



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

F(11)05

**GENERAL OPTICAL COUNCIL
AND
NATALIE CLARE MURRAY (01-21329)**

**Thursday, 12 May 2011
and
Friday, 13 May 2011**

SUBSTANTIVE HEARING

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**SUBSTANTIVE HEARING: NATALIE CLARE MURRAY
DAY ONE
Thursday, 12 May 2011**

FTP Committee:	Sir Alistair Graham – Lay (Chair) Mrs Corinna Kershaw – Lay Mr Rod Varley – Lay Ms Catherine Viner – Optometrist Mr Gordon Ilett – Optometrist
Legal Adviser:	Mr David Swinstead
Hearings Manager:	Mr David Henley BEM
For the Council:	Mr Christopher Whalley
For the Registrant:	Mr Philip Gaisford Mr Scott Alexander

[Hearing commenced at 09.32]

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

To my right is Mr David Swinstead, 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 Mr David Henley, the Hearings Manager, who will provide administrative support to the Committee. Next to Mr Henley is the transcriber, 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 a patient are to be discussed that patient has been allocated the letter 'A' in the allegation, and the patient 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 it with the words "Patient A" or "the patient".

It is the Council's policy for the determination of the Committee and a transcript of 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.

The matter has been listed, first of all, as a procedural hearing but I understand the parties have agreed that it can proceed directly to substantial hearing. So unless anything has changed, shall announce the procedural hearing as having commenced and we can now go to the substantial element of the hearing.

First, I need to check whether there are any applications that need to be made?

Mr Whalley: Sir, there are two applications. First, I would be very grateful for some more time. The two experts, Mr McPherson and Mr Munro, whose reports you will have seen, are present today. I would be grateful for some more time so that they may have a conversation in relation to some of the outstanding allegations. You will, of course, have noted that a number of the allegations have been admitted by Miss Murray. A further document was handed up this morning of which I hope you all have copies. This is a copy of a note of a telephone meeting between Mr McPherson and Frank Munro dated 9 May.

Sir Alistair Graham: Before we go any further, would it be helpful to clarify that we are all talking about the right documents and what numbering we give them? The really thick bundle is C1, and then we have a document C2 which is the note of the telephone meeting between Stephen McPherson and Frank Munro relating to the case against Natalie Murray?

Mr Whalley: Yes, sir.

Sir Alistair Graham: Then the document which we are labelling C3 is the Response to Queries by Vicky Lord Subsequent to the Report by Mr Frank Munro.

Mr Whalley: Yes, sir, that is the additional report from Mr McPherson.

Sir Alistair Graham: Then for the Registrant we have R1 and that is the only document which we have at this stage, is that right?

Mr Gaisford: Sir, yes.

Sir Alistair Graham: So you have asked for more time so that the experts can see if they can agree on certain matters?

Mr Whalley: Yes, Sir. Regarding C2 which is the note of the telephone meeting, to which I referred, the two experts have not had the opportunity to meet in person to have a discussion about some of the outstanding allegations.

Therefore, I would be very grateful if they could be given some more time, which will be advantageous in the long run.

Sir Alistair Graham: This is before we read out the allegation and check what is admitted and what is not admitted, is that right?

Mr Whalley: I think it would be right to do that, sir. I also have a second application to amend two of the particulars in the allegation which I believe I can deal with at this stage.

Sir Alistair Graham: How long do you feel that the experts will require?

Mr Whalley: I would hope 10-15 minutes, sir.

Mr Gaisford: Sir, I agree. I fully support that application. Could I just make the point that time is somewhat of the essence in this case and, while it might sound contradictory to ask for a bit of time to start with, the matter they are going to talk about, this being the case where there are substantial admissions, is only like to prolong matters perhaps unnecessarily? That is why we are fully in support of them speaking together. There has already been extensive cooperation between the parties to try to achieve this position, so just a few more minutes might shorten matters considerably.

Sir Alistair Graham: I agree entirely that taking time at the very beginning between the experts very often can save a substantial amount of time later in the hearing. I shall check with my colleagues but I doubt that there is any problem in allowing you do so, and perhaps you can alert us when the experts have completed their discussion when we break up so that we may convene?

Mr Whalley: Certainly, sir.

Sir Alistair Graham: You say there is a second application that we can deal with at this stage?

Mr Whalley: Yes, sir, if I could ask you to refer to the allegations. First, allegation 1.a.i which reads: "you did not conduct muscle balance tests other than "DV cover C". After "C" there should be inserted "Rx", which is a true reflection of the entry made by Natalie Murray.

Sir Alistair Graham: So we take out the semi-colon do we?

Mr Whalley: No, sir, in quotations "C Rx" semi-colon. In the allegation pleaded at 2.a.i it is the same amendment. The second amendment, sir, is at 1.c, the sentence in quotation before "yeas" should be 18, so it should read: "motor accident 18 years had diplopia surgery" etc. That is, again, a true reflection of the contemporaneous notes.

Sir Alistair Graham: Are those all the amendments?

Mr Whalley: They are, sir. I can also say that the Council are offering no evidence in relation to one allegation but when that is dealt with when we come to reading the allegations out, that may be a more appropriate time to do that.

Sir Alistair Graham: Mr Gaisford, do you have any difficulties with the amendments?

Mr Gaisford: No, sir, they were my suggestion.

Sir Alistair Graham: Thank you very much. I take it my colleagues have no problem with the amendments? [*Agreed*] So that application is agreed. Shall we suspend the hearing until your experts have had an opportunity to talk to each other and perhaps you will let us know when we may reconvene the hearing?

Mr Whalley: Certainly, sir.

[*Hearing adjourned at 09.40*]

[*Hearing reconvened at 10.22*]

Sir Alistair Graham: Is it possible to move to the stage of reading the allegations?

Mr Whalley: I believe it is, sir. That time was very usefully spent and we are now in a position to move forward with the allegations.

Sir Alistair Graham: What I suggest is that we go through the allegations and that, as we take each paragraph, we see what is admitted and what is not admitted. Would that be a helpful of clarifying matters?

Mr Gaisford: Sir, I have discussed it with Mr Whalley and we believe that we can do it even more expeditiously by merely indicating what is not admitted.

Sir Alistair Graham: Okay.

Mr Whalley: Before Mr Gaisford does that, I can deal with some allegations upon which the Council offer no evidence. First, Allegation 1.c –

Sir Alistair Graham: We are slightly getting ahead of our procedure. The first thing that we are required to do is to read out the allegations and probably I would need to take where you are not submitting evidence, or where they are admitted as the next stage. For the first stage, we formally have to read out the allegations. Normally, at this stage, ask the registrant to stand but, given the length of them and your situation, I shall not do that. We shall read the allegations first and then see what the exact situation is.

Mr Henley:

ALLEGATION

The Council alleges in relation to you, Natalie Murray, a registered optometrist, that:

1. On or about 26 March 2007, at a consultation with Patient A, you:
 - a. Did not conduct an appropriately targeted or full examination given Patient A's condition or known history, in that:
 - i. You did not conduct muscle balance tests other than "DV cover C Rx"; and/or
 - ii. You did not conduct pupil dilation.
 - b. Did not take an adequate history from the patient in that:
 - i. You did not elicit that Patient A had a diagnosis for asthma, despite having recorded "inhalers" under current medication; and/or
 - ii. You did not ask what Patient A was taking "dihydrocodine" and "other painkillers" for, despite having recorded both under current medication; and/or
 - iii. You did not ask Patient A what "bp" was for, despite having recorded it under current medication.
 - c. Did not adequately take or record Patient A's ocular history in that you recorded "motor accident 18 years had diplopia surgery to correct no probs no" and:
 - i. You did not ask or record how Patient A was injured; and/or
 - ii. You did not ask or record why diplopia resulted; and/or
 - iii. You did not ask or record whether this was a direct injury or nerve palsy; and/or
 - iv. You did not ask or record what surgery was carried out; and/or
 - v. You did not ask or record whether symptoms settled over time or rapidly after corrective surgery.
 - d. Did not make adequate records following your consultation with Patient A, in that:
 - i. You did not record whether you considered the lesion to be a choroidal naevus, a suspected choroidal malignant melanoma or a choroidal malignant melanoma; and/or
 - ii. You did not record the drug names fully, under current medication.

2. On or about 28 July 2008, at a consultation with Patient A, you:
 - a. Did not conduct an appropriately targeted or full examination given Patient A's condition or known history, in that:
 - i. You did not conduct muscle balance tests other than "DV cover C Rx"; and/or
 - ii. You did not conduct pupil dilation.
 - b. Did not take or record an adequate history from the patient in that:
 - i. You did not elicit that Patient A had a diagnosis for asthma, despite having recorded "inhalers" under current medication; and/or
 - ii. You did not ask Patient A what "bp" was for, despite having recorded it under current medication.
 - c. Did not adequately take or record Patient A's ocular history in that you recorded "motor accident 18 years had diplopia surgery to correct no probs now no injinf hes recently" and:
 - i. You did not ask or record how Patient A was injured; and/or
 - ii. You did not ask or record why diplopia resulted; and/or
 - iii. You did not ask or record whether this was a direct injury or nerve palsy; and/or
 - iv. You did not ask or record what surgery was carried out; and/or
 - v. You did not ask or record whether symptoms settled over time or rapidly after corrective surgery.
 - d. Did not make full or adequate records following your consultation with Patient A, in that:
 - i. You did not record your diagnosis of the lesion; and/or
 - ii. You did not record the size of the lesion; and/or
 - iii. You did not record the position of the lesion with precision in that you recorded it as "temporal to the disc" rather than "temporal to the macula"; and/or
 - iv. You did not record your reason(s) for not referring Patient A to a medical practitioner; and/or
 - v. You did not record the drug names fully under current medication; and/or
 - vi. You did not record that Patient A had reported to you that:
 - a. His right eye was becoming very dry; and/or
 - b. At night time his right eye was often unfocused so that he had to use full room lighting rather than a bedside lamp to read'; and/or
 - c. His right eye was itchy; and/or
 - d. It felt like there was something in his right eye; and/or
 - e. He was not able to produce any tears from his right eye.

- e. Did not refer Patient A for further investigation or conduct further investigation in circumstances where:
 - i. You had observed a lesion in Patient A's right eye; and/or
 - ii. You were unsure as to whether the lesion in Patient A's right eye was raised; and/or
 - iii. Patient A had reported symptoms to you, as outlined at paragraph 2.d.vi.a-e above; and/or
 - iv. An absolute scotoma was noted in the right nasal field above the horizontal midline of Patient A's right eye; and/or
 - v. The positioning of the absolute scotoma corresponded with the lesion in Patient A's right eye;

- 3. On or about 7 August 2008, you:
 - a. Did not refer Patient A for further investigation or conduct further investigation in circumstances where:
 - i. You had observed a lesion in Patient A's right eye on previous occasions; and/or
 - ii. You were unsure on 28 July 2008 as to whether the lesion in Patient A's right eye was raised; and/or
 - iii. Patient A had reported symptoms to you, on 28 July 2008, as outlined at paragraph 2.d.iv.a-e above; and/or
 - iv. An absolute scotoma was noted in the right nasal field above the horizontal midline both in the visual field tests taken on 7 August 2008 and on 28 July 2008; and/or
 - v. The positioning of the absolute scotoma corresponded with the lesion in Patient A's right eye; and/or
 - vi. Digital fundus images of the right eye had not captured the lesion.

 - b. You did not take responsibility for Patient A's care in that:
 - i. You did not interpret Patient A's threshold visual field test results yourself; and/or
 - ii. You did not obtain digital fundus images of Patient A's right eye that captured the lesion.

By virtue of the matters set out above at paragraphs 1-3, your fitness to practise is impaired by reason of your deficient professional performance and/or misconduct.

Sir Alistair Graham: Thank you. Mr Gaisford, you are going to tell us?

Mr Gaisford: Sir, it might be appropriate if my learned friend addresses you first on matters which are not going to be proceeded with.

Mr Whalley: Yes, Sir. The Council offer no evidence in relation to allegation 1.c in its entirety, 1.d.i and 2.c in its entirety.

Sir Alistair Graham: Is that it?

Mr Whalley: Sir, it is.

Mr Gaisford: Sir, a very small point, if one goes to 3.a.iii I think it should be a reference to 2.d.vi rather than iv.

Sir Alistair Graham: It is the wrong way round.

Mr Gaisford: The matters in dispute that I was going to identify, is that the charges are admitted save for 2.d.vi. a, b, c, d and e; 2e.ii; 2.e.iii; 3.a.ii; 3.a.iii and, finally, 3.b.i.

Sir Alistair Graham: Can we just check that we have those right: 2.d.vi is what you started with, is that right? [Agreed] 2.e.iii –

Mr Gaisford: Sir, 2.e.ii and 2.e.iii.

Sir Alistair Graham: [continues] 3.a.ii, 3.a.iii and 3.b.i.

Mr Gaisford: Sir, yes.

Sir Alistair Graham: I think that takes us to you, Mr Whalley, to present your case on behalf of the Council.

Mr Whalley: Thank you, sir. I shall address you very briefly in opening before calling the first two witnesses who are Patient A and the expert Mr McPherson. Given the very helpful admissions that you have just heard, I shall do my very best to limit their evidence to what is still disputed. You have copies of all the expert reports which no doubt you will have already read. Again, I shall do my best to focus on the points that are still disputed.

Before I turn to the facts, sir, I would remind you that it is the Council who bring the case today, and the burden of proof is on the Council to prove that case. That standard of proof is the civil standard which is the balance of probabilities. The Council must discharge that burden in relation to the factual allegations only which are set out at allegations 1, 2 and 3. The other matters of whether those admitted facts and proven facts constitute either deficient professional performance and/or misconduct are matters for your professional judgment, as, of course, is the question of whether Natalie Murray's fitness to practise is presently impaired.

Sir, my learned friend and I had a discussion about the number of stages in which we take today's hearing, and we are in agreement that we would encourage you to adopt a two-stage process. The first stage is to consider the facts admitted and proven, retiring to make a decision. Then hearing further submissions in relation to the deficient professional performance and/or misconduct and impairment at the same time. That is what is set down in the Rules and it often is not the standard procedure here but my learned friend and I are in agreement that it would be a sensible way forward today.

Of course, it is a matter for you and I am open to any recommendations my learned friend has but that is certainly what we would invite you to do.

Turning to the facts, the initial letter of complaint by the complainant in this case, Patient A, was sent to the Council on 13 November 2009. That letter of complaint is found at page 45 of C1, which is the agreed bundle of evidence and the evidence which Mr McPherson considered in preparation of his report. In his letter of complaint, he states that he attended Specsavers for a number of years but, in relation to these allegations, there are three relevant dates: 26 March 2007, 28 July 2008 and 7 August 2008. On the first of those two occasions, Patient A was examined by Natalie Murray. He states in his complaint that he informed Natalie Murray of his symptoms but that on each occasion, she did not carry out the necessary investigations, and did not recognise the signs of what subsequently turned out to be a cancerous melanoma. Of course, the allegations are not that there is a direct connection/causation from Natalie Murray's examinations and that melanoma but those are the circumstances of the case and his relevant background.

Following receipt of that complaint in November 2009, Mr McPherson was instructed to consider the case and prepare his expert report. Patient A will give evidence today about what information he provided to Natalie Murray at the examinations, and what questions he was asked by Natalie Murray and what treatment he was provided with. Of course, now that you are left with fewer allegations, his evidence will be focused on allegations 1.b, 2.b, 2.d.vi and 3.b.i. They are factual matters on which his evidence will be focused.

It is the Council's case that Natalie Murray did not take adequate history from Patient A in relation to his general physical health but as far as the ocular history, it has now been agreed that what was recorded was indeed sufficient. Mr McPherson will give evidence in relation to all the allegations save for allegation 2.d.vi which is entirely a matter for facts for Patient A and Natalie Murray to deal with in their evidence.

Mr McPherson will say that on 26 March 2007, Natalie Murray did not conduct a full examination and did not obtain an adequate history of Patient A's general health and, indeed, did not make adequate records of her findings.

In relation to 28 July 2008, he will say that the same concerns were present as I have just identified but he also states that, as far as the examination results on 28 July 2008, Natalie Murray should have conducted further investigations into Patient A's condition or, indeed, should have referred Patient A for further investigation.

On 7 August 2008, Natalie Murray did not examine Patient A. What Stephen McPherson will again say is that the examination results produced were the same as those produced on 28 July 2008 and, as such, Natalie Murray should have undertaken a further investigation or she should have referred Patient A for further investigation.

As well as the oral evidence that you will hear from both witnesses today, I invite you to consider all the documentary evidence that you have before you with particular emphasis on the two expert reports and the subsequent documents that they have agreed upon. I have handed up further photographs which I believe are marked as C5, I believe we are up to now. These are better copies of what you already have in the bundle of documents in C1. They are only of real relevance to allegation 3.b.ii.

Sir Alistair Graham: May I just clarify the numbering?

Mr Whalley: I may be ahead of myself, sir. If we are up to C4, then it will be C4. They are only of relevance to the last allegation that is before you. In short, the main concerns identified by Stephen McPherson are Natalie Murray's inadequate record-keeping, failure to carry out tests with pupil dilation on 26 March 2007 and 28 July 2008, and a failure to conduct further investigations, or to refer the patient for further investigations, following the test results of 28 July 2008 and 7 August 2008.

The Council will not be calling any additional evidence in relation to deficient professional performance and/or misconduct and, indeed, impairment, because the Council's position is that they are entirely matters for your professional judgment. It is, however, the Council's case that the facts admitted and, indeed, that are proven do amount to deficient professional performance and/or misconduct. As a result of that, Natalie Murray's fitness to practise is presently impaired. That is all I wish to say in opening, sir. If I may now move to call the first witness who is Patient A.

**PATIENT A, called and affirmed
Examination-in-Chief by MR WHALLEY**

Q. For the purposes of today's hearing, you will be referred to as Patient A to keep your identity anonymous. I shall, first, ask you some questions on behalf of the Council but, although I shall ask you the questions, I would be very grateful if you would try to direct your answers towards the Committee. First, may I confirm that, for the purpose of these proceedings, you are Patient A and you have seen the documents before you?

A. Yes, I have.

Q. You wrote to the General Optical Council in November 2009 to make a complaint, that is right, isn't it?

A. Yes, I believe so.

Q. For the purposes of that complaint, and in relation to Natalie Murray, when was the first occasion you attended Specsavers?

A. A difficult point.

Mr Gaisford: The witness may be led, sir, I have no problem.

Mr Whalley: Is it right that you attended for your first appointment with Natalie Murray on 26 March 2007?

- A.** Yes.
- Q.** And why did you attend on that date?
- A.** I was having problems seeing when reading in my right eye. It was difficult to focus, especially when reading at night.
- Q.** And at that appointment, do you recall what questions you were asked about the symptoms by Natalie Murray?
- A.** General health and the medication I was on, and the state of my eyes, if my sight had deteriorated since my last appointment.
- Q.** Do you recall the examination and procedures that took place on that date?
- A.** Yes, I do.
- Q.** And what were they?
- A.** I was asked to view the card on the wall. I was also asked to read a card. I was given various options in lenses. For instance, is it a sharper green with this or a sharper red with that, etc? Then I was given a peripheral vision test and glaucoma, what I call a “puffer test”.
- Q.** At that appointment, did Natalie Murray inform you of any particular problem or concern she had about your eyes?
- A.** No.
- Q.** You were given a prescription, no doubt?
- A.** Yes.
- Q.** When was the next appointment arranged, do you recall, at that time?
- A.** The next appointment was a year later, July 2008.
- Q.** That is 28 July 2008, that is right?
- A.** Yes.
- Q.** And leading to that appointment, how were your eyes?
- A.** My right eye had become slightly worse and, again, reading – not distance – where I had to read in full light rather than by the bedside lamp at night. The eye itself was sometimes dry and itchy.
- Q.** How were your eyes on that date compared with the year previously?
- A.** As I said, the tests were carried out again, I was asked to return to do the optical vision again.
- Q.** On 28 July 2008, how were your eyes compared with how they were the previous year in March?
- A.** The right eye I felt was very difficult to focus at times, especially when I was reading later at night. Distance-wise with my glasses, I did not really see much difference in my eyesight at all.
- Q.** The symptoms you have just given evidence about in your right eye, did you inform Natalie Murray of those?

- A.** Yes, I did.
- Q.** Do you recall whether that was as a result of being questioned about it, or did you provide that information unprompted?
- A.** No, I was asked again about my general health and if my eyesight was any difference, of it I had noticed any difference. I stated what I have just stated, it was a basic sentence, and then I went through the testing regime again.
- Q.** What was the outcome of that appointment: were any concerns identified?
- A.** Yes, the peripheral vision test was required to be done again because there were anomalies in it. I asked the question why and was told that this can happen once you have had your eyes tested, they can give a false reading on the peripheral vision test.
- Q.** It is right that because of that, you were asked to return for further tests?
- A.** Yes.
- Q.** You attended on 7 August 2008, so a week or so later?
- A.** Yes, 10 days or so.
- Q.** Whom did you see on that occasion please?
- A.** I saw a technician.
- Q.** What test did he or she conduct?
- A.** I was given the peripheral vision test, the small lights flashing about inside what I would class as the dome.
- Q.** You are not an optometrist but was that the same test that you had been given a week or so previously?
- A.** Yes.
- Q.** Following that test, did you speak with or meet with Natalie Murray?
- A.** I did not.
- Q.** Are you able to say whether the technician spoke with Natalie Murray?
- A.** Yes.
- Q.** Did you hear or see the conversation?
- A.** The technician told Natalie Murray that my peripheral vision test was the same.
- Q.** Do you recall Natalie Murray's response?
- A.** Just that my prescription would then be the same as it was last time.
- Q.** Do you recall whether Natalie Murray was shown or looked at the results?
- A.** No.
- Q.** Sorry, is that, no, you do not recall?

- A. I obviously would not know things computer-wise but I finished the test, I was behind the technician and Natalie Murray was going into her own room, and that is where the conversation took place.
- Q. As far as where the conversation took place, where was that in relation to where you were sitting? You were sitting one side of the machine -
- A. I would have thought it was barely six feet away, it was in the test area.
- Q. Was that on the side where the technician was recording the results of the test?
- A. Yes.
- Q. Thank you, I have no further questions for you. You may have some from my learned friend.

Cross-examined by MR GAISFORD

- Q. Yes, but not very many. I represent Natalie Murray and I want to ask you a few questions about what you have already said. May I make it clear that it is recognised that you have had a very worrying time over your eye. Could I take you back to these consultations with Natalie Murray? She asked about your general health.
- A. Yes.
- Q. And you said you had no health issues?
- A. That is correct.
- Q. I believe your position was that you wanted to get on and have your eyes attended to rather than deal with your general health, that was your stance on it, would that be fair?
- A. Well, my general health I view as being what I have. I have rheumatoid arthritis, I deal with that. Unless I am in the middle of a rheumatoid arthritic flair, I tend to class myself as being in good health.
- Q. I follow. You made a statement, which you can see if you like, that would likely have replied that there were no health issues since my health is generally fine and I am coping with my long-term conditions. I think that is what you just said really, you are coping and that was the position at the time. You also said, "I gave Mrs Murray any general information regarding my medication, because I wanted the appointments to focus on my eyes, not on peripheral issues"?
- A. That is correct.
- Q. Thank you. In July 2008 she asked you about dihydrocodeine and you told her that you have rheumatoid arthritis?
- A. That is correct.
- Q. Thank you. So she established the general nature of the medication that you were on, if perhaps not the actual names of the medicines?
- A. Yes.

- Q.** Could I just ask you, one of the medicines you were on were antihistamines, what did you have that for?
- A.** Hay fever.
- Q.** Right. I want to go back to 26 March 2007. You said you had various tests but what I do not believe you mentioned was she told you that she had found a mark at the back of your eye, that is right, isn't it?
- A.** Yes. Her exact words as I remember were that I had a freckle.
- Q.** Thank you, a freckle, and she gave you the impression from what she said that it was of no immediate concern and you could come back in 12 months?
- A.** That is correct.
- Q.** Thank you. Back you went on 28 July 2008 and did you get a letter from Specsavers asking you to go back in?
- A.** I believe I did.
- Q.** You went in, in response to the letter really?
- A.** It would be partly in response to the letter, yes.
- Q.** You said just now that your eye was sometimes dry and itchy?
- A.** Yes.
- Q.** That suggests that is not something that was passed on to Natalie Murray, the itchy dry eye. Can you recall now whether you mentioned it to her or not?
- A.** I think I did mention it.
- Q.** You think you did?
- A.** Yes.
- Q.** Right. Can you remember when the itchiness came on and the dry eye?
- A.** No, I can't say that I can pinpoint a date.
- Q.** Had it been going on for a little time before the consultation or not?
- A.** I would say probably a little time before the consultation, yes.
- Q.** Can you be sure that it was not something that came on after the consultation?
- A.** No, I am fairly sure it was before the consultation.
- Q.** Had you had it before, this kind of feeling?
- A.** Right. I had a motorbike accident when I was 18 years of age which severely broke my face. At that point, the tear duct in my right eye was damaged. The effects of that were quite a lot more onerous than the itchy dryness that I felt then but I would say there was a slight comparison to make.
- Q.** So your recollection is that, on this same occasion when you saw Natalie Murray, you had an itchy, dry eye and you believe that you mentioned it to

her. You went to see a general medical practitioner, a GP, in January 2009, so some months later when things had become bad for you?

A. Yes.

Q. What you told the doctor was about flashes I think that you were getting at that stage?

A. That is correct.

Q. You did not tell him anything about the dry eye did you?

A. No, I don't think I did.

Q. Would you forgive me for one moment, I have to make sure that I have asked you everything that I should. [Pause] I believe I understood what you were saying about the prescription. I believe that it was changed slightly on the second occasion, is that right, the prescription for your glasses? Much the same but a slight change.

A. Well, no. The prescription, as I understood it, was to be the same.

Q. Did you get new glasses?

A. No, I didn't.

Q. Those are all my questions, thank you.

Questioned by the Panel

Mr Ilett: I have a couple of questions to clarify a few points. You know when you had the visual field test done with this bowl in front of you, were any lenses used, did you wear your spectacles or was a lens put up in front of your eye while you were having that test, or was just with your naked eye that you had the test done?

A. I just put my chin into the machine and that was it. I watched the dot in the centre and then pressed the button when the individual lights came on.

Q. So there wasn't a little lens or anything in front of your eye?

A. No.

Q. You mention that you suffer from hay fever. Is that worse at any particular time of the year for you? A lot of individuals may find it is worse in February because of the trees, or worse at other times of the year. In your case, do you get it worse at any particular time of year?

A. The damp spells in the year are worse for my hay fever rather than the hot ones.

Q. Right. With the injuries that you have had, both the motorcycle accident that affected your tears, and your rheumatoid arthritis, have you ever had to use any other eye drops or anything for your eye problems?

A. No.

Q. With the problems you are getting around this dry eye, was it bad enough for you to attend for an eye test before you received a reminder, or was it just a minor irritation?

A. It was a minor irritation, it wasn't a dry eye all the time, it wasn't itchy all the time. It was as if you had something, you would give it a rub and a little while later it would appear to be okay. It seemed to be an irritation, as you say, rather than a permanent thing.

Q. Thank you very much.

Ms Viner: May I ask you a question as well about the visual field test. When you had your chin on the chin-rest and you were peering into the dome shape, were you asked to look just at the centre, or were you ever asked to look at a light or a target that was off-centre?

A. Purely the centre point.

Q. That is fine.

A. I was told at one point not to move my eye, because they must have seen that I had.

Sir Alistair Graham: Can I ask what prompted you particularly to go to your GP rather than back to the optician?

A. I had been to the optician in June. When the flashes came on – to let you understand, I run my own business – I did not understand the flash. I had never heard about a flash or anything other than I felt it could be a brain tumour. I did not necessarily relate it to anything that could happen inside the eye, so I went to my GP.

Q. Thank you very much. Unless anyone else has any further questions? [*no further questions*] We can probably ask this witness to stand down, thank you very much.

[*The witness stood down*]

Mr Whalley: If I could call the second witness please, Stephen McPherson.

**MR STEPHEN CHARLES McPHERSON, called and sworn
Examination-in-Chief by MR WHALLEY**

Q. Mr McPherson, can ask you to give your full name to the Committee?

A. I am Stephen Charles McPherson.

Q. I shall be asking you some questions first of all, and there may be some questions from my learned friend and from the Panel afterwards. While I am asking you the questions, I would ask that you direct your answers to the Panel please. You have a bundle of documents in front of you which are labelled SCM 1, 2 and 3. May I ask you to refer, first, to SCM 1. That document is an expert report that you produced, that is right is it not?

A. Yes.

- Q.** SCM 2 are documents that you considered in the preparation of that report?
A. Yes.
- Q.** And SCM 3 is a further report you prepared following the report you had seen from Mr Munro?
A. Yes.
- Q.** Can you confirm that all the facts stated in your report are true to the best of your knowledge and belief?
A. Yes, that is the case.

Mr Gaisford: Can I just interrupt? If Mr Munro could come in and hear the expert evidence, it would be helpful, that would be the usual course I believe?

Sir Alistair Graham: Yes. [*Pause in proceedings while Mr Munro is fetched*]

Mr Whalley: [*Continues examination-in-chief*] Mr McPherson, in your report where you have expressed an opinion, can you confirm that those opinions are true and that they refer to your professional opinion?

- A.** Yes, I can say that is true, they reflect my professional opinion.
- Q.** Before I ask you some questions about the allegations, could you briefly set out what your qualifications are please?
A. I am an optometrist, I have been working in practice for about 26 years, I have served on various committees related to my professional life. Largely, what I do is see patients on a daily basis, which I hope has given me some background to produce a report of this sort.
- Q.** You will be aware that a number of admissions have been made in this case by Natalie Murray, so I shall do my best to ask you questions on those matters which are outstanding. You are aware that there were three appointments when Patient A attended Specsavers. The first appointment was on 26 March 2007 on which occasion Natalie Murray identified that there was a lesion on the right eye. What is your opinion on that identification and that assessment?
A. We should really say that Natalie Murray showed good skills in identifying that a lesion was there. The lesion as you can see from the photographs is not directly at the posterior pole of the eye, so she clearly conducted a reasonably good examination according to the records using a Volk lens, which is the gold standard of examination, and she picked up the fact that a lesion was present in the eye. She made a reasonable description and drew a diagram on that visit of the lesion.
- Q.** Turning to the second appointment on 28 July 2008, we have just heard evidence from Patient A that he informed Natalie Murray about certain symptoms at that appointment. He had an itchy and dry eye and at night-time he was unable to read without room lighting other than a lamp. You are unable to say whether or not that was said, that is a matter for that witness. However, if that information had been provided about the symptoms, would you expect it to be noted down in the patient records?

- A.** Yes, it would be normal practice to note down the symptoms with which the patient presented at any given visit.
- Q.** Can I ask you to look at the patient record for that appointment on page 64 of C1, the large bundle?
- A.** I have page 64 in front of me.
- Q.** You can see in the bottom left-hand side of that page, we have an entry for peripheral retina and the entry is: “all quadrants checked, inf temp to disc, lesion not raised? no drusen”. What is your interpretation of that entry please?
- A.** The entry seems to indicate that all quadrants of the eye were examined, so they were visualised by the examination. It was noted that inferior temporal to the disc a lesion existed, it then says “not raised?”. It would be normal practice to put a question mark where there is some lack of certainty about these things, which, frankly, is not uncommon when you are examining an eye. It states there are no drusen present.
- Q.** Where you talked about the question mark, what would that suggest to you, there being a question mark after the word “raised”?
- A.** With a record on which I had written a question mark, it would cast doubt upon whether I was sure about the fact that I had just written. I think we could say that is pretty standard practice. Everything that you look at in an eye will not be an open and shut case. It is like taking a ping-pong ball, drilling a hole in it and trying to examine the inside of it, which is not terribly easy to do. Therefore, there is sometimes doubt involved and this is pretty much standard notation for saying this is what I think, I am not absolutely certain. That is what I would interpret from that.
- Q.** The next appointment for which Patient A attended was on 7 August 2008. On that occasion, Natalie Murray did not examine Patient A, a technician conducted a visual field test. As far as the relationship between the technician and the optometrist, with those test results what would you expect to happen?
- A.** It would be quite standard practice for a technician to take the results which had been asked for, as these results would be interpreted by an optometrist under normal circumstances. I was surprised to see that there was no recorded outcome of that examination. I would expect the optometrist to record what tests had been done and what they meant to them, how they interpreted the results.
- Q.** Are there any circumstances when the interpretation of the results is left to a technician?
- A.** No.
- Q.** Regarding the time between the first two appointments on 26 March 2007 and 28 July 2008, is right that there was a change in the lesion that had been identified in the first appointment?
- A.** We do not have an accurate description of the lesion that we could say is in cast iron but there is one change in the results apparent between the visits of

2007 and 2008 which is materially different. Those are the visual field plot results.

Q. At pages 25 and 26 of bundle C1, looking at the bottom right-hand pagination, you can see you set out a summary of what the concerns you have identified are. What concerns you most about this case, Mr McPherson?

A. To my mind, the most crucial thing is that abnormal findings were noted by the tests done certainly in the 2008 examinations, both in July and August, and no specific action was taken about these abnormal test results. There seems to be no conclusion as to why they were abnormal, and we have no follow-up from these results.

Q. What follow-up would you expect in those circumstances?

A. The main issue was that a field defect was both found and confirmed. First, you would expect the optometrist to think about why is that field defect there, and it would be certainly useful for the association to be made between anything noted on the retina and the field defect, to try to tie these things up. On both occasions, the Scottish eye examination does allow for supplementary examination for pupil dilation, a more detailed retina examination and there is no doubt that, if that had occurred, it would have strengthened the information available to the optometrist, and made it more likely that they would have taken appropriate action in this case.

Q. Thank you, Mr McPherson, I have no further questions at this stage. There may be some from my left.

Mr Gaisford: Sir, could I just have a word with Mr Munro about something not of a technical nature, would you forgive me if I just speak with him?

Sir Alistair Graham: Yes, of course.

Mr Gaisford: Sir, thank you.

Cross-examined by MR GAISFORD

Q. Could I ask you one or two general questions on behalf of Natalie Murray? I believe you say in your report that this is a rare diagnosis the way this turned out?

A. I think this is a very rare diagnosis, absolutely.

Q. It also follows from your report that this lesion developed fast?

A. I think the evidence is very much of that. If you look at the hospital records when compared with the findings of Natalie Murray, the symptoms which in due course developed for Patient A, which were clearly not the case at the time when he was seen by Natalie Murray, I agree that it has been a fast-developing lesion.

Q. Thank you. This is a matter that has been admitted at 1.a.i but while you are here I would like to ask you about it as it may become relevant at one stage of the Committee's considerations. It relates to the muscle balance test. You

said in your report that this was bordering on insufficient information. You are critical but, as I understand from the way you have put it, it is not gravely below the standard expected of an optometrist, would that be right or not?

A. That is right in this case, I would accept that to be the case. Any injury which occurs will stay with you for life however it has been repaired, so the gold standard would be that you would have more information about exactly what happened. He did not appear to have any symptoms and he had been seen in that practice for many years. Certainly, it would be fair that this would have no bearing on the eventual diagnosis of choroidal melanoma.

Q. Thank you. I have no further questions thank you.

Sir Alistair Graham: Mr Whalley, do you have anything further?

Mr Whalley: No, thank you, Sir.

Questioned by the Panel

Mr Ilet: I have one question. This relates to evidence that we have just heard from a previous witness and concerns the visual field testing. Are you familiar with the Humphrey Visual Field Analyser, do you use it in your practice?

A. Yes, I do.

Q. If a conversation were to take place next to the field machine after field testing had been done but before a printout had been obtained, would either the technician or the optometrist be able accurately to analyse the data at that time, or would a printout be required?

A. The data on the screen simply give you numerical values which are not related in any way to the patient's age. Therefore, these values would be extremely difficult to interpret. In addition, no reliability indices are indicated there, so I would say that any assessment on the screen is an almost useless thing to do. You would require a printout to make a proper analysis of the result.

Q. Thank you.

Ms Viner: Can I just ask a question about the appointment on 26 March 2007, where you say that Natalie Murray had shown good clinical skills in being able to note a lesion that was away from the posterior pole. In your opinion, with the examination with a Volk lens and slit lamp would the view of that lesion in that position have been a binocular one using the instrumentation that was used?

A. That is highly unlikely on the basis that the pupil size of someone in their fifties will not be very large and, if you try to view obliquely, even if you use a lens that is designed for use in small pupils, it is most unlikely that the view would be binocular, and I do not think you would expect to get a depth perception element without pupil dilation.

Q. Is there any way you can suggest that Natalie Murray's recording of the lesion at that first visit in 2007 could have been made other than by the technique

which was used which you just said would not perhaps have given a binocular view?

A. I believe that she did not optimise the examination to give herself a good chance of telling whether it was flat or not. If a lesion is significantly raised, you will see differences in focus as you move the slit lamp over the different layers of the retina but, certainly, it would be a difficult judgment to make if we are looking for small changes.

Q. Thank you.

Sir Alistair Graham: Could I just clarify this issue relating to the visual field test where Patient A was brought back, as I understand it, to have a second visual field test, have I got that right?

A. Yes, that is correct.

Q. This was carried out by a technician and there was no recording of the optometrist having analysed the results, is that the situation?

A. That is certainly the way I see it.

Q. Where is the evidence to support that? Where do I have the documentation to confirm that analysis was not done?

A. Simply because there is no record of the visit. I suppose we have to make the assumption that, as there is nothing recorded on the patient notes, we have no evidence that anything did happen. We do not have much evidence that nothing happened other than the witness statement that said they discussed it in the corridor on the way past. You would expect to have a written record of the outcome, because the field requires analysis. Someone has to look at it and say what does this mean to me; that would need to be done by an experienced professional.

Q. So it would be quite a common situation that a visual field test is done with the optometrist present?

A. The optometrist would not be present doing the test but they would be given the results.

Q. As I understand it, there was one test done and there was a worry about whether this was a rogue test of some sort.

A. Yes.

Q. The patient was invited back in August to do a further test?

A. Yes.

Q. Would that be quite common?

A. That is normal practice. Visual fields are not a straightforward test, there are many subjective elements in it and patients are sometimes not very good at the test, although the test indices help us with that. A lot of advice frequently given about visual fields is that, if something does not look quite right, the first thing you do is simply do it again. If you look at the results of the two tests, there may have been some fixation errors in the first test in 2008 for the right eye which might cast some doubt upon the reliability of it. In fact, a second

test was done a few weeks later which had better reliability indices, which may make you more comfortable but it showed almost exactly the same field defect, which would make us much more comfortable that the initial field test was also telling us something real and was reliable.

Q. So it should have been shown on the patient record that a further visit had taken place, a second visual test done and what the conclusion of the optometrist was of that result?

A. That is exactly correct.

Q. Thank you, if there are no further questions?

Re-examined by MR WHALLEY

Q. The Chairman was asking about records so perhaps we could look at the records. My understanding is that they are at pages 59-61 of exhibit C1.

A. Yes, I have that.

Q. Is it right that these are the records from that date? The first document we can see has the date of 28 July, which would suggest it is the previous appointment?

A. 28 July, so what page is that?

Q. Page 59, which I believe is the record from the appointment on 28 July.

A. I agree.

Sir Alistair Graham: While we are on that, there is a reference to Thursday, 7 August?

Mr Whalley: That is correct, Sir. Perhaps Mr McPherson can help. Looking at page 59, first of all, do you understand that is a record from the July or the August appointment?

A. That is dated to me to say 28 July 2008.

Q. So the entry in the centre of that page for Thursday, 7 August would be for the next appointment?

A. I am looking at the date at the top of the page, on the top line, which is two thirds of the way along, where it says 28/7/08.

Sir Alistair Graham: I can see that but I am just querying why there is a reference to 7 August?

Ms Viner: Is that the collection, because it says fitted by Matt, collection 7/8?

A. That would make sense to me and that was the case according to the data we received, that when he collected his glasses he also had the additional field test done. That would make sense although the prescription here is dated 28 July, and 7 August is presumably when his glasses are collected and a supplementary visual field test was carried out on that date. You may have noticed that some of the photographs were dated 7/9/08 which we assume is an error and that it meant 7/8/08.

Mr Whalley: So is it right to say that the only record in these documents from 7 August is at page 60 which is a visual field test?

A. Yes. There seem to be no optometric notes whatsoever. We simply have visual field plots with no conclusion or no optometric notes of any description that I can see.

Sir Alistair Graham: Where would they be shown? It seems to me it is an important document to clarify what exactly should have happened.

Mr Whalley: Sir, that is exactly what I was hoping to ask Mr McPherson about. If we look at the record for 28 July, those records start at page 62 and run through to page 67. What are the documents that you would expect to be recorded after the visual field results were relayed to Natalie Murray?

A. Computerised records can work in various ways. Going by my own experience, it is possible in our practice to select a full examination record which will then give you a pro forma, something like you see here on page 62. If someone came back for an additional supplementary appointment within a few weeks, the purpose of that, as seemed to be the case, was to repeat the visual field test and, secondly, to have the photographs of the retina redone. The visual field test was certainly carried out and it confirmed the field defect which was recorded on 28 July. My best understanding of what was suggested by Natalie Murray of "need other side" is I can only suggest it meant she was hoping to capture an image of the temporal retina of the right eye to show the image which would be good practice. Certainly, the photographs that were taken were exactly the same, on the same alignment and showing the same detail, or lack of it, as those carried out in July.

My practice would be to select not a template like this but somebody would do the field test and give it to me, and I would then click on where it says supplementary visit, or I may simply note "visual fields repeated, I note fields confirmed defect", and I would then go on to say "dilate pupil, examine eye and check what is happening" or perhaps refer the patient. However, you would expect to see a note that the patient had attended the practice in the optometric notes, and you would expect to have a conclusion from the tests which were done as to what it meant to you and what your next action would be.

Q. So you cannot point to an example in here of what you would expect to see?

A. There appear to be no optometric notes from the visit of 7 August of which I am aware, which is not normal practice.

Sir Alistair Graham: And the notes might have been required to ask the patient to come back?

A. Absolutely. The conclusion could have been that this is still an unclear finding and we think we should see you in six months, as the most appropriate action. It could say absolutely anything but you are required to formulate a conclusion to the tests you have done. There is no evidence of that having happened in this case.

Mr Whalley: Thank you, Mr McPherson, I have nothing further.

Sir Alistair Graham: Are there any further questions for this witness? [none]
Thank you very much.

[The witness stood down]

Mr Whalley: Sir, that is the case on behalf of the Council.

Sir Alistair Graham: Thank you very much. Mr Gaisford?

Mr Gaisford: Sir, I propose to call Natalie Murray. Could I raise one matter first of all? I would prefer to call her once only, so I would like her to deal with matters that have been admitted as well as with matters that are still not admitted, so that I do not have to recall her and she can give her evidence in one seamless go. I do not know whether that is acceptable to the Committee?

Mr Swinstead: You are a professional Committee with experience possibly on previous occasions of hearing all the evidence from a registrant at one time, but only relying on the relevant pieces of evidence you hear at the relevant stages. So if there are any matters relating to fact, you would deal with them at this stage. If she deals with matters which may more properly go to the later stages, you can put those out of your mind at this stage and then recall them at a later stage.

Mr Gaisford: Sir, I am happy with that.

Sir Alistair Graham: It is a matter for you in the end to decide.

Mr Gaisford: Thank you very much. I shall call her now to give evidence. [pause]

**MRS NATALIE CLARE MURRAY called and affirmed
Examination-in-chief by MR GAISFORD**

Q. Mrs Murray, could you just confirm that you are Natalie Clare Murray, and I believe you were formally Natalie Clare Ashman, is that correct?

A. Correct.

Q. And that name appears on some of the papers we have put into the Committee. Your qualifications are BSc (Hons) Optometry Glasgow Caledonian University 2003, and core competencies from the Scottish Committee of Optometrists 2006, is that correct?

A. Yes.

Q. Is your professional experience that you worked in Specsavers in Inverness prior to qualification in 2004 and, following your qualification, you worked throughout with them?

A. That is correct.

- Q.** And you were working full time, is that right?
A. I was.
- Q.** But you are currently working part-time for obvious reasons?
A. Yes.
- Q.** Because you have a baby due in August?
A. Yes, and I went back part-time after my first child.
- Q.** Yes, I see, so there was another period of part-time work but otherwise full-time throughout?
A. Yes.
- Q.** And your plans are to stay in optometry or not?
A. That is correct.
- Q.** With the same employer or not?
A. Yes, with the same employer.
- Q.** Could you just confirm whether or not you had any other complaints apart from this one?
A. I have not.
- Q.** I want to deal with this one, so if we go to 26 March 2007. You have the bundle in front of you so if you turn to page 68 of that bundle, it may assist you. One has seen from these records that Patient A attended Specsavers in various years starting in 1999 but was that the first time you saw him in 2007?
A. It was, yes.
- Q.** So on 26 March 2007 you carried out his eye examination on that date, the first time you had met him?
A. Correct.
- Q.** What is your recollection now of what happened on that occasion?
A. From the test in 2007, he presented for an eye test. He was relatively happy with his distance vision. He felt that his near vision was a little worse and he had complained that he was getting some blurring in his right eye intermittently with his close work. He had reported no other problems.
- Q.** So his distance vision was alright?
A. Absolutely fine. He reported to me no general health issues when I asked the question "how is your general health?" When asked which medications he was taking, he reported to me what I have recorded in the notes. When asked about his previous ocular history, he reported that he had an injury to the eye, as is noted in the records that happened many years ago, he had some surgery at the time and he currently had no problems as a result of the injury that had happened in the past.
- Q.** In the note on page 68, one sees "no headache – no flashes", what does that refer to?

- A.** I would ask if he had been suffering with any headaches and he reported no. I asked if he had any double vision or flashes of light in his vision, to both of which he reported no.
- Q.** Thank you. Did you notice anything about his right eye?
- A.** In the examination of the right eye, the only thing of note was the mark at the back of the eye.
- Q.** If we turn to page 70 where it says “pigment patch temporal from macula 2 disc”, could you help us with what that means?
- A.** The keyboard in the practice is on a Bluetooth system for the keyboard and for the mouse, and often they do not communicate too well and sometimes when you type, it appears on someone else’s screen and vice versa. Hence the reason why the text is not complete. Interpreting what it is meant to read, it should say “pigment patch temporal from macula oval in size 2 disc diameters long by 1 disc diameter high, not raised and no drusen”.
- Q.** Thank you. So you checked all the problems with the eye and you noticed this patch, 3mm long and 1.5mm high, is that correct?
- A.** Correct.
- Q.** And your view was that it was flat?
- A.** Yes.
- Q.** Can I just ask you generally about your experience of this? Have you seen lesions like that before?
- A.** You see many in practice, they are a bit like buses: you get one rarely and then you can have several one after the other, a couple within a week, sometimes two in a day, so the frequency depends.
- Q.** In a year, how many would you say?
- A.** You could average it out and say you see perhaps one or two a month, possibly more, it is quite variable.
- Q.** When you have seen these lesions, have you ever referred them on for further investigation?
- A.** There have been several lesions that I have found that I have referred for a further opinion and of melanoma variety as well, although they were not retinal ones. However, there have been previous lesions that I have referred for a second opinion.
- Q.** Thank you. Going back to the case of Patient A, you have described the lesion and what was your view as to what should be done about it?
- A.** I was entirely happy with the lesion I had seen in the 2007 visit and was comfortable with how it looked. I felt that it was appropriate to review the patient again and to reassess it the next time we saw the patient back at the practice. There was nothing about it that made me feel suspicious in any way.

- Q.** What would you be looking for when deciding whether or not it was suspicious, what kind of things?
- A.** You would be looking for a colour. Something that was much deeper and more darkly pigmented would make me more suspicious. Also the size of the lesion, the larger the lesion is the more suspicious I would be. Its position – if it were close to the optic nerve, that would make me suspicious. Also if it is in the area of the macula, which means it could affect the vision side of things.
- Q.** Just to help the lay people among us, the macula?
- A.** The macula is the specific point at the back of the eye where the line of vision is from. So if there is any disruption to that area, that could affect the vision which could be reduced or distorted.
- Q.** I interrupted you, what else would you be looking for?
- A.** Also whether the lesion is flat or raised, and the presence of any detachment or fluid around the lesion itself. Also if there had been any unusual pigment on the surface of the lens, which is like an orange type pigment.
- Q.** So that was your view on this occasion in 2007. He has given evidence about it, as you have heard, and said that you described it as a “freckle”?
- A.** Precisely. If I were mentioning it to the patient, I would mention it as a mark or a freckle at the back of the eye, as sometimes people find it easier to understand what I am trying to explain to them.
- Q.** And how was it left with him as far as you are concerned, this freckle at the back of the eye?
- A.** He was entirely happy with it at the time, and we would review him at his next sight test in 12 months.
- Q.** Just pausing there, was there anything else that you now feel you should have done on that occasion in 2007?
- A.** I do appreciate that having a dilated exam would have allowed for a much clearer view of the lesion, and it would perhaps have given more certainty as to the nature of the lesion.
- Q.** Were a similar case to present itself to you, what would you do?
- A.** For all lesions I carry out dilated exams for a more thorough examination.
- Q.** How was it left with Patient A?
- A.** That we would review him again in 12 months’ time, take a look at the lesion to see how it looked at the next appointment. My usual practice is to say to patients, if you feel there is any change before your 12 months come round, don’t hesitate to come back to see us.
- Q.** He came back a year and four months later on 28 July 2008, and you saw him on that occasion, that is right isn’t it?
- A.** Correct.
- Q.** The reason that he had come back, so far as you were concerned, was what?

- A.** He had responded to the recall that we had sent him. He possibly felt that there may have been a slight change in his distance prescription but, primarily, his reason for visit to the practice was because we had sent him a reminder letter.
- Q.** Looking at page 62, I should have pointed out the page number before, and where it says "reason for visit" it states "RFV respond to call", possible slight prescription change, "svd DV OK"?
- A.** Single vision distance glasses, his distance vision was okay with those. His near vision was okay without any prescription, he removed his glasses to read, and he was suffering no headaches at the time. Again, I asked about his general health and this time he reported that he suffered from rheumatoid arthritis. Again, I asked which medications he was taking as I noted in the records, and ocular history about the accident that had previously happened. The next sentence says no injuries "no inj" or infections "inf" or "hes", no hospital visits recently. Also reported family history of diabetes and glaucoma.
- Q.** Thank you very much, you recorded it as on previous occasions?
- A.** Yes.
- Q.** If I can just break off there for a moment. The recording of medications on both these occasions, is that satisfactory in your view or not?
- A.** I have recorded the medications as the patient has told them to me and, if the patient had reported any specific names of the medications, they would be noted, so I can record the information that the patient has provided.
- Q.** And what about general health, do you think that was adequate?
- A.** Again, when asking the patient how his general health was, I recorded what he has told me.
- Q.** And what is your current practice with regard to general health and medication?
- A.** I tend to ask a little more in depth, probe the patients a little more and perhaps ask if they have had any GP visits, if they have any conditions that are being medically managed and in relation to medications that they take. If they report that they are not taking any medications, I will probe to ask if they have anything prescribed by their GP and relate those back to the general health. Therefore, if they are taking any medication, I put that into the general health side of things and what the condition is for which they take the medication.
- Q.** Did Patient A mention anything else that he was suffering from when you saw him in 2008?
- A.** Everything that the patient reported to me is recorded in the history and symptoms section.
- Q.** He gave evidence this morning that he sometimes had a dry eye?
- A.** That certainly was not reported to me. I asked him if he had any recent injuries or eye infections, and he reported no.

- Q.** Can you help the Committee with what happened on this occasion, what tests were carried out and what the result was as far as you were concerned?
- A.** Going through the sight test, a refraction was carried out, the prescription was obtained and there was very little change in the prescription from the previous year. Also a Volk exam was carried out to assess the health of the eyes, so looking at the front and at the back of the eyes. In the assessment of the front of the eye, nothing abnormal was seen and they both looked perfectly normal. Again, in the back of the eye the lesion was noted in the right eye, as is noted in the records. Following the sight test itself being completed in the test room, the patient was then taken outside to complete a visual field test and to obtain photographs of the lesion.
- Q.** Looking at page 64, under the heading of “external eye ophthalmoscopy”, these are the test results are they?
- A.** Of the eye examination.
- Q.** Yes, thank you. Can you just help us with the bottom line “peripheral retina R” right, “all quadrants checked”, what does it say after that?
- A.** Expanding on what is written there, inferiorly temporally to the disc, lesion not raised, no drusen.
- Q.** Right. There is a query between “raised” and “no drusen”, can you help the Committee with that?
- A.** Correct. I have no explanation as to why there is a question mark there. It may have been a typographical error. If I had been in any doubt as to whether the lesion had been raised or not, the patient would have been referred at that time and would not have been recalled for further testing. He would automatically have warranted to be referred if there were any doubt that the lesion was raised.
- Q.** How would you record it if you had a query in your mind as to whether the lesion was raised?
- A.** I would type “lesion raised”.
- Q.** Where would the query go if there were a doubt in your mind?
- A.** I would not put a question mark, I would put “possibly” or something of that nature – I wouldn’t put a question mark in there.
- Q.** We heard evidence earlier from the expert that it is common practice to put the query in records if there is a question mark in the mind of the recorder?
- A.** Yes. As I recorded in the reason for visit, when the patient had felt that there was perhaps a change in his prescription, I have written “poss” as short for “possibly” slight change in prescription, rather than record “prescription change ?” That is not something that I would put in my records.
- Q.** Can you said with any certainty whether this lesion was raised in your mind or not?
- A.** Absolutely not raised.
- Q.** Can you help with how that question mark got into the records then?

- A.** I cannot explain it I am afraid, a typographical error, typing missed key stroke, that is the only explanation I would have for it.
- Q.** At the time, what was your practice with regard to any raised lesion or possibly raised lesion?
- A.** If a lesion is raised, it automatically is referred, that is not something I would keep and remonitor. The patient would automatically be referred to ophthalmology for a second opinion.
- Q.** I may have covered this already. Had you done that in the past before this?
- A.** Yes, any lesions that were suspicious were automatically referred.
- Q.** We shall come to it in a moment, I believe there was one at about this time, a similar case, is that right?
- A.** Correct.
- Q.** Similar in that there you felt it was raised?
- A.** Yes.
- Q.** If we could deal with this examination in July 2008. How were matters left with the patient, because we have heard that he had to come back?
- A.** Following the sight test on the day, I was not happy with the field vision test that he had done so I wanted to repeat that. The photographs that were taken did not show the lesion, so I wanted to repeat those to obtain photographic evidence of it. Therefore, the patient was advised to return when it was convenient for him to do so in order to repeat those tests.
- Q.** And was that done on 7 August 2008 when he came back?
- A.** Yes.
- Q.** His recollection was that he was not getting any new spectacles I believe, what is the position?
- A.** There is a minimal change in the glasses prescription but I believe that he changed his glasses at the time as the dispense record shows.
- Q.** As what shows?
- A.** The dispense record in the notes.
- Q.** Can you help me with where that is?
- A.** On page 59.
- Q.** Where should we look to see that?
- A.** This record is a record of an order for glasses which was done on the day of the sight test. He chose glasses and an order was processed. It is written that the date for collection of his glasses was 7 August, and it is noted in the bottom right-hand corner to repeat the right eye fields and photograph which was done on the day he collected his glasses.
- Q.** So where it says "fields & photo"?
- A.** Correct.

- Q.** Before that it says “phone when” – what is the next word?
- A.** “phone when ready”, that was just to phone the patient to advise him that his glasses were ready for collection. Following the sight test, he did purchase glasses.
- Q.** Thank you. So he is to go back in for the test to be repeated. Moving on, he came in on 7 August, the test was repeated as we have heard, and it was carried out by a technician.
- A.** Correct.
- Q.** We heard that the technician spoke to you in the corridor and it was said that it was the same, is that correct?
- A.** The field of vision test was done and if he came in at some point during the day while I was running my usual clinic, he would do the field of vision test, photographs would be taken, the technician would take a printout from the field machine to show to me the test that had been completed. The usual practice was to knock on our test room door and to hand us the field of vision test results which we would then look at. Or if we were around the practice, they would come to find us and hand us the records for us to have a look at. Therefore, it may well have been that I had just finished a test with a patient and was going back to the test room to take the next patient in, and that may be the time that the technician had approached me with the field results.
- Q.** Right. So the technician told you that it was the same, is that right?
- A.** No, the technician would hand me the field results and I would decide whether there were any changes with the results.
- Q.** Alright. Can you now remember whether you did that in the corridor, in your own room or elsewhere?
- A.** I could not tell you the exact location where that was done.
- Q.** Thank you. If we could now pause there following the appointments in 2008. You have had time to reflect on those two appointments, do you feel you went wrong anywhere?
- A.** Yes, certainly. The repeat field results that were done I feel now should have been repeated again to confirm the field loss that was noted on those. Field results are a subjective result and can be variable, even between the same patient under the same set of circumstances. Therefore, you could do a test in the morning and in the afternoon and still have a different result, so I believe they should have been repeated to confirm the field loss that was found on the second set. The photographs do not show the lesion but that is down to the use of the camera, so further training being needed in how to locate the lesion to be able to photograph it. Those are two things I have rectified: being able to use the camera to do that, and further training.
- Q.** You mentioned earlier dilation?
- A.** Any patient who has a lesion is automatically recalled to have a dilated exam done, so that it can be viewed more clearly binocularly and it makes it easier for photographing the lesion as well. The way in which I practise has changed

from when I saw Patient A. I keep a diary of all the patients I see on a daily basis and note beside the patient a record of the supplementary tests that I have requested to be done. As the supplementary tests are done, I have them marked off in the diary so that I can confirm that the patient has repeated the test. If they have been asked to return to repeat tests, I can mark off when the repeat tests have been done and whether the patient had been referred as a result of any subsequent tests that were done.

Q. I was going to ask you what changes you have made to your practice. First of all, you keep this diary with those details in it. What other changes, if any?

A. As we discussed from previous evidence that has been given, there was no note of the field results in the patient records of me recording anything on the day the patient returned to have the field test done. So all field tests that are now done I sign as proof that I have seen the results and, if I want the test to be repeated, I write on the field record "test to be repeated", whether I want that done with a prescription lens or any specific requirements to be done. That is kept in the records so that, when the patient comes back, the information is there to hand. As far as record-keeping, more detailed notes are taken, the patients are questioned further and the information that they give me is not taken at face value as they tell me. Also for the end of the sight test, there is a summary box on the electronic records which I annotate also with the tests that I have requested to be done. I record exactly what I have told the patient at that visit, whether they are going to be followed up, their review time and so on.

Q. You mentioned muscle balance tests earlier?

A. Yes, they are all done routinely as part of every sight test. We do a cover test at distance and at near, and we check their motility as well, which checks all their muscle actions.

Q. Can I just ask about appointment times? How long was allowed at the time that Patient A came to see you?

A. I believe that appointment times were between 20 and 25 minutes in 2007 when Patient A attended, and in 2008 it was a 25 minute appointment. When I returned to work, I increased my test times to 30 minutes to allow extra time to take note of these. As such, the rest of the opticians at our practice have now followed suit and increased their test times to allow more time with each patient. The practice I had of viewing field results and viewing photographs that were taken, as the tests were completed the technician would come to knock on the door for us to view the results, I now do not do. I now get the technician to bring the results to me and they are left for me to review through the day as time allows, or at the end of the day, so that I can sit down with the tests that were done and cross-reference them to the previous tests or to the patient's test record that is on the computer system at the time.

Q. Going back to the question of record-keeping, a criticism has been made of your record-keeping. Do you accept those criticisms?

A. Yes.

Q. Have you done anything about it?

- A.** I have been on a training course which was a complete day's training course in communication skills and record-keeping. That was through lectures and through interaction with patients who attended on the day as well. I have booked some further training courses in relation to some of the points that the case has highlighted also.
- Q.** In our bundle R1 is a certificate in relation to an Advanced Optometric Skills Course that you are going on, it is at page 14. That does not give us a date, when is that?
- A.** It is September/October time, I cannot remember the precise date.
- Q.** Alright. How definite is it that you are going on that?
- A.** That is a certainty, my place on the course is confirmed.
- Q.** Do you have the confirmation?
- A.** I have email confirmation on my computer.
- Q.** So, if necessary, one could try to get that typed out?
- A.** Yes.
- Q.** Thank you. While you are dealing with this matter, if one goes over to tab 4, one sees CET points, that is continuing professional development is it -
- A.** Correct.
- Q.** - by another set of initials. This is a record for you as you have established. Could I ask you generally, are you up to date with your continuing professional development?
- A.** Yes, I am.
- Q.** How long are the cycles for optometrists?
- A.** It is done on a three-yearly cycle and you need to obtain 36 points within a three-yearly cycle. We are two years into the current cycle and I have obtained more than the 36 points to date.
- Q.** Also in the bundle, if one goes to the last of the tabs, there is an anonymised set of records relating to a patient we are calling E, can you go to page 21 in tab 7? What was the date of this consultation?
- A.** The date of the patient attending for the test was 24 April 2007.
- Q.** Yes, half-way down page 21 on the right 24 April 2007. It says that Mr E has a slightly raised IOP?
- A.** Intraocular pressure.
- Q.** "Both eyes on repeat occasion. He also has a small naevus on his right macula which has not previously been noted. It appears very slightly raised on Volk, pale, even greyish, no drusen, well demarcated, please refer" – whose handwriting is that?
- A.** That is mine.
- Q.** Did you see this patient?

- A. I did.
- Q. Does that accurately reflect what happened on that occasion?
- A. Yes, the patient had attended routinely for a sight test and, as a result of the consultation, I had decided to refer him given that there had been mark, a freckle or a naevus found to the back of his eye, and he had raised pressures.
- Q. Thank you. I am reminded to ask you, did you dilate on that occasion?
- A. The patient was recalled for dilation. The primary sight test was conducted on 27 March and the patient was recalled on 24 April with a recall appointment, when she was dilated to allow a clearer view of the lesion. As is annotated on page 22, in the writing under Examination, in the middle of the page, I asked a colleague to look at the lesion for his opinion on it, and that is the handwriting that appears on the top section of that.
- Q. Thank you. There is one matter I should have dealt with earlier, and I am taking it out of sequence unfortunately. Dealing with the 7 August 2008 when the patient went back in 10 days after the previous appointment, it has been admitted on your part that you did not refer or conduct further investigations of the observed lesion. There being an absolute scotoma noted in the right nasal field above the horizontal midline, it is now admitted that the positioning of the absolute scotoma corresponded with the lesion in Patient A's right eye, and that the digital fundus images of the right eye had not captured the lesion. If I could ask you about that. The charge continues that you did not interpret the threshold visual field test results yourself. Did you do that?
- A. The field results would have been brought to me by the technician for me to make a decision on. As I said, I now sign the field results as proof or evidence that I have viewed the results.
- Q. Do you feel that you got it right on this occasion?
- A. With hindsight, I would like to repeat those results so that we could have a second set of results to confirm whether that field loss was a confirmed field loss, or whether it was an anomaly at the time.
- Q. Thank you. Those are the questions that I wanted to ask.

Cross-examined by MR WHALLEY

- Q. Mrs Murray, I have a few questions for you given, of course, the facts you have admitted. Within the allegations, you admitted that your record-keeping at the time perhaps was not adequate, that is right isn't it?
- A. Correct.
- Q. If I can ask you to look at the allegations please, you have a copy in front of you. Looking at allegation 2.d please, you can see there are six particulars set out there. Is it right that you have admitted that you did not make full, adequate records in relation to numbers (i) through to (v), that is correct is it not?
- A. Correct.

- Q.** You heard Patient A earlier give quite detailed, specific evidence about the symptoms he told you of when he attended for the July appointment. He was clear that he mentioned his eye was dry and itchy, and that he was having difficulty reading without full light on. The logical conclusion would be that you failed to record notes for other matters and you failed to record those symptoms as well?
- A.** No, those symptoms he presented with are quite important symptoms in relation to the health of the front of the eye and, if they were presented to me, they would have been noted. At that visit in July, he was asked if he had any eye infections of late and reported no to that question.
- Q.** The notes for that appointment, if I could ask you to turn to those please in the larger bundle, at page 64, which have probably been referred to. These are notes of the appointment of 28 July 2008. You have already been asked about the question mark on the entry at the bottom of the page. If I could ask you a couple of questions on that please. Both experts have agreed – Mr McPherson and Mr Munro – and I can read you what they said about that point. They have said that the presence of the question mark within the notes in the record would normally indicate that the clinician is either uncertain or suspicious. In those cases, further investigations should have taken place. Of course, they are experts in the field and are taken as that, and they are very clear that the question mark suggests uncertainty about that. Why is that something that you never use in your practice?
- A.** Everyone records their own personal notes differently and has their own forms of shorthand. As I stated earlier, if I am uncertain about something or if the response I get is an uncertain response, I would put “possibly” as has been recorded in reason for visit when the patient described whether their distance vision had changed or not – possibly slight change in prescription, that is how I would record things if I felt there was any doubt about it.
- Q.** How do you explain the question mark, how do you think that appears on the record?
- A.** As I said, the only explanation I have is that it could have been a typographical error or a missed key stroke etc. A question mark is not something I would use in my record-keeping.
- Q.** Has that happened on other occasions, that a question mark has appeared when you did not mean to enter that?
- A.** Not that I have been aware of. There are typing errors within patient records, we are not the best typists in the world, and this computer system was new to us and was fairly recent at the time of the appointments in 2007/08. If there are question marks on the records, it is not something that I would be aware of unless something was raised from it.
- Q.** In terms of entry, what is the computer system like, is it a standard keyboard that you use to enter information?
- A.** We have now moved practice and are in a new practice, and the basic computer system is still running on the same programmes. We used to have Bluetooth keyboards and Bluetooth mice to type with but we now do not have that, they are physically connected into the stations. Other optometrists in the

practice found that with the Bluetooth connection sometimes when you typed, the information would not appear on the screen; or it would appear on the computer screen in the test room adjacent to you, so the connections with the Bluetooth were obviously cross-wired, and vice versa. If an optician testing in another room had typed something; that information appeared on my test screen. So there were some troubles with the system.

Q. That is slightly different, that is information being typed and not recorded. Your evidence is that this is your error in hitting the question mark.

A. Yes, my typing. When I type there are letters dropped from some of the words in the typing, and that is just my mistyping, missing letters or the computer not picking up when I keystroke the letters. As I said, I am not the best typist in the world.

Q. It is a standard QWERTY keyboard?

A. Yes, a normal keyboard with flat keys.

Q. I do not want to get too bogged down in this but the question mark requires the shift key to be pressed and then a question mark inserted, so it is not simply just pressing that button. Therefore, what I am suggesting is what the experts have said is right, that the question mark can only mean a query at that point?

A. As I said, if I were to query whether the lesion was raised or not, it is not something that I would have remonitored. It is something that I would automatically have referred, so at the end of the sight test I would have said to Patient A, 'I am not happy with what I have seen in your eye, I am going to refer', rather than saying, 'I have seen something in your eye and I am going to monitor you again in 12 months' time'.

Q. Turning to the final appointment when you did not examine or see Patient A on 7 August, we know on that date that the technician conducted the tests. You say in your evidence that you could not say where you were when you looked at the results.

A. Correct.

Q. Therefore, how can you be certain of the fact that you did look at the results?

A. All field results are taken to the optician to be viewed, and my usual practice is to view the field results in my test room because that is usually where I would be. As I said, we were interrupted with a knock on the door to have a view of the test results. I honestly could not tell you where I was at the time when I viewed the test results, it was such a long time ago and every patient is different. So depending on where you are in the practice will depend on whether you view the information.

Q. That is your standard practice but can you say for certain on that date that you did have a look at those field test results?

A. I viewed all test results that the patients had done.

Q. You heard from Mr McPherson that there is no record of the interpretation and conclusions or indeed the action thereafter, you accept that?

- A.** Correct.
- Q.** With all medical notes, is it right that the conclusion is that, if it is not written down, it did not happen?
- A.** When we used to recall patients to redo photographs or to redo a field of vision test, it was not our usual practice to reprint another patient record to annotate to say that the patient had returned on that day and record the test procedures they had done. However, I would now sign the records as evidence they had been done, a full test sheet is not printed to say the patient came into practice. The fact that the date is on the field test shows that the patient was in the practice on that day and did that test. If you were not in the practice on that day, the results were left for you to view the next day you were in, so they were put into your test room to be viewed. Whereas now we keep folders separately for each individual optician and they review the results when they return. The records are signed as evidence to say that has been the case, which is why I now keep the diary to mark off from all the results I have seen.
- Q.** So at the time in August 2008, how was the interpretation of the results by the optometrist recorded – I do not understand where the records were made?
- A.** There is no physical record that I have recorded of any information on that day that the patient returned other than the tests that the patient has done.
- Q.** At the time, was there a procedure that you should have followed to record that information?
- A.** With hindsight that is now what I do but at the time that was how the practice was run, that is how things were.
- Q.** Thank you, Mrs Murray, I have nothing further.

Mr Gaisford: Sir, I have no re-examination.

Sir Alistair Graham: Thank you very much.

Questioned by the Panel

Mr Ilet: I have a couple of questions. It may seem a little impertinent but what is the date of birth of your first child?

A. St Patrick's Day, 17 March 2009.

Q. Secondly, when you are presented with visual field plots, obviously in a busy practice, are you given all the patient notes, all the previous field plots and everything else, or were you at that time presented with all that detail, or were you just presented with the raw data from that particular test?

A. When the patient comes in for a repeat, the technicians will just present us with the field results that would be done on that day. Then we would request any previous notes to compare to.

Ms Viner: Referring back to page 70 which is the appointment of 26 March 2007 when you first saw Patient A. You have recorded the size of the lesion that is

seen there. Other than saying it is temporal from the macula, there is no indication as to how far away from the macula it might have been. Can you recall how far away from the macula it might have been?

A. From the drawing on the notes is how I would record it. At the time, there were no photographs available to be taken, so the sketch that I had done would indicate the location of it.

Q. You said it was not possible to take photographs at that time?

A. Correct.

Q. Why was that?

A. I do not believe we had a fundus camera at that time.

Q. Thank you. I also want to look at the referral that was made around the same time for Patient E, which is at R1 page 21. This was at about the same time wasn't it?

A. Yes.

Q. It was about March 2007 when you first saw Patient A?

A. Yes, it was the first appointment.

Q. Bearing in mind that these patients attended at similar times, you dilated, if I understand correctly from the evidence you gave, Patient E –

A. Correct.

Q. - even though the lesion was fairly close to the macula.

A. Correct.

Q. But you did not dilate Patient A when the lesion was further away from the macula. Bearing in mind that these patients attended at very similar times, why was your practice different for Patient E compared to Patient A?

A. Because of the location with Patient E, it was in the macula area and I wanted to take a closer look of the lesion at that area. I was also unsure with that patient as to whether or not his lesion was raised, so I wanted to have a closer look at that, and that would allow me to obtain a better view. Also he was an older patient and I felt that the view I had of his lesion was not clear enough for me to make a judgment with.

Q. Thank you, I think that is all I have.

Sir Alistair Graham: Can I just clarify a couple of points that slightly puzzle me? It sounds from the evidence you have given to us today that this complaint was a major wake-up call both for yourself and for the practice generally, would that be a fair conclusion?

A. I would say, yes.

Q. In that you changed your record-keeping, or improved your record-keeping. Have you changed some of your clinical practice?

A. Absolutely, yes.

- Q.** It seems clear that when Patient A came back for the second visual field test, there was no standard arrangement in the practice for filling out a separate patient record sheet to record the outcome of what happened then. Am I right in that?
- A.** That is correct.
- Q.** There wasn't any standard practice. I am still a little unclear whether there is a standard practice now. You have set up some arrangement of recording in your diary but I am a little unclear as far as patient records whether the system has fundamentally changed?
- A.** When the patient returns to do a repeat field of vision test, the information is written on the field record itself, so you sign to say that you have seen it. Any information I personally record, I write on that field record and that is my record of when the patient returned and what happened with that test. You can then access the computer and you can edit the original test date with an amended date to say field of vision test completed, photos repeated, patient referred etc. So you can edit the original test that was done and you just put the date in of the return appointment that the patient came to. You would not necessarily have to recreate a whole new record, so when the patient comes back for a follow-up visit, it is easier to see all the information on one test.
- Q.** So there isn't an arrangement, as Mr McPherson referred to, whereby you can say that this was a supplementary visit arising from a previous visit and record any information there?
- A.** You could print out a separate appointment. When patients come back to repeat fields or to repeat photographs, there is not a scheduled appointment booked in with an optician to have those tests done. Those tests are conducted by our pre-screeners or our technicians, the tests are done and the optometrist views those test results. So there is no appointment booked into our computer system to confirm an arrival, to then generate a patient record as you see from the patient records here. You can access the computer records in the consultation room and edit those records with the date of the return visit and put in the information of the return visit and any tests that were done, whether it was decided to monitor or refer, and what you told the patient on that visit.
- Q.** Thank you very much. *[No further questions from Panel]*

[The witness stood down]

I am conscious whether, since the Committee have been sitting here for quite some time now, it would be sensible to have a short break before we proceed any further. It is not quite time to break for lunch yet but perhaps we could have a 10-minute break.

Mr Henley: Lunch is here if you want it, it is entirely up to you.

Sir Alistair Graham: Right, if lunch is here, should we perhaps break for lunch now at 12.30. As time is pressing, would 45 minutes be sufficient so that we reconvene at 1.15?

Mr Gaisford: Yes, sir.

[Hearing adjourned at 12.28]

[Hearing reconvened at 13.17]

Sir Alistair Graham: Mr Gaisford, I believe we were still with you.

Mr Gaisford: Sir, that is the case for the practitioner

Sir Alistair Graham: That brings us to summing up as far as the factual stage is concerned.

Mr Whalley: Indeed, Sir. I can address you fairly briefly and, hopefully, succinctly in relation to factual matters which are outstanding, and these are very much limited now by the admissions that Natalie Murray has made. By my calculations, the disputed facts are 2.d.vi, 2.e.ii and iii, 3.a.ii, 3.a.iii and 3.b.i. I hope that I am right with that. In relation to those particulars which are disputed, 2.e.ii and iii and 3.a.ii and iii form part of the same particulars for two separate appointments on 28 July 2008 and the 7 August 2008, so they are the same particulars but for two separate dates.

First, in relation to the facts of 2.d.vi, this allegation goes to the second appointment on 28 July 2008. You heard from Patient A this morning who was clear in his evidence that he informed Natalie Murray that his right eye was dry, it was itchy and he later said in evidence that he felt something was in it and he had to rub it. He also said in evidence that he had to use a full room light and was unable to read with a bedside light. He said in evidence today the same thing that he said in his letter of complaint going back to November 2009.

Natalie Murray in her evidence stated that these matters were simply not reported, which is the reason why they are, therefore, not recorded in the patient records. In my submission, Patient A was very clear and he recalled specific symptoms, not a brief mention of a problem but very specific facts as set out in particular vi.a-e, and his evidence has been consistent right from 13 November 2009 to his evidence earlier this morning.

Admissions in relation to her failures in inadequate record-keeping may, and indeed do, add credibility to his evidence that these matters were reported but simply not recorded as other information, symptoms and history were not recorded, which have been admitted by the registrant.

In relation to 2.e.iii and 3.a.iii, those particulars will turn on your findings in relation to 2.d.vi, because those allegations are that the reported symptoms in 2.d.vi were not recorded on the two further dates in July and August. 2.e.ii and 3.a.ii both concern the entry on page 64 of bundle C1, which is the record for the 28 July and, again, that is an allegation that is repeated for the appointment on 7 August but, again, that was not recorded. The main focus

is on the entry on page 64 which is to do with the question mark that is recorded there.

The document handed up this morning which was C2, is a telephone note, the agreed evidence of the experts on that point. They have agreed that the question mark entry suggests uncertainty. Given their agreement on that point and what is, in my submission, the unlikelihood of typing a question mark on the keyboard without intending to do so, it is more likely than not, which of course is the standard of proof, that Natalie Murray was unsure as to whether the lesion was raised, which is why the question mark was entered. That, based on the experts' evidence and the difficulty in typing a question mark, has to be right.

Turning to the final fact that is disputed and denied, which is 3.b.i, this is an allegation concerning 7 August 2008 that the registrant did not interpret the threshold visual field test results herself. Patient A in evidence said that the technician spoke with Natalie Murray to inform her of the results and she said to issue the same prescription. His evidence again, in my submission, was consistent with his complaint which is found starting at page 45, with the relevant section on page 47 at paragraph 10 of that letter, where he explains what he witnessed on that day in terms of the technician speaking with the registrant.

Mr McPherson said in his evidence that there is no record that Natalie Murray had looked at the results on that day and interpreted them. Natalie Murray has accepted that there is no record and, of course, that has now changed and she makes sure that there is a record. However, at that time, there was no record of that interpretation and her conclusions from that. In my submission, if a treatment has been taken and conclusions drawn, there has to be a record of that and, if there is no record, the only conclusion can be that simply did not take place. For all medical records, there has to be a reliance on what is documented and, if it is not documented, in my submission it simply did not take place. If that is right, the evidence is that Natalie Murray did not interpret the results herself and simply relied upon the technician's interpretation of them. That is all that I wish to say in relation to the facts.

Sir Alistair Graham: Thank you very much. Mr Gaisford?

Mr Gaisford: Sir, on behalf of Natalie Murray, there is a very small area of dispute and I shall be correspondingly brief. I shall take the points in the same order as did Mr Whalley: 2.d.vi, 2.e.iii and 3.a.iii all relate to the same issue about not recording that Patient A reported the dry eye etc. As with all the submissions I make at this stage, they rest principally on your assessment of the practitioner. As you are aware, she is a practitioner of good record, a person of good character and a person who has made substantial admissions in the case. In fact, you may think she has admitted the gravamen of the charge and where the particular weight lies, she has made those admissions and she is, accordingly, to be treated as a practitioner of integrity and probity. It is hard to see why, having made those admissions, you may think, she should deny certain specific aspects.

First with regard to the dry eye, she was quite clear in her evidence, as she was clear in her evidence throughout, whether she was making admissions or disputing matters, that she would have noted that. You remember her evidence, which she has just given, it was clear and cogent evidence in my submission. She did record other matters on presentation, for example she bothered to record that there were no headaches. Regarding this question as to whether or not he mentioned the dry eye, I would ask you to recall that he said he sometimes suffered from a dry eye. I suggest, on behalf of the practitioner, that the dry eye is not the reason that he returned. That was because of the recall, as it indeed appears on the notes, and I believe it accords with what he said about getting a letter and responding by attending. Therefore, it may be that he had a dry eye before or after this occasion at some time or, indeed, at other times, and it may not be entirely relevant that he suffers from hay fever. I submit on behalf of the practitioner that it is not made out that that she failed to note that complaint but that complaint simply was not made.

May just raise one other matter in relation to it, which is that, with regard to 2.e.iii, the allegation is that Natalie Murray "Did not refer Patient A for further investigation or conduct further investigation in circumstances where: iii. Patient A had reported symptoms to you, as outlined at paragraph 2.d.vi.a-e above" and, similarly, at 3.a.iii. In my respectful submission, there is no connection between not referring or taking further investigations and the dry eye complaint, because that was not a reason for carrying out further investigations or referring. As you are aware, it is not being suggested that there is any connection between the dry eye and the lesion. Indeed, as you know, the telephone note of what the experts agreed at C2 records under d.2.vi, both agree that the symptoms reported here by Mr A are not related to vitreoretinal disease. I say there is not a connection between the two and that is a misapprehension on behalf of the Council if it is suggested that there should have been further investigation or referral as a result of any mention of dry eye. So those are my submissions with regard to the first of the three matters.

Secondly, I am sure that if the lesion was raised, based on the question mark which appears in the note, that is an unfortunate inclusion in the notes but Natalie Murray says it was a mistake. Again, I rest on her character, her admissions as to the gravamen of the charge and, of course, I defer to your assessment of the practitioner. You know that it was her practice to refer suspicious lesions, because very much at the same time Patient E, as it happens, turned up and there is evidence that she did refer. So there is cogent evidence that was her practice.

Could I just deal with what the experts said? They say it is normal practice to put a query if one is unsure of a diagnosis, and I entirely accept that. What the experts do not say is that you necessarily record a query in that way, and Natalie Murray's case is that it was a typing error, her typing is not very good, there were problems with the computer and it is not her practice to put a

query. She would have recorded the question differently. Again, I go back to her character and the way she gave evidence.

Finally, at 3.b it is our submission that she has admitted the gravamen of it all, you did not interpret Patient A's threshold visual field test results yourself. She has accepted responsibility for what went wrong and we say that she accepted responsibility for reading the result but simply got it wrong. Of course, we do not have any evidence to present that she went and did that but not everything that the practitioner will do will be seen by others or necessarily recorded. Therefore, we cannot prove that she interpreted but, as was pointed out very fairly and properly by Mr Whalley on behalf of the Council, the burden of proving matters is on the Council, and it is not for Natalie Murray to prove the contrary.

If I may go back to one other matter. I believe it was suggested that the experts had also said that, if something is not recorded, then it did not happen. We do not accept that for one moment that is correct and I am not sure where that comes from. It would be a grave philosophical error to adopt that just because someone has not recorded something, it has not happened at all. Again, I rest on the character of the practitioner, the way she gave her evidence and the way she has admitted the gravamen of the charge: it would be wrong indeed if she did not admit that as well. Sir, those are my submissions.

Sir Alistair Graham: Thank you very much. I shall now ask the Legal Adviser to advise the Committee on how we should proceed.

Mr Swinstead: Sir, my duty is to tender advice to you as to the law, rather than to direct you to the law. The position is that you are the judges of both the law and the facts. You have now reached the stage of, first, determining whether the facts alleged which have not been admitted have been proved by the evidence you have heard under the provisions of Rule 50. The burden of proof with regard to any disputed fact rests throughout upon the Council. There is no burden on the registrant at any stage in these proceedings to prove anything. As far as the standard of proof, the Council must satisfy that, on the balance of probabilities, it has proved its case on the individual particular of the allegation that you are at that moment considering. The civil standard of proof means is it more likely than not that the matter you are considering occurred.

Although there is one standard of proof, care must be taken in its application to this extent. There are cases, and it is a matter for you whether this is such a case, where the allegations are such that a heightened examination of the evidence may be necessary by reason of the inherent unlikelihood of the alleged event having taken place, the seriousness of the allegation itself and/or the seriousness of the consequence if it is proved, making its commission less likely. These are all matters of common experience requiring the application of good sense on your part to the issues before you. They do not require a different standard of proof or a specially cogent standard of evidence, merely the appropriate careful consideration by you of

the facts before you are satisfied that the matter under consideration has been made out.

You must consider each particular of the allegation separately. Your approach must be with regard to each individual factual allegation: have the Council proved the fact to my satisfaction on the balance of probabilities? Anything less and the registrant is entitled to a finding of not proven. In this allegation, a number of the particulars allege that the registrant did not do something or another. These are allegations that the registrant did not do and should have done what is alleged. These particulars are not merely narrative. These allegations involved an expressed or implied assertion of culpability, that is of blame. In order to find each individual particular proved, you must be satisfied to the required standard that the registrant did not do what is alleged and, in not doing what she should have done by the standards of good practice which were relevant at the time, her conduct was culpable. That is in not doing what she should have done, she was blameworthy.

You have heard expert evidence in this case. An expert witness is permitted to give his opinion on the issues before you but you are not bound by an expert's opinion. It is not the proper approach to expert evidence that you should simply accept an expert's evidence in the absence of reasons for rejecting it. If you find the evidence and opinion of assistance, you are entitled to rely upon it in coming to your conclusions. If you do not find it of assistance, then you are entitled to reject it and to place no reliance upon it. What you make of expert evidence is entirely a matter for you. As to your approach to individual pieces of evidence, you are entitled to draw inferences but you must not speculate. If you feel that it is proper, you may draw an inference provided that there is an evidential basis for it. On the other hand, it would be wrong to speculate.

Finally, I remind you that when Mrs Murray gave evidence, she dealt with matters not only relevant to the factual stage, which is the stage where we are at the moment, but also gave evidence on matters which may become relevant at a later stage in this hearing. Therefore, I remind you and advise you only to consider the matters in her evidence which are relevant to the factual stage of your inquiry. Sir, that is my advice, unless either party wishes me to say anything further, or to correct anything that I have said.

Sir Alistair Graham: Do either party have any comments on what the Legal Adviser has said? [*No comments*] It is now time for the Committee to deliberate in private on this particular stage of the proceeding, so I shall ask Mr Henley to clear the room

[*Hearing adjourned at 13.38*]

[*Hearing reconvened at 14.26*]

Sir Alistair Graham: I can now announce the findings in relation to the particulars of the allegation.

Determination

The Committee took account of all the evidence placed before it, both written and oral. It also took account of the submissions of Mr Whalley on behalf of the Council and Mr Gaisford on behalf of the registrant, and accepted the advice from the Legal Adviser.

At the commencement of the hearing, Mr Whalley offered no evidence on particulars 1.c in its entirety, 1.d.i and 2.c in its entirety. The registrant admitted all the particulars of the allegation as amended, save for the particular 2.d.vi, 2.e.ii and iii, 3.a.iii and iii and 3.b.i.

The Committee made the following findings: 2.d.vi found not proved. The Committee accepted the evidence of the registrant that if Patient A specified these symptoms, it was satisfied that it was her practice to record such symptoms accordingly. The Committee also took into account the fact that in his evidence, Patient A was not consistent about what he might have said to the registrant at the time of the examination. The Committee was satisfied that he was a credible witness but, after the passage of time, it was not surprised that Patient A's recollection was a little uncertain.

2.e.iii and 3.a.iii found not proved. Both of these particulars fall because of the findings as outlined above.

2.e.ii and 3.a.ii found not proved. The Committee was satisfied on the evidence from the registrant that it was not her practice to use a question mark to indicate her uncertainty about a particular clinical issue. The Committee was also impressed as to her willingness to make admissions where she felt she had made a genuine mistake.

3.b.i is found proved. The Committee was satisfied that for the registrant properly to interpret the second visual field test, she would have required more information than the documentation provided by the technician who carried out the test, who would have provided the field plot alone rather than the full patient record.

The Committee also heard evidence about the very informal process for dealing with visual field test results and, since this complaint has been made, the practice as a whole has radically changed its arrangement for the proper consideration of such tests.

That concludes our determination on these matters. We can now move on to evidence of deficient professional performance.

Mr Whalley: That is right, sir. Could I just clarify, if I may, your intentions for the next stage? Do you intend to hear submissions on misconduct and deficient professional performance and then retire, and then return to hear submissions on impairment?

Sir Alistair Graham: I don't see why we should not. Does anyone have any problems about that?

Mr Gaisford: Sir, what I would ask is that these matters be taken together so that it would make it a three stage process if it went through to the end. That means that, at this stage, you would be deciding whether or not misconduct is made out; whether or not deficient professional performance is made out and, if either of those were made out, whether her fitness to practise was impaired.

Sir Alistair Graham: By that you mean currently impaired?

Mr Gaisford: Yes, indeed. I cannot see the necessity for splitting it. The parties can rely on the Committee to keep separate those issues. It does have the advantage of speed, if I may say so, not that I am trying to cut corners but I do have a pregnant client behind me.

Sir Alistair Graham: Yes, I appreciate that entirely. The Committee are sympathetic, if the Legal Adviser sees no complication?

Mr Swinstead: Sir, I see no complication. If the parties are content and the Committee feel they can do it that way, I certainly see no difficulty.

Sir Alistair Graham: Are we happy to proceed on this basis?

Mr Whalley: Certainly, sir. I shall, therefore, address you in relation to deficient professional performance and/or misconduct and impairment. As I indicated in my opening, sir, I shall not present any further evidence in relation to either of those matters, because they are matters for your professional judgment. I do invite you to consider the General Optical Council Code of Conduct from April 2010. If you do not have copies available, sir, I shall ensure that copies are handed up.

In particular, you may consider that codes 1, 6 and 19 are relevant. You do not have copies?

Sir Alistair Graham: No, it would be better to have them in front of us. Do we have some copies available?

Mr Henley: No, we don't.

Mr Whalley: I can perhaps get some.

Sir Alistair Graham: If you read any particular references, as long as we see a copy that is fine.

Mr Whalley: Code 1 states you must: "Make the care of the patient your first and continuing concern".

Sir Alistair Graham: That is the new Code of Conduct?

Mr Whalley: Yes, 2010. Code 6 states you must: “Maintain adequate patients’ records”. Code 19 states you must: “Ensure your conduct, whether or not connected to your professional practice, does not damage public confidence in you or your profession”. Of course, sir, you may find other codes relevant in this case but, in my submission, those are the ones that have particular relevance.

This is a case involving one patient over three appointments but, despite that, in my submission, you can properly find misconduct and/or deficient professional performance. The definition of misconduct will be dealt with by the Legal Adviser and my learned friend may also address you on that point. Misconduct, in my submission, suggests either a deliberate act or a reckless act or omission. That is supported by the evidence in this case, not necessarily deliberate but reckless omissions on behalf of the registrant.

Deficient professional performance would suggest a standard of skills and proficiency which falls short of that which is expected of a Registered Optometrist. The difference with that is that, in normal circumstances, deficient professional performance is something that is evident over a period of time with perhaps more than one patient. Therefore, in my submission, it may well be that you consider misconduct is more relevant given the admitted facts and, indeed, proven facts in this case. I do not seek to address you any further on that because, as I said, it is a matter for your judgment.

Turning to the question of impairment, similarly, this is a matter for your professional judgment but, in my submission, if you do find misconduct and/or deficient professional performance, you can properly find that the registrant’s fitness to practise is presently impaired. You have already identified impairment as of today. It is right to say that most of her evidence provided details of remedial actions and steps she has taken, the training she has undertaken and changes in her practice based on what she described as a wake-up call from these incidents in 2007 and 2008. Despite this, in my submission, you can find current impairment given the serious nature of misconduct and/or deficient professional performance in this case, which is supported by the evidence you have heard from both witnesses and which you have read in the expert report of Mr McPherson.

There are a number of factors which you may take into account when considering the question of impairment and these are set out in a number of case authorities, to some of which you will no doubt be referred by my learned friend and the Legal Adviser. I just wish to refer to a couple of those cases, if I may, sir.

The factors to take into account when considering impairment were first set out in the fifth Shipman Inquiry by the then Dame Janet Smith. These factors are as follows: whether the registrant presents a risk to patients, has brought the profession into disrepute, has breached one of the fundamental tenets of the profession or has acted in such a way that her integrity can no longer be relied upon. That was a report in relation to a GMC case but is equally applicable, in my submission, in this tribunal. Those factors were endorsed in

the case of *Zygmunt v GMC* [2008] EWHC 2643 (Admin) when Mitting J, as well as adopting Dame Janet Smith's observations, also adopted the decision of Silber J in the case of *Cohen v GMC* [2008] All ER 581. In the *Cohen* decision, Silber J stated that:

"When considering impairment, the Fitness to Practise Committee should take into account the need to protect the public, the collective need to maintain confidence in the profession and the need to declare and uphold proper standards of conduct and behaviour".

So there are some similarities with what was set out in the Fifth Shipman Inquiry. Those are the facts which I respectfully ask you to consider when deciding on the matter of impairment and, in doing so, in my submission, you can properly find that the registrant's fitness to practise is indeed presently impaired. Those are my submissions unless you have anything you wish me to help you with further.

Sir Alistair Graham: Thank you very much. Mr Gaisford?

Mr Gaisford: Sir, if I could indicate, first of all, the documents upon which I shall rely. You have already in R1 two testimonials from the employers. I do not know whether you have had a chance to see these yet but they are at pages 19 and 20 behind tab 5 and 6, and I shall be submitting that these are relevant at this stage. You have already been referred to the certificates which we say is relevant to the question of remediation. At the risk of frightening everyone, could I produce a written skeleton of my argument, which was produced with a view to shortening matters rather than lengthening them and in ignorance of your Legal Assessor today? Could you receive those at the moment and I shall come to them shortly.

Sir Alistair Graham: Do we have copies of them?

Mr Gaisford: Not yet. The authorities are on the back of some of these so you will have the authorities and the brief submission that I make. I know it looks a lot but it is not really. [*Copies distributed*] I am afraid that I do not have enough copies of the authorities but there should be enough copies of the brief submissions which I shall make in a moment.

Sir Alistair Graham: This document is R2.

Mr Gaisford: Sir, I am not coming to that for just a moment. I wish to address you briefly, first of all, on the background features of the case, which I am sure the Committee have already picked up on. You have heard this morning that this was a rare diagnosis in relation to which this practitioner failed in the way which you now have quite clear. It was one that developed fast which reflects back on the position in July 2008 and even more so in relation to March 2007. As has been alluded to very fairly by Mr Whalley, this was a one-off failure in the sense that it is the treatment of one patient, albeit on two or three separate occasions, but it all ties together and it is only in relation to that patient.

Could I also indicate that there are positive aspects in relation even with regard to the patient, towards whom this practitioner lapsed. Mr Munro was good enough to indicate that she showed good skills in picking up on this lesion, recording it and drawing it, and it may be that the optometrists on the Committee will see further positive aspects such as the test for glaucoma perhaps, the fact that the visual field test was repeated, although it comes in the focus of a criticism, fundus photography was requested and there was a Volk examination. This patient was, of course, recalled which was deemed to be appropriate. So there were positives and we say fitting more with the usual practice of this practitioner.

We say she has shown insight into her deficiencies in treatment because of the substantial admissions she has made, almost comprehensive admissions. Fourthly, as remediation in the courses with particular regard to record-keeping and the Advanced Optometric Skills course that she is to take. Also remediated beyond the cause of her employers by instituting a private diary to make sure that the deficiencies are not repeated, and times of consultation have been adjusted to make sure that she is not under any pressure of time that unduly interferes with patient safety. You have also heard her in detail about the changes in her practice. So a combination of factors, we say, render it unlikely that such faults will ever be repeated, and this Committee can be confident that they will not.

May I just say with regard to some of the facts that have been admitted, the muscle balance test (1.a.i/2.a.i), Mr McPherson, whom I believe I referred to earlier as Mr Munro, mentioned that with regard to that he confirmed in his report that he said bordering on insufficient information, and you will recall his evidence that this was not at the more grievous end of the scale of matters. As regards the inadequate medical history, the practitioner, although she should have given each individual illness and got each individual medication right, gave an indication of what was amiss with this particular patient's health. It was clear from what she put down that he was someone who suffered from asthma, had to take painkillers, had blood pressure problems and so on. She could have done better and does now do better but I submit with regard to those admissions that they do not really contribute towards a finding of misconduct, deficient professional performance or, indeed, impairment of fitness to practise.

The gravamen of this case, you may think although I defer to the optometrists on the Committee, is failure to dilate and failure to act on the repeat visual field findings which should have been done a third time, and there should have been further investigation or referral. So a poor standard in those respects but only in certain respects and, as I said, only in relation to one patient. May I then put that into the legal context, which I can take briefly, and refer you to the skeleton argument that I have just put in.

If I may say by way of warning, if one looks at the authorities backing up those submissions, the commentaries may be out of date and, in any event, they are not authoritative, when one looks particularly at the authorship in one or

two regards. Therefore, I would invite you to disregard the commentaries. It is the judgments of the Court of Appeal and High Court which, of course, count. I make this submission as I say in relation to the allegation that the practitioner's fitness to practise is impaired by reason of misconduct and/or deficient professional performance.

As was recognised in the most recent of cases which I am quoting *Cheatle v General Medical Council* [2009] EWHC 645, they are distinct issues and, plainly, as the Committee has already taken on board, it is its task to decide, first, whether there has been misconduct, then whether there has been deficient professional performance, or the other way round. Then they need to consider whether or not fitness to practise is impaired if either of those is found.

Misconduct is a concept, I submit, of substantial gravity, it is the same as serious professional misconduct under the old General Medical Council rules as was made clear in the Court of Appeal case in *Meadow v General Medical Council* [2006] EWHC 146. It does not have the take the form of any moral fault or turpitude, it may take the form of incompetence or negligence. If it is of high degree, and that is mentioned in *Meadow* at paragraph 201: "Mere negligence does not constitute "misconduct"", but, "depending upon the circumstances, negligent acts or omissions" that are particularly serious "may amount to "misconduct"". I have quoted the case of *Calhaem v General Medical Council* [2007] EWHC 2606 (Admin) there with the reference that you see. It must, as described by Collins J in *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), a description approved by the Court of Appeal, amount to "the sort of conduct which would be regarded as deplorable by fellow practitioners".

For the purpose of completeness, I do not think it really contributed to the recent development of the law in this area but I have quoted the case of *Threlfall* [2004] EWHC 2683 (Admin) because this was a case before the General Optical Council. It gives limited assistance but it was a case on the necessity for giving reasons which is not employed here. It says that, "A clear distinction between negligence and professional misconduct should be drawn", paragraph 58, and it says what it comes to is a cursory examination of the circumstances of that case were found capable of being found to fall seriously below the required standard. Of course, that case was on different facts and, indeed, issues of the practitioner's probity we raised in relation to her.

Therefore, my submission with regard to misconduct is that, in the circumstances of this case, it has not reached that degree of gravity qualifying as misconduct, given the positive features, the limited extent of the negatives and the other matters which I have already urged upon you.

Secondly, deficient professional performance, the authorities were summarised very helpfully in *Calhaem*, where the position is reduced to five principles and only the last three deal with deficient professional performance. It is there pointed out that: "(3) "Deficient professional performance" ... is

conceptually separate from negligence and from misconduct". I do emphasise this:

"It connotes a standard of professional performance which is unacceptably low and which (save in exceptional circumstances) has been demonstrated by reference to a fair sample of the [practitioner's] work.

(4) A single instance of negligent treatment, unless very serious indeed, would be unlikely to constitute "deficient professional performance"."

There is a last point to the effect that it is not necessary or appropriate to extend the interpretation of "deficient professional performance" to encompass matters which constitute "misconduct".

Relating all that to this case, we submit that, yes, there was a lapse on the part of this practitioner but you do not have a fair sample of this practitioner's work, save that you do know from those who employ her that she is usually competent and, indeed, diligent. Therefore, it is my submission that deficient professional performance is not made out in this case.

Moving, thirdly, to the question of impairment, were you to find, contrary to my earlier submissions, that either misconduct and/or deficient professional performance were made out, then one looks at the question of impairment of fitness to practise. The point I make is that on the authorities cited, a finding of misconduct does not necessarily lead on to a finding of impairment. Impairment of fitness has been said to be an elusive concept and in *Zygmunt* the GMC was taken to task for not giving a definition that people could work with. I have to say they still have not done that, I am afraid, but that is the position – an elusive concept. However, what is clear, as the Committee and you, sir, have already taken the point, is that one is dealing with it not at the time of any misconduct but at the date of the hearing. As it was put in *Meadow*, the panel's task:

"is not to punish the practitioner for past misdoings but to protect the public against the acts and omissions of those who are not fit to practise. The [panel] thus looks forward not back. However, in order to form a view as to the fitness of a person to practise today, it is evident that it will have to take account of the way in which the person concerned has acted or failed to act in the past."

So the Panel looks forward and not back in its view of fitness to practise, today will be informed by the way in which the practitioner has acted in the past. Echoed in *Azzam v GMC* [2008] EWHC 2711, as I say:

"It must behove a FTP to consider facts material to the practitioner's fitness to practise looking forward and, for that purpose, to take into account the evidence as to his or her present skills or lack of them, and any steps taken since the conduct criticised, to remedy any defects in skill."

Thus evidence of remediation is highly relevant to the Committee's consideration at this point, as it is already very well aware. Those are my submissions. The matters relevant to impairment include, of course, the need to protect the public and the public interest, whether the shortcomings or errors are current, whether the shortcomings that arose are remediable or have been remedied, or are likely to be repeated. You take into account evidence as to current skills as apparent from those three authorities I finally cited.

Here there is substantial evidence that the deficiencies in relation to this one patient were not typical, first of all, of this practitioner's practice and, secondly, that they have been remediated. Therefore, we submit that her fitness to practise is not currently impaired. Sir, those are my submissions.

Sir Alistair Graham: Thank you very much. [*No questions from Committee*] I shall ask the Legal Adviser now to advise us.

Mr Swinstead: Sir, I do not know whether you would be assisted by having my advice printed out and, therefore, having it in front of you. The trouble is that it is in two parts, because I prepared it on the basis of the separate stages but, if you would find it of assistance, it would take a few minutes to hand out copies. It involves a little bit of jumping about. After paragraph 1 on the second stage, it requires one to jump to paragraph 2 of the third stage and then back to finish the second stage before moving on.

Sir, you have now reached the stage when you are required to consider whether or not, on the basis of the particulars of the allegation that have been admitted or which you have found proved, you find that the registrant is guilty of misconduct/deficient professional performance under the provisions of Rule 50.

It is a matter of judgment for you to consider whether the registrant's fitness to practise is impaired. In order to reach that conclusion, it is necessary that you undertake a two-stage process. If you find that there has been misconduct/deficient professional performance, you must ask yourself whether the registrant's fitness to practise is impaired as a result of that misconduct/deficient professional performance. It is, first, necessary to judge its seriousness, then to set it in context and, finally, to determine whether or not it was sufficiently serious that, even having regard to its context and all the other relevant matters put before you, you conclude that today and looking forward from today the practitioner's fitness to practise is impaired. A finding of misconduct/deficient professional performance does not lead inevitably to a finding of impairment.

I remind you that in the case of the *Roylance v GMC* (No.2) [2000] 1AC 311 Lord Clyde defined misconduct as:

“a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of

propriety may often be found in reference to the rules and standards ordinarily required to be followed by a (medical) practitioner in the particular circumstances.”

In *Doughty v GDC* [1988] AC 164 PC, it was defined as being:

“... conduct connected with the profession in which the (practitioner) concerned has fallen short, by omission or commission, of the standards of conduct expected among (practitioners) and such a falling short must be serious ...”

Issues that may be relevant in this case were considered in the case of *Calhaem v GMC* [2007] EWHC 2606 (Admin). In the course of his judgment, Mr Justice Jackson indicated that on the issue of misconduct, he derived a number of principles from the authorities which he set out. They are:

- “(1) Mere negligence does not constitute “misconduct” within the meaning of Section 13D (2)(a) of the Opticians Act 1989. nevertheless, 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”.”

Then he turns his attention to deficient professional performance.

- “(3) “Deficient professional performance” within the meaning of Section 13D(2)(b) is conceptually separate from negligence and from misconduct. It connotes a standard of professional performance which is unacceptably low and which (save in exceptional circumstances) has been demonstrated by reference to a fair sample of the optometrist’s work.
- (4) A single instance of negligent treatment, unless very serious indeed, would be unlikely to constitute “deficient professional performance”.
- (5) It is neither necessary nor appropriate to extend the interpretation of “deficient professional performance” in order to encompass matters which constitute “misconduct”.”

With regard to the issue of impairment, you should have regard to a number of matters which include the way in which the registrant has acted in the past, both before and after the misconduct. You must consider the context of her behaviour and her current level of insight and, if appropriate, her current level of skill. Again, if relevant, you must consider whether the misconduct/deficient professional performance you have found is remediable and what steps the registrant has taken to remedy the shortcomings which led to the findings that you have made. Finally, you must consider what the risk is of the misconduct being repeated.

Your task is to consider whether, by reason of the misconduct/deficient professional performance, the registrant's fitness to practise is impaired today and looking forward from today, in other words has it been so egregious, has it been so serious, that, looking forward, are you persuaded that the registrant is simply unfit to practise without restrictions or at all. Alternatively, the misconduct/deficient professional performance may be such that, even within the context of an otherwise unblemished career, and bearing in mind, if relevant, any steps towards remediation that she has taken, you may conclude that, looking forward, her fitness to practise is unimpaired, the misconduct/deficient professional performance notwithstanding.

In reaching your decision, you are entitled to have in mind the public interest in the form of maintaining public confidence in the profession generally and in the individual registrant, in particular, when determining whether the particular misconduct qualifies as misconduct which currently impairs the practice of the registrant. Where a registrant violates such a fundamental rule of the profession, her fitness to practise may be impaired if the public is left with the impression that no steps have been taken to draw to the attention of the registrant the profound unacceptability of the behaviour which has led to the findings.

I emphasise that this is a matter you must consider; it is not a test in itself. In such a case, where the firm declaration of professional standards to as to promote public confidence in the profession is required, the efforts of the registrant, if any, to address the problems and reduce the risk of recurrence may have much less significance. It is a matter for you whether a particular case falls into the category of one where steps to remedy the shortcomings found have a considerable relevance to the decision on impairment and those where such steps may have less relevance.

I remind you that you should not have regard to any testimonial evidence that goes purely to mitigation of any sanction on the issue of impairment. You must have regard to all the testimonial evidence placed before you from fellow professionals which goes to the issue of remediation and present competence, because that is relevant to the issue of impairment, but you should only take account of purely mitigatory evidence if you reach the stage of considering sanction and when you are considering sanction.

When considering the issue of impairment, you should have in mind the public interest and, in particular, the following matters:

- (1) The protection of the public and, in particular, patients;
- (2) That public confidence in the profession should be maintained.
- (3) The declaring and maintaining of proper standards of conduct and behaviour.

Sir, that is my advice subject to whether either party would wish me to add anything to what I have said or, more importantly, to correct anything that I have said.

Mr Gaisford: Sir, no, thank you.

Mr Whalley: No, thank you.

Sir Alistair Graham: Thank you very much. The Committee will now meet in private to come to its conclusion on these issues. If you could clear the room.

[Hearing adjourned at 15.15]

DAY TWO
Friday, 13 May 2011

[Hearing commenced at 10.45]

Sir Alistair Graham: I can now announce findings in relation to deficient professional performance and/or misconduct.

The Committee considered the submissions of Mr Whalley on behalf of the Council and those of Mr Gaisford on behalf of the registrant. It accepted the advice of the Legal Adviser.

Patient A attended for consultation on 26 March 2007. On this occasion, the registrant did not conduct muscle balance tests other than DV cover C Rx, nor pupil dilation. Further, she did not take an adequate medical history from Patient A, nor did she make adequate records with regard to recording the drugs names of the patient's current medication. At this consultation, she did correctly establish the presence of a lesion in the patient's right eye. Patient A returned for a consultation on 28 July 2008 following the sending of a reminder letter. At this examination, the registrant again did not conduct muscle balance tests other than DV cover C Rx, nor an examination of the eyes with pupil dilation. She did not make full or adequate records of a diagnosis of, nor the size of the lesion. Further, she did not record the position of the lesion, nor did she record the reason for not referring the patient. She again did not record the drug names of the patient's current medication. She did not refer the patient for further investigation of the lesion.

The patient attended for a further field of vision test and digital fundus image capture of his right eye. The registrant did not interpret the patient's visual field test results and the digital fundus image of the right eye did not capture the lesion.

The Committee, first, considered whether there had been deficient professional performance. It had regard to the case of *Calhaem v GMC*, in particular the principle that deficient professional performance is conceptually separate from negligence and from misconduct. It connotes a standard of professional performance which is unacceptably low and which, save in exceptional circumstances, has been demonstrated by a reference to a fair sample of work.

The Committee was satisfied that this was not an exceptional case and, on the basis of these deficiencies, only concerned one patient, so it concluded that the test for deficient professional performance was not met.

The Committee went on to consider misconduct. The Committee, in particular, noted the definition set out in the case of *Doughty v GDC*, namely:

“... conduct connected with the profession in which the (practitioner) concerned has fallen short, by omission or commission, of the standards of conduct expected among (practitioners) and such a falling short must be serious ...”

In reaching its decision, the Committee was very much aware that the experts instructed by both parties came to similar conclusions about the significance of the omissions by the registrant to investigate fully the lesion which she found when she carried out the examination on 27 March 2007 and 28 July 2008. Mr Stephen McPherson, on behalf of the Council, in his summary on page 25 of his report concludes that:

“A reasonably competent optometrist would be expected to follow up a finding of a retinal lesion, and a dilated examination would have assisted this process of detailed examination and clearly recorded findings. Pupil dilation is not compulsory” –

that is under the Scottish GOS rules,

“for patients under 60 years of age but the option to carry this out is available.”

He went on to stress that:

“The opportunity to review” on 7 August “the pigmented lesion with dilated fundus examination was again not taken up.”

He further concludes that:

“The findings indicate to me that the association between the pigmented lesion and the visual field loss should have been made and, even if this was not fully understood, the presence of unexplained visual field loss would prompt referral for ophthalmology assessment.”

Mr Frank Munro on page 8 of his report, when referring to the examination of Patient A both in 2007 and 2008 concluded that:

“Failure to carry out dilation was indefensible in these circumstances, especially when there is funding provided for this through the GOS.”

That is in Scotland. He also concludes in referring to the further visual testing on 7 August 2008 that:

“This date is pivotal in this case. As stated before, had Mrs Murray acted on the repeated visual field findings and intervened by carrying out a detailed dilated examination, and a further repeat field test, she would have been in a much stronger

position to make a decision on whether a referral was appropriate.”

Both experts concluded that there had been poor record-keeping and Mr Munro on page 8 of his report refers to inconsistent record-keeping and poor decision-making by Mrs Murray.

The Committee concluded that, on the basis of this evidence, her omissions were serious and that, consequently, this amounted to misconduct. Therefore, Natalie Murray is not guilty of deficient professional performance but is guilty of misconduct.

I now announce the findings regarding impairment. The Committee took account of the submissions of both parties on the issue of impairment and the testimonials and other documents placed before it. It accepted the advice of the Legal Adviser.

In reaching its decision, it noted its earlier finding that the registrant was open in admitting the mistakes she had made in carrying out her examinations of Patient A, and gave impressive detail of how her practice had now changed, as had the practice of her colleagues. The Committee was satisfied that this demonstrated that the registrant has shown considerable insight into her deficiencies and has taken important remedial steps to ensure that her practice is now up to the standard of a reasonably competent optometrist. The Committee noted her extensive CET record and her ongoing commitment to further study.

The Committee concluded that her deficiencies were capable of remediation and on all the evidence before it, she has taken appropriate steps to remedy her deficiencies. It was satisfied that, by taking the steps that she has, and in demonstrating the insight she has shown, there is no likelihood of these matters being repeated in the future.

The Committee have, therefore, concluded that today and looking forward from today, the registrant’s fitness to practise is not impaired. Consequently, the Committee found that the fitness of Natalie Murray to practise as an optometrist is not impaired.

The Committee considered whether it would be appropriate to issue a warning. The Committee concluded that, in the circumstances of this case, it is not necessary.

Unless there are any further matters for us, this concludes this hearing. Thank you very much.

[Hearing concluded at 10.52]