partially familiar with.

**Ms Kershaw:** I think all of us are partially familiar with it, some of us more than others.

**Mr Stern:** Right. I have to say it is like a good novel. Every time I read it there is another point in there; that something emerges from it. What I will do – I will need to do this in any event – is to quote various aspects from it, so that all members of the Committee can follow the points that I am making, and thereafter if there is anything further that anybody wishes to draw attention to, then of course they are quite within their right.

So first of all, so that we have it accurately reported, it is [2007] EWHC 2606, and I don't need to rehearse all of the facts but I do need to, and I think it is important, just to mention some of the facts because the point that I am making about this is when you look at the facts contained within this particular

case and the level of seriousness attached to it, to each of these allegations, and you see what the learned Judge said about it, in my submission it is important.

So first of all, Dr Calhaem in the case was “an experienced consultant anaesthetist”. I am on paragraph 4 – I will just give the paragraph numbers of where I am quoting bits from. There was an operation for a patient to remove a growth from the nose, and Dr Calhaem administered drugs by means of a small cannula inserted into the vein. The patient became unconscious, but it became apparent that she was allergic to suxamethonium and suffered an adverse reaction, and then at about 12 o'clock following a discussion between the surgeon and the anaesthetist, the anaesthetist left the patient and went off to anaesthetise another patient. A different consultant anaesthetist then noticed that the patient's condition was of concern, and he increased the oxygen levels and he went to see Dr Calhaem and offered to help, and Dr Calhaem declined that offer. He then went back to the recovery room to check on the patient himself. So the allegations were numerous, but at paragraph 9:

“Allegation 3: prior to induction of anaesthesia you did not record Patient A's baseline

Allegation 10. You allowed the operation to proceed in circumstances where the actions were inappropriate.

Allegation 13. Before induction, and every five minutes thereafter, you did not record Patient A's vital signs.

Allegation 15. After surgery, but before Patient A's removal to the recovery room ...

Allegation 16. You removed Patient A's inner tracheal tube.

Allegation 18. Patient A was taken to the recovery room ... On arrival her

- a. blood pressure was low
- b. oxygen saturation levels were low.

Allegation 20. You left Patient A to anaesthetise another patient. You failed

- a. In any event to record the results of [that].

Allegation 22. ... the patient had

- a. failed to regain consciousness
- b. became agitated
- c. had a decerebrate movement

Allegation 23. ... you failed

- a. to anaesthetise Patient A again
- b. or replace the endotracheal tube
- c. arrange a CT scan”

And all of this, it was said, is just the parts that he admitted. The issue between the parties was how serious these matters were, paragraph 15:

“In addition, the GMC were alleging numerous further breaches which the practitioner denied. When the Panel announced its decision on the facts, the Panel rejected some of those further alleged breaches, but found others of those further alleged breaches to be proved.”

Essentially they found – this is paragraph 15, the finding is set out there:

“that Dr Calhaem’s actions had been irresponsible; serious departure, inappropriate; serious departure, irresponsible; serious departure”

on a number of occasions so essentially it was a five hour operation in which there were a number of irresponsible actions carried out in the round by the doctor.

Page 8 or paragraph 19, part 3, the present proceedings, the learned Judge then set out what the grounds for appeal were, and in dealing with this at paragraph 26, coming on to the relevant matter, he deals with it in this way:

“The word, ‘misconduct’ in section 35C(2)(a)” – which is, of course, within the Medical Act not applicable here, nevertheless, the words must mean the same – “does not mean”

– and this is the part that I would like you to note –

“any breach of a duty owed by the doctor to his patient. It connotes a serious breach which indicates that the doctor’s fitness to practise is impaired.”

And then he talks about the phrase:

“efficient, professional performance does not mean any stance of substandard work. It connotes a level of professional performance which indicates that the doctor’s fitness to practise is impaired.”

Just pausing as an aside for a moment, the Council has chosen to allege “misconduct” not “deficient professional performance” here, so that needs to be clear, but it is worth looking at what it is that the Court has interpreted as being “deficient professional performance” to give you, as it were, a commensurate idea of the level of seriousness that needs to be attached to

the actions or inactions of a professional, both in terms of professional performance and/or misconduct.

Then at paragraph 30, the learned Judge goes through a number of previous cases, and as I am sure you know from having looked at this authority, supports these previous authorities and derives five principles, which I will be coming to in due course or at least some of them. At paragraph 30, he deals with the case of *Preiss v General Dental Council* [2001] 1 WLR 1926, where the Privy Council held that a course of treatment provided by a dentist to one patient was so unsatisfactory as to constitute serious professional misconduct. Nevertheless, the Privy Council went on to hold that admission would be substituted for sanction of suspension, and Lord Cooke said:

"It is settled that serious professional misconduct does not require moral turpitude. Gross professional negligence can fall within it. Something more is required than a degree of negligence enough to give rise to civil liability but not calling for the opprobrium that inevitably attaches to the disciplinary offence."

Then in paragraph 31, *Krippendorf v General Medical Council* [2001] 1 WLR 1054, the reason the Privy Council proceeded on the basis that the right approach, at least in this case, was to assess the appellant's past performance over a period of time. So that is in professional performance, and in *Rao v GMC* (PC Appeal no. 21 of 2002), the Privy Council noted that only one incidence of clinical failure was alleged. That incident undoubtedly amounted to negligence, but it was only a borderline case of serious professional misconduct. Having regard to all the circumstances, the appeal was allowed.

In relation to *Silver v General Medical Council* [2003] Lloyd's Med. 333, the Privy Council quashed the finding of serious professional misconduct. The principal breach in that case was a failure to make a home visit to the patient over a period of nine days. Sir Philip Otton, on delivering judgment, said:

"In the instant case there can be little doubt that there was negligence and that it was open to the Committee to find that this constituted professional misconduct. However the Committee should have gone on to consider as a separate issue whether this amounted to serious professional misconduct. It is by no means self-evident that if this question had been posed it would have been answered in the affirmative. It was relevant to consider that this was an isolated incident relating to one patient (albeit over a number of days) as compared with a number of patients over a longer period of time."

Then it took into account the forty year period that this practitioner had with unblemished professional conduct. As you know, there was a question from *R (Campbell) v. General Medical Council* [2005] EWCA Civ 250 as to whether

or not that is something you can take into account or not, so I will leave it there.

At paragraph 62:

“but as a general rule the GOC should not (and their Lordships have no reason to suppose they would) seek to aggregate a number of totally dissimilar incidents and alleged shortcomings in order to make out a case of seriously deficient performance against any practitioner.”

So in other words what they were saying in relation to deficient professional performance is it has to be a series of acts by the practitioner over a longer period of time, and at paragraph 63 it says:

“On the other hand one isolated error of judgment by a surgeon might give rise to liability in negligence but would be unlikely, unless very serious indeed, to amount to, by itself, seriously deficient performance.”

The same must apply to misconduct in my submission, and if one, as it were, just interposes for a moment. What you have here is, on the face of it, an isolated error of judgment. There is nothing outside of that single error. What is, you may think, clear on the admission by Dr Pointer is that he should have made it clear to the patient that the patient should return within a period less than 12 months. 5, 6 and 7 are in fact repeated in different formats, but that is essentially what it comes to.

At the bottom of page 12, there is comment from *Roylance v. GMC* [2000] 1 AC 311:

“‘serious professional misconduct’ is not statutorily defined and is not capable of precise description or delimitation. It may include not only misconduct by a doctor in his clinical practice, but misconduct in the exercise, or professed exercise, of his medical calling in other contexts...it must be linked to the practice of medicine or conduct that otherwise brings the profession into disrepute, and it must be serious...it has been referred to as ‘conduct which would be regarded as deplorable by fellow practitioners’.”

Paragraph 37, defining seriously deficient professional conduct – I think it is a misstatement by the Judge but anyway I think we know what he means –

“was based upon a thorough and detailed assessment of the practitioner’s practice.”

So, the five principles, as set out at paragraph 39 of the judgment:

“Mere negligence does not constitute ‘misconduct’ within the meaning of the Act. Nevertheless, and depending upon the circumstances, negligent acts –

that is plural –

“or omissions which are particularly serious may amount to ‘misconduct’. (2) A single negligent act or omission is less likely to cross the threshold of ‘misconduct’ than multiple acts or omissions. Nevertheless, and depending upon the circumstances, a single negligent act or omission, if particularly grave, could be characterised as “misconduct”.”

So a rather long way, I am afraid, that I get to the crux of the point, that the acts in this particular case cannot be described as particularly grave in any shape or form. Just so you have the conclusion of the learned Judge in this regard at paragraph 56:

“My conclusion on this issue is that Dr Calhaem was in breach of his duty of care to Mrs A in each of the four respects identified by the panel.”

and then he makes this point:

“None of these breaches, taken in isolation, amounted to misconduct. Taken together, however, they form part of a wider picture, which is relevant to misconduct.”

So the situation where you have a consultant anaesthetist who had acted in a series of ways over five hours, irresponsible and inappropriate. As I understand the judgment by the learned Judge, he was saying that none of those breaches taken in isolation amounted to misconduct, but together, they form a wider picture which was relevant to it.

I think those were all the matters that I need to address you about in relation to that case. Of course there are a number of authorities in relation to the issue, but essentially, they point and come back to the same criterion. The criterion is it must be serious, it must be grave – whichever way you want to express it – in order for the case to come within misconduct, and one can understand the rationale for that because clearly, each of us, as professionals, make mistakes on a fairly regular basis. I don’t like to look at it in that way, but we all do. We all make mistakes on a fairly regular basis, and it can’t be right that every mistake we make can amount to misconduct, so what the High Court has sought to do is to give guidance to bodies that deal with professionals and say it has to be grave in order for you to find misconduct, and not just a negligent act, not just a breach of duty because that happens in this day to many of us on a fairly regular basis. So in my submission, looking

at that single aspect that you have in this case, which is a single factual aspect, in my submission that is not capable of amounting to misconduct within the description of that in the case of *Calhaem* and various other authorities.

That is my submission at this stage.

**Ms Kershaw:** Thank you. Ms Wingfield?

**Ms Wingfield:** Madam, thank you. Madam, the allegations in relation to this particular matter, misconduct is alleged as a result of the matters that are set out above, and it therefore, does encompass more than one specific fact, and you have a number of issues here. It is not a single incident in my submission, not least because the advice given to the mother on 12 October was that she should return with her child in 12 months' time. That advice was repeated approximately a week later when Dr Pointer was made aware that the mother was unhappy with the outcome of the first attempt to carry out an eye examination. There are issues arising as a result, again, which is part of the factual basis upon which there are admissions; the fact that there was an incomplete examination. There was no attempt by Dr Pointer to ask the mother of the patient to bring the child back sooner, and there was no attempt, despite the incomplete examination, to refer the patient for a specialist examination elsewhere.

Madam, in my submission you do have an issue where the outcome for this child could have been serious. The examination was incomplete, and a child just short of three was being told that she didn't need to be seen for a further year. You have heard from the mother that there had been a substantial difference in the child as a result of her having her spectacles with which she could see trees.

Madam, in my submission the combination of all of the separate parts that are admitted and found proven is more than one mere negligent act. It is indeed "taken all together" as has been suggested by a case from which Mr Stern has quoted. Taken all together, in my submission, you have misconduct, and not least, as I say, because of the fact that it was not just on one occasion that the wholly inappropriate advice was being given.

**Ms Kershaw:** Thank you.

**Mr Lucraft:** Perhaps at this stage I can just invite the panel to look at the wording of the facts. Paragraph 5 deals with 12 October. Paragraph 6 deals with 20 October, and paragraph 7 sets out two things that it is said that Dr Pointer did not do, so:

“(a) did not request that Patient...”

And then (b) in its amended form:

“(b) refer patient A for specialist examination by the Hospital Eye Service.”

The issue at this stage is whether as a matter of law those facts can amount to misconduct. Perhaps I can reaffirm what Mr Stern has set out, that the key test is that, as set out by Mr Justice Jackson in the case of *Calhaem* that he referred you to, which has more recently been referred to Mr Justice Cranston in the case of *Cheatle v GMC* [2009] EWHC 645 (Admin). I don't intend to take you through the paragraphs of *Calhaem* that he took you to, but really just to reaffirm what the test is:

“Mere negligence does not constitute ‘misconduct’ within the meaning of section 35C(2)(a) of the Medical Act 1983. Nevertheless, and depending upon the circumstances, negligent acts or omissions which are particularly serious may amount to ‘misconduct’.”

A second principle is this:

“A single negligent act or omission is less likely to cross the threshold of ‘misconduct’ than multiple acts or omissions. Nevertheless, and depending upon the circumstances, a single negligent act or omission, if particularly grave, could be characterised as ‘misconduct’.”

He then goes on to deal with deficient professional performance, and the distinction between that and misconduct.

I think it was the case of *Preiss* which was referred to, where in some ways the everyday use of the word looking at the conduct, which was regarded as ‘deplorable’ by fellow practitioners, is one way of looking at whether something amounts to misconduct in the way that people will understand. I think the important thing is not to, as it were, try and put my own words on to the words that have been given by an experienced High Court judge. So I am just going to repeat it again:

“Mere negligence does not constitute ‘misconduct’...Nevertheless, and depending upon the circumstances, negligent acts or omissions which are particularly serious may amount to ‘misconduct’.”

Then a second principle:

“A single negligent act or omission is less likely to cross the threshold of ‘misconduct’ than multiple acts or omissions. Nevertheless, and depending upon the circumstances, a single negligent act or omission, if particularly grave, could be characterised as ‘misconduct’.”

So the question, Madam, we are being asked at this stage is simply as a question of law; the facts as admitted to, do they come within that definition?

**Ms Kershaw:** Are you both content with the legal advice? [Yes] Thank you, in which case I will ask you to withdraw, and we will consider the submissions.

[Hearing adjourned at 13.58]

[Hearing resumed at 15.01]

**Ms Kershaw:**

### **Findings in relation to misconduct**

On 12 October 2009 Dr Pointer was asked to examine Patient A. At the time she was six weeks short of her third birthday. The patient's mother explained that she was concerned as her daughter had, in her words been 'squinting' while watching television and reading over the past three months. Dr Pointer undertook a number of tests as part of what turned out to be an incomplete eye examination. His conclusion was that there was no problem with her eyes. He said that the mother should bring her daughter back in 12 months' time.

It has been accepted by Dr Pointer that he advised the mother of Patient A that she was squinting out of habit and there was no problem with her eyes or words to that effect; and that Patient A should attend for a return appointment in 12 months. He also accepted that he repeated that advice on 20 October 2009 when she came to collect a copy of the examination record as she intended to seek a second opinion elsewhere. He also accepted that he did not request that Patient A return for a further appointment in the near future so that the incomplete examination could be completed, or refer Patient A for specialist examination by the Hospital Eye Service. The mother went for a second opinion, which resulted in the referral of patient A to the Hospital Eye Service when glasses were prescribed. Patient A's mother gave evidence to the Committee today that Patient A remains under the care of the Hospital Eye Service and wears glasses full time.

The question for the Committee at this stage is whether the facts set out at paragraphs 5, 6 and 7 can in law amount to misconduct. The Committee was referred to the case of *Calhaem* and in particular the passage in the judgment where Mr Justice Jackson sets out a number of principles on the issue of misconduct having reviewed a number of other authorities.

The Committee found that Dr Pointer did not acquit himself well with this patient. From the material before the Committee he is a man with lengthy experience of treating patients in a general optometric practice.

The Committee was of the view that he clearly made an error in his management of Patient A. The question is whether his actions and omissions amount to misconduct. Applying the test in *Calhaem*, and in particular what Mr Justice Jackson said at paragraph 30(2) that a single act or omissions is less likely to cross the threshold of “misconduct” than multiple acts or omissions. The Committee found that the acts and omissions did not in this case amount to misconduct although they were negligent. The error was not so serious as to amount to misconduct. No doubt Dr Pointer will have reviewed his practices with pre-school children and the unique circumstances of this case will not recur.

The Committee thus found Jonathan Pointer not guilty of misconduct.

Thank you all for attending here today.

*[Hearing concluded at 15.04]*