General Optical Council

BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(10)17

AND

ROBERT KING (01-8584)

Monday 20 and Tuesday 21 June 2011

SUBSTANTIVE HEARING

General Optical Council

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ROBERT KING

Monday, 20 June 2011

Fitness to Practise Committee:	Ms Mercy Jeyasingham MBE (Lay) (Chair) Mr Peter North (Lay) Mr Alan Baldwin (Lay) Ms Yvonne Norgett (Optometrist) Mr Stephen Reily (Optometrist)
Legal Adviser:	Mr David Swinstead
Hearings Manager:	Mr David Henley BEM
For the GOC:	Ms Margaret Bromley
For the Registrant:	Mr Ian Stern QC

[*Hearing commenced at 09:31*]

Ms Jeyasingham: Good morning. 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 procedures 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 of the Committee. Where advice on any issue is not accepted by the Committee this will be indicated in the course of its decision on that issue.

To your right is David Henley, the Hearings Manager, who will provide administrative support to the Committee. Next to Mr Henley is the transcriber who will be keeping an official record of all that is said today during the sessions of the hearing in 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. If the patient’s name is mentioned in the course of the Hearing, the transcriber will delete the name from the transcript and replace the words “Patient A”, or “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 are being discussed, the determination and transcript will be redacted accordingly.

The matters today have listed as a Procedural Hearing, but I understand the parties agreed they can proceed directly to a Substantive Hearing. Unless anything is changed, then I will announce a Procedural Hearing as having commenced and now we go to the substantive element of the hearing.

Ms Bromley: There is one point which is an amendment of the Allegation; shall I do that now?

Ms Jeyasingham: Obviously that is an application you are making, Ms Bromley?

Ms Bromley: Yes. You will see that the Allegations right at the end include both an allegation of misconduct and of deficient professional performance. The Council are proceeding only on misconduct.

Ms Jeyasingham: That is deleting 2(b)?

Ms Bromley: Yes.

Ms Jeyasingham: Are there any other applications to be made? You agree with this, Mr Stern?

Mr Stern: Madam, we do agree with this, but in fairness the issue to be put before you, the position is this that both of those allegations were set out in the allegation sheet as you can see. On 4 May this year a letter was received by the Association of Optometrists, who represent the practitioner, from the solicitors Bevan Brittan who, as I understand it, represent the General Optical Council. In that letter it says:

> “We recently carried out a review of the allegations against your client in the light of the evidence, including the experts’ reports. We have also taken into account the decision in the case of *R on the application of Vali v General Optical Council* [2011] EWHC 310 (Admin), we have decided that it is not appropriate to pursue the allegation of misconduct against your client. Therefore we will apply at the start of the Hearing

to amend the allegations to delete paragraph 2(a), misconduct. I would be glad to know of your consent to the amendment".

That was consented to. That is 4 May and of course thereafter we pursued and prepared the case on the basis of deficient professional performance.

About 6.30 on Thursday evening, Ms Bromley sent an email saying that there was an error and that it should, in fact, read that she has applied to amend it. Obviously you will understand the position from the practitioner's point of view that here we are, one working day before the Hearing and the practitioner is informed that there is no case against him for misconduct. Then it says there is a case against misconduct and there is no case in relation to deficient professional performance.

I don't want to waste a lot of time in relation to opposing it; it is right, in my submission, because the practitioner needs to hear that you have heard it, it was clear this has caused him, not to say the least, some consternation. We don't object to it, but it is somewhat odd, you may think, that originally it was thought there was no case in relation to misconduct and now there is only a case in relation to misconduct. No doubt we will pursue this at the appropriate time.

Ms Jeyasingham: Thank you, Mr Stern. Ms Bromley, what do you say about that?

Ms Bromley: All I can respond to that is it was entirely my error. It was never the intention to drop misconduct. The letter was an error; I should have picked it up earlier. I have apologised and will apologise to the Committee, but they have consented the amendment and I am not sure that it is helpful to spend any longer about; all I can say is it is entirely my fault; it is an error. I have apologised to my opposite number and to Mr King, I have apologised to the Committee, but as I say, they are consenting.

Ms Jeyasingham: Do the Committee have any questions? [*No questions from the Committee*]

In which case we will accept it. Mr King, can you stand, please, while the Hearings Manager reads out the Allegation, which has been amended.

Mr Henley: [*Reads*]

"The Council alleges that in relation to you, Robert King, a registered optometrist

1 On 12 February 2009 at a consultation with Patient A you did not adequately investigate the cause of patient A's symptoms in that:

a) You did not adequately investigate the patient's history and presenting symptoms in that:
i. you did not obtain a full patient history
ii. you did not ask Patient A questions about the type of visual aura experienced, the duration or other associated symptoms;
iii. and/or did not record such investigation

(b) You did not:
i. perform a dilated examination of the peripheral fundus of Patient A's right eye;
ii. perform an examination of the anterior vitreous of Patient A's right eye;
iii. use a binocular indirect viewing technique; or
iv. refer patient A for such examinations with an appropriately qualified health care professional;

(c) The FDT visual field test which you used was inappropriate on its own and you failed to supplement it by performing a visual field assessment by confrontation.

2 In carrying out your examination you did not take account of the following risk factors:-

(a) that Patient A was a high myope;
(b) her gender
(c) the presence of a nasal visual field defect in her right eye;

and as a result did not assess fully the eye health of Patient A and by virtue of the matters set out above your fitness to practise is impaired by reason of :

(a) misconduct"

Ms Jeyasingham: Are any of the allegations as set out admitted?

Mr Stern: No.

Ms Jeyasingham: In which case I will turn to Ms Bromley ask for your opening statement.

Ms Bromley: As far as the bundle is concerned, we have no papers, I understand. Can we perhaps distribute the bundle?

Ms Jeyasingham: For the record we will call this bundle C1.

[*C1 is distributed*]

Ms Bromley: The allegations before you arise from the visit by Patient A to Scrivens Opticians on 12 February 2009. She was concerned about

problems with her right eye. Scrivens were not her usual opticians, who were based in Aldershot, but Patient A had moved north, but not registered with a new optician. She continued to use the firm in Aldershot even though she had moved to Yorkshire.

She asked her partner to try and get her an appointment with an optician locally and he was able to get an appointment with Scrivens and Patient A was seen by Mr King on 12 February.

Patient A first noticed problems, she says, on 9 February and it is the Council's case that Patient A told Mr King that she had flashing lights and a blank spot and she said that it was a bit like a migraine without the headache. Mr King's record of the visit is at Tab B, page 109.

Mr Stern: May I apologise just for a moment, there is a typed version which has been hole punched on the right hand side, so you were, as it were, open it up. It may be helpful for you to have. I haven't given the page number, but if you want to give the page number, it can be – 109 in yours, a variation of how you want it to be.

Ms Jeyasingham: We will call that 109A and R1. This is agreed?

Ms Bromley: It is the first time I have seen it, so I haven't had a chance to compare.

Mr Stern: If there are any errors, then it can be amended.

Ms Bromley: In addition to 109 there is also 111, two pages further on, a transcript which was prepared by Mr King, which is in the bundle, so perhaps the two together should give you a clear transcript if it is on the sight test card. You will see that the record of the visit makes no mention of flashing lights or a blank spot. It says simply:

> "Right eye less clear, last few days".

I haven't seen a witness statement from Mr King, but it is understood that his evidence will be that Patient A made no mention of flashes or flashing lights and that she said that she was suffering from a migraine and he is not in dispute that she is a migraine sufferer. There is therefore a dispute on the facts as to what exactly Patient A told Mr King at this visit.

It is the GOC's case that Mr King should have asked questions about the aura, about the loss of vision such as how long it had been on-going and should have obtained a better description of the symptoms.

Mr King carried out a sight test and reassured Patient A that there was nothing to worry about. She was told that she needed a new prescription for glasses.

It is the Council's case that the possibility of a retina break or a retinal detachment should have been in Mr King's mind at this visit and he should have asked further questions and carried out further tests in order to confirm or eliminate a possible diagnosis of retinal detachment. It is our case that the tests that should have been carried out are those that are listed in Allegation 2 (b).

Following the sight test Patient A was taken to another room where a visual field test was administered by another member of staff, who is an unqualified member of staff. There is a copy of the visual field test at page 113, which is extremely unclear. I understand that in fact we did ask for the original to be brought, but I understand that that fades with time and it is not much clearer. There is, however, at Tab B, a copy of the visual field test at page 29, which is effectively being filled in by Mr King. That is a marked up copy of the visual field test and Mr King it is his handwriting on the left which says:

> "Field results indicated a loss of sensitivity, as opposite"

In the course of the visual field test it is Patient A's evidence that on at least two occasions she said:

> "Has it started yet, I can't see anything?"

I understand you will be hearing from Paula Norton, who is the member of staff who administered the visual field test. She simply says in her statement that she carried out the visual field test, printed the results and handed them to Mr King, who said the patient would have to come back. Again there is a dispute in the evidence here that Miss Norton says she told Patient A she would have to have her visual field test re-done and that she could do so when she collected her glasses. Patient A denies that she was told that she would need the visual field test re-doing. Even if she was told this, it is the Council's case that it was not appropriate to leave this until the spectacles were ready. If it was necessary to redo the visual field test that should have been done the same day. In any event, the visual field test showed a defect and it should have increased the awareness of a possible retinal detachment. There should, therefore, either have been an immediate referral or the visual fields should have been re-tested the same day.

Four days later, on 16 February, Patient A went to see her GP as her symptoms were persisting. The record of the GP visit is at Tab F, page 119. You will note there:

> "History: suffers from migraines and has had an aura past five days like flashing lights, a blind spot in front of right eye, but no headaches followed and symptoms are not resolving.
>
> Saw opticians who could not find anything wrong".

The GP then carried out examinations, found nothing and prescribed diclorenac sodium.

Patient A went back to the GP in 19 February and she saw a different GP who advised her to go to the eye casualty unit at Sheffield Hospital that day. This she duly did and the hospital records start at Tab G. She went that day and was diagnosed with a retinal detachment in the right eye. The notes of that start at page 135. The history sheet of the examination on 19 February 2009 again notes:

> "Has seen flashes and floaters for the past eight days. Vision gets blurred with field defect".

It is apparent that they carried out a confrontation test and the level of detail of examinations is on page 136. It was decided that she needed an operation. Page 137, still part of the examination: "Then a macula off detachment".

Page 137, 22 February she was admitted, the day prior to the operation and underwent an operation on 23 February. The notes are on page 138. On the morning of the operation the surgeon discovered a retinal detachment in the left eye and she subsequently underwent a further operation on 18 May on her left eye. That doesn't really concern these proceedings mostly as to the history.

Patient A is here to give evidence. You will see at Tab C there is a statement from her and I was going to call her, have her statement stand as her evidence-in-chief. I don't know whether you would like time to read that first, or whether you are simply happy for her to read it into the record?

Ms Jeyasingham: Perhaps she can read it into the record.

Ms Bromley: Could we call Patient A?

Mr Swinstead: Mr Henley, just before you do that, I wonder if I could just pose a question to Ms Bromley so it is clear from the outset. In the allegation you have large number of allegations that the Registrant did not adequately investigate, did not obtained, did not ask, did not perform. You had one, "Failed to supplement"; is it right for the Committee to understand that all those allegations are not effectively failures in the sense that they are culpable failures, or rather did not in any narrative?

Ms Bromley: No, they are culpable failures.

Mr Swinstead: In their own minds, the Committee can substitute the word "Failed" with the word "did not" in the sense of "failed" imports culpability?

Ms Bromley: Yes.

Mr Swinstead: Thank you.

Mr Stern: In our respect, just before the witness comes in, it would be much easier if you just read the statement rather than having to get the witness to read her whole statement. That is not necessarily the thought for her; it would be much quicker for you to read it. It is not necessarily to be read and it is part of the bundle as an exhibit already.

Ms Jeyasingham: I'll just ask the Committee. Did you read it before? [*Confirmed*]

Okay, we will do that.

Mr Stern: Page 32.

[*Pause*]

Ms Jeyasingham: Have we all read it?

PATIENT A, called and sworn
Examined-in-Chief by MS BROMLEY

Q. We will refer to you as Patient A to maintain more anonymity. I don't know if you want to introduce the Committee?

[*Introductions by Committee members*]

Ms Bromley: You should have a ring binder in front of you. If you could open that up to Tab C, page 32? Can you just confirm that that is a witness statement that you made in connection with these proceedings and that it is your signature on page 35 and that you are the person described in that statement?
A. Yes.

Q. Can I just take you through a couple of other emails that were in the bundle? Tab B, first of all pages 15 to 16, do you have that? Is that your handwriting?
A. It is, yes.

Q. Is that the complaint you made? The date is 17 August 2009?
A. Yes, it is.

Q. Page 18, there is an email there, is that an email from you?
A. Yes.

Q. Finally, page 22, that is an email from you, is it?
A. Yes.

Q. This last email dated 12 February 2010, is that in response to the letter at subpages 19 - 21?
A. It is, yes.

Q. Thank you. I don't know if you have had time to read the other emails I have just taken you to?

Ms Jeyasingham: That may be useful.

[*Pause*]

Can you just go over which ones we were supposed to read just to make sure?

Ms Bromley: Yes, it is Tab B, it is the documents that Patient A has identified at pages 15 and 16, our email at page 18, Mr King's representations which are 19 to 21 and then Patient A's email, page 22, was read - those previous pages.

[*Pause*]

Ms Jeyasingham: That's fine.

Ms Bromley: Thank you very much. That is my examination-in-chief, the documents standing for that and I am sure Mr Stern has some questions.

Cross-examined by MR STERN

Q. I am going to ask you some questions on behalf of the practitioner, all right?
A. Yes.

Q. First of all, as I see from the documents, you complained in August of 2009, some six months or so after this consultation that you had?
A. Yes.

Q. The Optical Council then wrote to Mr King in November and you have seen his letter of response on 12 December 2009, which is at page 19 in the bundle, and you have just gone through that or seen it.
A. Yes.

Q. You responded to it, so you know precisely what it is that he is saying about what took place at the consultation?
A. Yes, it was two years ago.

Q. That is precisely my point. You know from what he said in December 2009 that looking back now looks quite difficult to remember the consultation, I'm sure.

A. That is why I wrote quite a lot of it down.

Q. Where is that? You mean in the August?
A. Yes.

Q. You didn't write anything before that?
A. I returned back to work, yes I did and that is where the complaint originally came from, the dates and everything from the original complaint.

Q. Do you have that written document?
A. No, because it was written on the -?

Q. Sorry, just so we are clear about it: the document that you are talking about, is this document on page 15?
A. It is the original complaint, yes.

Q. That is the first time that you wrote anything down about it? That is what I am trying to understand.
A. It was written in note form prior to that, because I wanted to make sure I had the recollection correct with dates and things that had happened.

Q. Just before you wrote that out?
A. Yes.

Q. When you came to the practice on 12 February you were wearing your contact lenses and you had your glasses with you as well? Do you remember?
A. I don't believe I did.

Q. That is your recollection is it?
A. It is not habit – I wore contact lenses all the time; I didn't usually have my glasses with me.

Q. Your recollection is that or you are just saying usually you didn't take them with you?
A. I would say that usually.

Q. Prior to this sight test you had not had one for two years?
A. No.

Q. No, that is not right, or no you are agreeing with me about it?
A. I am agreeing with you.

Q. You had been over-wearing your contact lenses?
A. Yes.

Q. Your contact lenses were under-powered?
A. If that is what was said at the time of the test, then yes.

Q. That is what I am asking. Do you remember that being said or not?
A. I don't remember that being said, to be honest.

Q. When you came in on 12 February – again, I don't know if you will remember, but you did not look well.
A. I believe that was what was written in Mr King's notes. Yes, I did not look well: I was very stressed, there was an awful lot of personal things going on at that time.

Q. I don't want to ask you about your personal life, obviously. I'll leave it at that. Would you agree that you didn't look well, for whatever reason? Obviously Mr King wouldn't know what those personal reasons are and I am not asking you – you did not look well.
A. If that was Mr King's interpretation of the way I looked, then that was Mr King's interpretation. I know I was very stressed at the time.

Q. All right. I won't go into personal matters. Your right eye was blurry; is that right, or you told him it was blurry over the previous few days?
A. No. What I believe I said was it felt like a migraine, but without the headache. If you have never experienced a detached retina you would have no idea what it looks like.

Q. Thankfully I haven't, but leaving that aside at the moment, let me ask about the right eye, we will address the migraine point in a moment. At the time you were describing your right eye as exhibiting some blurring?
A. Yes.

Q. You agree with that?
A. I think I said there was a blind spot. There was a blank spot; there were flashing lights and a blank spot. I don't believe I said "blurring".

Q. Because you said "I think I said blank spot".
A. Yes, it was a blank spot and flashing lights.

Q. Did you say "It was a blank spot", or are you saying you may have said something to do with blurring?
A. I don't believe I said "blurring". It was a blank spot and flashing lights.

Q. I appreciate that things happened very quickly after you saw Mr King, because you then saw a number of practitioners, didn't you? You saw them on 16 February, you saw them on 19 February, you then went to the hospital and saw a number of other people as well?
A. Yes.

Q. Obviously all of those, coupled no doubt with the considerable stress you were under for all sorts of reasons, does make it difficult to distinguish between each of those examinations?
A. Yes.

Q. First of all, you were a migraine sufferer or were at that time.
A. Yes.

Q. No doubt the stress you were under that presumably brings on migraines?
A. Yes.

Q. Did you have a migraine at the time that you saw –
A. No.

Q. I'll just finish the question before you answer it – did you have a migraine at the time in which you saw Mr King? I appreciate that by the 16 February you might not have had a headache, later on, but did you have a headache at that point, 12 February?
A. No.

Q. Are you sure about that?
A. Very.

Q. You describe it as feeling like a migraine.
A. No, it was like a migraine, but without the headache.

Q. I am going to suggest to you and I need to make this clear to you that on 12 February you did not describe it as not having a headache, but in fact saying that you had a headache. It may be the way you describe the symptoms, I don't know.
A. I wouldn't agree with that. I would say that it was like a migraine but without the headache.

Q. These had not been dissimilar to your previous migraines, had they? This was not dissimilar to your previous migraines?
A. Not dissimilar, but I still did not have the headache.

Q. In fact in your statement you said "The problem is difficult to describe".
A. Yes.

Q. Did you find it difficult to describe when you spoke? Bearing in mind this is the first opportunity, this is the first time that you had a consultation? It is a difficult thing to do isn't it, at the very first did you find it difficult to describe what was going on? It is not a criticism of you, because sometimes –
A. It is difficult to describe and it was a blank spot and I did feel like I was going mad, which again is what I said. It was flashing lights, it was a blank spot, there was something there, but I couldn't see it, because it was a blank spot.

Q. Did you say it was like the experience you had with a migraine?
A. It is like a migraine but without the headache.

Q. You described it as an experience like a migraine?
A. Yes.

Q. You were asked – again I know this will be very difficult for you to remember this, but let me just, for completeness, ask you about it, you were asked about a number of things, you were asked about a loss of vision, whether you had a loss of vision.
A. I don't recall that being asked.

Q. You were asked about floaters and flashes.
A. I don't recall that being asked.

Q. Let me suggest it was asked and you said that you did not have floaters and flashes at that time.
A. I don't recall it being asked, so I can't comment.

Q. Do you recall being told to go to your general practitioner if the headaches persist or if the symptoms persist?
A. I don't recall that.

Q. You did, in fact, go to your general practitioner.
A. I did, yes, at the advice of my husband and my line manager at the time.

Q. You had to come back and collect glasses, didn't you?
A. Yes.

Q. You were told that you would have a repeat field test when you returned?
A. I disagree with that.

Q. Have you seen the statement of Paula Norton, the lady who dealt with you?
A. No, I haven't.

Q. All right. If you haven't seen it I won't take you to it now. The position is this that a lady took your field test, didn't she?
A. Yes.

Q. During the course of that you described as the machine having dots.
A. Yes.

Q. If I was to say to you it didn't have dots, what would you say about that?
A. I will say what I can see is dots.

Q. That is your recollection then, that it was dots?

A. That, to my memory is what a field vision test is: it is dots and you press the button.

Q. That may be your understanding of it, but I am asking about your recollection. That is all we are looking at, your recollection of what took place on 12 February.
A. On that day I asked her to restart the machine at least twice because I couldn't see anything.

Q. There is a dispute about that and it is that that is not right. You carried out the test and it was not dots. That is what I am asking – can you remember that now or not?
A. I couldn't see anything; that was why I asked her to restart it twice.

Q. Right. You did manage to carry out the field test?
A. Because after asking her twice to restart it and to my mind it still wasn't working, I just wanted to get out of the place, so I just randomly clicked.

Q. I see. You randomly clicked and managed, in relation to one eye, to get it right.
A. Fair enough.

Q. Now after that test, you went to choose some frames.
A. I did.

Q. You weren't that much in a hurry to get out, were you?
A. I was asked to choose frames and unfortunately I don't like wearing glasses, so I like to take my time choosing frames.

Q. I am not criticising you. All I am saying is that you obviously weren't in that much of a hurry to get out.
A. I wanted the test to be over.

Q. You did then go and choose some frames. Did you pay for those frames?
A. Yes, I did.

Q. With the same woman who carried out the field test?
A. I can't remember if it was the same woman.

Q. She repeated to you after you had paid for the spectacles that you should return to have your test redone.
A. I don't recall her saying that.

Q. It follows if that was said to you, you have completely forgotten that.
A. I don't recall her saying that. My husband was with me at the time and he doesn't recall that either. Obviously he is not here.

Q. He is not here. He doesn't recall it. As I understand it he was speaking very loudly on the telephone at the time.
A. Right.

Q. Do you remember that?
A. Nope.

Q. He was on the phone to a brewery.
A. Fine.

Q. Does that make sense?
A. Yes, he was the landlord of a pub at the time.

Q. Obviously Paula Norton wouldn't know he was a landlord unless she heard him talking on the phone.
A. She would probably know from the address that he was a landlord of a local pub.

Q. The other thing that you put in your statement is that you indicated that because you were a high prescription, you said that that leant itself to certain conditions.
A. Yes.

Q. Are you saying you said that to the practitioner?
A. Yes, I did.

Q. I suggest that is not right at all, that you didn't say that.
A. No, I would suggest that I did. I recall specifically saying it lends itself it certain conditions.

Q. You didn't say that at all at the time.
A. No. I am sorry, I have been told since this eye has been -10 for many, many years, the left eye has been -10 for many years and I was told for many, many years to be very careful, because my eyesight would lend itself to detached retinas. I know specifically I said that.

Q. You knew that at the time?
A. Yes.

Q. Right. Did you say "Do I have a detached retina?"
A. No, I didn't say "Do I have detached retina?" I said "It lends itself to certain conditions". I was not going to tell Mr King his job. He should know that job.

Q. If you feared that you may have detached retina, why didn't you just say that? It wasn't a guessing game.
A. Because it is up to Mr King to find out.

Q. Surely you wanted him to find or do the best for you, didn't you?
A. Yes, but I know I didn't say "Is it a detached retina"? I checked back and said "It lends itself to certain conditions".

Q. Yes, but if you knew that it was those conditions, you were talking about a detached retina, why didn't you say that? If you say you said about certain conditions?
A. I didn't say that.

Q. The way you put it at page 15 in which is your initial complaint, you say that:

> "The problem was difficult to describe"

You have accepted that today;

> "but seemed to be a blank spot"

A. Yes.

Q. I just need to understand how many days was it before the 12 February that these symptoms had come on?
A. Sorry, I don't.

Q. Forgive me, you have not understood my question. On 12 February you went to the optometrist and you say you indicated certain things. What I am asking you is when did those symptoms come on before 12 February? How long before 12 February?
A. It was a few days, but I am not sure.

Q. You have written categorically here, on or around 9 February.
A. Because I recall that on 9 February we went to a Valentine's Ball and I know I was having problems then. 9 February I know it was certainly present.

Q. If we look at page 119, have you seen the GP record?
A. No.

Q. You saw a GP, as we know, on 16 February and then you talked about an "aura". Is that a word you used?
A. No, it is not a word I used.

Q. Aura: are you familiar with that term or not?
A. Yes, in terms of epilepsy, yes.

Q. Also in terms of migraine or not?
A. Not particularly, no.

Q. It said that, or at least you reported, on 16 February that you had it for the past five days, which would have been the day before, 11 February.

A. I suppose so.

Q. All I am asking is how long the symptoms had been going on? Can you remember or not?

A. I know definitely on 9 February we went to a Valentine's Ball and I was having issues with it then.

Q. Whatever the days were, that was what was said to the general practitioner on 16 February. That general practitioner carried out a sight test on you. He used various pieces of equipment to look into your eyes.

A. Yes.

Q. He diagnosed –

A. She.

Q. She; I beg your pardon. There is an aura. Did she say what the problem was?

A. If I recall correctly she wasn't sure. She gave me some tablets and said to return in a couple of days if it hadn't cleared up.

Q. All right, that is exactly what she has written there: "if not clearing in the next few days". She diagnosed an aura, but you didn't understand what that meant.

A. No.

Q. Fair enough. On page 135, these are your medical records and I understand you may not have seen these either, can I just ask you about them? This is 19 February and it says:

> "The right eye has seen flash"

- so it is in singular;

> "and floaters for eight days"

You hadn't mentioned anything about floaters. You certainly didn't mention those to Mr King, did you?

A. Not that I recall, no.

Q. You haven't put it in your complaint or your statement.

A. Right.

Q. On 19 February you were telling the doctor, if this note is accurate, that in fact you had seen a flash, singular, that is what it looks like, and floaters for eight days. That takes you back to 11 February again.

A. Right.

Q. Do you know whether you mentioned floaters?
A. I don't recall to be honest. Again, it is two years ago.

Q. Do you remember whether that was a symptom you had?
A. To be quite truthful, with eyesight as bad as mine, I often get floaters anyway. Whether they worsen or not is –

Q. Yes, but do you remember whether you mentioned that to the doctor at the hospital or not?
A. I don't remember.

Q. Then a little further down it says "Full field". You could see okay, could you? As well as you can?
A. As well as I could.

Q. All right. Over the page to page 138, you can see this is 23 February now, so this is the day of your operation. We can see 507, let me help you if you don't know; do you know what that means, 507?
A. No.

Q. That is five days ago, nasal field defect, so that would take you to 18 February. Is that when the blank spot came on?
A. No.

Q. In any event, once you discovered that you had a retinal detachment then you obviously wanted to cancel the glasses, we have seen that in the documentation.
A. Yes.

Q. That was done and there was obviously some difficulty between your husband and Scrivens, nothing to do with Mr King, but eventually they paid money back for the glasses.
A. Yes.

Q. That is what he phoned up about. Were you there when he phoned?
A. Sorry, is it my husband are you referring to?

Q. Yes.
A. On what day when he phoned, because there were a few phone calls?

Q. Were there? He first of all phoned up asking for the money back for the spectacles.
A. We phoned up as we left the hospital to say could we have the money back, because obviously those spectacles were obviously now no good.

Q. Yes, I understand. That is what you phoned up about?
A. Yes.

Q. Thank you very much.

Ms Jeyasingham: Can I ask the Committee if they have any questions?

Ms Bromley: I don't have any re-examinations, thank you.

Questions from the Committee

Mr Reily: Can I just ask you a couple of questions about the symptoms that you described to Mr King? You describe in the notes that you were having symptoms in the right eye; can you recall whether you were having any symptoms in the left eye?
A. No, I don't recall any symptoms in the left eye.

Q. Are you able to differentiate between symptoms in the right eye, symptoms in the left eye, or symptoms in both eyes together?
A. I am not sure I understand that, sorry. The right eye, there were definite symptoms. The left eye I didn't know anything was going on in the left eye at all. It wasn't until the day of the operation.

Q. When you have migraine problems can you tell me whether the symptoms you get with the migraine are from your right eye or from the left eye, or is it normally in both eyes?
A. It is normally both, I think.

Q. You think?
A. It is quite difficult.

Q. Can you tell whether it is either eye in particular or one side of your vision?
A. It is both to be honest, but it is just there is flashing lights, things go black, I get blank. My hands look like they are crawling with worms is the only way to describe it. It is very strange.

Q. Okay. Normally when you have a migraine you have a headache?
A. Yes.

Q. Do you normally get that headache at the time of visual disturbance?
A. I tend to get the visual disturbance and then as it goes on the headache comes on and then the headache gets worse and the visual disturbance goes back.

Q. Thank you very much.

Ms Norgett: My question is a follow-up to that. Have you ever experienced visual symptoms for migraine but without the headache?
A. No.

Q. You always get the two together?
A. Yes, I always get the two together.

Q. Thank you.

Mr North: Good morning, Patient A. I have a few questions for you. When you were doing this visual fields test –
A. At the opticians, yes.

Q. Yes, that first appointment at the opticians, you said in your evidence you kept pressing the button, you wanted it to be over.
A. Yes.

Q. Why did you want it to be over?
A. I was very stressed at the time and to be honest it was quite a relief to think there is nothing wrong.

Q. Why did you think there was nothing wrong?
A. Because Mr King had said that everything was fine, I just needed new specs and the contact lenses were a bit out of date.

Q. Okay. This was your first appointment with Mr King.
A. Yes.

Q. Did you mention migraine?
A. Yes.

Q. Could you describe to me how you did it? I know it probably difficult to recall.
A. I think I said "It feels like a migraine, but without the headache" and he may have asked "Do you suffer from migraines", and I said "Yes".

Q. Were there any subsequent questions after?
A. I don't believe so, but again it was a long time ago.

Q. That has been very helpful. Thank you very much.

Ms Jeyasingham: Mr Swinstead.

Mr Swinstead: Sorry, it should be Mr Stern and then –

Mr Stern: I don't have any further questions, thank you very much.

Ms Bromley: I don't have further questions.

Ms Jeyasingham: In which case, Patient A can stand down.

[*The witness stood down*]

Ms Bromley: The next stage will be to call my expert witness, Adrian Jones. I wondered if you might like the opportunity to read the experts' reports, because they are both in the bundle at Tab D, please. There are two reports there, that of Adrian Jones and that of Professor Whitaker, who is instructed by the AOP. Obviously they are reasonably lengthy; I thought you might like the opportunity to read them. If you want them, they are not in the bundle, the references that Dr Jones refers to in his report, I do have the bundle, all the references here if you like.

Mr Stern: May I respectfully agree with my learned friend it will be helpful and certainly quicker if you were to read the reports, they are quite detailed, and some are easier than others; I appreciate that. In addition to which, there are some research papers that have just been referred to – there are some in the bundle you might want to look at and there are some additional ones that Dr Jones, I don't know why, it is not his report, but it is here for you to look at. Indeed, there is an additional one as a result of that, that we would like you to look at as well. It is entirely up to you, but I would have thought that if you have the overall picture before you hear from the experts, that will make it easier.

Ms Jeyasingham: That is a good idea. We are going to have these as – I am just checking what we are calling them. This will probably be C2.

Ms Bromley: It will, C2.

Ms Jeyasingham: Plus R2.

Mr Stern: Yes.

Ms Bromley: These are arranged – Tabs 1 -16 correspond with the list at the back of his report.

Ms Jeyasingham: Right.

Mr Stern: That is R2.

Ms Jeyasingham: Sorry, Ms Bromley, what are you asking us to look at?

Ms Bromley: I am not asking you necessarily read all the references, although some of your practitioner colleagues might find them more interesting. Because they are referred to in Dr Jones' report, then you ought to have them available if you want to refer to them.

Ms Jeyasingham: Because this is going to be quite a bit of reading for us, we should clear the room.

Ms Bromley: Yes, absolutely.

Ms Jeyasingham: Then it will give the Committee a chance to read it as well.

Mr Stern: Realistically this is an hour's reading.

Ms Jeyasingham: Really!

Mr Stern: If you want to be convinced in your minds as it were and an hour is conservative.

Ms Jeyasingham: Let's adjourn for an hour while we read it and just be available afterwards.

Mr Stern: We are not going anywhere. I am just trying to give you some extent of how much we have.

Ms Jeyasingham: Thank you.

[*Hearing adjourned at 10:39*]

[*Hearing reconvened at 11:41*]

Ms Jeyasingham: Ms Bromley.

Ms Bromley: May I call Dr Jones, please?

DR ADRIAN JONES, called and affirmed
Examined-in-chief by MS BROMLEY

Q. Dr Jones, can you just confirm who you are?
A. My name is Adrian Jones, I am an optometrist in South Wales, I am registered with General Optical Council.

Q. Your practice address?
A. 10 High Street, Barry.

Q. You should have a ring bundle you have your elbow on. Could you turn to Tab D, pages 41 to 59, can you confirm if that is a report you wrote in connection with these proceedings?
A. Yes.

Q. Can you just go back to the beginning of the report, page 42? You have set out there your experience. You haven't provided a CV and unfortunately you weren't able to download one today.
A. No, I'm sorry.

Q. I am sure Mr Stern will ask you any questions he wants to about your experience. Is that still as set out on page 42, is that still your current experience and expertise?
A. I am currently between jobs in the hospital. I no longer work for the University Hospital of Wales, but hopefully I shall be taking a post in Bristol or in Singleton, Swansea for the next coming months.

Q. Right. You mention there you established your own practice in 2006, what is the split between time spent in private practice and time spent on hospital and other work?
A. Now most of the time is in private practice, but prior to that when I was working in Bristol and in the University Hospital of Wales it was predominately hospital practice.

Q. When did it change?
A. Around about 2005/6.

Q. Could you next turn to page 47 of your report? You are talking the section headed "Clinical Notes from the Department of Ophthalmology at the Royal Hallamshire Hospital". Those are in page 3 of the bundle. About three lines down in your report you talk about confrontation visual field testing.
A. Yes.

Q. Could you turn to page 135 and the results of the confrontation test, is that shown on that page?
A. I would expect that is what it is.

Q. Can you just explain in a bit more detail which bit you are looking at?
A. I am looking at the two checker crosses in the middle of the pages with the ticks and a cross on it.

Q. What is the result of this showing, as you understand it?
A. It is documented the wrong way round, which is quite common for confrontation tests. Generally speaking visual field test results are plotted on the page as if the patient was looking at the page and this is recorded as if you are looking at the patient, which means it is laterally the wrong way round. It suggests that there is a infra temporal field defect, but I suspect it is an infra nasal field defect in the right eye.

Q. Which in layman's language is?
A. A field defect on the right side, on the right eye.

Q. It says "full field"; do you know what they mean by that?
A. I suspect that it means that the left has no field defect as far as the consultation is concerned.

Q. "No RAPD"?

A. RAPD is a relative afferent pupillary defect.

Q. Is there any significance to that?
A. Yes, relative afferent pupillary defect occurs if there is a lesion between the front, receptor layer of the retina and the chiasm, usually associated with optic nerve problems, but can be associated with large, retinal lesions such as retinal detachments or extensive AMD and it really should affect one eye significantly more than the other.

Q. Thank you. Turning to page 136 of the hospital notes, there is a note there that says "wavy macular off detachment". It is under the drawing of the eye. Can you explain what is meant by, or the significance of wavy macular off detachment?
A. I am not entirely sure what wavy means; I suspect it is in reference to the shape of the retina. It quite often looks corrugated once it is detached. The fact that the detachment was extended from the temple retina which is on the left towards the right – the lines coming out of it are supposed to represent the optic nerve. That is halfway across that circle is where the macula is. The macula has responsibility for the high visual acuity that we are all very well used to.

Q. In terms of detachment, in terms of the seriousness - ?
A. Yes, basically the longer the retina comes off, the poorer the prognosis for visual recovery and that is more applicable as it approaches towards the macular area.

Q. Does the fact that it is a macular detachment have any significance in terms of how long it has been in existence?
A. No, I don't think so.

Q. Up above the pictures of the eyes on this page it says "tobacco dust, right eye". Can you just explain if that has any significance?
A. Yes. Tobacco dust is generally thought of to be either pigment shed within the photoreceptor's outer segments, or indeed, blood cells from damaged blood vessels in response to usually a retinal detachment. They can migrate around the vitreous, which is the jelly part of the eye that can be seen when you have a slit lamp. It suggests it could be very indicative of a detachment or a tear.

Q. Turning over to page 48 of your report, you mention on 16 February that the patient went to see her GP, who examined her eyes and prescribed tablets. Are you able to assist me with the degree of expertise a GP would have in identifying retinal detachment?
A. Generally speaking GPs are not very well trained at ophthalmic examination. Most GPs, unless they have a special interest in ophthalmology, will spend at about two weeks as a fourth or fifth year medical student in an ophthalmology clinic, so their exposure to eye problems is fairly small. They are generally

more than happy to defer clinical decision making to an optometrist and to any other healthcare practitioner.

Q. Moving onto page 50 of your report, under the heading "Myopia", you have some statistics there that say that patients with high myopia have a prevalence of up to seven per cent. In terms of Patient A's prescription did she fall within that category?
A. Yes, I would say so. She was over -10 and we can generally agree that is considered as high myopia.

Q. Page 51, you talk there about gender and retinal detachment is on the whole more common in males, but non-traumatic detachments are more common in females. Is that still your view?
A. It is fairly controversial, as has been pointed out to me by Professor Whitaker. It really draws on my experience, the majority of retinal detachment I have seen in the practice happens to be women and some of the statistics I found fitted nicely with that. It could be argued either way there are similarly enough papers that suggest an alternative view and similarly that says there is no specific difference between the two.

Q. Pages 52 to 53 of your report you refer to some of the different guidelines that are available, including the College of Optometrists, the American Optometric Association, the Welsh Eye Care Initiative. Do any common themes emerge from the various guidelines in terms of risk of retinal detachment and what to do?
A. The common theme for practitioners presented with patients who may or may not have a retinal detachment is a dilated fundus examination, ideally using some sort of indirect technique.

Q. In terms of a patient complains of flashing lights and flashes, do you know what the top few causes of flashing lights are?
A. Yes, you are talking posterior vitreous detachment, retinal detachment, retinal tear, migraine aura, raised intracranial pressure, anything that really affects the outer retinal layers. There are a couple of drugs that do it; digoxin is the well-known one. There are probably others, but they escape me at the moment.

Q. Thank you. Page 54, you talk there about seven lines down about risk factors that this patient had. You mention high myopia, gender. Do you still stick behind this risk factor?
A. I concede it probably is less of a risk factor, but it is certainly something that I look for – the non-traumatic detachment.

Q. The chronic retinal detachment in the left eye –
A. That is retrospect and Mr King wouldn't have known that.

Q. Turning to the top of page 55, you talk there about the presence of a nasal visual field in the right eye "should have raised the level of suspicion". Could you also turn to Tab B, page 29, which should be the marked up copy of the visual field test? Unfortunately we don't have a very clear copy. Could you just explain where you are talking about how this is shown on this visual field test, that there was a nasal visual field defect?

A. If you imagine that you are the patient looking at the page, the circle in the middle represents the macular. I suspect the dot on the right hand side represents the blind spot where the optic nerve is and then on the left hand side that is the nasal side of the visual field and the dark areas represent areas where there is reduced sensitivity to the target. The percentages represent confidence limits.

Q. Is this, in terms of the level of defect, can you make any comment on that from that information?

A. Without knowing the false positives and false negatives fixation losses, I can't determine the reliability of the field test, but it looks like a nasal field defect that is more prominent in the inferior aspect.

Q. Page 56 of your report, paragraph 6 you talk about the description of symptoms:

> "Similar to a migraine, but without a headache. Such a highly myopic patient should increase the practitioner's suspicion"

Can you assist me as to what the degree of possibility was that this patient had a retinal detachment or how alert the practitioner should have been?

A. A diagnosis of a migraine is reasonable, but you can't categorically exclude all of the diagnoses. Since the next bit on your list of differentials is likely to be PDT - the patient is a big young for that – it tends to happen in over 60s, it is going to be a retinal break of some description. Even going down your list you are going to probably want to have a look at it, have a good view of the optic nerve anyway.

Q. Do you know is there any information as to how many practitioners would have dilated in these circumstances?

A. Funnily enough the AOP produced a reference this morning, a paper that looked at what optometric practitioners do in the UK faced with the patient presented with flashing lights. Admittedly the patient was older than the one in question here, but roughly a brief glance at it – about two thirds of those would like to have dilated the pupils of a patient. Something like 90 per cent of those would have done it on the same day if they had a chance.

Q. Just turning to page number 57, it is 16 of your report, just checking some cross references. You talk in the middle of the page the reduction in vision from 6/12 on that day with presentation to 6/36. Where you got that information from is page 135 initially.

A. Yes, 135 and 6 as well.

Q. That would have been on 19 December?
A. That is right, yes.

Q. Then the day of surgery – it is page 138; is that a significant deterioration?
A. That is a going on a standard chart probably from around the halfway point to almost the top of the chart.

Q. You set out your summary at pages 57 to 58, do you stand by what you say in that summary?
A. Yes, perhaps less about the gender, as we discussed earlier.

Q. Could you next turn to Professor Whitaker's report, which starts at page 60? It is right, isn't it, you have seen this report before and you have had a chance to read it. Just a few things arising from this. First of all page 62, under the heading "History and Symptoms"; he talks there in the middle about there appears to be no complaint of flashes or floaters at the time of the examination and as we have heard, that is one of the factual disputes. If Patient A had complained of flashes and a blank spot would that affect the likely diagnosis in terms of shifting the balance between migraine and retinal detachment?
A. Yes. Also you would be more inclined to think of a retinal detachment as a possibility.

Q. Professor Whitaker also talks about prevalence rates, obviously a migraine being much more likely. In your view is it reasonable to rely on prevalence rates when reaching a diagnosis?
A. Not at all.

Q. Do prevalence rates preclude investigation of any other likely causes?
A. I would suggest not, no.

Q. Page 63, visual field tests, the test undertaken at Mr King's practice was the FDT test. You mention there that it is a quick test not designed to measure visual field sensitivity in detail. In terms of the quickness how quick is it?
A. I didn't mention that. Professor Whitaker did. It is a fast test; I think it can screen 30˚ in around about 30 seconds.

Q. Does that make it easier to repeat it?
A. Yes, it does.

Q. Why is that?
A. Patients are generally less fatigued if the test is short.

Q. What is this particular test aimed at in particular?

A. The FDT perimeter is mainly looking for the glaucomatous loss in patient with glaucomatous optic neuropathy more than anything else, but it is useful for other things as well.

Q. Professor Whitaker says it has been criticised in terms of its reliability; is that something you accept?
A. Yes, absolutely. It is generally criticised for being not terribly reliable, certainly as far as detecting early field loss of glaucoma is concerned; I am not aware of any statistics with regard to any other methodology.

Q. He also said:

> "It is not designed to measure visual field sensitivity"

How relevant is that to this particular case?
A. The FDT is designed to look at a specific set of cells in the retina as well as thought to be more susceptible to glaucomatous damage than any other set of cells. I would suspect that set of cells is also susceptible to retinal detachment as well all of the other cells in the retina. Bear in mind that Mr King has no other form of perimetry, it is reasonable to use that perimeter for this type of problem.

Q. Should it be supplemented by anything else?
A. I think so. All essential 30˚ fields for patients with suspicion of a peripheral retinal disorder can be supplemented by other appropriate tests that are available.

Q. Over on page 64, there is some criticism or comment about the technique of the confrontation – towards the bottom half of the second paragraph; can you explain what the advantages are of using confrontation?
A. Confrontation does come in for a lot of criticism and it really needs to be taken in context. Confrontation is a very rapid assessment of peripheral vision which either involves finger counting, or how many hands, red beads, to assess a patient's peripheral vision. Most of the criticism is levelled at picking up settled field defects, such as those that arise in glaucoma is a good example and I agree, it is not particularly useful for that sort of thing unless there is a significant loss of visual fields. It is quite reasonable at picking up gross visual field defects, so the statistics – some of the references in Professor Whitaker's report, if you look at the types of pathology that they have tried to assess, the type of pathology that gives rise to quite gross defects, the confrontation test is quite reasonable at picking these up. Given the speed and the availability it is not unreasonable to do that.

Q. Also, at the bottom of page 64, over on the top of page 65, Professor Whitaker is quoted as talking about the Scottish and Welsh Guidelines as being appropriate as a benchmark in this particular case. Then he says that:

> "Scottish optometrists are at least required to dilate the pupil and use an indirect slit lamp lens as part of their contract and are paid accordingly"

Do you have any comments to make on that?

A. I don't think the cost really should be taken into consideration when patient care is considered; there is no reason why, if you are going to undertake a test that is beyond the scope of the sight test as you see it, as far as fee-based items is concerned, it is not unreasonable to charge the patient or refer the patient to somebody who is able to do that investigation appropriately. In this case it would probably be the local eye hospital.

Q. Are there options of charging patients privately?

A. Yes, absolutely.

Q. Page 65, the final section talks there at the bottom about there is a number of techniques outlined in bold, which he says:

> "Should be used by a reasonably competent optometrist specifically looking for retinal detachment"

Do you have any comment on that?

A. Sorry; say that again.

Q. Towards the bottom half of page 65, he is setting out the allegations and then there are four things set out there and then comments that all those things above would be done by an optometrist "specifically looking for retinal detachment". Do you have any comments on that?

A. Yes, they would be performed by somebody specifically looking for retinal detachment, but since that is really your next probable diagnosis that is what you should be excluding in this case.

Q. Over on page 66, 2(a) says, talking about risk factors:

> "(a) that Patient A was a high myope"

He concludes by saying:

> "By itself, that is not in my opinion sufficient reason for a reasonably competent optometrist to abandon the far more likely diagnosis of a migraine aura."

Do you have any comments on that?

A. If you have a young patient that is a high myope who is symptomatically presenting you with symptoms that could be interpreted as retinal detachment you would be naïve just to exclude that without any further investigation.

Q. Would there then be any way of excluding retinal detachment without carrying out those tests that you looked at earlier?
A. Say that again.

Q. Without carrying out the tests that are set out on page 65 under paragraph (d) can you exclude retinal detachment?
A. Not really, no. Having said all that in conducting all those examinations, investigations you could still not see a retinal detachment.

Q. Then Professor Whitaker's summary; do you have any comments on that?
A. Nothing, I don't think, unless there is anything specific you want me to comment on.

Q. You mentioned some of the references and I just wanted to take you to Reference number 3, that starts at page 81, this talks about the confrontation field tests. You understand these much better than I. Page 83 is the page we are on, is that right? Can you explain?
A. These are different types of pathology that result in fairly gross visual field loss. I suggest that as you go down the table the field loss becomes less gross and more subtle. The sensitivity is the ability of the confrontation test to correctly identify those with a defect. I guess that is put up against an automated perimeter, yes, the full threshold static test.

Q. This is telling us what?
A. This is telling us if the defect is fairly gross then the confrontation is rather quite good, because as it becomes more settled and it becomes less good at picking it up and unfortunately they don't have a retinal detachment case in there, because that would be very convenient. Certainly if the FDT is picking it up and it is within the central 30˚ then it is going to be a reasonably gross field test, but somewhere in the middle I would suspect that that lands. It is difficult to extrapolate from this.

Q. The column immediately below that table where they say confrontation tests are assessed with some of their patients, is that effectively what they are saying there?
A. Sorry, where are we here?

Q. Below the table about three lines down it says:

> "If confrontation tests are assessed"

Is that saying what you have just said?
A. I think so, yes.

Q. Page 85 of this document in the left hand column, starting from:

> "Would examination of the VF help in the detection of such conditions?"

Can you just explain what the conclusions are and they are saying in this section?

A. This section refers to two cases of optometrists missing a retinal attachment in the '90s where the expert evidence that was heard suggested that detection of a field defect in such a case would be significant as far as the outcome was concerned.

Q. Towards the bottom of this section, in terms of using direct ophthalmoscopy or indirectly ophthalmoscopy?

A. It suggests that even through dilated pupil direct ophthalmoscopy may be inadequate at detecting that peripheral retinal detachment.

Q. Moving onto some of the other witness statements, you should have in the bundle Tab C, page 39, a witness statement of Mark Robinson. You have seen it before, is that right?

A. Yes.

Q. He talks there in the first paragraph about visual field testing's most common use is in the "detection and investigation of glaucoma"; would you agree with that?

A. Yes, I would agree with that.

Q. Then he concludes in paragraph 5:

> "- a commonly known fact, most hospitals would not consider it acceptable for patients to be referred with only a field defect and no other accompanying signs and symptoms, unless the defect found is a repeatable defect"

Can you comment on that in the context of this case?

A. Yes. He is hitting the nail on the head. They wouldn't be interested if there were no signs and symptoms, but in the context of this case it is very important. The patient obviously has signs and symptoms that may or may not be suggestive of a retinal detachment and I think a field defect would be very significant in that case. The context of repeating the visual field test, or the concept of repeated visual field test is a very acceptable practice, however, it has to be taken into context with the pathology that you are possibly investigating. For a chronic disease such as glaucoma, a couple of days, a couple of weeks, or even a couple of months may not make any difference. In the context of something much more acute, such as retinal detachment, then obviously that tells me it is very important all of a sudden.

Q. In context Patient A had ordered some glasses, do you have any idea how long it might have taken for the glasses to be delivered?

A. I can't comment; I suspect a week.

Q. In terms of dealing with that would that be an acceptable delay in a retinal detachment case?
A. No.

Q. Why not?
A. Because as the time delay goes on the prognosis of visual recovery becomes worse.

Q. Briefly, just the statement of Paula Norton which is at page 36, on page 37 at the top she talks about the instructions she gives to patients:

> "focus on the black dot and then press a button when they see a moving dot"

In terms of the FDT machine that was being used, are those appropriate instructions?
A. No, it is not a moving dot; it is a moving grid, or a series of black and white stripes – a square.

Q. Could you perhaps explain in a bit more detail what the FDT test looks like?
A. The FDT is made up of, if I am correct, they are 10˚ squares – I can qualify that reference by looking it up; I can't quite remember off the top of my head – of, in effect, shimmering bars that move and that is presented at different places at different contrasts and the patient is asked to look at a central spot and asked to press the button when they see an area of shimmering lights. Whereas a conventional perimeter can measure visual field test works by smaller, white dot lights at various intensities. That sort of describes something in-between.

Q. Up the top in the same paragraph she says that:

> "If the test is clear I do not print off the test."

In the context this is an unqualified person, as I understand it, can you comment on that.
A. It is something I wouldn't do.

Q. Why not?
A. Because it is my neck on the line. I would like to see the results of all the tests that I delegate to unqualified colleagues. It is something that I wouldn't do, but it is up to the individual practitioners, if that is the way that they wish to practice then that is their call entirely.

Q. Do you know if it is possible to print off a test if it is clear?
A. As far as I am aware, yes.

Q. I do not have any further questions. I am sure Mr Stern has some for you.

Cross-examined by MR STERN

Q. Can we start then because you have not brought your curriculum vitae, so obviously I need to know a bit more about you; that would be helpful for you to be able to give us that information. First of all, as I understand it, you graduated in 1997?
A. Yes.

Q. You then were in a small practice, is the way you describe it, in your pre-registration year. What does "small practice" mean?
A. In terms of floor space it was small; in terms of patient numbers it was pretty big.

Q. How many optometrists?
A. Two.

Q. You and one other?
A. Yes.

Q. You then spent six months in an optometric practice in a small and independent group of practices in the Cardiff area?
A. Yes, it is the same chap who owns five or six practices in and around the South Wales area.

Q. Are each of those single practitioners?
A. A majority yes, you can say they are single practitioners.

Q. Just so we are clear about this you worked in one practice where there was another practitioner; in the six months in the group of practices you were working on your own?
A. Yes, fairly much on my own.

Q. You then went back to Cardiff University and undertook your doctorate and that was concluded in 2003?
A. Indeed.

Q. You say you worked as a locum; is that in the same practice where you had been working before?
A. Yes, and at practices in and around South Wales and the South West, basically an hour's drive limit.

Q. How many days a week were you working as a locum?
A. Between two and three days a week.

Q. These are single practitioner practices?
A. Sometimes; not always.

Q. Then you started working in 2003 in the Cardiff Eye Unit, which was for a glaucoma clinic.
A. That is correct.

Q. 2004 you were at Bristol Hospital, again in relation to glaucoma.
A. And contact lenses.

Q. Then in 2006 you set up your own practice.
A. Yes.

Q. What were you doing between 2003 and 2006?
A. I was mainly working in the hospital between Bristol and Cardiff and a day or so a week primary care locum.

Q. Primary?
A. Primary yes; a high street locum.

Q. Again, working on your own in the main?
A. It depended what type of practice it was in.

Q. In 2006 you set up your own practice. How many people work in that practice?
A. Just myself and my wife occasionally.

Q. She's an optometrist?
A. Yes.

Q. Now have you ever worked full-time in England?
A. Not full-time in England. I have worked in London.

Q. That is just doing the locums in the South West – Bristol?
A. Yes.

Q. So far as retinal detachment is concerned, the incidence of retinal detachment is somewhere between 3.8 to 12 per 100,000 patients, is that right?
A. Yes, roughly.

Q. You know the papers; that has saved good time. Now at 12 patients per 100,000, that equates, according to one of the references you produced, to a practitioner seeing retinal detachment once every 1.3 years.
A. That's right.

Q. Obviously that is statistics. Those statistics don't apply for individuals. Less than 0.2 per cent of those end up with some form of retinal break, which eventually has a detachment of the retina. Did you read that? I don't just want you to agree with me.
A. I am not entirely sure which document you are referencing there. How are you doing that?

Q. From your reference.
A. Could you point that out?

Q. Yes, of course, number 12.
A. Number 12, the College document.

Q. "How to deal with a patient complaining of flashes" – this is the College document. If you look at page 5, on the clinical management, you will see that.
A. Yes.

Q. That is where I have it from, your document.
A. Right, okay.

Q. Depending obviously on a number of other factors, because these are, as it were, statistics and therefore a more general assessment, not necessarily to a particular individual – some individuals may not have seen a retinal attachment.
A. Agreed.

Q. The point is the retinal detachment is rare.
A. It is rare, yes.

Q. Migraine symptoms are very common.
A. They are more common, yes.

Q. About 10 per cent of the population.
A. I would say that is correct.

Q. Do you want the reference – about 10 per cent or thereabouts?
A. Yes, that is right.

Q. It is very much more common.
A. Yes.

Q. It follows obviously that an optometrist is considerably more likely to come across a patient with a migraine than retinal detachment.
A. I agree.

Q. Now, the optometrist must of course come to a judgement about the cause of the symptoms that the patient expresses.
A. I agree.

Q. Obviously as you are aware Mr King is an experienced optometrist; I don't know if you know anything about him at all.
A. Not really, only what has been written.

Q. You don't know anything about any of his other patient record cards; you never looked at those or anything like that?
A. No.

Q. You say in your report, although you had altered your evidence about it this morning, is that because of the risk factors for retinal detachment, this should have been included as part of the thinking of a practitioner in these circumstances.
A. I agree.

Q. If he had considered it a possibility or a possible cause then the most sensible thing would be to dilate when using the slit lamp.
A. Or arrange for that.

Q. Or arrange for that, but in his case that would have been possible to dilate. You have seen nothing that would have prevented him from doing that, if he thought it were appropriate?
A. Not that I am aware of, no.

Q. You set out the risk factors at page 54.
A. 53?

Q. I am looking at 54, so if you just go to that for a moment and then I will come onto the other parts in a moment. It is under "Expert Opinion", about seven lines down you say:

> "In this case the patient had risk factors for detection of retinal detachment on account of her high myopia".

I am not sure there is a paper that supports that, but let's assume for the moment that is agreed. Is there a paper that shows that?
A. There is.

Q. Certainly there is qualified agreement in relation to it. It was always assumed to be the position.
A. It is. There is a paper on it; I don't think it is here. It is in reference to the Scottish study that was highlighted by Professor Whitaker.

Q. All right. Secondly you say the risk factor here is gender. Are you withdrawing that?
A. It can be argued either way. My personal experience is that the patients that I have seen with idiopathic retinal detachment of this age that have high myopes have all been female, so that is my clinical experience.

Q. Obviously Mr King wouldn't know what your experience is and he can't be blamed for not knowing what your experience is.
A. No, he can't.

Q. What I am asking you is if you look at the papers, we have looked at them – I can take you through them if you want, are you saying that gender is a risk factor? That is to say being a female is a risk factor?
A. In some papers it says yes, in other papers it says no.

Q. Show me the papers where it says that, please, if you would? Your reference is to number 3, which is the American Optometric Guidelines, isn't it?
A. Yes, but it references two papers in it.

Q. Yes, it refers to two papers. Have you looked at those papers? It is number 81 and 83 in the reference. It is reference number 3 in your reference, which is the American Optometric Association, which I pause for a moment to ask you this, are you suggesting that an optometrist in the UK should a) be aware of these guidelines?
A. Possibly not.

Q. Are they sent to every optometrist in this country?
A. No.

Q. Or b) that they should apply these guidelines?
A. No.

Q. Because optometrists, without going into detail, operate on a different basis, do they not, in the States than they do here.
A. Yes.

Q. Let's just be clear about that before we look at this. There are page numbers on this document, but it says "Statement of the Problem 15"

Ms Jeyasingham: Is this under Tab 3?

Mr Stern: Yes. It is reference 3 and you have the Statement of Problem 15; let me read it will save a bit of time:

> "Retinal detachments in general are more common in males, however, non-traumatic retinal detachments are more common in females"

A. I am not on that page.

Ms Jeyasingham: The numbering is at the top of the page.

Mr Stern: It is your reference, so I am rather assuming that you are familiar with it.
A. Page 11.

Q. Can you see? I am assuming that is where you have it, because you put the reference to number 3 when you made that point. Then afterwards you can

see that after "retinal detachments in general are more common in males", there is a number 81:

> "However, non-traumatic retinal detachment are more common in females: 65 per cent in males"

There is a reference to 83, so if you look at the reference pages you will see that refers to a reference 1993 and the 1983 reference. Do we have those?

A. No.

Q. Is there any other study that you can point us to which shows that is the position?

A. Probably, but I don't have them to hand. I am not in disagreement that it is controversial.

Q. Let me ask you this: are you saying that an optometrist in a local practice would know or be aware that gender is a potential risk factor?

A. I probably think not.

Q. Right, let's just look at one or two papers if we can; if you look at page 103, please? This is in the main bundle, C1 "Case-control study of idiopathic retinal attachment". If you look at the abstract, which is the part you can see about eight lines down it says:

> "The risk of IRD appeared to increase with increasing age and the relative risk for self-reported myopes, compared with non-myopes, was elevated"

If you look at the last line it says:

> "The risks do not appear to be related to gender"

- myocardial, history, etc –yes?

A. Yes.

Q. In fact this is a study which shows that it is more prevent amongst males.

A. Yes, correct.

Q. Were you aware of these studies when you wrote your report?

A. It is fair to say that you can't be aware of every study on every subject when you write these reports.

Q. I appreciate that, but what was the sense of your review of the papers when you came to say that a risk factor was gender?

A. My statement was mainly based on the guidelines from the States and personal experience.

Q. I don't think you have mentioned personal experience in your report.

A. Probably not.

Q. We haven't seen those papers; obviously in relation to one of the papers, I am not saying it is one of those, I didn't know, but certainly in relation to one of the papers where there was a prevalence of women in relation to retinal detachment, that was a result of the fact that there were more women in Iowa. Do you remember that study or not?
A. Probably.

Q. One has to have some degree of caution about this, do you agree?
A. You have to be cautious about all statistics.

Q. Yes, I respectfully agree. The point I am making to you here is it is obviously not helpful to put down some of these risk factors when, in fact, it is not.
A. It may be.

Q. It is may be, because there is just no evidence for that.
A. In my opinion, in my experience it may be.

Q. Page 77, please. This is the epidemiology of retinal detachment:

> "A survey of rhegmatogenous retinal detachment during 1976 conducted on the population of Iowa. The annual incidence (per 100,000 population)", etc.

Then it says:

> "These incidents of non-traumatic phakic detachment for men and women were similar, although there was a preponderance of women that reflected their greater representation in the general population".

Yes?
A. Yes.

Q. This is your reference, number 2. Mr Whitaker also refers to it. The reason that particular survey says that there is a preponderance of women is because there is a greater representation in the general population. There is an exercise here about any of the research papers as well.
A. Absolutely, I agree.

Q. Also if you look at page 70, please? This is made in 2010:

> "The Epidemiology and Socioeconomic Association in Scotland: A two-year prospective population-based study"

If you look at on the left hand side of page 70, the conclusion:

> "the estimated annual incidence of primary RRD in Scotland is 12.05 per 100,000 – 7,500 new cases annual in the United Kingdom. RRD incidence increases with age, is more common in men and right eyes and is strongly associated with affluence."

If you look at page 71:

> "Age and Sex Distribution"

It says:

> "Table 2, there is a marked variation with both sex and age. A significantly higher incidence of all types of RRD was seen in the males".

As you rightly say it is controversial to say that gender in terms of female is a risk factor.

A. Yes, I agree.

Q. Can we put that to one side?

A. Indeed.

Q. The third risk factor that you say is a risk factor, going back to your report, is a chronic retinal detachment in the left eye, page 54. You go on to say:

> "The latter would not have been known to Mr King at the time of the sight test"

That is not a factor, obviously, that he could have taken into account as a risk factor.

A. Absolutely and that sentence qualified that.

Q. The risk that this patient presented with was high myopia?

A. Agreed, the biggest risk.

Q. That is the only risk on the risk factors that you have set out. Can we look at the tests that were carried out on this patient? Page 109 is the record card. I grant you the writing is not always easy to read, but it is a lot better than some. We have the typed version, I hope, on the left. Has that been inserted in your bundle, Dr Jones?

A. Is that this?

Q. Yes, if you put that beside it that will stay in the bundle. A pan-optic ophthalmoscope was used. Do you know about a pan-optic ophthalmoscope?

A. I know about it.

Q. Is it right to say that gives you a panoramic view of the retina, which is five times larger than a standard ophthalmoscope?
A. I am not sure if it is five times a standard ophthalmoscope. I spoke to our technical services and I think in my report, that it gives the degree.

Q. 25˚; whether it is five times or not.
A. It is certainly larger than the standard direct ophthalmoscope

Q. Let's not quibble about the exact degree, but it is larger. If we just keep our finger in page 109, then move to 138, we can see that this patient did, on 23 February when she was in the hospital, in the middle of the page you will see "No PVD either eye". Do you see that?
A. Yes.

Q. What is PVD?
A. Posterior vitreous detachment.

Q. I don't think you explain that; obviously some people will know what it is.
A. Posterior vitreous detachment is a condensing of the vitreous, which is the jelly that fills the back of the eye. It is initially attached to the retina in various places, the main one being the optic nerve. As you age, it solidifies, condenses and pulls away from the retina. It is generally found in the over 60s and as a result of the traction of the retina it can result in a tear or a detachment.

Q. "Can" being the operative word.
A. Yes.

Q. Lots of people have PVD.
A. Absolutely.

Q. Obviously people who have PVD may, in due course, have retinal detachment; it is a limited number as we have seen end up with retinal detachment.
A. Yes. I agree.

Q. Is it right to say that in the main – this is a generalisation – it is PVDs that cause the flashes?
A. I would say that is quite a reasonable statement for those patients of that age.

Q. Also floaters; are they most likely seen as a result of PVD?
A. Yes.

Q. Going back to 109 if you can, please? It may not have been obvious to you when you wrote your report, but Mr King used the slit lamp.
A. Yes, he did because he did the Van Herick Test.

Q. He used the slit lamp in order to see and we can see the media are clear.
A. Right.

Q. You can see the word "media". I am suggesting to you that says "clear".
A. Yes, I agree.

Q. You know that the contact lenses that the patient wore were underpowered. We can see that.
A. Yes.

Q. If we look at the right hand side of the page, if we see in the third block down there is -10.75 and then -13, etc.
A. Yes.

Q. That relates to the spectacles.
A. Yes. I assume so.

Q. We can see – again, the copy is not that clear, it is looks like "two years old" or something like that.
A. Yes, I agree with that.

Q. Coming down the page on the right hand side we can see, again the dark parts and obviously not good as well – you can see "IOP", intraocular pressures.
A. Yes.

Q. They are equal at 19 in each eye.
A. I agree.

Q. Just so everyone has that particular angle, there it is on the right hand side: "19 in each eye"; so they were equal?
A. Yes.

Q. Do you agree that if a patient has a retinal detachment it is less likely that they would be equal?
A. It is less likely that they would be equal, yes.

Q. The visual acuity was shown as good, yes?
A. Yes.

Q. Do you agree that would indicate that the macular was intact?
A. Yes, I would agree with that.

Q. Everyone is familiar with the intraocular pressures. Intraocular pressures; a number of readings are taken –
A. That is a very good point.

Q. The average is given.

A. Absolutely.

Q. Six will be taken and then an average is set out here.
A. Yes.

Q. Obviously the question of the symptoms expressed by the patient is a matter for the Panel, not for you and not for me?
A. Yes.

Q. If you consider on the face of this patient's record card, this is a perfectly reasonable examination of a patient.
A. Of a non-symptomatic patient, yes.

Q. Non-symptomatic means symptoms as recorded.
A. As recorded, yes.

Q. As recorded there is nothing wrong with this examination?
A. No.

Q. Assuming for a moment that the patient complained of having a headache.
A. Yes.

Q. I appreciate there is a factual dispute, but let's assume that is the position, if that is right, then it wouldn't be appropriate to carry out a field test.
A. Yes, it wouldn't be appropriate.

Q. The field test, the FDT takes 20˚ of the central vision?
A. Yes, it is 30˚.

Q. It is 20˚ in this particular one. The FDT test, whatever your criticisms or anyone else's criticisms of it are, is a test or a machine or a piece of equipment that is used in a number of optometric practices.
A. I would have thought so, yes.

Q. It is not in every practice.
A. Definitely not, no.

Q. It is a reasonable piece of equipment. Obviously any optometrist can only use the equipment that they are given by the company.
A. Agreed.

Q. Could we look at page 89, please? You would agree, would you not, that the best course of action if you have the automated field test, that lacks a sensitivity in one part or another, that the best thing to do is to repeat it?
A. Yes. You mean when a field defect is found?

Q. I don't think you can call it a defect in terms of being repeated, can you?

A. If you have one plot, then yes, there is a defect.

Q. A loss of sensitivity, whether it is a defect or not a defect, obviously that has to be assessed, but the purpose of doing it is you don't rely on it; there is a defect.
A. I agree.

Q. You would agree, I think we have already said this, that the confrontation test, when you just put your finger in front of somebody, it is very basic optometric knowledge, but putting your finger in front of somebody is a very gross test.
A. It is indeed.

Q. By which, the paper you referred to showed, unless you have a very gross problem, is unlikely to have any greater sensitivity than the field test.
A. You need to define what you are meaning of "gross" is.

Q. These are your words; why don't you define it first?
A. Those papers showed quite nicely that as the field defect was more subtle it becomes less effective.

Q. That's right. Do you agree that the alternated test is of greater sensitivity than the confrontation test?
A. Yes.

Q. It would be better to repeat that rather than using, what I am going to call the finger confrontation test?
A. Not necessarily.

Q. It depends on the extent of the –
A. Field defect.

Q. It would be a reasonable option to re-do that field test?
A. Yes, absolutely.

Q. Can I ask you to look at page 89? Just looking at the abstract, as it were, the last five lines, it says:

> "Most confrontation field tests were insensitive in the identification of field loss. The most sensitive method as examination of the central 20˚ visual field with the small red target. Assessment of the visual field does include such a test."

Is that the alternated test?
A. I would suggest that in this context it is an extension of a confrontation test. That is how I read it.

Q. You are right, I am told.
A. Happy to be corrected.

Q. Page 90, just so we can see, says about half-way down on the left hand side:

> "Most confrontation tests are not sensitive enough to identify small or shallow defects in visual field"

Is the point you were making, just before it.

> "The most sensitive method was examination of the central 20˚ visual field with a small red target. No patients with field defects missed by the central red field test had the defects identified by the examination of the peripheral field, but three had them identified by red colour comparison. The combination of these two tests thus achieves the overall sensitivity of 76 per cent, with no loss of specificity.
>
> Assessment of the central visual field is usually sufficient to identify defects, since central field representation greatly dominates all levels of the visual pathway. Isolated peripheral field defects that do not produce abnormality of the central field are rare."

Do you agree with that?

A. Yes, I would agree with that.

Q. Again, looking at the field test, it would be important to repeat that test to see whether there is, in fact, a defect, or a problem with the machine, or a problem with the user of the machine.

A. Whether it is manifest or not.

Q. Manifest: that is a good way of putting it. If you just look at page 92 very briefly, I will just ask you to look at the results part of this page, which is at the top of that page, 92, it is an older group of individuals than the patient we are concerned with:

> "The mean age was 54.8 years. 69 subjects returned a normal test after a single test administration. Nine subjects required two administrations and two subjects required three or more administrations to return to a normal test. One subject still tested unreliably after four tests. The number or severity of abnormal locations did not predict the number of trials necessary to overcome the learning effects. Fixation loss was the most common reliability problem, subject to demonstrated learning defects did not differ significantly in age, visual acuity, refraction, test time from those who did not"

In other words, you have to repeat the tests in order to be able to do them.

A. Yes, I agree. That is generally accepted for all types of perimetry.

Q. Thank you very much. One other matter in relation to the tests if I may. Do you agree that a myope with average sized pupils would see tobacco dust under ophthalmoscopy or a slit lamp?
A. The examiner is a myope?

Q. No, the patient.
A. Sorry repeat the question.

Q. Would you be able to see tobacco dust through ophthalmoscopy or a slit lamp in an undilated?
A. Probably not.

Q. Not even with a myope?
A. Not even with a myope.

Q. Let's look at page 52, please and it might be helpful if we just have open at the same time Professor Whitaker's report at page 64. I just want to look at the issue in relation to guidelines. You have told us when you dealt with the American Guidelines point, likewise you refer to Scotland and Wales and without going into detail again there are different sets of tests that are compulsory in Scotland and a different system.
A. I believe so yes. I have not practiced in Scotland, so I am not completely au fait with it.

Q. Likewise Wales?
A. No, not necessarily. Wales is more of a needs-driven examination.

Q. Right. The position in relation to this, as you put it in your report, is that there is no specific guidance for patients at risk of retinal detachment from the College of Optometrists?
A. No, you are correct.

Q. I'm taking your report. Page 53 of your report, just looking at the middle of the page you deal with how to deal with a patient complaining of flashes and floaters; that is a College document, page 53 in your report.
A. Yes.

Q. You set out six points there from that document:

> "1. Myopia of greater than 3.00;
>
> 2. Patient with retinal detachments in the other eye"

Although it did in fact transpire that this patient did, in fact, have a retinal detachment in her other eye, it had not been noticed by the practitioner.
A. Agreed.

Q. "3. Patients who have had had intraocular surgery, patients with retinal degenerations, such as lattice or other retinal degenerations."

That was not this patient.

A. We don't know that.

Q. The point that I am making is that it was not known to the optometrist at the time. Obviously the optometrist can only assess the risk factors on what they know at the time, not what they know four months later.

"4. Patients over the age of 50;"

That is not this patient.

"5. Patients with a strong family history of retinal detachment;

I don't believe there is any evidence of that.

"6. Patient with certain systemic disease"

This patient did not have. The only risk factor here was myopia greater than three.

A. That we know of.

Q. I keep coming back to this, we can only go back. What we are dealing with here; let's make it clear, we are not dealing with some academic view of whether something did or did not occur. We are looking at what the practitioner knew at that time.

A. Yes. Point five could have been asked.

Q. Perhaps it was. You criticised general practitioners is a fair way of putting it, on the basis that general practitioners you say don't know a lot about eyes. That is the way you are putting it, isn't it?

A. That is a generally accepted view.

Q. Generally accepted: by who?

A. General practitioners that I know; ones that I see coming through medical school. Those I give lectures to as opposed to writing.

Q. Obviously we don't know anything about this GP who examined the patient on 16 February, so yours is a general comment rather than a specific one?

A. Yes.

Q. To become a GP you have to do four separate rotations in hospital medicine.

A. If that is the case then yes.

Q. You have no idea whether this GP did ophthalmology in one of these four?
A. I would suspect that he probably did a rotation. Post grad rotations are we talking about or under graduate?

Q. Post graduate.
A. I don't know.

Q. In any event, even with, if we look at the relevant notes at page 119, even with what is recorded there is flashing lights and blind spot but no headache, there is no mention of floaters in that assessment, so we just have an aura for the past five days, like flashing lights and a blind spot. Even in those circumstances the GP did not refer the patient on.
A. Clearly.

Q. He did examine the fundus and found no abnormality – NAD – no abnormality detected. Madam, I don't know what time you want to break, but that would be a convenient moment if you are going to break now.

Ms Jeyasingham: It might be a good point to break. You want to continue questioning after lunch?

Mr Stern: Yes.

Ms Jeyasingham: Can we come back at 2 o'clock?

[*Hearing adjourned at 13:00*]

[*Hearing resumed at 13:58*]

Ms Jeyasingham: Mr Stern.

Cross-examination by MR STERN (continued)

Q. Can we resume please by looking at that paper that you were given today, the paper of Shah and Others entitled "The content of optometric Eye Examinations for a presbyopic patient presenting the symptoms of flashing lights?" Do you have a copy there?
A. Yes.

Q. Can we look at the bottom left hand corner? We can see it is a paper received in June 2008 and ultimately accepted in October 2008. The abstract, just looking at the first page, says that they took what was called "Standardised patients"; I don't know if you have heard of them called that?
A. Sort of, but never in that description, but I know what they are talking about.

Q. They say that:

> "Standardised patients are the gold standard methodology for evaluating clinical care. This approach was used to investigate the content of optometric eye care for a presbyopic patient who presented with recent photopsia."

Photopsia is flashing lights?

A. Yes.

Q. What they did was they took a total of 102 community optometrists and those optometrists:

> "consented to be visited by an actor for a recorded eye examination. This actor received extensive training to enable accurate reporting of the content of the eye examinations."

I am still on the first page for anybody who is following it, under "Methods".

> "accurate reporting of the content of the eye examination via an audio recording and a checklist completed for each clinical encounter. The actor presented unannounced (incognito) as a 59-year-old patient seeking a private eye examination and complaining of recent onset flashing lights."

That is the point, the actor goes in and complains of recent onset of flashing lights.

> "*Results:* The presence of the symptom of photopsia was proactively detected in 87 per cent of cases. Although none of the optometrists visited asked all seven gold standard questions relating to the presenting symptoms of flashing lights, 35 per cent asked four of the seven questions. A total of 85 per cent of optometrists asked the patient if he noticed any floaters in his vision and 36 per cent of optometrists asked if he had noticed any shadows. The proportion of the tests recommended by the expert panel that were carried out varied from 33 to 100 per cent – Specifically 66 per cent recommended dilated fundoscopy to be carried out either by themselves or by another eye care practitioner and 29 per cent of optometrists asked the patient to seek a second opinion."

It says:

> "Our study has highlighted substantial differences between different practitioners in the duration and depth of their clinical investigations. This highlights the fact that not all eye examinations are the same, but inherently different and that there is no such thing as a "standard sight test". Further optometric continuing education could focus on history taking, examination techniques and referral guidelines for patients

presenting with symptoms of posterior vitreous detachment, retinal breaks and secondary retinal detachment".

Turning over the page if you can, on page 106 on the column at the top, this is a quote that you made in relation to another study. The first paragraph says:

"If shown that the eye care that they provided is supported by the actions of a significant body of reasonably competent optometrists -"

Then it refers to various cases that you may or may not know about;

"Justice in these cases and in consumer complaints is facilitated by an evidence-based investigation of the content of optometric eye care."

Again, halfway down on the left hand side it makes the point that you were making in relation to the guidelines; that is to say:

"The exact format and content will be determined by both the practitioners' professional judgement and the minimum legal requirements."

As we know there are no guidelines in relation to retinal detachment.

Looking at the right had side, in the bottom right hand corner, we can see that it says:

"This paper has four aims:

(1) to provide data on the content of typical optometric eye care in the UK for a presbyopic patient who present with recent onset flashing lights;
(2) to evaluate how appropriately the eye examinations were carried out for that patient;
(3) to investigate the differences between localities and different types of practice;"

We don't need to worry about (4) because it is the research technique of using SP on this individual here.

On the right hand side of page 107, we can see under the subheading "Flashing lights and floaters", it says:

"Optometrists often encounter patients complaining of floaters and/or flashing lights, both of which are classical symptoms of acute posterior vitreous detachment (PVD) and retinal detachment, typically in a patient aged over 40. PVD occurs as an ageing process of the vitreous and its prevalence increases proportionally with age and degree of myopia."

In the next paragraph it says:

> "Flashing lights, floaters, a visual field defect and loss of vision are the four most common presenting symptoms relating to a PVD, retinal break or retinal detachment."

Then it says:

> "The differential diagnosis of these symptoms could vary from ocular migraine or an uncomplicated PVD to a retinal tear with associated retinal detachment. In a series of 200 patients with PVD, 13 per cent presented with flashes only; and in a series of 115 patients with retinal detachment; 2.6 per cent had presented with flashes only, which was similar to the proportion with floaters and greater than the proportion with floaters and flashes."

Then it goes through each of the symptoms and it picks up flashing lights, and it says over the page on page 108 about 10 lines down on the left hand side:

> "It is important to diagnose whether the flashing lights are as a result of a migraine or due to a PVD. Flashes of light as a result of PVD are almost always monocular and noticed in dim rather than bright illumination."

Then it says about four lines further down from that:

> "In migraine patients, the flashing lights ('aura') are almost always binocular but rarely migraine can affect the anterior visual pathway and produce monocular symptoms. The visual aura in migraine patients is usually described as a central black patch – which enlarges into one half of the visual field and subsequently fades out of the peripheral visual field"

Then it deals with floaters, I am sure we don't need to trouble too much on that.

Over the page, please at 109 on the left hand side it says:

> "Practicing optometrists are likely to be aware that it is important for all patients presenting with new onset flashes and/or floaters to undergo dilated binocular indirect ophthalmoscopy."

Then it deals with the recall interval. Then it deals with research questions and at the end of that section on the left hand side, just above the sub heading "Methods", it deals with *Table 1*. It says:

> "It is stressed that the list of possible tests and questions in *Table 1* is not intended to define good practice, but more to be a list of possible relevant investigations"

Then you can see that the optometrists that were selected were selected from a variety of different areas; in other words, the chains – Specsavers, Vision Express, medium sized and also independents.

Mr Swinstead: Sorry, I don't know whether we are actually wanting Dr Jones to say "Yes", he is nodding. So far I don't know if he has said anything. As you are going through are you wanting him to say yes to agree with you, because he is nodding and I don't know if that is being recorded?

Mr Stern: If you could say "Yes".
A. It is printed in front of me, so I am not going to say no.

Mr Swinstead: The only reason I make the point is because otherwise it is Mr Stern's monologue and it is quite helpful if when you nod your head you could simply say "Yes" and then it could be recorded so that somebody reading it knows what Mr Stern appears to be –

Mr Baldwin: Chairman, an indication of "Yes" though would need to indicate whether or not he is saying yes to Mr Stern and is agreeing with what he says.

Mr Swinstead: Sorry, I'll speak for Mr Stern; what he means is laying the ground to ask questions, is that right?

Mr Stern: That is what I am trying to do.

Mr Swinstead: All they are trying to do at the moment so that it isn't a complete monologue, because Dr Jones is affirming, agreeing that is what is in front of him. If you look at him occasionally and he nods, just say yes, so it picks up.

Mr Stern: Do you disagree with anything that has been written here and set out?
A. No.

Q. I don't just mean disagree in the sense that I read it out, but do you disagree with anything in the content of it?
A. I don't think so.

Q. If you look at Table 1, you will see the research questions that are set out, in page 110.
A. Yes.

Q. At Table 2, on page 111, you will see a summary of the standardised patient history, symptoms and responses to questions asked during the eye examination.
A. Yes.

Q. The reason I am going through this; I don't know whether or not people have read it, but obviously if you haven't had it for very long, it is quite a detailed paper, I do want to make some points about it. I don't want to invite you to listen to me by way of a monologue, as it was described, but on the other hand I need to make sure that you have looked at it and taken the points that I am making.

Mr Swinstead: I'm terribly sorry, I wasn't criticising you.

Mr Stern: I didn't say you were, I was just saying it is important that they make sure they understand the paper.

Mr Swinstead: I think everyone does; it was just that Dr Jones was not reacting; he was assenting by nodding.

Mr Stern: All right; let's look if we can at page 112, please? On the left hand side:

> "Concerning the primary research question, the presenting symptom of flashing lights was proactively identified in 87 per cent of cases; in 80 per cent of cases simply by asking the patient their reason for attendance and in a further seven per cent of cases, where the reason for the visit was not established, by the practitioner specifically asking about flashing lights. 13 per cent of optometrists did not ask the SP's reason for visit or ask specifically about flashing lights. In these cases the SP informed the optometrist he had recently been seeing flashing lights and was concerned."

That is how it came out in relation to some of them; in others the patient had to give the information because the optometrist had not asked.

Questions are listed in Table 3, which you can see at page 112. We can see on the right hand side of page 112:

> "36 per cent of optometrists asked if the patient had noticed any shadows in his vision and 18 per cent asked if the SP had suffered any head trauma."

Over the page, please, at 113, it says four lines down from the top:

> "A full summary of the contents of the eye examinations is included in the Appendix."

- which is attached to the paper. A couple of lines down it says:

> "100 per cent of optometrists visited checked the patient's distance vision. 48 per cent examined the anterior surfaces of the eye using a slit lamp"

Under half used a slit lamp according to this.

A. Yes.

Q.
> "These optometrists may have carried out van Herick assessment of the anterior chamber angle, although this was not assessed by the SP."

The point is the actor, because the optometrist is finding it difficult to be able to assess whether or not the van Herick was used.

A. Yes, I agree.

Q.
> "None of the optometrists visited inspected the anterior chamber angle using gonioscopy"

That is not a surprise really.

A. No.

Q.
> "13 per cent of optometrists looked for the presence of pigment granules in the anterior vitreous (Shafer's sign or tobacco dust)."

That is the tobacco dust point you were making.

A. Yes.

Q. Only 13 per cent looked for that.

A. Yes.

Q.
> "66 per cent recommended dilated fundoscopy. Of these 63 recommended that the dilation should be performed on the same day -"

12 within a week and eight return when it was convenient for that person to do it. Are you with me? Page 113.

A. Yes, I am with you.

Q. Further down on the left hand side, towards the end of that column on the left, the bottom of that same paragraph:

> "Of the 102 examinations, 24 included pupil dilation, 77 were without dilation"

And one practitioner just referred immediately without asking any questions.

A. Yes.

Q. Also on the foot of the left hand side:

> "It is of concern that three optometrists did not check the intraocular pressure using any method on a patient of this age group."

A. Yes.

Q. "Of the 77 optometrists who carried out undilated fundus examinations, 77 per cent of these optometrists used monocular direct ophthalmoscopy, 26 per cent used indirect ophthalmoscopy with the slit lamp – and 9 per cent used both methods."

A. Yes.

Q. What we have here is that even in the presence of individuals coming in with flashes, 34 per cent of these optometrists did not recommend dilation.
A. Yes.

Q. On the right hand side of the page 113, about 10 lines up:

> "39 per cent of the sample recommended an update of the current spectacles and 92 per cent issued a prescription."

We deal with the urgency here of referral for those that did decide to refer.

On the right hand side of page 114 in the paragraph in the middle:

> "A total of 52 per cent carried out visual field testing, almost invariably using perimeters (of the five optometrists who carried out confrontation, three carried out an automated visual field test as well).
>
> 68 per cent of optometrists advised a re-examination interval. A minimum interval of 12 months was advised and a maximum of 24 months. Most (55 per cent) advised two years, with 11 per cent advising one year and the remainder (2 per cent) advising 18 months (32 per cent made no recommendation)."

What we have is a situation here where a patient is providing symptoms of flashing lights and roughly a third do not carry out dilation and a considerable number, almost all of them, 68 per cent of optometrists, advise a re-examination interval of between 12 and 24 months.
A. Yes.

Q. Do you consider, having looked at this paper, that these optometrists are somehow a body of unreasonable optometrists?
A. No, I cannot defer from that.

Q. It is clear, is it not, from this that there is a reasonable body of optometrists who would not dilate, even in the face of symptoms of flashes.
A. Yes. Can I qualify that?

Q. Of course you can.
A. Could you tell me what the duration of the symptoms were?

Q. It is in the paper. You tell me.
A. I think it says that they are long-standing in nature. "A standardised patient has a long-standing history". It may not be directly applicable in this case, which is short history. I am happy to stand corrected if I am wrong.

Q. If you look, this paper has four aims, which is why I read it out to you. It says:

> "(1) to provide data on the content of typical optometric eye care in the UK for a presbyopic patient who present with recent onset flashing lights;"

Just tell me where it says that.
A. I am just going to try. I am fairly sure I read that, but I could stand corrected.

Q. In fact, let me help you out, on page 111, Table 2 is a summary of a standardised patient history, if you look at the third down it says:

> "You describe the flashes as being in the right eye on the right hand side. The flash appears as a quick flash (in a downward motion) and lasts one to two seconds. You have noticed them about three times over the last week."

A. I beg your pardon, it was the floaters that had been there for years; sorry. I stand corrected.

Q. Floaters are a different matter. Flashes are a recent onset in the last week. Yes?
A. Yes, three times in the last week.

Q. That is what I said, in the last week. Coming back to my point that I made, on the face of recent onset of flashes, it is right is it not, that a third of this sample, approximately, did not dilate?
A. Did not wish to dilate, but two thirds did.

Q. 66 per cent, yes. It comes to a third and two thirds, obviously.
A. Yes.

Q. If we look at page 115 and look at comparisons, just so we have an idea of what breadth of the individuals or bodies involved in this, you have:

> "five optical corporate bodies, Specsavers, Dollond and Aitchison, Boots Opticians, Vision Express and Optical Express; they account for approximately 25 per cent of the practices and each corporate body has more than 150 practices. - These five corporate bodies are

> classified as 'large multiples', other groups with more than one practice as 'small multiples' and the remaining practices, where there is only one practice address given, 'independents';"

If you look you will see halfway down that same side, at the beginning of the next paragraph:

> "There were no significant differences in either the duration or cost of the eye examination between the different types of practice."

Then in the middle of the next paragraph it says:

> "There was no statistically significant differences between the different practice types."

In other words, whichever practice type it was, whichever practitioner it was, there is pretty much the same in multiples, in small multiples and independents.

A. Yes.

Q. On the right, at page 115 under the subject "Discussion":

> "Floaters and photopsia are common symptoms reported by patients who consult optometrists, although symptoms are a poor predictor of whether a retinal break is present."

Do you agree with that?

A. Yes.

Q. If we look at page 117, obviously if there is anything in-between that I have missed out and you will refer to I am sure you will.

A. Yes.

Q. Page 117 on the left hand side, towards the end of the first paragraph:

> "In our study 64 per cent of optometrists did not ask the SP about the presence of any shadows in his vision and only 18 per cent asked if he had recently had any head trauma which could explain the symptoms.
>
> One practitioner referred the patient to Accident and Emergency upon learning about the patient's symptoms without performing any further tests. His rationale for referring without performing any tests is questionable as he advised the SP that all cases of floaters and flashes need to be referred to an eye casualty."

Do you agree with that?

A. I don't agree with that, but if there are - not protocols, local guidelines in different places, some do specify that all flashing lights and floaters should be referred.

Q. Any flashing lights and any floaters should automatically be referred.
A. Yes, there is one in West Wales that does that. Whether practitioners apply to those guidelines I am not entirely sure. I have heard of it.

Q. Right; that is not the guidelines that your part of Wales has?
A. No. They are very localised those types of guidelines.

Q. The NHS would come to a standstill if everybody who presented with floaters or flashes –
A. I completely agree with you and that is the argument.

Q. On the right hand side it deals with:

> "The College of Optometrists' document discussed above recommends the minimum examination that should be carried out if a retinal break is suspected-"

It includes a dilated fundus. It says:

> "In view of this guidance, it is of concern that 87 per cent of optometrists did not examine the anterior vitreous (Shafer's sign) for the presence of pigment cells and 34 per cent of optometrists did not recommend a dilated fundus examination."

Then over the page at 118 in the second paragraph down; this talks about:

> "In a clinical practice survey carried out in 1998, of the 4,000 optometrists who responded, around 50 per cent stated they would carry out indirect ophthalmoscopy when examining a diabetic patient. Although the SP was unable to have a dilated fundus examination for all 102 visits, 38 per cent of optometrists examined the fundus undilated using indirect ophthalmoscopy"

Further down on the left hand side at 118, the penultimate paragraph reads:

> "We have assumed in this paper that dilated fundoscopy is the gold standard for a patient presenting in this way because this is the consensus in the literature."

Do you agree that it would be the gold standard to do that? It is quite clear from this paper that there is a reasonable body of optometrists who did not carry out.
A. It is quite clear from the paper that two thirds of optometrists wished for a dilated fundus examination; it doesn't address whether or not they would use

an indirect ophthalmoscope as far as I am aware and not dilated, as far as I can read into this.

Q. We are talking about dilation?
A. Yes.

Q. What I am saying is we are assuming that, what is says that a dilated fundoscopy is the gold standard.
A. If that is what it says, then -

Q. I'm asking you whether you agree with that. That is the consensus in the literature; it says. You describe it in your report as the minimum standard in the College Guidelines. Obviously there is a very big difference between the minimum standard and the gold standard.
A. The College guidelines don't specify dilated fundoscopy.

Q. I'm sorry, I didn't hear that.
A. As far as I am aware the College guidelines don't specify dilated fundus examination for retinal detachment patients.

Q. You accept it would be reasonable not to do so?
A. No.

Q. On what basis do you say no?
A. If you want to exclude the retinal detachment you would perform a dilated fundus examination in my opinion.

Q. Yes. What you are saying and what you put in your report is that – perhaps it is fulfilled by this study; you say:

> "Most optometrists would choose to perform a dilated examination"

A. Yes.

Q. That is borne out by this study, Shah.
A. Yes.

Q. Most would, but that doesn't mean to say that a reasonable body of optometrists would not dilate it, would it?
A. No, but most would. We are applying the rules that most appropriately trained optometrists - that is the yard stick of this Hearing, isn't it? We are comparing our practitioner here as to what most appropriately trained optometrists would do.

Q. That is your assessment of the test is it?
A. It is what I was led to believe. Correct me if I am wrong.

Q. The point is not for me to correct you; I am asking you questions, but that is your assessment is it?
A. That is my assessment. It is what a reasonably competent optometrist would do, or a reasonably competent optometrist in this paper – 66 per cent would like to perform a dilated fundus exam.

Q. Yes.
A. One third of them did not.

Q. That is the point. Just because 66 per cent do it doesn't mean that all the other are unreasonable optometrists and I thought you had already agreed that you have no indication that any of those other optometrists were unreasonable or didn't represent a reasonable body of optometrists.
A. Perhaps they are reasonable in that case.

Q. Perhaps they are.
A. Perhaps they are; I don't know. I am sure that you can gather from this paper that 66 per cent of those optometrists wish to perform a dilated fundus exam when faced with a patient presenting with flashing lights.

Q. You can take it that I understood that, but the point I am asking is a different one. You are saying that most would do it and therefore anyone that does not do it is unreasonable; that is your assessment of the test.
A. What is yours? I am really lost about what you are asking here.

Q. Just looking at 118, on the right hand side right at the bottom, he says:

> "It is estimated that eight per cent of patients attending for eye examinations present with symptoms of flashes and/or floaters. Our results show that the optometric management of these patients is very variable."

I think you would agree that that is what this survey shows.
A. Yes, but the consistent factor is that two thirds of them wished to perform dilated fundus examination when presented with this patient.

Q. Yes, and your point is what?
A. That represents a bigger proportion than those that does not.

Q. Yes.
A. Sorry to state the obvious.

Q. That is not the point being made here; it just says that the optometric management, not just in relation to dilation, but in a variety of tests - there is a whole range of tests that some do and some do not do.
A. Yes.

Q. On the right hand side of page 119, second paragraph down:

"In view of the differential diagnosis for a patient presenting with flashing lights, it is noteworthy that 39 per cent of optometrists did not ask about headaches."

They didn't even ask for their general health.

A. I agree.

Q. Page 120, under the "Comparisons" it says:

"It is reassuring that the comparisons between different types of practice revealed no significant differences for all the data in *Table 5* above, indicating this type of patient would receive similar care and attention regardless of the type of practice that he consulted."

A. Yes.

Q. On the right he talks about the limitations of the study:

"Optometrists who volunteered to participate in a study of this nature may be more confident of their skills and may have performed better than those who declined participation. Hence, our results may overestimate performance although we believe that the option of full anonymity will have helped to allay possible concerns about the research highlighting poor practitioner performance"

Far from this being an unreasonable body, the authors of this paper are suggesting that they perform better as individuals because they were likely to be more confident in volunteering themselves, if you like.

A. Yes, but that is somewhat speculative.

Q. Yes, of course it is. Then over the page, page 121, in the conclusion section, in the end of the first paragraph it says:

"A total of 64 per cent of the 102 optometrists we sampled complied with the College of Optometrists' guidelines for a patient that was characterised by our SP."

A. Yes, I am not sure which guidelines they are referring to, though.

Q. Thank you very much.

Ms Jeyasingham: Have you finished?

Mr Stern: Yes, Madam.

Re-examination by MS BROMLEY

Q. Dr Jones, just picking up from this study which you spent some time looking at, had you had the opportunity to read the whole study before you were asked questions about it? I know you were taken to certain parts, but had you had the opportunity to read the whole thing before you went into the witness box?

A. Yes, briefly.

Q. Is there anything else within the study that you would like to bring out?

A. It is interesting that there is a significantly low number, proportion of practitioners that perform the slit lamp examination; I wonder if that might change if they had the opportunity to dilate the patient, whether the Standardised Patient was very objective to having his pupils dilated because of the type of study he was involved in, so he made a big thing about not doing it. I wonder if those might change again; it is very speculative, but looking at the anterior vitreous through undilated pupils is difficult, I find. I take my hat off to those guys who even attempt it, because you are not going to see very much.

Q. If I can just go back, you were asked about intraocular pressure right at the beginning of the cross-examination and you asked whether you agreed that if a patient has retinal detachment it is less likely that they would be equal. Does it rule it out altogether, though, that the pressures were equal?

A. No, of course not.

Q. You were also asked about PVDs and that in the main they cause flashes, which you agreed with, but in terms of the particular patient in this case, how relevant would these be?

A. They do occur at an earlier age in patients who are higher myopes, but you are not likely to see a PVD in a 30 year old unless there is a history of blood trauma.

Q. If PVD is less likely in a 30 year old how does that affect the diagnosis for this patient, all the things that you would have on the radar?

A. You still look for it, there is no harm in that, but just because there isn't PVD doesn't mean there is not going to be a detachment, because you can still have detachment without one.

Q. You were asked about repeating the visual field test, if you recall; you said it was important to repeat it was my note, but in terms of timescale over what sort of timescale would you repeat it in this particular patient?

A. Given an FDT screener is extremely fast I wouldn't see any reason not to repeat it there and then after the patient has been dispensed, within the same day I would suggest or possibly the next day.

Q. Any later than that?

A. Given the context which we are talking about I would say that was probably not a good idea.

Q. Just coming back to this paper which we spent a long time looking at, on page 115 under the heading "Discussion", it says:

> "Floaters and photopsia are common symptoms – although symptoms are a poor predictor of whether a retinal break is present."

Can you explain what they mean by that?
A. A retinal break?

Q. No, what they mean by symptoms being a poor predictor.
A. A high number of patients will present with symptoms of flashing lights, floaters and not have a retinal break.

Q. In terms of the optometrist who is presented with some of these flashing lights/floaters-?
A. They are more likely to experience patient that present and not have a retinal break than those who present and do have a retinal break; is that what you are after?

Q. No, but if someone is presented with flashing lights, what are the sort of things that the practitioner needs to have on their radar?
A. A PVD, retinal detachment, a retinal break, raised ICP and any other retinal type problem going on.

Q. Therefore, what examination should they carry out?
A. It would be clinically naïve not to consider those and therefore they really need to look at the fundus via a dilated pupil.

Q. Thank you; I don't have any further questions. I imagine the Committee may have some questions.

Ms Jeyasingham: Do we have any questions?

Questions from the Committee

Mr Baldwin: I am a lay member in the context of these proceedings and it may be because of that I don't understand something that you have said. Could you turn to page 62 of Professor Whitaker's report? You were very dismissive of the assertions to be found in the penultimate and the penultimate sentences of the main paragraph there.
A. Right.

Q. What you said was you simply cannot rely on prevalence rates.
A. Yes.

Q. Do you stand by that?
A. If you rely on prevalence rate you get caught out, absolutely. There are lots of big epidemiologic studies into all sorts of diseases, eye diseases as well as other diseases and there is always a question as to how much you apply the results of those epidemiologic studies to the individual sat in front of you.

Q. Even if the probability is 1,000 to one?
A. Even if the probability is 1,000 to one.

Q. I know that you have resiled from your point about gender.
A. Right.

Q. You made that assertion based on the paper on which you cited at number 2 in your index in which the statistical probability of a woman having this particular problem for that particular age group was about two per cent higher.
A. Right.

Q. A probability of about two per cent higher is about as small as you could possibly imagine; the probability of 1,000 to one is a very large probability or improbability, depending on which way you are looking at it. Do you still stand by the first assertion that I referred you to, it being a matter to which you would not have any regard?
A. You have to take into consideration, you have to apply this stuff on an individual basis and since there really are perhaps only three or four highly possible different diagnoses for presenting the case, you would have to look at them as best possible. The diagnosis of migraine you could argue by exclusion, so you have to exclude everything else, no matter how remote. Obviously you can't do that for everything, but you can do that to the best of your ability. A simple dilated fundus examination may well be the only thing an optometrist can do, but that is better than not doing anything at all.

Q. I hear the answer.

Mr Reily: Just to be absolutely clear, just talking about the FDT field, in your experience would you say that the field that is shown in the FDT is consistent with retinal damage which isn't really visible with a direct ophthalmoscope?
A. Is it consistent with the possibility of detecting retinal detachment what you are asking?

Q. Yes.
A. As a nasal visual field detector?

Q. Yes. Could it also be consistent with somebody who had given them the test and then decided not to -?
A. Yes, absolutely.

Q. What I am getting at is: are the areas checked in a sequential way?

A. As far as I am aware it is a random selection of the areas.

Q. If you checked you would expect to get as a field?
A. Yes, but it is not unreasonable to get that type of thing as well. Because it is haphazard that could be a haphazard field.

Q. That field could be achieved or could be demonstrated by somebody that had given up on it.
A. Yes, absolutely.

Q. Do we have any indication on whether the right or the left eye was tested first?
A. I would suspect the right eye first. Most practitioners do right left.

Q. Okay. Thank you.

Ms Norgett: There's been some debate about the symptoms that are recorded in the eye examination - we haven't heard all the evidence from the eye examination and we haven't discussed that, we don't yet know what was said and we don't know what we are going to ultimately believe of what was said, but in this scenario the symptoms remain a bit uncertain and given that we have more or less left the gender thing behind, do you think that the myopia alone is enough to implicate a dilated indirect examination?
A. My personal practice, it is just me - I dilate everybody who is over a -10. I know there are practitioners that don't. I don't know if there is any research done into practitioner habits on this subject and I would be quite interested to find out, but I am not aware of anything. We all like to practice defensively and yes, a symptomatic patient who is a high myope I personally would dilate them.

Q. That is based on your own practice rather than any guidelines?
A. Yes, absolutely. I don't think there are any guidelines.

Q. Thank you very much.

Mr North: No questions, thank you.

Ms Jeyasingham: I have a few questions, Dr Jones. You obviously examined the patient record as well as other documents and you have looked at some research as well. It was really about the history of symptoms as well as what is recorded there. Again I am a lay member of the Panel, so you need to explain to me what you would expect to see recorded given some of the symptoms that have been agreed and disagreed between the Registrant and the patient.
A. This paper provides you with a gold standard of what should and shouldn't be asked. From what I have read it is pretty comprehensive. Certainly time, duration, which eye is affected, any other associated symptoms, i.e. for a

headache type thing, a family history, trauma, the fact that the symptoms are not going away after three days would certainly start the alarm bells going. The migraine visual aura for a migraine lasts about half an hour or so then followed by a headache. I am certainly aware the headache lasts for a few days, but generally the visual symptoms resolve – not always – some people are left with permanent visual loss from a severe migraine. Those are some of the things. The fact that the patient is or apparently is giving the symptoms of it is like a migraine but different, so trying to weed out what really is different about it.

Q. Given what was recorded on the card, because there is something recorded about the migraine, with some of these other questions would you have expected to see them or not? Take me through what was recorded with what was said.
A. As experienced practitioners we don't write everything down and that is fair comment, I would probably expect to see a little bit more detail, yes, certainly about no recent trauma and these have been going on for three days.

Q. It is page 109.
A. I would expect a little bit more detail; you are not going to write every negative down, otherwise you would end up writing an essay about it and it is just not practical. Yes, a bit more detail about that and perhaps some questions about floaters and things like that to follow.

Q. Even if it is recorded as a negative?
A. Yes, those big things, floaters and trauma and shadows and things like that.

Q. Family history you would expect to see?
A. There is nothing written down under family history so I assume it was asked and there was a negative reply.

Q. That's all the questions from me.

Mr Swinstead: Are there any questions arising?

Further cross-examination by MR STERN

Mr Stern: I have just one question relating to the issue of prevalence. All the primary healthcare workers work on the basis of what is the most likely case, don't they?
A. Yes, you work through a list of likely causes so you get a differential diagnosis.

Q. For example, if you go to see your GP with a pain in the stomach, the GP doesn't say "I'm going to investigate cancer because it could be cancer", which it could be.
A. Yes.

Q. You go for the most likely cause first don't you?
A. Yes, which is what?

Q. It depends what it is you ask; I don't know – it may be a whole range of things. The point I am making is the point you were asked about, which you appeared not to accept that the prevalence, that is to say the most likely cause is the one that the practitioner is likely to look at first.
A. Indeed, but do you do that at the risk of not looking at anything else, is what I a driving at? Since the next most likely cause is likely to be a retinal break or PVD, which you have to excuse as well.

Q. It comes back to the full circle – you have to be careful about this – it depends on the symptoms that are expressed to them.
A. Yes absolutely.

Q. That's why you have to be careful about it. When you say that, somebody here may take the view that what you are saying is in all circumstances, but when we have the symptoms as expressed on the face of the document and as I said it is not about you or me, that if those symptoms are on the face of the document, you have already accepted that this is a perfectly adequate test.
A. If the symptoms are as the patient presented, then not.

Q. That is the point I am making.
A. Exactly, yes.

Further re-examination by MS BROMLEY

Ms Bromley: I'm not sure if I entirely followed your answer to that last question. You were asked about it depends on the symptoms expressed and then it was put to you that you have accepted that if the symptoms are – I don't want to put words into your mouth – I didn't get the question down.
A. You are saying that if those symptoms were as presented on the record card, then it would be reasonable not to do anything further, because there are really no symptoms on the record card about retinal detachment, but symptoms presenting in the patient are a retinal detachment. Yes, there are these two different scenarios.

Q. Yes.
A. The comments are regarding the prevalence for an asymptomatic patient is not really relevant anyway. The comment with regard to a symptomatic patient is still relevant because you still have to exclude all the other differential diagnoses.

Q. Good.

[*The witness stood down*]

Ms Bromley: I don't have any further witnesses to call.

Mr Stern: Madam, I wonder if you would like a break, because I would just like to consider the position in connection to the evidence as it is at the moment, in case there are any submissions I wish to make to you.

Ms Jeyasingham: That's fine, Mr Stern. How long do you think you need; a break for half an hour?

Mr Stern: I would have thought less than that.

[*Hearing adjourned at 14:54*]

[*Hearing resumed at 15:14*]

Ms Jeyasingham: Mr Stern.

Mr Stern: Thank you, Madam, thank you for the time, I am grateful. I seek to submit that there is insufficient evidence for the case to proceed beyond the stage at which it presently is at. Can I make two discrete submissions? The first relates to particulars 1 (a) ii and iii. 1 (a) ii alleges that the practitioner did not ask the patient about the type of visual aura experienced. There is no evidence that the patient indicated that she had a visual aura. She specifically said she did not use that term. It follows that there is no evidence on 1 (a) ii and if that is right then 1 (a) iii likewise because that is the recording of ii.

Likewise, 2 (b), that is, as I understand it, no longer supported as a risk factor. It is a little difficult to follow what lies behind head 2 because it reads:

> "In carrying out your examination you did not take into account the following risk factors –
>
> (a)
> (b)
> (c)
>
> And as a result did not assess fully the eye health of Patient A"

It really comes back to the circular with head 1 (b), that is to say not carrying out a dilated examination. It is slightly repetitious, but that is what it comes back to.

The first submission is in relation to these two discrete points. The second umbrella if you like is this: I accept that there is a conflict of evidence in relation to the symptoms expressed by the patient. In my submission, obviously I can't make a submission in that regard – well I could, but I am not

going to – but taking the evidence at its highest, there is no evidence on which you could conclude that no reasonable body of optometrists would have acted in the way that the practitioner did, even, as I said, if it is right that the symptoms expressed by the patient are accurate. I assume for this purpose that they are.

First of all, there are no guidelines. Secondly even if those symptoms, which are limited to two, were expressed there were no other risk factors. Thirdly, it is clear from the paper that we have just looked at in detail, the paper of Shah that a suitable body of optometrists, for which you have no evidence they are not a reasonable body, would not have dilated the pupils of the patient with the symptoms expressed. That is it in a nutshell. It is only a reasonable body that you are concerned with; this is not an academic exercise of whether you might have done something different, or whether somebody else might have done something different; that is not the basis of the test as I am sure you will be told in due course. That is my submission.

Mr Swinstead: Just for absolute clarity, Mr Stern, effectively what I think you are saying is that whatever, even if some of these individual factual allegations are found proved, that what would be found proved could not be found to be misconduct.

Mr Stern: No.

Mr Swinstead: Effectively your test of the reasonable optometrist – the point I am making is that you are saying whatever is found, it can't reach a level where this Committee could find misconduct, whatever is found proved, is effectively what you are saying, or do I misunderstand?

Mr Stern: I'd better go over it again.

Mr Swinstead: Just to make it absolutely clear.

Mr Stern: The position is this, one starts with the premise that if the symptoms are as expressed by the practitioner in the notes, there is no criticism of the patient examination. That is the evidence at the moment. Only if the patient has expressed the symptoms that she has described is there a criticism and that criticism is that what the practitioner should have done is carried out a dilated examination. What I am submitting is that it may be that if that is right a practitioner could or should have carried out a dilated examination, but there is no evidence that no reasonable optometrist would have acted in the way that would have done and therefore there is no evidence upon which one can conclude that in not carrying out a dilated examination he has acted outside that Bolam/Bolitho test. When he suggests in head 1 he did not adequately investigate the cause, that is based on symptoms, but 1(b) you did not perform – that is only necessary, 1(b) i, in the circumstances where the symptoms are as the patient describes. Likewise 2, 3 and 4 and all of those I

am submitting would only follow if no reasonably qualified optometrist would have not have done what is set out.

Mr Swinstead: Mr Stern, it is my fault – we step one back, what you are saying there is no culpability, i.e. there is no failure. That is what I am trying to work out which stage we are at. We are not at misconduct, we are saying no culpability.

Mr Stern: That's right. 1(b) and (c) and 2; 1(a) ii and iii I have already dealt with.

Mr Swinstead: It is no culpability.

Ms Jeyasingham: My understanding is that is your submission and you are not offering any other evidence.

Mr Stern: At this stage it is not my final submission.

Mr Swinstead: Madam, could I perhaps just help? I didn't stop Mr Stern in full sway, but we may need just to deal with the fact that we are at some point in the Rules between Rule 45 and Rule 46. Madam, I don't think you will find it there, they are in the Rules between Rule 45 and Rule 46. Normally, and I am saying this before Ms Bromley starts, so that she can deal with it and if necessarily Mr Stern can come back, there is no provision formally in your Rules for what Mr Stern is doing, which is a half-time submission, effectively saying "You have heard the Council's case, there isn't a case"; effectively saying there is no case to answer.

You will have to first consider whether you will accept to hear that submission and then resolve it if you decide you will, because there is nothing in the Rules. This isn't a final submission, this is what you might call Rule 45A. We have to imagine it is there, which effectively is saying is there at this stage – has sufficient evidence been adduced that the factual allegation or each individual factual allegation is capable of being proved, not that it would be, but it is capable of proof. His submission further is that it is not because it doesn't meet the culpability test; Mr King is not blameworthy.

Mr Stern: That is precisely it. I am sorry, Madam, you will hear from me again.

Mr Swinstead: It is now for Ms Bromley to resolve that, then Mr Stern has the right to respond and perhaps Ms Bromley could start by indicating whether or not you object to Mr Stern notionally making an application under the notional Rule 45A, if I can put it that way?

Ms Bromley: The short answer is no, I don't. If it is not specifically provided for in the Rules, my instructions are that it would be unfair to seek to prevent that submission being made. No, I don't object to it.

Mr Stern: If I may just answer in relation to that, I am grateful, and for the sake of consistency there was something that was certainly done by a Panel last week and certainly I am sure it is something that has been done before, so as a matter of natural justice it must be right that we have all the reasons, as it were, on the record. Thank you.

Ms Bromley: It is my opportunity to respond to this submission. The Legal Adviser has already touched upon the test in that you are not making a decision now on the case, you have to be satisfied at this stage, whether is evidence on which you could find the allegations proved, not that you would find the allegations proved, so you simply need to consider what you have heard from Patient A and from Dr Jones and consider whether there is enough evidence there on which you could find allegations proved, that it is acknowledged a dispute on the facts as to exactly what was said in the examination. You have heard Patient A give very clear evidence that she told Mr King that she was suffering from flashes or flashing lights and a blank spot. You have heard from Dr Jones as to the sort of questions that he would have expected Mr King to ask Patient A. None of that is documented in the patient history, obviously we have not yet heard from Mr King as to what he says he asked her.

In my submission there is clearly sufficient evidence on which you can find Allegation 1(a) i, ii and/or iii proved in that questions were not asked about the type of visual disturbance expressed, the duration, other than it is noted that for a few days – there is nothing noted about associated symptoms and iii is included, because obviously when we drafted this we don't know whether Mr King's case is going to be whether he asked questions and didn't record them, or whether he never asked the questions.

As far as 1(b) is concerned, you have heard a lot from Dr Jones and you have heard a lot about this study, the Shah study, on which a lot of weight is placed by Mr Stern. Some of the important things to note about this is that the standard patient specifically told the optometrist that he was visiting that he didn't want to be dilated and that is on page 113, if you want the reference to it. He was told if the optometrist visited wanted to carry out a dilated fundus examination, the SP acted in a nervous manner and asked the practitioner if this would affect his vision, if this information had already not been volunteered. He was told by the research team not to undergo pupillary dilation unless it was his last practice visit of the day. One has to look at this study in that context in that if you were an optometrist who had a patient saying "I don't want to be dilated under any circumstances" and was resistant to it, yet even in the light of that resistance we have heard that two thirds still went on and dilated. It may well have been if it was a different factual scenario, those percentages could well shift; obviously one has to deal with this on the factual scenario on which the research was based, but Mr Stern is putting a lot of weight on this, but you have to be cautious about how you approach this research and you can't use this research as the absolute

guidance as to what is or what is not the conduct of a reasonable body of optometrists.

We know absolutely nothing about the optometrists who took part in this research; they were guaranteed anonymity so not even the researchers know anything about the optometrists or the extent to which they are a representative sample. As I say we need to approach this with caution. In my submission you can't rely on this study as being an absolute indicator as to would or would not be done by a reasonable body of optometrists. Even on the basis of this research, 66 per cent faced with a patient who did not want to be dilated still went ahead and dilated.

I would have to accept that 2(b) is no longer an issue; Dr Jones has accepted that gender is something that is a very complicated question and wouldn't have expected to see that as a risk factor.

Those are most of the things I want to say. My submission is that there is evidence on which you can find these allegations proved. You need to hear from Mr King and make up your mind once you have heard both sides and it will be premature to throw the matter out at this stage. Unless you or your colleagues have any questions, those are my submissions.

Ms Jeyasingham: Thank you.

Mr Stern: The issue of whether you will hear Mr King is not the basis for keeping a case that is not in based in fact. Obviously if the case proceeds you will, but that is not the basis for deciding that there is sufficient evidence clearly. I am afraid that the position is this that I don't think it is entirely accurate what has been said to you about this paper. It is not that the individuals said that they specifically did not want to be dilated prior to the offer of dilation. The whole point is that only 66 per cent, two thirds, recommended dilation. Obviously the patient didn't go in and say "Whatever happens I don't want to have dilation", because that would, some may think, have slightly damaged the research. What happened was the patient found excuses not to have dilation, but the point is whether or not the issue of dilation was raised by the practitioner. That is the point. 66 per cent recommended dilation; that is what it is about. The point is a bad one made by Dr Jones and indeed repeated by my learned friend, if I may say so.

What you are asked to do is not rely on this study; that is essentially the submission that is being made to you. We can assume from that or infer from that that it is accepted from the Council that this study does show what a reasonable body of optometrists does, but for whatever reason you were asked to ignore it. I ask rhetorically on what basis can you ignore it, because this is clearly what a reasonable body of optometrists do. It is not a question of saying "This is what you would like optometrists to do" and therefore we will, as it were, say there is a case because this is what we would like optometrists to do. That is not your function, if I may say so in respect to your

function. It is to look at the evidence and to see what it is that a reasonable optometrist can do. You have to rely to some extent on the evidence of witnesses, you have to rely on the evidence that emerges from papers and this is about as clear a paper as you will find in relation to what a reasonable optometrist can do; you have no other means of assessing it and what it is that has been found in this paper. It has not been made clear, certainly in the submissions that you have just heard, as to why it is you should reject it. As I said, the initial basis is that the SPs did specifically not want to be dilated is neither here nor there, that doesn't affect the issue which is the central issue, which is the recommendation to the patient and the fact that the SP has tried to make an excuse afterwards is irrelevant to the study. In my submission there has been no answers asked by the Council to support the case.

Ms Jeyasingham: Okay. Mr Swinstead.

Mr Swinstead: Madam, I don't think I need touch on the issue of the making of the application, because you have heard Ms Bromley accept and you may well think that it is clearly a matter of justice that such an application is made, despite your Rules, you should consider it and Ms Bromley has conceded that. The issue that you have to decide and I have posed the question already is that has sufficient evidence been deduced on behalf of the Council on each of these individual factual matters which goes to make up the allegation that it is capable in trying to prove, not that it would be, but that it is capable of proof? Clearly if it is incapable of proof, then effectively there is no case to answer for Mr King on each of those individual factual particulars.

You have heard from Mr Stern that effectively he looks at the submission in two ways: he deals firstly with the individual allegations of 1(a) ii and 1(a)iii and 2(b), but secondly he has the competence submission which, as you heard, effectively argues that the issue of culpability, if I can put it that way, has not been made out because it has not been demonstrated that a reasonable body of optometrists would not have acted as Mr King acted, effectively.

The most helpful test, despite the fact that these are regulated proceedings and the test that is often used is the criminal case of *R v Galbraith* [1981] 1 WLR 1039, because whilst these are not criminal proceedings, in this case the Council brings the allegation and it is for the Council to prove it. Although the standard of proof for you is the balance of probabilities as opposed to a criminal standard of beyond reasonable doubt, bearing in mind where the burden lies it may be helpful if I go through with you the principles in the case of *Galbraith*, because those principles are helpful in general terms when you are dealing with the issues that you have to at this stage. *Galbraith* effectively says this, and I will try and translate it, as it were, into regulatory language, if I can put it that way:

> "If there is no evidence that" - the factual particulars have been made out against the Registrant then - "there is no difficulty";

you would stop the case:

> "(2) The difficulty arises where there is some evidence but it is of a tenuous character, for example because of inherent weakness or vagueness or because it is inconsistent with other evidence. Where" – you conclude that the Council's – "evidence, taken at its highest, is such that" you "properly directed" –

- were advised and properly directing yourself as to the burden and standard of proof could not find any individual allegation proved, it is your duty on the submissions being made to stop the case.

Now I go onto what is perhaps a slightly more difficult area: where, however, the Council's evidence is such that:

> "its strength or weakness depends on the view to be taken of the witnesses' reliability or other matters which are generally speaking within the province of-"

- in this case, a jury and I keep to the original words;

> "and where on one possible view of the facts there is evidence on which a jury could properly come to the conclusion that the defendant is guilty"

I specifically don't translate there;

> "then the judge should allow the matter to be tried by the jury."

Of course what is being said there is that where a judge is faced with an issue on the evidence where on one view the jury could convict, the judge should leave it to the jury for them to decide. The distinction here is that you are both the judge and the jury and so if it were that you, looking at the evidence, concluded that possibly on one view you might find a particular allegation proved, but when on further consideration, at this stage, considered that you could not, then of course you could stop the case here. The difference being that the judge has to leave it to the jury to let them decide, but because effectively you are the judge and jury, if you are, as it were, in some dilemma about it, you can resolve it at this stage in the sense of saying "There is some evidence, but we don't think we would ever be satisfied of it sufficient that we could find this particular of the allegation proved".

Essentially the position is, because you are effectively the judge and jury, it is for you at this stage to consider, as I was saying, the question has on each individual particular of this allegation, has sufficient evidence been adduced

on behalf of the Council that each one of these factual allegations is capable of being found? If you conclude that it is not then effectively what you are saying is there is no case to answer on that factual particular. Obviously you would find it effectively not capable of proof. Were you to conclude that all the factual allegations that that was the case, then clearly that would be the end of the case.

That is my advice, unless you wish for me to say anything further to correct what I have said.

Mr Stern: I am just considering whether not you may find it helpful to deal with the test, the Bono test?

Mr Swinstead: I'll put it in a very straightforward way; there may be a majority view amongst optometrists as to how to act in a particular situation. There may be a respectable or respected minority view of how optometrists would act in a particular situation. Either of those is acceptable. It is only where somebody would fall outside what either a majority or a respectable minority would consider the appropriate course taken in a particular set of circumstances that that optometrist could be considered to be, because we are dealing with negligence, particularly in civil cases, it could be considered perhaps to be negligent or to have fallen below the standard expected of a reasonable optometrist. If a reasonable body of optometrists would consider acting in a particular way then it is difficult to say that that optometrist, or a particular optometrist has fallen below the standard expected if he has acted in accordance with what a reasonable and respected minority would do in particular circumstances. Is that a fair way of putting it, Mr Stern?

Mr Stern: It is an accurate way, yes.

Mr Swinstead: What I have tried to do is translate it a bit into the regulatory proceedings and I hope that is acceptable to you, Ms Bromley.

Ms Bromley: Yes.

Ms Jeyasingham: In which case, can we clear the room?

[*Hearing adjourned at 15:45*]

DAY TWO

Tuesday, 21 June 2011

[*Hearing resumed at 12:17*]

Ms Jeyasingham: I am going to read out the Determination.

Findings in relation to the application made on behalf of the Registrant at the conclusion of the Council's case.

The Committee has considered the application made by Mr Stern on behalf of the Registrant and the submissions of Ms Bromley, on behalf of the Council, in reply. It has accepted the advice of the Legal Adviser. It has taken account of all the evidence presented to it.

It first considered whether it should consider the application, bearing in mind that no provision is made for such an application in the Rules. It noted that Ms Bromley accepted that such an application could be made in accordance with the principles of natural justice.

The Committee agreed with this submission and considered that as a matter of justice it should entertain such an application.

The Committee first reminded itself of the question that it was required to consider. It must consider whether the Council has adduced sufficient evidence on each of the particulars of the allegation so that they were individually capable of being found proved. It noted that Mr Stern argued that the actions of the Registrant did not fall below the standard of the reasonably competent optometrist and that, consequently, his actions were not culpable.

Patient A attended the Registrant for a consultation on 12 February 2009. She complained of a grey area in her vision and of symptoms she associated with migraine but without a headache. The Registrant examined her but it is alleged that he did not adequately investigate or obtain her history and presenting symptoms and did not record the same. It is alleged that he failed to perform such tests as were required to investigate her complaint adequately or to refer her to another appropriate health care professional. Further, it is alleged that he did not conduct an appropriate visual field test such as the confrontation test. In carrying out his examination he did not take account of the fact of Patient A's myopia, her gender or the presence of a nasal visual field defect in her right eye.

The Committee first considered the expert evidence for the Council of Dr Jones. It was concerned as to the quality of his evidence as an

expert. It noted that he did not provide his CV to the Committee. The Committee considered that on a number of occasions during the course of his evidence, he appeared to be giving evidence of his own personal practise and experience rather than relying upon the standard of the reasonably competent optometrist. He appeared to indicate in his report that, with regard to the College of Optometrists' Guidelines, these provide the minimum standard to be expected of the reasonably competent optometrist but in his oral evidence he accepted that these set out best practice. It also noted that in relation to the relevance of gender with regard to retinal detachment, one of the papers he cited did not support his written assertions. He eventually resiled from his original position in his oral evidence on the relevance of gender in considering the incidence of retinal detachment. It further noted that the basis of his conclusion as to the relevance of gender in the incidence of retinal detachment was based entirely on his own experience.

Further, Dr Jones gave evidence of six risk factors which could indicate the presence of retinal detachment but that in the case of patient A, he conceded that only one was present, namely her myopia. There was possibly another present, namely a detachment in the other eye, but he accepted that the Registrant would not have been expected to know of this at the time of the consultation.

Finally the Committee noted his evidence that if the matters complained of were as the Registrant recorded them in the notes rather than as Patient A gave in her evidence, the Registrant's actions could not be criticised.

The Committee then considered the evidence of Patient A. It accepted that she gave her evidence honestly and in accordance with her recollection of what had taken place. Nevertheless, it had some concerns as to the clarity of her recollection and she herself accepted that recollecting events of two years ago was difficult. The Committee considered that she was mistaken in her recollection of the manner in which the visual field test was conducted. She accepted that, at the time she was under considerable stress as a result of events in her personal life, and that she had made no notes of what had occurred at this consultation until some six months after the event. Finally she saw up to five professionals in a relatively short period of time when she was suffering from this condition. As a result, the Committee concluded that it could not safely place reliance on her evidence as to what she had told the Registrant at the consultation.

By reason of its conclusions, the Committee determined that with regard to all the particulars of the allegations there was insufficient

evidence presented by the Council on which it could find the particulars proved.

Consequently, the Committee found the following:

1(a) (i), (ii) and (iii): Not capable of proof;

1 (b) (i), (ii), (iii) and (iv): Not capable of proof;

1 (c): Not capable of proof;

2(a), (b) and (c): Not capable of proof.

Consequently, the Committee could not find Robert King guilty of misconduct and it follows that his fitness to practise as an optometrist is not impaired.

The Committee did not consider that it was either necessary or appropriate to give the Registrant a warning.

Therefore the case is concluded, thank you.

[*Hearing concluded at 12:23*]