General Optical Council

BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

F(11)15

GENERAL OPTICAL COUNCIL

AND

ROGER MIGUEL ROBINSON (01-18543)

SUBSTANTIVE HEARING

Friday, 9 December 2011

General Optical Council

SUBSTANTIVE HEARING: ROGER MIGUEL ROBINSON (01-18543)
Friday, 9 December 2011

Fitness to Practise Committee:	Ms Mercy Jeyasingham MBE (Lay) (Chair) Ms Margaret Hallendorfff (Lay) Mr Rod Varley (Lay) Ms Catherine Viner (Optometrist) Mrs Helen Tilley (Optometrist)
Legal Adviser:	Mr Iain Ross
Hearings Manager:	Mr David Henley BEM
For the Council:	Mr John Hepworth

The Registrant did not appear in person and was not legally represented.

[*Hearing commenced at 09.30*]

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. I will ask the members of the Committee to introduce themselves and the capacity in which they sit and if they have any conflicts of interest which they need to declare. [*Introductions*]

Ms Tilley: I need to declare that I was at University with Melanie Davies; I was at University with her, but I don't think that I have seen you since then.

Ms Jeyasingham: Can I just clarify that you, Melanie Davies, are not giving evidence, you are just a member of the public?

Ms Davies: Yes, that is right.

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

To your right is Mr David Henley, the Hearings Manager, who will provide administrative support to the Committee. Next to Mr Henley is Mr Nisbet, the

transcriber, who will be keeping an official record of all that is said today during the sessions of the hearing at which the parties are present.

The remaining persons sitting in the hearing room, rather than in the public and press areas, are members of the respective legal teams.

All parties are reminded that where details of a patient are to be discussed, those patients have been allocated various letters in the allegation; where the patient's name is mentioned in the course of the hearing, the transcriber will delete the name from the transcript and will replace it with the words 'the patient'.

It is the Council's policy for the determination of the Committee and a transcript of the proceedings to be displayed on the Council's website for public viewing, but where matters of health are being discussed, the determination and transcript will be redacted accordingly.

Mr Hepworth, I understand that there is an application to be made to proceed in the absence of the Registrant?

Mr Hepworth: Madam, that is right. I do not know whether or not I could ask Mr Henley to provide details of the efforts which have been made to serve various documents on the Registrant?

Mr Henley: The bundle has been given to the Committee.

Mr Hepworth: It has. I am grateful for that. Madam, I think that the appropriate starting point is Rule 21 within the Fitness to Practise rules, and that is at page 140 in your handbook.

Ms Jeyasingham: Sorry, could I just clarify that this is the same bundle?

Mr Henley: It is, yes.

Mr Hepworth: So Madam, Rule 21 of the Fitness to Practise Rules, page 140 of the handbook reads:

> "Where the Registrant is neither present nor represented at a hearing" – and that is the situation here – the Fitness to Practise Committee may nevertheless proceed if –
>
> a) they are satisfied that all reasonable efforts have been made to notify the registrant of the hearing; and
>
> b) having regard to any reasons for absence which have been provided by the registrant they are satisfied that it is in the public interest to proceed."

Madam, in relation to the first point upon which I need to satisfy you, that all reasonable efforts have been made to notify the Registrant of the hearing, I refer you to the bundle which is headed, 'Service of Notice of Inquiry'. You will see that, at page 1 of the bundle, you can see that the entry for Mr Robinson in the Register gives his address in Bell Air in La Romain in Trinidad and Tobago, and gives an email address which ends @hotmail.com.

Turning to page 7, you can see on 30 October 2011, the notice was sent to the address in Bell Air in La Romain and also, at page 9, you can see that a copy was sent to the hotmail address. At page 10 of the bundle you can see that the letter sent to Trinidad and Tobago reached the destination country. I think from previous experience that is as much information as you can get if a letter is being sent abroad – that it has reached the country.

At pages 11 and 12 you can see that the notice was also sent to the address in Gravesend which was another address which was known to be one with which the Registrant was connected. You can see that in relation to that one, at page 13, that that was not delivered; it was returned back to sender.

You may anyway have been satisfied that the Council had taken all reasonable efforts to serve the notice because it had served on the addresses which the Registrant has on the Register but I am able to give you some very good news. If you look at page 14 you can see that there is an email from Mr Henley to an address which ends @live.com. You can see that the notice was served to that email address. That is a live email address and I have some email threads to hand to you which show that. I should say that this email address – @live.com – came to the Fitness to Practise department's attention as being a possible email address for Mr Robinson relatively recently and efforts were made to contact him on that email address. As you will be able to see from the three email threads that I am about to pass to you, it is a live address and Mr Robinson has responded to emails sent to it.

[*Documents distributed*]

I am afraid that – as is the way when emails are printed out – it is a rather convoluted format, but hopefully it will make some sort of sense.

In these papers there are three email threads and the only amendment which has been made is to number each particular email; they run from one through to nine; one is the oldest email and nine is the most recent. The reason why there are three threads is because, as replies have been sent, replies have been sent to earlier emails in the thread, so as to make it rather more complicated than it may ordinarily have been.

I will refer to the emails, if I may, by their number. You can see email number one, sent on 27 November, where I want to check, in effect, that this is a live email address for Mr Robinson.

You can see from email number two, on 28 November, that Mr Robinson confirms who he is and says that he is not contesting the allegations.

In email number three I ask him a series of questions and email number four, as I have not received a reply, is a 'chaser'.

Email number five, which is in email thread B and in C – but we will concentrate on B – is a reply from Mr Robinson.

At page 2 of email thread B, could I ask you to concentrate, for a moment, on the 'PS' to Mr Robinson's email which says:

> "Would it be possible to communicate without the use of post, for convenience? It would be much appreciated."

In email six, still in thread B, I asked for two further pieces of information; email seven I was not able to send the Hearing Bundle, because it would not get through although I understand that the one sent from the Council had no such problems, so I think that the problems may have been within my own email system. Then moving to email thread C, you can see email eight repeats the two issues raised in email six and adds a third one and then you can see email nine which was sent in the early hours of yesterday and Mr Robinson says, 'It is okay to proceed in my absence'.

So Madam, I hope that you and your colleagues accept that the Council has taken all reasonable steps to serve the notice on the Registrant and, more than that, that service has in fact been effected, if not beforehand then certainly by using the email address which ends @live.com and you can see that at page 14 within Mr Henley's service bundle that the information was served and service has been effected. I should say, though, that well before that the Council had complied with the Rules in so far as it served the various notices on Mr Robinson's registered address.

Madam, if you are satisfied that all reasonable efforts have been made to notify the Registrant of the hearing, then you have a discretion whether or not to proceed in his absence and that discretion – as it is stated in Rule 21 – needs to be exercised in the public interest.

Madam, in the Council's submission it is in the public interest to proceed today. Mr Robinson himself does not ask for an adjournment; he is content for the hearing to proceed in his absence. That is the point that I make most strongly. Madam, I know that you will be aware of this and I apologise for going through it again but there are various criteria which I ask you to consider, they come from the case of *R v Jones (Robert)* (No 2) [1972] 1 WLR 887 which was made applicable to regulatory proceedings in the case of *Tait v Royal College of Veterinary Surgeons* [2003] All ER (D) 286 (Apr). Madam,

the considerations in *Jones* which a court has to consider – of course that was a criminal case – are as follows.

One, the nature and circumstances of, in this case, the Registrant's behaviour in absenting himself from this hearing and, in particular, whether his behaviour was deliberate, voluntary and such as plainly waived his rights to appear. Two, whether an adjournment might result in the Registrant attending. Three, the likely length of an adjournment. Four, whether the Registrant – though absent – is or wishes to be legally represented at the hearing, or has, by his conduct waived his right to representation. Five, whether an absent Registrant's legal representatives are able to receive instructions from him during the hearing and the extent to which they are able to present his case. I should say that Mr Robinson is not represented. Six, the extent of the disadvantage to the Registrant in not being able to give his account of events, having regard to the nature of the evidence against him. Seven, the risk of the Committee – in this case – reaching an improper conclusion about the absence of the Registrant. Criterion eight set by the Court of Appeal was seen not to apply by the House of Lords; so the next consideration is the general public interest and the particular interest of victims and witnesses that a hearing should take place within a reasonable time of the events to which it relates. Ten is the effect of delay on the memories of witnesses and eleven does not apply because it relates to when there is more than one registrant.

Madam, if I may summarise those considerations, it is clear in the Council's submission that Mr Robinson has voluntarily absented himself. If you adjourn the case there is no likelihood of him attending on the next occasion; he has given no such indication. I know, Madam, that you and your colleagues will not hold his absence against him. Of course you will still consider the Council's evidence on its merits and you will decide whether or not the case is made out. There is one witness who is ready to give evidence today – Dr Susan Blakeney. To wrap everything up in the Council's submission, there is a strong public interest in having matters before this Committee dealt with as quickly as is consistent with the interests of justice to maintain public confidence in the regulation of the optical professions. The Council therefore submits that the case should proceed today in the absence of the Registrant.

Madam, I apologise if I have taken a long time to make my submissions to you; I have nothing else to add unless you have any specific questions of me.

Ms Jeyasingham: Thank you.

Ms Viner: Mr Hepworth, in terms of this alternative email address through which you have demonstrated that you have communication with the Registrant, can we ask how it came to light that this was an email address which you could use to contact him?

Mr Hepworth: Madam, you can and I do not think that there is anything prejudicial in me answering you. There was a conference which involved papers being submitted from eye care professionals in various countries and one came from Trinidad and Tobago and it was thought that that could be Mr Robinson's email address so that is where the information came from.

Ms Viner: Right and that email address was passed on to you by a third party?

Mr Hepworth: It was passed on to me by the Fitness to Practise department here; where the information came from to give to them, I am afraid I do not know.

Ms Viner: Okay.

Ms Tilley: I do not know if it is relevant but in the emails it says, "I no longer practise as a dispensing optician" so I am confused, because he has an 01 number which is an ophthalmic optician.

Ms Jeyasingham: He was practising as an optometrist.

Ms Tilley: I do not know whether that is relevant or not.

[*Panel confers*]

Mr Hepworth: I don't think that there is any dispute that he is on the Register as an optometrist. I cannot explain why he may have described himself in other terms.

Ms Tilley: That is fine.

Ms Jeyasingham: In which case I will invite our Legal Adviser to advise us.

Mr Ross: You have already been referred by Mr Hepworth to Rule 21 of the procedural rules which gives the Committee an absolute discretion to proceed even though the Registrant is not here and in this case he is neither here nor is he represented.

Madam, the email thread clearly shows that the Registrant is aware of the fact of this hearing and has voluntarily absented himself from attending. That is perhaps understandable given that the email thread also show that he has now emigrated from the United Kingdom to Trinidad and Tobago and has therefore chosen not to attend. He has also stated that he accepts all of the allegations and the Committee should take into account the general public interest in the expeditious disposal of the cases and those are the factors that should be borne in mind. Given that the amount of contact that there has been with the Registrant and his replies, the Committee may feel that no unfairness would be caused if the hearing were to continue today. That is my advice.

Ms Jeyasingham: Thank you. I just want to check with the Committee that all members are satisfied that we should proceed? [*Agreed*]

In which case, let us move on to opening. So, Mr Hepworth, can I invite you to present the evidence?

Mr Hepworth: Madam, thank you, yes. The Council's evidence is comprised of the hearing bundle which I know that you now have before you. Mr Robinson only gave you his consent to pre-read the bundle yesterday.

Ms Jeyasingham: Mr Hepworth, I am sorry but I have missed a step; we should really read out the allegation:

ALLEGATION

The Council alleges that in relation to you, Roger Robinson, a registered optometrist:

1. On or about
   a. 6 August 2007;
   b. 9 December 2008:

   1.1 failed to perform an adequate fundal examination in relation to patient GM in that you failed to identify macular damage in the patient's left eye; or in the alternative
   1.2 failed to record that you had identified macular damage in the patient's left eye;
   1.3 recorded that patient GM's cup/disc ratio in both eyes was 0.2 when this was inaccurate;

2. In relation to
   a. Patient RA on or about 24 November 2008;
   b. Patient SC on or about 30 October 2008;
   c. Patient SF on or about 11 October 2008;

   2.1 failed to carry out retinoscopy, even though the patients were visiting the practice for the first time; or in the alternative
   2.2 failed to record the retinoscopy which you carried out;

3. In relation to
   a. Patient RA on or about 24 November 2008;
   b. Patient TS on or about 12 June 2008;

   3.1 failed to assess ocular muscle balance even though this was a possible cause of the patients' presenting symptoms; or in the alternative

3.2 failed to record your assessment of ocular muscle balance;

4. On or about 24 November 2008

4.1 failed to measure Patient RA's near visual acuity despite the patient complaining about this; or in the alternative
4.2 failed to record your measurement of Patient RA's near visual acuity;

5. On or about 26 November 2008

5.1 failed to measure Patient WM's intra ocular pressure to check for glaucoma despite the patient being elderly and more prone to developing glaucoma; or in the alternative
5.2 failed to record your measurement of Patient WM's intra ocular pressure;

6. On or about 26 November 2008

6.1 failed to conduct a basic field test in relation to Patient JW to ascertain whether or not the stroke which the patient had suffered had affected her sight; or in the alternative
6.2 failed to record the basic field test in relation to Patient JW which you conducted;

7. In relation to
   a. Patient MC on or about 6 December 2008;
   b. Patient HD on or about 21 October 2008;
   c. Patient CP on or about 14 November 2008;

7.1 failed to undertake cycloplegic refraction to ascertain whether or not a weak prescription was justified; or in the alternative
7.2 failed to record the cycloplegic refraction which you undertook;
7.3 failed to test accommodation to help to diagnose whether or not the patient was long-sighted; or in the alternative
7.4 failed to record your testing of accommodation;

8. In relation to
   a. Patient MC on or about 6 December 2008;
   b. Patient CP on or about 14 November 2008;
   c. Patient TS on or about 12 June 2008;

8.1 inappropriately issued a prescription; or in the alternative
8.2 failed to record adequately your justification for issuing a prescription;

9. In relation to:
   - a. Patient SC on or about 30 October 2008;
   - b. Patient SR on or about 28 October 2008;
   - c. Patient HD on or about 21 October 2008;
   - d. Patient JY on or about 4 December 2008;
   - e. Patient SH on or about 30 October 2008;
   - f. Patient SF on or about 11 October 2008;
   - g. Patient CP on or about 14 November 2008;

   9.1 inappropriately prescribed spectacles; or in the alternative
   9.2 failed to record adequately your justification for prescribing spectacles;

10. On or about 20 November 2008 issued an incorrect prescription in relation to Patient LG;

11. In relation to:
   - a. Patient SH on or about 30 October 2008
   - b. Patient GM on or about 9 December 2008
   - c. Patient DB on or about 18 October 2008
   - d. Patient SF on or about 11 October 2008
   - e. Patient WM on or about 26 November 2008;

   11.1 failed to obtain any information in relation to symptoms and/or patient history; or in the alternative
   11.2 failed to record the information in relation to symptoms and/or patient history which you obtained

12. In relation to:
   - a. Patient CB on or about 15 November 2008;
   - b. Patient HD on or about 21 October 2008;

   12.1 failed to investigate headaches reported by the patient; or in the alternative
   12.2 failed to record your investigation of headaches;

Your actions as described in paragraphs 1 to 12 were not of the standard expected of a registered optometrist;

AND

By virtue of the facts set out above, your fitness to practise is impaired by reason of deficient professional performance.

Mr Hepworth, please continue now.

Mr Hepworth: Madam, thank you. As I said, the bundle, as you can see comprises of the statement of Dr Blakeney and then the exhibits which she produces and lastly a letter from Mr Robinson which was sent to the Council earlier in the proceedings.

Madam, what I propose – and, of course, I am in your hands, but rather than ask you to read the bundle before Dr Blakeney gives her evidence but to call her and perhaps take her through her evidence in a little more detail than I would ordinarily have done and ask her, through her evidence to show you the important parts of the bundle and then, if before you ask her questions, you need a little time to read the bundle or read parts of it which you were not able to read as she was giving her evidence you could take that time before you ask questions. The alternative, of course, is that you read the bundle now and Dr Blakeney can give evidence afterwards, but I hope that I can perhaps for shorten at least some of your reading by the manner that I propose.

Ms Jeyasingham: Luckily for you, Mr Hepworth, we have all read the bundle in advance so we can proceed with your witness.

Mr Hepworth: In which case, Madam, I am very grateful and I will try to take her through rather more rapidly than I was planning.

In relation to the bundle there is an apology which comes immediately and it is in relation to pages 3, 4, 5 and 6. I am afraid that pages 3 and 4 are repeated as page 5 and 6; that is an error and for that I apologise.

Madam, you and your colleagues may already have undertaken this procedure but could I refer you, please, to exhibit SB/2 which starts at page 23 of the bundle. You can see there that there is a collection of patient records but because the patient records were very efficiently redacted, I think that the only way in which one can cross-refer the patients to Dr Blakeney reports is by the date of birth of the patients. I have undertaken that activity, Madam, so it might be helpful if I let you know which records relate to which patients. I have noted the initials in the top right hand corner of each page to guide me and that may help you. Pages 24 and 25 relate to patient RA; pages 22 through to 47 relate to patient MC; pages 49 and 50 relate to patient SC; pages 52 to 57 HD; pages 59 and 60 relate to patient SH; pages 61 to 66 relate to patient GM; pages 68 and 69 relate to patient SR; pages 71 and 72 relate to patient JY; pages 74 to 79 relate to patient DB; pages 81 and 82 relate to patient SF; pages 84 through to 105 relate to patient ZL; pages 107 and 108 relate to patient WM; pages 110 to 114 relate to patient CP and lastly, pages 116 to 119 relate to patient JW.

Madam, the first thing to explain is the structure of the allegations; for the most part, allegations are made in the alternative. When Dr Blakeney did the analysis which led to the report which led to the statement, looked at the records which were produced by Mr Robinson and noticed, as you will hear from her, that there were large gaps in the notes which were made. It is a matter of logic that if there is an absence of a note about something then one of two alternatives must have caused that. Either the thing was not done or it was done and it was not recorded. You can see, Madam, that those alternatives are put in the allegation. Madam, in the Council's submission, it will clearly be a matter for you in due course as to whether one or the other is more or less serious depending on what you find proved, but at the least there was a failure to record something which should have happened and the alternative is that it did not happen. I am afraid, Madam, that as you analyse the evidence that will have to be one of the matters that you deal with on a fairly basic level: where does the evidence take you to and what do you find proved on the balance of probabilities. That is the reason why the allegation is structured in the way it is.

Madam, you can also see that in some of the allegations the word 'adequate' is used. That is used with a specific meaning in mind. If someone fails to do something adequately then it means that either it was not done at all or that it was done but it was done inadequately. In the Council's submission both alternatives are contained within that one factual allegation.

Madam, as I have mentioned, the allegations are based on the evidence of Dr Susan Blakeney; she is the only witness from whom you will hear. I am reluctant to summarise her reports because, in the Council's submission, they are thorough but concise and well written reports upon which I would hesitate to seek to improve. I refer you to them and having read them you will be familiar with their content.

I might perhaps ask you to turn to the last document in this hearing bundle? It is at pages 275 and 276 which is the Registrant's own account. If I refer you please to the fifth paragraph on page 275, Mr Robinson wrote:

> "Having had the opportunity to review the report" – that is Dr Blakeney's report – "subsequently sent to me and to consult with a professional adviser, I accept that there may be things I could do to improve upon my clinical practice and decision making."

In the Council's submission there is an acceptance there of some inadequacy as far as his practice is concerned. He then goes on to explain what other action he either had taken or was planning to take. Madam, that is consistent with his indication given in his recent emails that he was not contesting the allegation. Madam, I do need to emphasise that in a later email, it is email number five in email thread B, in response to my question which said,

> "You indicated below that you are not contesting the allegations; which of the allegations do you admit and which do you deny?"

He replies, in email five, at the bottom of the penultimate paragraph, "I do not admit any of the allegations." So there is no admission from the Registrant before you today save for those limited admissions to which I have already drawn your attention.

Madam, I think for form's sake it falls on me to remind you that, of course, at the moment you are at the facts stage and at the facts stage there is a burden which falls on the Council: Mr Robinson has to prove nothing and any fact alleged can only be found proved by you if the Council satisfies the burden which is incumbent on it and the standard to which that burden relates is on the balance of probabilities – to put it in summary form, if you find, after hearing the evidence, that a particular fact is more likely than not to have occurred, then you can and must safely find it proved.

Madam, that is all that I intend to say in opening. Unless there are any issues with which I can deal on a preliminary basis, I will call Dr Blakeney?

Ms Jeyasingham: You may call Dr Blakeney.

Dr SUSAN BLAKENEY, called and sworn
Examined-in-Chief by Mr Hepworth

Q. Could I ask you please to give your full name to the Committee?
A. Yes, Susan Blakeney.

Q. You will see on the table in front of you a bundle of documents. As we go through your evidence I will be asking you to refer to that bundle. The page numbers are in the bottom right hand corner and everybody has a copy of the bundle in front of them. If you need to refer to a document that not everyone is following at that point then please let people know where you are moving to in the bundle so that everybody can follow you as you give your evidence.
A. Okay.

Q. The Committee members have already read the bundle so they will already have read your statement and the reports which you prepared, so I will just ask some supplementary questions.

Could I ask you first to confirm your statement, so could you please turn to page 1 of the bundle and follow that through, if you would, to page 14?

With apologies for pages 3 and 4 being copied at pages 5 and 6, can you confirm that that is the statement which you have prepared and signed in relation to these proceedings?
A. Yes.

Q. Have you had the opportunity recently of refreshing your memory about what happened, by using this statement?
A. Yes.

Q. Do you stand by the contents of this statement or is there anything which you wish to change?
A. I stand by it.

Q. Could I ask you please to turn to page 124 in the bundle? Page 124 is the exhibit sheet and then the exhibit itself starts at page 125 and goes through to page 135. Is that a document which you recognise?
A. Yes.

Q. Is that the report which you prepared for the PCT after carrying out an investigation into Mr Robinson's records?
A. Yes.

Q. Have you had the opportunity to read that recently?
A. Yes.

Q. Again, do you stand by its contents or is there anything which you would change?
A. There is nothing which I would change.

Q. I will ask you a few supplementary questions now. Could you turn, please, to page 2, paragraph 8 in your statement? In paragraph 8 you refer to the Local Optical Committee's sight test framework and you then go on to say that the

> "framework outlines which procedures would be expected to be included in a GOS sight test".

Could you just explain, please, for the benefit of the Committee why such a framework was required?
A. Yes, as I am sure that the Committee realises, the definition of a sight test in the legislation is quite vague and does not specify exactly which tests are – and therefore are not – part of a statutory sight test. So, partly because of the funding issues around the NHS sight test, the LOC in Kent decided – and there were other areas in the country which did something similar – to come to a consensus as to which tests would normally be included in a sight test and therefore which tests would not normally be included. The rationale for this being that if something was not included in a sight test, the practitioner could legitimately charge a private fee for that if they so wished.

Q. Thank you. The next question which I am going to ask relates to paragraph 16 in your statement which is at page 4; could I ask you please to turn to that?
A. Yes.

Q. Paragraph 16 relates to Patient GM and GM's notes are exhibits SB/5 which start at page 136, so perhaps have a marker at page 4 and then have page 136 and following available to refer to also.

At paragraph 16 you are referring to the cup/disc ratios and in that paragraph you refer to your view that this

> "may have been being done 'as if by rote' by Mr Robinson."

And then you say that:

> "This was highlights was in relation to Patient GM where Mr Robinson continued to use this annotation even though it was clear that findings in both eyes were not the same."

I wonder if you could explain to the Committee why you came to that conclusion.

A. Yes, of course. The cup to disc ratio is a measurement which we use when we look at the back of the patient's eye; it is a fairly crude method but the quantification is useful – it quantifies the appearance of the optic nerve. We are all different; we all look different at the back of our eyes just as we all look different from the front. So I found it quite surprising that Mr Robinson had recorded the cup to disc ratio in all 16 patients as being the same as each other and the same in each eye.

If I could just go back a little bit – when I prepared my report I generally looked at the most recent examination only and that is something which I do when I am examining records for the PCT as I feel that it is unfair to go back to records which may be several years old and criticise a practitioner's practice when they have already improved things. So, I generally look at the most recent records.

So, if you look at page 140 of the bundle – which is the most recent record where Mr Robinson had examined this patient, on 9 December 2008, then you can see – I accept that the photocopy is not that clear – that the visual acuity that is recorded – so that is at the bottom at the right hand side of the page – appears to be 4/9 in the right eye – and I think this is domiciliary patient which is why it is not 6 – and PL – which stands for perception of light – in the left eye. So there was clearly a difference there – there is something different between the patient's two eyes. So I then looked at the ophthalmoscopy findings which are on the left hand side of page 140. There, it appears to be noted that there is retinal damage in the right eye – which is the eye with the better vision – and there is no such marking on the retina of the left eye. It looks like it had been written 'clear' on the left eye and that had been crossed through. I therefore looked at the older records to see if I could ascertain what was going on because it seemed anachronistic to have that that way round.

If you look at page 142 – which was when the patient had been seen and I think it was about a year earlier – I cannot quite read the date on this photocopy but I am sure that it was about a year earlier. If you look at the left hand side of that record, you can see that the findings are written down the middle – clear, clear, clear, clear and so on – and a big bracket around the findings says "R plus L" – so that is right and left – and the annotation at the back of the patient's eye, where it says "fundus" – at the bottom of the left hand side of the page – it says "normal" – right and left and the lens is marked clear. That is despite the fact that the patient is still noted as having a visual acuity – given on the right hand side of the record – of 6/9 in the right eye and perception of light in the left eye.

It is clear that this patient has something wrong with their left eye, yet it has apparently has not been recorded on the previous visit and when the patient attended on 9 December 2008 it appears to have been recorded in the wrong eye.

Does that answer your question?

Q. Thank you. Can I ask you please to go to page 18 in your statement, so back to page 4? You are referring here to Patients RA, SC and SF and if you need to refer to their records then they are SB/6 beginning at page 143. In this paragraph 18 you indicate that there is no note of Mr Robinson conducting retinoscopy and I would like to ask you where you would expect to see such a record of retinoscopy having been carried out.

A. Where on the record?

Q. Yes.

A. If you look at the right hand side of page 145, half way down on the right hand side it says RET and under that it says R and L. It does not matter where it is written but on this particular record card that is where I would expect to see it.

Q. What would you expect the record to consist of?

A. I would expect there to be some figures there, similar to the ones that are in the subjective and possibly some annotation of the quality of the reflection which you have when you are doing retinoscopy – not necessarily that – but at the very least I would expect some figures to be there.

Q. Could I take you please now to paragraph 21 of your statement? This is at page 7. Your first sentence,

> "Mr Robinson's recording of the visual acuity was never greater than 6/6."

What – if any – is the importance of that?

A. When you are recording how far a patient sees down the letter chart, you generally record the size of the smallest line of letters which they can read. On most letter charts the smallest line of letter is better than 6/6; 6/6 represents the so-called normal visual acuity. Many people, however, can see better than that and the importance of pushing the patient to read as small as letter as they can is when you are looking at follow up visits and trying to ascertain whether the patient's visual acuity has reduced. The smaller the bottom number, the better their visual acuity is. So, for example, if they could read two lines better than 6/6 – which would normally be 6/4 on most conventional letter charts – and actually the vision had dropped between the time at which you saw them at the visual acuity of 6/4 and it had dropped to 6/9 – which is normally the letter which is immediately above the 6/6 line of the conventional letter charts – then that could be significant. If, at the initial time, you had stopped at the 6/6 line when measuring it, then it would appear – when you saw them the next time and their visual acuity would be 6/9 – then that would appear to be only a more minor change and therefore you might miss a significant reduction in visual acuity in subsequent visits.

That was highlighted in a paper which I referenced which was published in 1989, which highlighted the variability of visual acuity measurements and gave some indication as to when a reduction in visual acuity would be significant for a patient.

Q. The next reference please, is to paragraph 24 within your statement, at page 8 of the bundle?

A. Yes.

Q. You write that:

> "it appears that Mr Robinson did not measure his intra-ocular pressure to check for glaucoma."

Patient WM's notes are at page 150 and following to page 152.

Again, I will ask you the same sorts of questions that I asked before; where would you expect to see a record of the measurement of intra ocular pressure?

A. On page 152 on the right hand side of the record, in the top right hand corner, it says "TONOMETER" and it says "TIME" and there is a space for readings for the right eye and the left eye and I would expect to see some figures there. There were on other records.

Q. In paragraph 26, on page 8 going over to page 9 you talk about Patient JW. That patient's records start at page 153 and onwards.

In the paragraph of your statement, you say:

> "For example in the case of Patient JW it may have been helpful to have conducted a basic field test … to determine whether or not the stroke had affected her sight."

The question that I want to ask about that is whether that is generally the case? Is a basic field test useful for anyone who has had a stroke or is it particular to this particular patient?

A. Visual field tests are useful in several instances. They can be useful in ascertaining whether the patient's eyes are healthy. They are one of the tests which are used to gauge whether a patient has glaucoma. They can also be useful in a patient with known disease – such as this patient who had a stroke – in ascertaining whether it had affected the patient's sight. Whether a stroke affects the patient's sight depends on which part of the brain the stroke affects. It is not uncommon to find that it causes a loss of the visual field which might cause the patient problems doing certain things such as reading or walking about. The reason why I mention it for this particular patient is that it would have been helpful – I believe – to have had a crude idea – and this patient was a domiciliary patient so the level of equipment that is used on a domiciliary visit is not necessarily as sophisticated as that which can be done in practice but a crude visual field test – I believe – I would have been useful in ascertaining whether the stroke had affected this patient's vision so that some advice could be given to the patient as to how to work round that. Just because this patient does have good visual acuity and he or she is seeing 6/9 in both eyes when seen in November 2008 does not necessarily mean that he or she does not have a visual field defect. So I think that would have been useful information; it might not have affected the spectacle prescription that was given but it might have affected the advice that was given possibly for rehabilitation if necessary.

Q. Can we now turn to paragraph 29 of page 9? I think that here you are referring to Patients MC, HD and CP and I will just give you one reference to keep us going; page 27 and ongoing are the records for Patient MC.

At paragraph 29 you say that

> "It would have been useful to have performed a cycloplegic refraction on the three patients."

Again, where would you expect to find a record of such a procedure having taken place?

A. If you look at page 28 for example – the layout of the records is the same for all patients, of course. There is not a specific box that I can see for a cycloplegic examination and that is no surprise – it is not something which we would do routinely on every patient – but I would expect there to be some note of any drugs that were used when examining the patient. That would be for instance, the word 'cyclo' maybe with the percentage used – 1 per cent or 0.5 per cent or something along those lines – with a note of a prescription beside it. So again, figures similar to what you have with the RET on page 28 – you can see RET there, so there would be figures which would be similar to that but with the word 'cyclo' next to it.

Q. Can I take you to the summary section, please, which is at paragraph 48 on page 14?

The first line of that paragraph reads:

> "In conclusion I believe that Mr Robinson's practice was inadequate in several respects"

You then go on to summarise the contents of the statement. You consider Mr Robinson's practice to be inadequate; against which standard did you judge his practice?

A. I was using the LOC sight test framework – these are NHS patients and, as such, we feel that a peer standard which was set by the LOC locally is the most appropriate one against which to judge them when deciding whether the standards required for a general ophthalmic services sight test has been conducted.

Q. Could you tell the Committee how many of these sorts of assessments have you carried out in the last five years – just very roughly? If you have to give a monthly or yearly figure, then please feel free to give that.

A. It varies a great deal. We do practice visits now in Kent – actually I have two next week and two or three the week after but it is quite a busy period; it probably averages out at about once per month but that is a real guess.

Q. I am going to ask you my final question which is a general question; at what level would you put the records which you saw from Mr Robinson within the group of records which you have seen from other people? Whereabouts in the 'league table' would he be?

A. They are some of the worst records that I have seen; that is not so much for their lack of information – although that certainly figures very strongly in that assessment – but because it appears that what is written on them – and particularly with the ophthalmoscopy findings – in terms of that degree of similarity I find very concerning indeed. That is what I largely base my assessment on. I think that his clinical decision making when deciding whether to prescribe spectacles is also shockingly bad in my opinion. You need to be aware of the context and the funding of the optometric sector and the fact that the clinical service itself is under-funded which means that practices have to subsidise their clinical activities by dispensing spectacles.

Q. I have no more questions for you but if you wait there, there may well be some questions from members of the Committee.

Questioned by the Committee

Ms Jeyasingham: Could you just clarify that last statement as I don't think that I quite understood it, Dr Blakeney?
A. The sight test fee does not cover the cost of providing the service; so in order for practices to survive they subsidise their clinical service by dispensing spectacles and other products – contact lenses, solutions and so on. There is always a temptation, therefore, to over-prescribe.

Q. And you suspect that that might have been a motive in this?
A. I have not discussed this with Mr Robinson at all; I have not spoken to him since the initial practice visit that we did many years ago but it is something about which I would want to ask him.

Q. Thank you; I will just check whether there are any other questions?

Ms Hallendorff: Was Mr Robinson the owner of the business or was he an employee?
A. I think that he was a partner.

Q. Was he a partner?
A. I think so; I am not 100 per cent certain on that but I think so.

Q. This may have an influence on how he prescribes?
A. It should not do.

Q. No, it should not do – I am not suggesting for a moment that it should do. Thank you.

Mrs Tilley: Would you expect a cyclo to be carried out on a first visit of a child or a repeat visit because I notice that they were wearing glasses?
A. Sorry?

Q. Would you expect a cycloplegic refraction to be carried out on a first visit as a child or every visit as a child?

A. Not every visit, certainly not every visit; I do not do cycloplegic refractions on every child, not by a long chalk; I think that it depends on the symptoms that the child is having and the clinical findings. My concern was that some of these patients were complaining of symptoms that were unexplained by the refractive findings so I would expect more investigation to be done and that might well have included a cycloplegic refraction. For instance if a patient is complaining of headaches and you find a clinically insignificant prescription then, in my view, it would be helpful to carry out a cycloplegic refraction to make sure that you are not missing a stronger prescription that the child is accommodating.

Q. It is just that in the record to which you refer they were wearing glasses?

A. Yes – but there were other records, there was not just one.

Ms Jeyasingham: I have a couple more questions; how long had Mr Robinson been in practice? Do you recall?

A. I think the Primary Care Trust showed – the date is in my statement at the beginning – April 2002 at Gravesend and January 2004 at North Fleet. I do not know what he did before then.

Q. Right, so it is since 2002. So did you also examine records of other optometrists within that same practice?

A. No, the only records that I examined are the ones which you have in my statement which I did for the report for the PCT.

Q. I just wondered whether there were other optometrists operating in that practice?

A. There were; how often they operated there or whether it was just holiday cover, I do not know.

Q. So he was the main practitioner there?

A. Yes.

Ms Viner: I have a couple of other questions as well please. I am just following up on the question about the cycloplegic refraction asked by my colleague; the patient about which you spoke – and I accept that you said that you looked at other records as well – I think that if my sums are correct that patient was nine years old?

A. You will have to remind me which patient it was.

Q. It was on page 28 I think – it was paragraph 29 of the statement that you had put together.

Mr Hepworth: Page 28 is within the records of Patient MC which I think is the patient about whom you are talking.

Ms Viner: The date of birth is March 1997 and that patient was seen in January 2006 so that makes the patient nine?

A. Eight years old, nearly nine.

Q. Yes, eight years old. So if I can follow up on my colleague's question about whether or not you would expect a cycloplegic refraction to take place and you said that if they had symptoms then you may well want to follow it up.

A. Symptoms that you cannot explain.

Q. Yes; now there is nothing in the history of symptoms box which is another matter completely. I am just wondering, at the age of eight and we do not know what the symptoms were, whether a cycloplegic refraction would have been absolutely necessary? If you have a very, very compliant child who is going to relax his or her accommodation by looking into the distance?

A. My concern on this patient – and there are other examples which are possibly clearer and it may be worth looking at the other ones to which I referred, maybe Patient CP to whom I referred in paragraph 31 but if we talk about this patient for a moment – my concern is that a low prescription was given to this child with no indication as to whether they were having any problems and no indication even as to whether they wear their glasses and that is why I was suggesting that it might be a possibility. I do think that this is probably not the best example and I would maybe use some of the other examples which we have not gone through but I am happy to run through those if that would help. Patient CP, for instance, if we can locate that section.

Mr Hepworth: CP is page 110.

A. If you look at page 111 which is the clinical notes, the symptoms and history says that the "school teacher says struggling focussing on blackboards near" yet the patient's vision is very nearly normal unaided and a very low prescription is found which is +0.25 which is the lowest spherical prescription, as you know, which can be given and that is prescribed and claimed for. That is possibly a better and a more clear cut example.

Ms Viner: Do I take it that the date of birth is 16 April 2002 and that is the patient's age.

A. Yes, six years old. Is that clearer?

Q. Yes that is perhaps a better example of what you were saying.

A. Yes.

Q. You also mentioned the acuity measurements and the sight test charts and the fact that to stop at 6/6 when other lines were available was not a good thing, so can I just ask did you actually see the sight test chart which was being used?

A. I probably did when I went round whenever it was that I visited the practice but this is purely based on examining the patients' records; I did not go to the practice and I did not speak to the practitioner.

Q. Yes and I accept that the majority of charts will have extra lines but just for clarity I wondered whether or not this chart did have?
A. I do not know but I should mention that when I revised the records again last night to refresh my memory, in older visits there some instances of 6/5 being recorded, actually in three patients, so as I mentioned in my statement I only looked at the most recent visit but I can imply from that that the chart must have had a 6/5 line.

Q. And that was in the same practice?
A. Yes, unless he changed it between visits.

Q. Yes, and then the patient with the stroke was Patient JW, is that right?

Mr Hepworth: Yes.

Ms Viner: In paragraph 26 you were talking about the recommendation that visual fields ought to have been carried out?
A. Yes – I cannot remember where the clinical records are of that patient?

Q. They start at page 153.
A. Thank you.

Q. This also highlights the possibility with the record keeping of saying that both eyes were looking identical when actually there must have been a difference?
A. Yes. Actually I think that it was the patient with the macular degeneration that I think particularly highlighted that and that was not this patient, he had good visual acuity, this one.

Q. Sorry, it is on page 157 that there was an indication – and I know that this was a previous visit – and you have mentioned that you only look at the most recent visit.
A. Sorry are we on page 157, so it is the patient with 6/5.

Q. Yes, on page 157 it says in the 'history and symptoms' box it does indicate there that the right was better than the left due to a stroke, I think?
A. Yes.

Q. Although that does not appear to be represented anywhere on the clinical findings there is evidence that the practitioner has inquired as to which eye might be better and how the patient is coping?
A. Again, you would need to ask the practitioner what that annotation meant – when I would be questioning a patient with a stroke I would want to know whether they had a hemianopia which I don't think that that annotation would indicate because it would affect both eyes.

Q. Thank you. The other thing that I would like to ask is that you have explained very well about the financial situation when someone is working in a practice and performing NHS eye examinations and how that does not cover the clinical cost of providing that service. You said – and this could be taken as quite a damning statement – that there is a temptation to over-prescribe and I just wonder where that evidence comes from? Is that in your evidence as an adviser to the PCT that you have seen a great deal of this going on? The temptation is to over-prescribe – as an optometrist I am concerned that my lay members may think that that is what I would do or what my colleagues would do?

A. It is a temptation – I don't think that anyone can deny that. I am also an adviser to the College of Optometrists and I receive queries from colleagues who are concerned that they may be subject to implied or overt pressure to produce sales. I don't think that we should be naïve to the world in which our sector works.

Q. So your evidence comes partly from your work as an adviser to the PCT and partly from your other work in the College?

A. Yes, correct.

Q. Thank you.

A. It should not influence – we all agree that it should not influence – but there is always that temptation there.

Mr Varley: I have just one question; earlier on in your evidence, Mr Hepworth referred you to paragraph 16 in your report and that was about the cup to disc ratio. Mr Robinson had recorded all 16 patients as being 0.2 and identical in both eyes. Now in your experience, statistically, what is the chance of that happening?

A. I am not a statistician.

Q. Nil? 5 per cent? 10 per cent?

A. I would expect that the cup to disc ratio should have a normal distribution – so that is the curve – I know that this will not come out in the transcript. [*Dr Blakeney draws a bell curve in the air*]

Some will be less than 0.2 and some will be more. I believe that the average – and this does depend on the age of the patient as the cup to disc ratio increases naturally as we age – but the average is around 0.2 to 0.3 but that does not mean that everyone is 0.2 or 0.3 because there will be a distribution on either side of that normal.

Q. So what you are saying is that basically he is just putting down the norm and there is no evidence that any measurement has been taken?

A. My conclusion was that, having looked at those patients it was very unlikely that there would be that degree of similarity, a) between patients and b) between eyes: we are not completely symmetrical; many of us have a slight difference in shoe size, in ring size – it is normal to have some difference in many people. That does not mean that the difference is clinically significant for that patient but it should be recorded as a difference. So my conclusion was that either he was not looking or that he was not accurately recording. I do not know which of the two that was.

Q. That's fine, thank you.

Ms Jeyasingham: I have a few more questions following up on my colleagues questions; you said that it may not be clinically significant?

A. Sorry, what might not?

Q. The recording of that?

A. The difference.

Q. Yes, so why is one supposed to record it?

A. So that we know if it changes: it does not matter what the back of a patient's eye looks like, as long as it does not change. That is how we determine normal from abnormal. So if a slight asymmetry is there – providing that stays the same – or even a gross asymmetry, actually – providing that stays the same over time – then that is normal for that patient. Part of the job of an optometrist is to determine whether the patient's eyes are healthy when they see them so asymmetry needs to be recorded so that changes can be ascertained more easily and more quickly later on.

Q. Thank you, Dr Blakeney. I have just one more question: you produced your report and did Mr Robinson see it?

A. I think that it was sent to him; he left the country but I am not sure what the timing was to be honest with you – you would need to check that.

Q. You were obviously not in correspondence and you did not speak to him at all – that is not your practice – you do not go in, records are sent to you, aren't they?

A. Yes.

Q. And you make your assessment of it and then you produce your report?

A. Yes.

Q. So is there no interaction with the practitioner, you do not question them?

A. We do sometimes, it depends on the case. The history of this case is that it went to the PCT's Performance Advisory Group in, I believe February 2009. I presented my report and they agreed that there were issues of concern so that went to the PCT's Decision Making Group a month later and I was not present. That was when the decision was made to refer it to the GOC. So I do not know what correspondence there was with the practitioner. What we normally do is to send them my report and then ask to discuss it with them. I do not how far we went down that route. I know that we did not have that opportunity because he left the country. Whether he received my report and then left the country or left the country before the report was sent, I really do not know but we have not had the chance to discuss it with him at all – either face-to-face or in correspondence.

Q. You would usually expect to talk to the practitioner?
A. Yes, of course, absolutely. You will see from the recommendations in my report to the PCT that the aim is to make the practitioner better – that is the whole reason for doing it, really. The recommendations are there to work through with the practitioner to improve any deficiencies which might be identified in the performance.

Q. Thank you, Dr Blakeney.

Ms Viner: In terms of the selection of the record cards, were these records cards from patients where there was some query by the PCT that an inappropriate prescription had been given? Is that how they were selected?
A. Partly, yes. The PCT identified that there were a number of small prescriptions that had been claimed for – because when the voucher is claimed they come to the payments agency at the PCT and that is how they are identified. I also asked for some other 'normal' records.

Q. So some records that were randomly selected?
A. Yes, absolutely, so it was a mixture.

Q. Right and who would have chosen those random records?
A. Not me; that was done by the Primary Care Agency – they would just pick their names off the claims.

Q. So the practitioner himself would not have offered the cards.
A. No, he would have had no influence in that. We send them a list of patients whose records we would like sent in and we normally photocopy them and send the records back. The practitioner would have no say in that.

Mrs Tilley: At point 18 you say that a retinoscopy or other forms of objective examination were not routinely performed; looking through there is a significant amount of retinoscopy recorded on the records. Do you know what sort of proportion was and was not?

A. I do not, because I only looked at the 16 records; they are the only ones which I saw. In the grand scheme of things there are things that are more important than that, I felt. But again, it is a matter about justifying the low prescriptions – that is what I was looking for evidence for and had difficulty finding.

Q. Thank you.

Mr Ross: Dr Blakeney, you only looked at 16 records, is that right?
A. Correct.

Q. How would you gauge that in terms of a representative sample of the whole of the Registrant's practice?
A. Quite small.

Q. So would you say that it was a fair sample?
A. I think that it was a sample which was sufficient to show that there were some concerns which needed further investigation.

Q. Thank you very much.

Ms Jeyasingham: Thank you. Mr Hepworth, are there any more questions for your witness?

Mr Hepworth: Madam, thank you, I have no questions arising out of the Committee's questions, so unless any member of the Committee has any more questions then I would ask for this witness to be released.

Ms Jeyasingham: Dr Blakeney you can step down.
A. Thank you.

[*The witness stood down*]

Ms Jeyasingham: Usually at this stage, Mr Hepworth, we would move onto closing submissions on the facts. Could I ask for a short adjournment at this stage because I think that our Legal Adviser would like to clarify a few issues?

Mr Hepworth: Yes, of course.

Ms Jeyasingham: So we will break for 15 minutes.

[*Hearing adjourned at 10.53*]

[*Hearing resumed at 11.09*]

Ms Jeyasingham: Mr Hepworth, I think that you were about to make your closing submissions and the facts.

Mr Hepworth: Madam, thank you very much and I will be brief because it was not that long ago that I opened the case.

Madam, can I just add one thing which may perhaps help you when you come to assess how to go about the mechanics of making the decision. Madam, it must be a matter for you but perhaps a helpful way for you to approach the issues will be to decide first of all, where this is an alternative, did the fact occur? If I could use as an example Allegation 2 which relates to those three patients and 2.1 alleges 'a failure to carry out retinoscopy." Madam, you might find it helpful if you decide first of all, in relation to each of those patients separately, has the Council proved – to the relevant standard – that there was a failure to carry out retinoscopy? If you conclude that that has been proved, then I do not think that you would need to consider 2.2, because I think that everyone accepts that if retinoscopy was not carried out then the Registrant could not be expected to have and indeed should not have recorded it. If you find, however, that the Council has not proved that there was a failure to carry out retinoscopy then I would ask you to consider whether there was a failure to record the retinoscopy. In those circumstances then I would ask you to go and consider the alternative. So, start with whether the act did take place and if you find that it did not take place then you do not to consider the record alternative, but if you find that the Council has not proved that the act did not take place then I would ask you to consider the record alternative.

Madam, other than that, I do not think that I have anything that I wish to add unless you have any specific issues with which I can help.

Ms Jeyasingham: Thank you, Mr Hepworth.

Can I now ask our Legal Adviser to offer us advice?

Mr Ross: Thank you; Madam and members of the panel, the panel's task at this stage is to make a finding on the facts and therefore to decide whether the facts have been proved by the Council to the required standard which is the civil standard – in other words, the bounds of probabilities. Is it more probable than not that the facts have been proved. That is the test which has to be applied. The Registrant should not disadvantaged by the fact that he is not here, the proceeding has gone ahead in his absence but that should not be held against him in any way. You have heard the evidence from the expert and you will obviously take that into account. Because she is an expert witness she is entitled to give her opinion on the matters alleged but you do not have to accept her evidence purely because she is an expert; whether or not you accept all or any of her evidence is entirely a matter for the panel.

That is my advice.

Ms Jeyasingham: Thank you. We will adjourn.

[*Hearing adjourned at 11.13*]

[*Hearing resumed at 15.48*]

Ms Jeyasingham: I am going to read out the findings in relation to the facts of the allegation.

DETERMINATION

Findings in relation to the facts of the allegations

The Committee has heard submissions from Mr Hepworth, on behalf of the Council, and accepted the advice of the Legal Adviser. The Committee also took into account the oral evidence provided by the expert witness and the documentary evidence.

The reasons for the findings of fact are as follows:

Allegation 1.1-1.2 – The Committee found that there was no evidence that on the dates in question the registrant failed to perform adequate fundal examinations on patient GM. Whilst the Committee accepted the expert's evidence it noted that she was unable to examine the patient and there was no other documentary proof to show macular damage apart from a referral form which post-dated the dates in the allegation. **Not proved**

Allegation 1.3 – The Committee found that there was no evidence that the Registrant's recording of GM's cup disc ratio was inaccurate. **Not proved**

Allegation 2.1-2.2 – There was no evidence to support the assertion that patients RA, SC and SF were new patients. **Not proved**

Allegation 33.1-3.2 – The Committee found that whilst an ocular muscle balance assessment was not recorded, there was no evidence that an ocular muscle imbalance was a possible cause of the patient's symptoms. In relation to patient TS there were no record cards produced in evidence. **Not proved**

Allegation 4.1 – The record in relation to patient RA for 24 November 2008 clearly indicates that near visual acuity was not measured. **Proved**

Allegation 4.2 – In the light of the Committee's finding on 4.1 it found this particular not proved. **Not proved**

Allegation 5.1 – The relevant patient records at page 108 of the hearing bundle show that there is no recording of an intra ocular pressure check whereas in other elderly patient record cards such a test has been recorded. The Committee therefore found on a balance of probabilities that because there was no record on Patient WM's card, it was more likely than not that the pressure check was not carried out. **Proved**

Allegation 5.2 - In the light of the Committee's finding on 5.1 it found this particular not proved. **Not proved**

Allegation 6.1 – The Committee noted there was no record card available in relation to Patient JW for 26 November 2008 and therefore this allegation could not be proved. **Not proved**

Allegation 6.2 – In the light of the Committee's finding on 6.1 it found this particular not proved. **Not proved**

Allegation 7.1 – There was no evidence that it was necessary to undertake cycloplegic refraction. The expert witness gave evidence that it was not always necessary to carry out cycloplegic refraction on children having previously worn spectacles. **Not proved**

Allegation 7.2 – In the light of the Committee's finding on 7.1 it found this particular not proved. **Not proved**

Allegation 7.3 – There was no requirement in the LOC sight test framework at page 125 of the hearing bundle to test accommodation and no evidence was presented that this test was necessary. **Not proved**

Allegation 7.4 – In the light of the Committee's finding on 7.3 it found this particular not proved. **Not proved**

Allegation 8.1 – The Committee found that there was no evidence that it was inappropriate to issue a prescription in respect of any of the patients included in the allegation. Further, under Section 26(2) of the Opticians Act 1989 (the Act) it is the duty of the optometrist to give a person whose sight he has tested a written prescription. **Not proved**

Allegation 8.2 – In the light of the Committee's finding on 8.1 it found this particular not proved. **Not proved**

Allegation 9.1 – The Committee found that there was no evidence that prescribing spectacles to any of the patients listed in the allegation was inappropriate. Further, in respect of each of the patients, with the exception of Patient SF, their eyesight is recorded as having improved with spectacles as prescribed. **Not proved**

Allegation 9.2 – In the light of the Committee's finding on 9.1 it found this particular not proved. **Not proved**

Allegation 10 – The Committee noted that the only evidence in relation to Patient LG was contained within the expert witness's report to her PCT. No patient record card was produced for this hearing. **Not proved**

Allegation 11.1 – There is no evidence that the Registrant failed to obtain information from patients. **Not proved**

Allegation 11.2 – On the balance of probabilities the Committee found that there would have been some sort of conversation between the Registrant and each patient listed in the allegation but he failed to record this. **Proved**

Allegation 12.1 – There was insufficient evidence that there was a failure by the Registrant to investigate headaches reported by each of the patients listed in the allegation. No record card for Patient CB was produced. **Not proved**

Allegation 12.2 – In the light of the Committee's finding on 12.1 it found this particular not proved. **Not proved**

Mr Hepworth, at this point we usually move on to deficient professional performance. Would you need a little time to consider the issues that have been proved and how to take this forward? I do not know if you need time to do that or if you would like to continue.

Mr Hepworth: Madam, I do not need any time, thank you. I am ready to make my submissions on deficient professional performance whenever you are ready to hear them.

Mr Jeyasingham: Thank you, then we will continue.

Mr Hepworth: Madam, thank you. As we move to the question of whether or not the facts found proved amount to deficient professional performance you leave behind questions such as standards and burdens of proof. When assessing this question it is a matter for the professional judgement of you and your colleagues and the time at which the judgement has to be made is the time of the assessment rather than today.

Deficient means what it says, and it means that it is below the proper standard. That has to be based on a fair sample of the optometrist's work and you heard from Dr Blakeney that she examined 16 records and you will remember the evidence that she gave about how those records were selected. In the Council's submission, 16 records chosen in that way is a fair sample and is enough to give an idea about the general level of practice but not so large a sample that it became unwieldy.

I will of course, respect the expertise which is present within the Committee but the matters that you have found proved – that the Registrant failed to measure Patient RA's near visual acuity despite the patient complaining about this; that the Registrant failed to measure Patient WM's intra ocular pressure, to check for glaucoma despite the patient being elderly and more prone to developing glaucoma and the failure to record information in relation to symptoms and/or patients' histories which he obtained in relation to five patients, Madam, in the Council's submission those are fundamental failings.

I do not think that I need to emphasise to the Committee in particular the need for an optometrist to maintain proper, complete and thorough notes, particularly in relation to symptoms and/or history because of the information that can be gleaned from that.

So Madam, assessment against a fair sample of the optometrist's work – the Council would invite you to conclude that that was done. The standard of practice which that exhibited clearly fell – in the Council's submission – quite a long way below the acceptable standard, so as to render his performance and his practice at the relevant time deficient.

Madam, those are the submissions that I wish to make in relation to the question to deficient professional performance unless there are any issues with which I can specifically help you.

Ms Jeyasingham: Thank you. I will then turn to our Legal Adviser.

Mr Ross: Madam, as you have heard from Mr Hepworth and I totally agree with this, there is no burden or onus of proof on either side in relation to deficient professional performance. Whether or not the facts found proved amount to deficient professional performance is entirely a matter for the professional judgement of the Committee.

Deficient means falling below the standard expected of a registered optometrist and, in relation to his professional performance that must be measured against a fair sample of his work and, providing you bear those two matters in mind, as I said, the matter of whether you find that it does amount to deficient professional performance is entirely a matter for the Committee.

That is my advice.

Ms Jeyasingham: Thank you; the hearing is adjourned.

[*Hearing adjourned at 15.59*]

[*Hearing resumed at 16.22*]

Ms Jeyasingham: I will read out the findings in relation to deficient professional performance.

Findings in relation to deficient professional performance

The Committee has heard submissions on behalf of the Council and it has accepted the advice given to it by the Legal Adviser.

The facts found proved concerned failures to measure visual acuity, intra ocular pressure and failing to record information in relation to symptoms and/or patient history. The Committee was particularly concerned that the failure to record symptoms and history involved five different patients. The Committee considered that whilst only 16 patient records were assessed by the expert witness, on the whole, there was an assessment of a fair representation of the Registrant's practice.

Given the totality of the proven facts and particularly the failures in relation to history taking and obtaining information about symptoms, the Committee found that this did amount to performance below that expected of reasonably competent optometrist.

The Committee therefore found Roger Robinson guilty of deficient professional performance.

In which case we can now move on to impairment.

Mr Hepworth: Madam, thank you. Again, at the impairment stage it is a matter of judgement rather than a matter of proof. The test of impairment – as I am sure you know – is made in the present tense, that is – is the Registrant's current fitness to practise impaired?

In the case of *Cohen v GMC* [2008] All ER 307, a useful test was suggested; it is a three stage test. It is not a formal test but some considerations to bear in mind when you are considering the question of impairment. In terms of the matter which you found proved, the practice which you found proved: is it remediable? Has it in fact been remedied? Is it likely to recur? I will come back to those questions, if I may, at the end of my submission.

The Registrant has not sought to place before you any evidence of his current practice. We understand that he is practising in Trinidad and Tobago but you have before you no evidence at all that his current level of practice has improved from that which was dealt with as part of the assessment and which you have found to have amounted to deficient professional performance.

Could I direct your attention, please, to the one indication that we have from the Registrant which is at pages 275 and 276 in the hearing bundle? This is a letter sent by the Registrant to the Council earlier in the proceedings.

I will draw your attention, if I may, in particular to the last paragraph on page 275, this is where the Registrant talks about what he would do going forward. The steps that he had actually taken were to read two articles on record keeping and he had also read some guidance on making accurate claims. Everything else that he mentions he was either in the process of doing or was going to do in the future. You have no evidence before you that those matters were actually completed. You may be of the view that it may be surprising if he had undertaken further such matters because of course he has practised in Trinidad and Tobago in some time, rather than here and able to undertake the matters that he had raised.

Madam, you found him guilty of deficient professional performance and in the Council's submission you have absolutely no evidence before you today that his practice is anything other than deficient today because you have had no evidence placed before you that he has improved his practice.

So to come back to the three questions which I posed: in terms of the practice that he exhibited, was it remediable? I think that the answer to that has to be that yes it was, because it is about failings in practice and such failings – unlike perhaps, deep set personality issues, are capable of being remedied. The second question is whether that practice has in fact been remedied? You have no evidence to allow you to answer that question affirmatively. There is no evidence to suggest that the defects have been remedied. Is such practice likely to recur? In the Council's submission the answer to that question must be yes. His practice was deficient when assessed; you have no evidence that the practice has been improved, so the logical conclusion is that it is likely to recur. You have no evidence that lessons have been learned, that insight has been shown or that remorse has been shown; you have had no evidence of those things which might allow you to answer that question in a different way.

Madam, I suppose that the last point that I have made and I repeat it, probably unnecessarily, but for the sake of completeness – he has practised in Trinidad and Tobago for some time so you do not have confidence about his competence to practise in the UK with all the various requirements that the UK has. I have to admit that I do not know what sort of requirements there are for somebody working in eye care in Trinidad and Tobago and you have not had that information provided to you by the Registrant.

Madam, those are the submissions that I would seek to make and I have nothing else to add unless you have any specific questions with which I can help.

Ms Jeyasingham: Thank you, Mr Hepworth. I now turn to our Legal Adviser.

Mr Ross: Madam, at this stage you have to decide whether as a result of being guilty of deficient professional performance the Registrant's fitness to practise is currently impaired. As with deficient professional performance there is no burden of proof of either side and it is entirely a matter for the professional judgement of the Committee. The Committee should bear in mind at the forefront of its consideration that it has a public duty to protect the public and the public interest includes not only patient safety but also upholding the reputation of the profession and declaring and upholding proper standards of conduct and performance. It is accepted that the deficient professional performance is remediable; the question is whether there is any evidence that it has been remedied. In relation to that I would urge you to re-read the Registrant's letter which is in the bundle and also have regard to the fact that it is also accepted that the Registrant has been in practice in Trinidad and Tobago for some time. The question therefore would be whether there is evidence that the deficiencies have been remedied and are they highly unlikely to be repeated and again these are entirely matters for the Committee's assessment. That is my advice to the Committee.

Ms Jeyasingham: Thank you, Mr Ross. We will clear the room for our deliberation. We will be coming to the end of the hearing for the day at 5 o'clock but if we do come to a decision we will tell you before that time.

Mr Hepworth: Thank you, Madam.

[*Hearing adjourned at 16.32*]

[*Hearing resumed at 17.18*]

Ms Jeyasingham: I am going to read out the findings regarding impairment.

Findings regarding impairment

The Committee has heard submissions on behalf of the Council. It has accepted the advice given to it by the Legal Adviser.

In considering the question of impairment the Committee has taken into account the following facts: first, the limited number of allegations found proved; secondly the Registrant's letter dated 23 June 2009 in which he has shown remorse and insight into his deficiencies by his acceptance of the allegations and his steps both taken and intended to improve his performance; thirdly the fact that it is accepted that the Registrant has practiced for some time in Trinidad and Tobago. The Committee, in considering these factors, did not consider that the Registrant posed a current risk to patients or that public confidence in the profession would be undermined to any appreciable extent by his deficient performance.

It was also accepted that the deficient performance was remediable. The Registrant's letter of 23 June 2009 demonstrates that some remedial steps have been taken and will continue to be taken.

In the circumstances the Committee found that the fitness of Roger Robinson to practise as an optometrist is not impaired.

Warning

However, the Committee has decided that it would be appropriate in this case to issue a warning regarding his future performance. A warning will be placed on the Registrant's registration for a period of 5 years; this period is necessary to maintain confidence in the profession and maintain standards. The Registrant's performance fell short of that of a reasonably competent optometrist and he should strive to improve his professional performance.

Revocation of interim order

The Committee hereby revokes the interim order for suspension of registration that was made on 5 September 2011.

Are there any further matters?

Mr Hepworth: Madam, no thank you.

Ms Jeyasingham: I declare that the hearing is now closed.

[*The hearing concluded at 17.21*]