

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

GENERAL OPTICAL COUNCIL

F(11)10

AND

KET FOONG CHONG (01-22323)

DETERMINATION OF THE INQUIRY: 5 DECEMBER 2011

ALLEGATION

The Council alleges in relation to you, Ket Foong Chong, that being registered under the Opticians Act 1989:

1. On 7th March 2009:
 - (a) Patient A consulted you advising that:
 - (i) he was experiencing double vision,
 - (ii) he had to shut his eyes to realign them,
 - (iii) the symptoms at 1(a)(i & ii) above were more pronounced at night,
 - (b) you were aware that:
 - (i) Patient A had reported the same symptoms at 1(a)(i-iii) above to you on 14th February 2009,
 - (ii) you had adjusted Patient A's refraction and dispensed a new prescription in response to 1(b)(i) above,
 - (c) you:
 - (i) re-checked Patient A's lens prescription,
 - (ii) recorded the same refraction and prismatic correction for Patient A as that recorded on 14th February 2009,

- (iii) informed Patient A that the lens prescription was correct,
 - (iv) informed Patient A that his eyes were still getting used to the new prescription,
 - (v) recorded in patient A's notes that *"No change. Can't seem to get a solution"*
- (d) you did not perform any further tests including:
- (i) ophthalmoscopy,
 - (ii) a fundus examination,
 - (iii) an anterior segment examination,
 - (iv) tonometry,
 - (v) automated perimetry,
 - (vi) any other appropriate clinical investigations,
- (e) you did not:
- (i) refer Patient A for further investigation of his presenting symptoms,
 - (ii) refer Patient A for an opinion by another optometrist or other competent specialist,
 - (iii) recognise the limits of your competence;
2. Your conduct and/or omissions at 1(d) and 1(e) above:
- (a) were inappropriate,
 - (b) were not in the best interests of the patient,
 - (c) was not of the standard expected of a registered optometrist;

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

DETERMINATION

Findings in relation to the particulars of the allegation

The registrant admitted particulars 1(b)(ii), 1(c)(i)-(v), 1(d)(i)-(vi), 1(e)(i)-(iii), 2(a)-(c) and the Committee found them proved.

The Committee notes that the registrant is unable to recollect the events which are the basis of allegations 1(a)(i)-(iii) and 1(b). It has therefore considered the evidence contained in the unchallenged witness statement of Patient A and reviewed the potentially factual matters covered by the expert report of Dr Adrian Jones. It has

heard submissions on behalf of the GOC and those made by Counsel on the registrant's behalf. It has taken the advice of the Legal Adviser.

Patient A consulted with the practice on 10 December 2008 and was not due to be seen again for another two years. He returned and was seen by the registrant on 14 February 2009 and on 7 March 2009. The registrant's notes record the comment: "No change. Can't seem to get a solution" on 7 March 2009. The registrant did not carry out further appropriate testing nor did he refer Patient A for further investigation of his presenting symptoms.

The events indicate that there was an ongoing problem for which the registrant took no further steps to diagnose, treat or refer.

Accordingly, on the balance of probabilities, the facts in allegations 1(a)(i)-(iii) and 2b(i) are found proved.

Findings in relation to misconduct

Mr Chong admitted has misconduct. The facts have been admitted and found proved. In assessing whether these amount to misconduct, which the Registrant has also admitted, the Committee has heard submissions from Counsel for the Registrant and the GOC and taken the advice of the Legal Adviser in applying its independent judgment.

The Committee has taken account of the relevant passages of *Calhaem v General Medical Council* [2007] EWHC [2007] EWHC 2606 at Paragraph 39:

(1) Mere negligence does not constitute "misconduct" ... nevertheless, and depending upon the circumstances, negligent acts 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".

The Committee took notice of the Code of Conduct (2005) in force at the time that Patient A was in the care of the Registrant. The same provisions apply in the Code in force since 2010. The Committee finds that, in breach of Paragraph 1, the Registrant did not make the care of the patient his first and continuing concern. He did not recognise the limits of his professional competence as required by Paragraph 9.

The Committee is satisfied that the allegations arise from the care of a single patient. The examination and prescription of 14 February 2009 did not resolve Patient A's problems. On 7 March 2009, when the Registrant could not find a solution to the patient's continuing problems, he took no steps to investigate or refer. He took no heed of there being a potentially serious consequence of leaving the patient with unresolved symptoms pending his next check-up two years later. The Committee

has not considered what was eventually diagnosed but the failure to recognise that there was a persisting problem which warranted further investigation or referral.

Accordingly, the Committee is satisfied that the Registrant committed misconduct by reason of the facts found.

Findings regarding impairment

In exercising its judgment in determining whether the Registrant's fitness to practise is impaired, the Committee has taken account of the submissions of both Counsel and taken the advice of the Legal Adviser. Impairment is not defined in the Opticians' Act 1989 or the Fitness to Practise Rules 2005 but, in this case, it is the function of the Committee to consider whether the misconduct which has been found proved is so serious as to raise the question whether the Registrant should be allowed to continue to practice, either with restrictions on registration, or at all.

The Committee has considered the Registrant's position as he is today. It notes that the allegations are serious in that they arise from the failure to act upon symptoms, investigate and refer a patient who, as a matter of fact, was subsequently found to have been suffering from glaucoma. The concerns here arose from the reliance on the results of a consultation with another practitioner three months previously in the practice and the registrant's subsequent failure to take further steps either to examine or refer which were, in fact, necessary.

The Committee is satisfied that the Registrant now has insight into the matters which have brought him here today. He admitted most of the allegations and did not deny those whose factual basis he could not remember. The registrant has had the benefit of peer review and has benefitted from mentoring. The Committee was cognizant of this aspect of his conduct.

The Registrant is aware that there was a deficiency in his dealings with Patient A on 7 March 2009. He recognises that he could and should have taken steps to ensure that Patient A had a referral to consider the question of why he had ongoing symptoms despite his new prescription. The Committee has been told that this is the only complaint which has been brought against the Registrant since he started in practice in 1972. The registrant has addressed these deficiencies and his examinations are now more systematic. He has changed the way he keeps records, maintains a greater awareness of the need for timely referrals and has addressed continuing professional development to ensure his skills and knowledge are those currently required of a reasonably competent optometrist. The Committee has had regard to relevant and appropriate references and testimonials from patients, professional colleagues and employers. Under the circumstances, the risk of future repetition is considered by the Committee as minimal.

Accordingly, the Committee finds that the Registrant's deficiencies are capable of being remedied and have been remedied in the period since March 2009.

The Committee found that the fitness of Ket Foong Chong to practise as an optometrist is not impaired.

In light of the seriousness of the outcome of this incident, the Committee has decided that it is necessary to impose a warning on the Registrant for a period of three years. This is an appropriate period that will indicate to the public and the profession the seriousness of the misconduct proved whilst upholding the standards of, and confidence in, the profession.

The Registrant is a long-standing member of the profession with a hitherto unblemished record. However, being a member of a profession brings privileges and responsibilities, which include keeping abreast of the standards of the profession and operating within the Code of Conduct for Individual Registrants. The Committee is mindful that whilst it was the Registrant's actions which were considered today, the issues of this case are pertinent to all members of the profession.

Chairman of the Committee: Francesca Jones

Signed _____ Date 5 December 2011

Registrant: Ket Foong Chong

Signed _____ Date 5 December 2011

FURTHER INFORMATION
<p>Transcript</p> <p>A full transcript of the hearing will be made available via the GOC website in due course.</p>
<p>Appeal</p> <p>Any appeal against an order of the Committee must be lodged with the relevant court within 28 days of the service of this notification. If no appeal is lodged, the order will take effect at the end of that period. The relevant court is shown at section 23G(4)(a)-(c) of the Opticians Act 1989 (as amended).</p>
<p>Council for Healthcare Regulatory Excellence</p> <p>This decision will be reported to the Council for Healthcare Regulatory Excellence (CHRE) under the provisions of section 29 of the NHS Reform and Healthcare Professions Act 2002. CHRE may refer this case to the High Court of Justice in England and Wales, the Court of Session in Scotland or the High Court of Justice in Northern Ireland as appropriate if they decide that a decision has been unduly lenient and/or should not have been made, and if they consider that referral is desirable for the protection of the public. CHRE is required to make its decision within 40 days of the hearing (or 40 days from the last day on which a registrant can appeal against the decision, if applicable) and will send written confirmation of a decision to refer to registrants on the first working day following a hearing. CHRE will notify you promptly of a decision to refer. A letter will be sent by recorded delivery to your registered address (unless CHRE has been notified by the GOC of a change of address).</p> <p>Further information about the CHRE can be obtained from its website at www.chre.org.uk or by telephone on 020 7389 8030.</p>
<p>Effect of orders for suspension or erasure</p> <p>To practise or carry on business as an optometrist or dispensing optician, to take or use a description which implies registration or entitlement to undertake any activity which the law restricts to a registered person, may amount to a criminal offence once an entry in the register has been suspended or erased.</p>
<p>Contact</p> <p>If you require any further information, please contact the Council's Hearings Manager at 41 Harley Street, London, W1G 8DJ or, by telephone, on 020 7580 3898.</p>