



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

**F(10)16**

**GENERAL OPTICAL COUNCIL  
AND  
ROGER JOHN STAITE (01-7953)**

**Tuesday, 17 May 2011  
SUBSTANTIVE HEARING**

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**SUBSTANTIVE HEARING: ROGER JOHN STAITE**  
**Tuesday, 17 May 2011**

Fitness to Practise Committee: Lady Margaret Wall – Lay (Chair)  
Ms Mercy Jeyasingham MBE – Lay  
Mrs Corinna Kershaw – Lay  
Professor Nizar Hirji – Optometrist  
Mr Stephen Reily – Optometrist

Legal Adviser: Mr David Marshall

Hearings Manager: Mr David Henley BEM

For the Council: Ms Margaret Bromley

For the Registrant: Ms Jane Mishcon

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*[Hearing commenced at 09.38]*

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

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

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

All parties are reminded that where details of a patient are to be discussed, that patient has been allocated the letter 'A' in the allegation, and the patient should only be referred to by that letter. Where the patient's name is

mentioned in the course of the hearing, the transcriber will delete the name from the transcript and replace it with the words "Patient A" or "the patient".

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

The matter today has been listed as a procedural hearing, but I understand the parties have agreed that it can proceed directly to a substantive hearing. So, unless anything has changed, I shall announce the procedural hearing as having commenced and now we go to the substantive element of the hearing. Are there any comments on that? [*Agreed*] Are there any applications to be made?

**Ms Bromley:** Perhaps it would be appropriate at this stage to mention a couple of points in respect of the allegations. If you have the list of allegations in front of you, you will see that allegation 1.a is set out in the alternative in that it says: "you did not adequately investigate Patient A's history, presenting symptoms" etc "or in the alternative did not record such investigations". Mr Staite has indicated in his response that he admits that he did not record such investigations, and the Council are happy to proceed accepting that admission and not, therefore, pursuing the "did not adequately investigate", if that is clear? In respect of 1.c which is "measure Patient A's intraocular pressure", Mr Staite has said that he did measure it but did not record it. Obviously, the failure to record is not alleged but the Council are happy to accept that he did measure it, so that is not being pursued.

**Mr Marshall:** Ms Bromley, are you going to amend?

**Ms Bromley:** Effectively. We are offering no evidence in respect of those two aspects.

**Mr Marshall:** That is only part of 1.a?

**Ms Bromley:** Part of 1.a, yes.

**Mr Marshall:** So as far as the semi-colon?

**Ms Bromley:** Correct.

**Mr Marshall:** And as far as the other amendment?

**Ms Bromley:** It is 1.c.

**Mr Marshall:** To delete entirely?

**Ms Bromley:** Yes.

**Lady Wall:** And you are not substituting anything for it?

**Ms Bromley:** No, those are my instructions.

**Lady Wall:** And b. stands?

**Ms Bromley:** Correct.

**Mr Marshall:** Madam, the Committee has a power under Rule 34 to amend if you are satisfied that it is just to do so.

**Lady Wall:** In those circumstances, we shall amend. Are there any further amendments? Just that. Are there any applications to be made?

**Ms Bromley:** No.

**Ms Mishcon:** Not from me.

**Lady Wall:** I should also ascertain whether there are any health matters to be discussed at the hearing. Although it is not on my script, I shall invite members of the Committee to make certain disclosures.

**Mrs Kershaw:** I know one of the testimonial witnesses, Tecwyn Jones.

**Ms Mishcon:** I should probably ask whether that makes any difference to Mr Staite.

**Mr Staite:** I have no objections at all.

**Professor Hirji:** I know the expert witness, Dr Harper.

**Ms Mishcon:** I don't have any objection to that.

**Mr Reily:** I know this witness.

**Lady Wall:** Right, so those are full disclosures.

**Mr Marshall:** As far as full disclosure, the Panel should indicate in a little more detail how they know someone. There is a difference between knowing someone professionally and as a close personal friend, for example.

**Mrs Kershaw:** Tecwyn is not a close personal friend. I have met him on two occasions and had a one-to-one conversation with him. I live in West Wales and we were at the same occasion where he was speaking.

**Professor Hirji:** Dr Harper was an employee of another organisation of which I was a Director some 10 years ago and, subsequently, he has been a professional colleague and I would say not a close friend but a friend.

**Mr Reily:** The expert witness is a fellow examiner of the College.

**Lady Wall:** Are there any objections?

**Ms Mishcon:** We have accepted the report of the expert and I do not think that, unless Mr Staite has any objections, we would have any objections to that at all.

**Lady Wall:** Thank you. So there are no more preliminary matters to be discussed before we embark on the substantive hearing. Before we do embark on the substantive hearing, may I invite the parties to explain to the Panel how they wish to proceed in this case, given some of the detail that is in the bundle?

**Ms Bromley:** Perhaps if I go first. As you will hear, Mr Staite is admitting all the allegations now that those amendments have been made, and he admits misconduct. He does not admit impairment. I propose to summarise the important facts for you, bearing in mind it is admitted, because we still need to make findings of fact. I shall address you on misconduct, because you still need to make a finding of misconduct. Then we would move on to the impairment stage but, to some extent, I am in your hands, bearing in mind that the first two stages are admitted, so I am happy to condense them into one if that suits the Committee?

**Lady Wall:** The first stage is admitted.

**Ms Bromley:** Misconduct is admitted.

**Lady Wall:** Yes, but that is part of stage one. What would you like to say, Ms Mishcon?

**Ms Mishcon:** We do admit the allegations. The only thing I would say, which does not change the admission at all, is to point out in 2.b that we fully accept that Mr Staite did not “seek advice on the urgency of such a referral”. It goes on to say: “despite Patient A’s recorded presenting symptoms, her pre-disposition to retinal detachments as a result of being very myopic and your own findings”. It says including the results of the visual field test. The only thing that I would say about that is that, although he accepts responsibility for the fact that he did not see it, Mr Staite did not see the visual field test on 11 February. That is the only comment that I would make about that. Apart from that, he does accept that there were things he should have done that he did not do and that they are capable of amounting to misconduct. Therefore, we are, to a certain extent, in your hands as to how you want to deal with the first stage. As far as we are concerned, we are here to argue whether or not his fitness to practise is impaired.

**Mr Marshall:** Rule 50 of this Committee’s Rules contemplates a single stage, encompassing facts, misconduct and impairment. However, in accordance with the guidance from the courts, the practice of this body is to divide that into three stages. First of all, you make a finding as to whether the facts contained in the allegation are proved. Secondly, you make a discrete finding as to whether, as a matter of judgment, those facts amount to misconduct. Thirdly, you consider whether there is impairment by reason of that misconduct and, if so, you move on to a fourth stage of sanction. My advice

is that you should follow that procedure, particularly if there is any concern about the extent to which matters are admitted. Things may proceed more quickly than in a fully contested case but I suggest you follow each of those stages. If there are in a moment clear and unequivocal admissions to each of the facts set out in the allegation, it would be sufficient for the Committee to accept that those facts have been proved, although you still need to hear evidence to understand what the case is about. I am not suggesting that you necessarily need to retire and produce a written determination on the facts if the admissions are entirely unequivocal.

**Lady Wall:** Thank you. Does anyone have any comment on that? [*no comments*]  
Thank you, that is the procedure that we shall adopt following the advice of our Legal Adviser. Would you like to present your case?

**Mr Henley:** Madam, shall I read the allegation first?

**Lady Wall:** I am sorry, yes.

**Mr Henley:** Do you want me to read it as amended?

**Lady Wall:** As amended, yes, please.

**Mr Henley:**

### **Allegation**

The Council alleges that the fitness to practise of you, Roger Staite (a registered optometrist) is impaired in that:-

1. During a consultation with Patient A on 11 February 2009 you did not:-
  - a) In the alternative, did not record such investigations –

**Ms Bromley:** I am not sure that makes sense.

**Lady Wall:** No, I don't think it makes sense either.

**Ms Bromley:** I think you would have to say that you did not record –

**Professor Hirji:** You would have to say Patient A's history and presenting symptoms.

**Ms Bromley:** So instead of "adequately investigate" say "did not record".

**Lady Wall:** I think you should make it absolutely clear, because initially we were asked to erase certain allegations.

**Ms Bromley:** Yes, but, unfortunately, it then says "did not cause such investigations" which we have just deleted which wasn't very sensible. It

might make more sense to put “did not record Patient A’s history and presenting symptoms” – is that alright?

**Lady Wall:** This is very important that we have the allegations absolutely clear. Would you like to retire for five minutes to clarify them?

**Ms Mishcon:** I could make a suggestion.

**Lady Wall:** I think that you should retire to get it clear, because we are going to read all of this into the transcript and we do not want any double negatives.

*[Hearing adjourned at 09.52]*

*[Hearing resumed at 10.17]*

**Lady Wall:** We now have a new copy of the original allegations. This copy before us contains the amendments. However, it also contains 1.c the Council offers no evidence, which the Committee do not think is an allegation. Therefore, we shall put a line through it because it is meaningless. On that basis, we shall ask Mr Henley to read it out.

**Mr Henley:** I am sorry, Madam Chairman, perhaps you should first announce that you have agreed to those amendments.

**Lady Wall:** We have had an opportunity to read the amendments and now they are much clearer and we shall proceed on that basis, so we have agreed them.

**Mr Henley:**

### **Allegation**

The Council alleges that the fitness to practise of you, Roger Staite (a registered optometrist) is impaired in that:-

1. During a consultation with Patient A on 11 February 2009 you did not:-
  - a) Fully record Patient A’s history or the investigations you carried out;
  - b) Perform a dilated examination of Patient A’s left retina.
2. Following your examination of Patient A on 11 February 2009 you did not:-
  - a) Refer Patient A as an emergency on the same day to an ophthalmic unit for ophthalmic assessment; or, in the alternative,
  - b) Seek advice on the urgency of such a referral

despite Patient A’s recorded presenting symptoms, her pre-disposition to retinal detachments as a result of being very myopic and your own findings.

3. During a consultation with Patient A on 16 February 2009 you did not:-

- a) Refer Patient A as an emergency on the same day to an ophthalmic unit for ophthalmic assessment.

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

**Lady Wall:** Thank you. This document is to be referred to as C1. Now we are proceeding to the admission stage. I do know whether the registrant or the registrant's representative will respond to this but are any of the facts set out in the allegation admitted?

**Ms Mishcon:** Madam, they are all admitted as amended, other than the fact that the registrant's fitness to practise is impaired.

**Lady Wall:** Thank you and, on that basis, would you like to present your case, Ms Bromley?

**Ms Bromley:** Mr Roger Staite is an optometrist registered with the Council and the allegations which he has admitted arise from two appointments between Mr Staite and Patient A on 11 and 16 February 2009. Patient A attended at Dollond & Aitchison on 11 February 2009 complaining about a half-moon of darkness appearing in her left eye, and this is noted on the record card which you will find at tab D, page 55. The record comprises pages 55 and 56. You will see on page 55 at history & symptoms: "a half moon of darkness appearing in left eye" and various other notes about blood pressure and uncle has tunnel vision. There are no other notes recorded as to questions regarding how long it had been there, for example, whether it had come on suddenly or any other record about the questions that Mr Staite asked Patient A. In her letter of complaint, Patient A –

**Lady Wall:** Can we just go back to that pre-screening eye-test. There is no name, age and date?

**Ms Bromley:** It is on the previous page 54 where it shows surname and other details. There is a slightly better example at tab B pages 33 and 34, where it has been copied in a different way, it is landscape rather than the other way round, which gives you a better idea.

**Ms Mishcon:** The originals are here if anyone wants to see them.

**Lady Wall:** That would be very helpful. [*Original records handed to the Committee*] This does not seem to be signed. Is it accepted that this is Mr Staite's handwriting?

**Ms Bromley:** He can no doubt give evidence about it.

**Mr Staite:** It is.

**Ms Bromley:** As I said, the copies at pages 33 and 34 give a slightly better impression as to how it appears in real life. At tab B page 21, you have Patient A's letter of complaint to the GOC, which was made on 23 October 2009, some months after she had seen Mr Staite. In her second paragraph, she refers to going to see him on 11 February 2009. She says:

"I explained that I had a gritty feeling in the eye and that a half moon shadow appeared in the corner of my eye. I was given the advice that there was nothing wrong with my eye except the glands in my eye-lid were altering due to my age (I was 49 at that time) and the medication I was taking. Within a few days I had lost 90% of my vision in that eye."

Referring back to the notes of that visit, he records the half moon of darkness, as we have seen, but he does not refer to the gritty feeling. In the first examination on 11 February, Mr Staite undertook most of the core elements of a regulation eye examination and he noted the presence of a large floater, which is noted on page 34 in the top right, where it says "large floater", something that he picked up and recorded. However, he did not undertake a dilated examination in the left eye, which is something that he admits. He did request a visual field test which is on page 36 in tab B where we have the visual field test of 11 February 2009. The test for the left eye shows defects in the top quadrant. It is Mr Staite's case, which has been accepted, that he did not review that on 11 February, he accepts that he should have done and, indeed, had he done so, it would have been more likely that he would have made an emergency referral because of what is shown in that visual field test. It is a matter of great concern that, having had the visual field test done, he then does not review the results on the day.

Patient A is then sent away and told there is nothing to worry about. She comes back again on 16 February 2009. There is no record card for this visit, which is again accepted, but it is apparent from her records, particularly at tab D page 59 that she was referred. You can see about four lines down, it says: "Prescription details from current sight test" and the date 16 February '09 is inserted, which indicates that she was seen on that date and that is the only record of it. Under the heading "Points requiring attention" in the first line it reads: "... but now complains of a shadow across the upper field of view in this eye. Field test shows a large area of field loss in this left eye - see enclosed chart. Query shallow detachment? A specialist exam as a matter of some urgency is recommended". It is dated 17/2/09 so it is not until the next day that he notes this referral, and this is a referral to the GP and not to an eye hospital or A&E. The visual field test that was referred to and is enclosed with that is immediately afterwards at page 60. It shows the loss in the upper half. So the referral is not sent until 17 February, it is not received by the GP practice until two days later on 19 February, and that is at tab E page 76. This is a slightly clearer copy of the document we just looked at and has Mr Staite's stamp in the box and it has a receipt stamp of 19 February.

Patient A is then referred on to Mr Barr who is a consultant ophthalmologist at the Aberystwyth Eye Centre. She is not seen by him until 11 March 2009 which is at page 78, and this is a letter from Mr Barr to Mr Davies, a

Consultant Vitreo-retinal Surgeon at Singleton Hospital, Swansea. He refers there to having seen Patient A on 11 March and refers her on for specialist advice. He refers there to the fact that he had lasered the right eye.

**Ms Mishcon:** Could I ask that one other page is put in, and that is page 80. It shows that she was seen as an urgent consultation despite it taking so long.

**Ms Bromley:** That is page 80 which is the report back to the GP from Mr Barr: "This patient was seen as an urgent consultation". So it has taken a bit of time to get from the GP to Mr Barr.

**Lady Wall:** Do we have the date of the GP's referral to Mr Barr?

**Ms Bromley:** We don't. To some extent, that is outside the control of Mr Staite.

**Lady Wall:** Nevertheless, for completeness.

**Ms Bromley:** Unless it is somewhere in these printouts which I find very difficult to read, no, I do not off the top of my head. Someone is saying page 120. That is the referral from Mr Staite to the GP.

**Lady Wall:** No, the GP is down below.

**Ms Bromley:** There is a date of 20 February, so he refers it on the day after receiving it, and she is seen on 11 March. Patient A at that stage was diagnosed with a left retinal detachment and right eye peripheral retinal changes requiring laser treatment and that can be seen from the letter to which I have just referred you at page 78:

"Examination revealed a complete posterior vitreous detachment on the left with a sub-total bullous retinal detachment, macula off and two large retinal breaks at 3 o'clock and 9 o'clock."

Patient A was then referred to Singleton Hospital for treatment of the left retinal detachment and for the intraocular pressure. I believe she was managed at the Aberystwyth Eye Hospital for the intraocular pressure. She was first seen at Singleton Hospital on 1 April which is tab E page 82, a letter back from Mr Davies to Mr Barr, setting out the findings:

"... was found to have a total detachment when seen by you in clinic ... I confirm your findings of a total detachment in the left eye with some inferior tears and there was some cloudiness of the vitreous and some rigidity in the retina, which suggests some PVR formation. I have discussed the possibility with her of surgery ... I have given her a guarded prognosis, but arranged to admit her in the next few weeks for surgery."

She underwent surgery for the first time on 16 April, and at tab G page 152 there is a letter from Patient A to Mr Davies advising him of the outcome of her visit. She sets out her own summary of her case. She has been suffering

from constant headaches: "Inflammation of the eye had NOT improved". She concludes by saying:

"I am still very concerned that after 6 weeks my eye does not seem to be getting any better - additional problems such as the pressure and inflammation is not helping matters."

So she is obviously having a very unpleasant time. Then she underwent a further operation on 18 June, which is on page 151, a letter to Dr Nicholls which states:

"This lady had left eye removal of silicone oil and cryobuckle applied to the left eye on 18<sup>th</sup> June 2009. Today she presented with raised intraocular pressure in the left eye."

and it sets out the medication that she was on. She has since had to undergo further surgery which is at tab F. This is now in September 2009:

"I took her back to theatre yesterday to wash out some residual emulsified oil and a persistent bubble of oil in her posterior chamber. Post-operatively she still has a pressure of 24 despite using multiple glaucoma drops."

It sets out the ongoing problems.

"In view of the distance involved, I think this could better be managed locally and wonder whether she could be reviewed in the near future in Bronglais."

I believe she lives closer to Aberystwyth and was having to travel to Swansea for these operations.

That is a brief summary of the facts and treatment of Patient A. Next, I propose to take you to the expert witness report of Dr Harper, which is at tab C. This is agreed. Dr Harper is here and perhaps it would be appropriate if I were to put him in the witness box and take you to the report so that, if you have any questions for him, you can ask him those questions.

**DR ROBERT HARPER, called and affirmed  
Examination-in-Chief by MS BROMLEY**

- Q.** Dr Harper, you should have a bundle in front of you and at tab C, page 38, can you confirm that is your report dated 4 August 2010?
- A.** Yes, I can confirm that.
- Q.** And it was prepared in connection with these proceedings?
- A.** Yes.
- Q.** You set out on page 40 your CV and your expertise. Can I take you, first of all, to the section headed Opinion which is on page 43? You are asked there,

“Whether it is likely that the detachment in [Patient A’s] left eye was present at the examination on 11<sup>th</sup> February 2009”, which was the first attendance. You conclude there that it is likely that the detachment was in fact present on 11 February, is that right?

**A.** Yes, that is correct.

**Q.** The visual field test on 11 February you refer to part way down. We have heard from Mr Staite that he didn’t in fact review it on 11 February. In terms of practice within an opticians, would you expect a visual field test to be reviewed on the day it is done?

**A.** Yes. The test is undertaken for a purpose which may be often times to try to screen or case find for a separate condition that is not the topic of today’s case, and that is glaucoma, which is the primary reason why the test would be undertaken. There are other cases where a visual field test will be undertaken because the patient has some symptoms, so in this case a visual field test has been undertaken. However, it would be expected that the results of the test would be passed through to the optometrist to allow them to inform their management of the patient.

**Q.** Can we turn to the visual field test which is on page 58, do you have that?

**A.** Yes.

**Q.** This was done on 11 February 2009 and you deal with this in your report. Can you just explain what is shown by the visual field test?

**A.** Page 58 shows the result of the visual field test in both the right eye and the left eye, and the result for the right eye shows that the patient saw all of the feint lights presented to them. However, the result for the left eye indicates that the patient had a loss of sensitivity in the upper part of their field of vision, so towards the top part of the area that they were looking at. This left eye is amblyopic, it is a lazy eye, it does not see so well since childhood, so one would expect that eye not to see quite as well as the right eye. That is evident in terms of the visual acuity of the patient but, as far as the visual field test, there is a preferential drop in sensitivity of the patient in the upper part of the visual field test result.

**Q.** We know she had complained of a half moon of darkness, does that marry up?

**A.** Yes, I believe that the findings of the visual field test are not inconsistent with the patient’s presenting symptom of the half moon of darkness in the left eye.

**Q.** Coming back to your report at page 44, at the to you comment about the fact that Mr Staite had noted the presence of a large floater. How much weight should that have carried in terms of concern about the detachment or prompting further tests?

**A.** The primary symptoms of a retinal detachment are the sudden onset of flashes and floaters and then visual disturbance, variously described as a shadow or curtain coming across the field of vision. There are other explanations for the presence of floaters, these are debris in the gel of the eye behind the lens, between the lens and the retina at the back of the eye. Most people in this room will have floaters they will be aware of, perhaps when on

holiday looking at a bright sunny sky, so a brightly-lit uniform background. So floaters are a common occurrence which can be benign and innocuous. In the event that the vitreous gel comes away from the back of the eye, there can be a sudden onset or change in the appearance of floaters, which can be a cause for concern, and should alert an optometrist to assess for the possibility that the patient has a retinal detachment.

**Q.** On page 44 of your report, you say in the middle of the final paragraph:

“It would have been expected that an average competent optometrist would have possible retinal detachment on their clinical “radar” when faced with such a presentation.”

I presume you stand by that?

**A.** Yes. It is fair to say that the primary presenting symptom which Mr Staite has documented on his record card of a half moon of darkness appearing in the left eye, that is a symptom that should alert an optometrist immediately as to the possibility of retinal detachment and merit further questioning, and highlight the need to undertake a more detailed examination of the patient to exclude the possibility that the primary presenting symptom is one that could be caused by a detachment.

**Q.** Other examinations would have included a dilated examination, is that right?

**A.** Yes, a dilated examination would have offered the optometrist a better view of the retina and the vitreous in front of that, and would have given a greater opportunity of detecting the problem had there been one. However, a dilated examination may not have been necessary had the optometrist felt that they had detected an abnormality that merited referral without the need to dilate the patient. Therefore, it is not that dilation was essential but, in the absence of detecting a problem and with that symptom, it would have been indicated.

**Q.** Are you saying that either you do the dilated examination, or you make the urgent referral but you don't do nothing?

**A.** Yes, if one can see an abnormality without dilating, the dilation is not necessary. The dilation becomes necessary with a worrying symptom like that in the absence of you detecting any explanatory finding to account for the symptoms.

**Q.** Okay, thank you. Finally, at page 47 of your report in the summary, you say in your final sentence:

“In my opinion, the actions of Mr Staite in his dealings with [Patient A] fell well below the standard expected of an average competent optometrist.”

That remains your opinion?

**A.** Yes. On the basis of the absence of following up on the primary presenting symptom and on the basis of failing to make an emergency referral for this patient, yes.

**Q.** Thank you very much. I have no further questions. I don't know whether there will be any cross-examination for you.

**Ms Mishcon:** I have no questions.

### Questions from the Panel

**Professor Hirji:** Good morning. I would like to take you to the record card on page 55. I note that in your report, you have made no reference to an afferent pupillary defect, which might have been present at the time of the initial visit. Looking at the record card, would you say that suggests that particular aspect of the examination was not conducted?

**Ms Bromley:** Sorry, I did not quite catch the question?

**Professor Hirji:** Dr Harper's report mentions additional tests or tests that really would have given evidence of a presence or absence of detachment, but he has not mentioned the fact that there is no pupillary response recording on the first visit. I wonder what his view might have been in terms of whether this would have been a useful piece of information to have at the outset.

**Mr Harper:** Yes, I would agree with that. The presence of a left eye pupil defect would have added further evidence as to the likelihood or otherwise of a retinal abnormality. In that sense, that test would have usefully been included as part of this examination, I agree.

**Q.** If you turn to page 80 of the bundle, you will see that the ophthalmologist report from Dr Barr mentions that there indeed is a fairly significant left afferent pupillary defect? You are in agreement with that?

**A.** Yes.

**Q.** Thank you.

**Mrs Kershaw:** Could I take you to page 82 which has been referred to though it is not within your report? It is the last two sentences in which I am particularly interested:

"I have discussed with her the possibility of surgery and she has decided that she wishes to have an operation on the left eye in an attempt to flatten the retina and improve the vision. I have given her a guarded prognosis but arranged to admit her in the next few weeks for surgery."

Could you tell us a little more about that stage of decision-making?

**A.** I can try to do so. I ought to qualify my opinion here. I am an optometrist and not a retinal surgeon. My understanding is that here is a patient who has an amblyopic left eye that already has poor sight, and the retinal detachment was a total retinal detachment involving primarily the inferior retina but also what is known as the macula, so the central part of the retina had detached. The prognosis in these cases is always much poorer in so far as the surgical

outcome. It sounds like a dialogue had taken place between the patient and the surgeon in so far as the prospects for improvement in vision post surgery, and that a decision was reached to go for surgery but that dialogue had become more balanced in terms of risks and benefits than might otherwise be the case in an eye that had (a) good vision at the outset and (b) had presented earlier with a less substantial detachment, and where the macula had been on in the first instance as opposed to what is known as a macula off retinal detachment. That is my understanding of the comments in the letter there but I would go back to my opening comment that I am not a vitreo-retinal specialist, and that is a qualified view of an optometrist so far as my understanding of those elements of the letter.

**Q.** Thank you very much.

**Ms Jeyasingham:** I would like to ask you about the urgency and emergency. You say in report under 5.7, the last paragraph:

“The College of Optometrists’ recommendation on referral urgency in relation to a retinal detachment” –

There were some symptoms in this case. In that case, what would you have expected to see on 11 February when symptoms first arose? It is really to understand the difference between the urgency of referral.

**A.** This patient presented with a sudden onset symptom that falls within the spectrum of those that might arise with a patient suffering from a recent onset retinal detachment. In that scenario, I would expect an optometrist, if they had detected the retinal detachment, to have made the same day an emergency referral. Emergency is defined within 24 hours, so it may well be the case that, if a patient presents to a practice late on in the day, emergency would still be covered by the next day. It would probably be fair to say that an optometrist, when faced with a scenario like that, would send the patient immediately to the local A&E ophthalmic unit.

**Q.** So that is what you would have expected.

**A.** An alternative would have been to make a phone call to the local unit to discuss the findings, and to seek the advice of whomever was triaging referrals on the day. That might have resulted in a dialogue between the primary care practitioner and the hospital in terms of the appropriateness of the referral given the findings.

**Q.** So advice would have been sought?

**A.** That is an alternative that could have been to seek advice on the day.

**Q.** In this case, an emergency 24-hour referral was not made but on the 16<sup>th</sup> a referral back to the GP was made as a matter of some urgency. There seems to have been quite a long delay. Is there something on the referral form that one would expect to make to the GP to speed that up? It does say emergency on the form.

**A.** It says “with some urgency” I believe on the GOS18 referral form. It probably would have been most appropriate for the patient to be directed towards the local casualty unit with that letter, and a copy sent to the general practitioner.

**Q.** So with a retinal detachment, the delay makes prognosis poorer?

**A.** Yes, indeed.

**Q.** Thank you.

**Lady Wall:** Are there any questions arising from that?

**Professor Hirji:** I have one more. Following what one of my colleagues asked you earlier on, with respect to the guarded prognosis that was given to her, if you turn to page 126 I want you to confirm what is written there, and perhaps expand on it if you have a view. You will note that the left eye visual acuity is down to perception of light. If I can get you to turn over post-surgery on page 136, in the letter from the ophthalmologist who did the repair, Mr Davies, he suggests that it has improved to counting fingers. Also in that particular letter, it says immediately after surgery repair, it was 6/60 which is where she was originally, if you remember, when she attended the practice.

**A.** Yes.

**Q.** Then it reduced down to counting fingers. Have you any thoughts about how this happened?

**A.** I had not considered that before you asked the question. It is a possibility that there is some oedema, some fluid accumulation on the retina that is causing a variation in her vision. It is also possible that counting fingers with a sore, inflamed eye is not so very far removed from 6/60 which is the top letter of the conventional letter chart. Therefore, to some extent, the variation or reliability of the visual acuity measurements at these moments is perhaps not always ideal. That is another possible explanation that it may not be a genuine change in visual acuity.

**Q.** In conclusion, Dr Harper, would you say that the surgery has been somewhat successful?

**A.** Yes, both in terms of the vision aspect but also I think the surgeon would say that it has been successful if the retina is flat, because it is not just a question of the straight-ahead vision on the letter chart. It is also a question of her field of vision which, even with the poorer eye, is very useful for patients in terms of navigation, orientation and mobility.

**Q.** So in the existing amblyopic eye, what would you say the overall result in your opinion is for this particular patient?

**A.** It has been a success for her given her starting point. A retinal specialist would feel that this has been a successful outcome.

**Q.** Thank you.

**Mrs Kershaw:** In relation to the urgency of her being referred, and then presumably the urgency was maintained to do something about the situation, I would like

to take you to page 67, about two inches down from the top of the page there is an entry for 25 March 2009 which reads: "vitreous detachment v anxious that appt in Singleton is in another week, thought it was more urgent, will ring eye clinic to reassure". Do you have any comment to make on the timescale involved in her wait for the surgery, and its impact if any?

**A.** The patient is anxious and anything that has happened to this patient by way of delay post-referral by Mr Staite once the GP has received his referral, on I believe the 19<sup>th</sup> which was the date of that stamp, there have been a number of other delays. Part of that may have related the perceived urgency of the case on the part of the communication between the two ophthalmologists. I believe Mr Barr saw the patient in Aberystwyth on 11 March, and it was the next month, I believe, before surgery was carried out by Mr Davies. Therefore, the initial assessment on presentation in Aberystwyth has guided the specialist consultant's decision not to treat it as an acute episode in that sense of meriting urgent surgery. He presumably had concluded that the prognosis would be the same or very similar in the event of a delay of a few more weeks based on this patient's particular presentation. However, often times it may well be that a detachment is picked up on, surgery is arranged for the next day but there can be moments where you have the patient's clinical findings which mean such a delay falls within the reasonable decision-making of one ophthalmologist to another in the context of questions about the ultimate prognosis.

**Q.** Presumably, it can vary across the country, more particularly between England and Wales?

**A.** Yes. There are always huge pressures on ophthalmic departments, and there may well be non-clinical reasons that are factored into the ultimate timing of outpatient consultations and theatre sessions, yes.

**Q.** Thank you.

**Ms Jeyasingham:** Can I just ask one further question of clarification following on from my colleague? Usually, with an emergency within 24 hours there might be a better prognosis in the case of a retinal detachment. Are you saying that with a further delay, you go past a certain time when much more can be done? Is that my understanding of your answer to my colleague?

**A.** If a patient presents with a retinal detachment, usually you would want that patient to be referred as an emergency on that same day and they would then be assessed by a consultant retinal specialist, who would usually operate within a very short timescale, either the same day, the next day or very shortly thereafter. There are, however, occasions where the prognosis for the patient might be similar if there is some element of delay surgically. I do not profess to be an expert in those cases but some of that will centre on the extent to which the detachment has been present already prior to referral to the hospital unit.

**Q.** From what we can see from the records, by the time the patient went to Dr Barr, though it was still with some urgency, when she saw the ophthalmic surgeon there was a further delay because it wasn't that – turn it around very quickly?

A. Yes, that is reasonable, that is my understanding.

**Lady Wall:** Are there any further questions?

**Ms Mishcon:** May I ask one question arising out of that? Given that we can see from page 80 that Mr Barr saw Patient A as an urgent consultation, are you surprised that it took some three weeks for her to be seen by Dr Barr from the time that the GP referred Patient A on as an urgent referral?

A. Yes, because at this stage the prospects of the prognosis were unclear. So, yes, it is perhaps less of a surprise post Dr Barr to Mr Davies but, at this stage, following receipt of the referral within the unit in Aberystwyth, it is surprising that such a delay had occurred, given that, at that stage, the prognosis for the patient had yet to be established.

Q. And we do not know what happened to the prognosis during that three-week period, do we?

A. Correct.

**Lady Wall:** Thank you.

**Ms Bromley:** Thank you, Dr Harper. [*The witness stood down*] Madam, that is all that I intend to say about the facts of the case. I am not calling Patient A, she was unwilling to become involved in the proceedings because of everything she has been through and, bearing in mind that the allegations are admitted, it was not felt necessary to put her through that sort of stress. Madam, unless you or your colleagues have any questions, those are my submissions about the facts. I presume we can now move on to deal with misconduct subject to any submissions that my learned friend may have to make about the facts.

**Lady Wall:** Just let me see whether the Panel have any further questions about the facts? [*No questions*]

**Mr Marshall:** The Committee must decide at this stage whether the facts alleged in the allegation have been proved. The burden of proof is on the GOC but you have heard that all the facts are admitted. Evidence has been produced which appears to support the facts, and it has not been challenged. Unless there are any matters of particular concern to you, it is not necessary for the Committee to withdraw to consider this matter at length.

**Lady Wall:** Do the Committee accept the facts? [*Agreed*] So, for the purposes of the record, the Committee accepts that the facts have been proved.

**Ms Bromley:** Thank you. So we move on to deal with misconduct. Obviously, misconduct is a matter for your judgment, not a matter of proof. You, as an expert Committee, are best placed to judge misconduct. Again, Mr Staite admits that the facts you have found proved amount to misconduct, and I would refer you to the expert's report. We have heard from Mr Harper and you have had the benefit of reading his report. I would refer you again to his summary on page 47 in which he expresses the opinion that Mr Staite's professional performance was unacceptably low. He summarises that: "the

index of suspicion as to the possibility of a retinal detachment and Mr Staite's own subsequent examination revealed a visual field defect that he had not accounted for". He concludes by saying: "The actions of Mr Staite in his dealings with [Patient A] fell well below the standard expected of an average competent optometrist".

The authorities often make the observation that it is more difficult to pass the threshold of misconduct where you have just one incident as opposed to more than one incident. Here, you have, arguably, two incidents in that you have 11 February and 16 February examinations and allegations are made in respect of both, particularly the failure to make a note of referral. In my submission, particularly in the light of Mr Staite's admission of misconduct, the fact that misconduct is made out, and it is open to you to make that finding, his conduct represented serious failings in that not only was there a failure to make an urgent referral, but there was a failure to carry out appropriate examinations, and a failure to record investigations that he did carry out, and a failure to record all the questions that he asked of Patient A. Of course, the consequences for Patient A have been devastating. The failings were wide-ranging over a period of about six days between 11 and 16 February. Those are my submissions on misconduct, unless I can help you further.

**Lady Wall:** Thank you. Are there any questions relating to submissions on misconduct? [*No questions*] Legal Adviser, is there any comment you wish to make at this stage?

**Mr Marshall:** My advice is this. Having found the facts proved, the next question for the Committee is whether, on the basis of those facts, the registrant is guilty of misconduct. Case law indicates that a finding of misconduct requires a serious breach of professional standards. In the case of *Calhaem*, the judge said:

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

This question is a matter for the judgment of the Committee. There is no burden of proof to be discharged by either party. It is relevant that the registrant has admitted misconduct but the judgment must be made by the Committee. That is my advice.

**Lady Wall:** Thank you. Is there anything you would like to say, Ms Mishcon?

**Ms Mishcon:** Just briefly. I know that you have been referred to Dr Harper's report and we accept the findings in it. I do not take a point on this but it is something that we have highlighted to the Council that, strictly speaking, we can see from page 41 that he was instructed to look at this on the basis of deficient professional performance, and he does not, strictly speaking, deal with misconduct in his report, we can see from the bottom of that. However, Mr Staite feels that, although one could take an argument on whether this was

a single breach in the light of *Calhaem v GMC* [2007] EWHC 2606 (Admin), he personally feels that this was a serious shortcoming on his part. We feel that, even if we argued it, it is likely that you would come to the conclusion that this was misconduct on his part, although we do have arguments, as you know, regarding whether it amounts to impairment. For that reason, we feel it is better to accept that at this stage.

**Lady Wall:** Thank you. Perhaps you could all withdraw while we consider the matter of misconduct.

*[Hearing adjourned at 11.13]*

*[Hearing resumed at 12.12]*

**Lady Wall:** These are our findings.

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

The Committee has found the facts proved. It has seen documentary evidence to support the allegations and has heard oral evidence from an expert witness, Dr Robert Harper, who is an optometrist. The evidence was not challenged and the registrant has admitted the facts.

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

The Committee found Roger Staite guilty of misconduct. The facts of this case are that on 11 February 2009, Patient A consulted the registrant complaining of, among other things, a half moon of darkness. The registrant failed to record fully Patient A's history or the investigations he carried out. He failed to perform a dilated examination of her left retina. As a result of her presentation, he should have referred her as an emergency on the same day to an ophthalmic unit for ophthalmic assessment or should have sought advice. In fact he concluded the consultation apparently without taking any further action. The records do not indicate that he gave any advice to the patient, or a recall date.

Patient A returned for a further consultation on 16 February 2009. On this occasion, the registrant did refer Patient A, but he referred her to her GP, not to an ophthalmic specialist. He indicated that there was a degree of urgency in his referral.

Subsequently, Patient A was referred to an eye service and, in due course, she had retinal detachment surgery.

The Committee has carefully considered whether the facts found proved amount to misconduct. It recognises that not every lapse from proper professional standards will amount to misconduct. The breach must be serious. Furthermore, an isolated breach is less likely to amount to misconduct than a series of breaches. The Committee has noted that the registrant apparently has an unblemished career of 42 years, although it has

not yet heard evidence about his history or the reasons why his failings took place in relation to Patient A.

The Committee has taken into account that serious errors took place on two successive consultations. On the basis of the expert evidence, the departure from acceptable standards was considerable. It notes that the registrant himself regards his actions as misconduct. The Committee has concluded that the failings in this case were sufficiently serious to cross the threshold from professional failings to professional misconduct.

**Ms Bromley:** Thank you. We move on now to impairment. This is denied by Mr Staite. Impairment of fitness to practise is concerned with the position now, as opposed to misconduct which concerns matters in the past. As is well-established in the authorities, including *Meadow v GMC* [2006] EWHC 146 (Admin), *Bolton v Law Society* [1994] 1 WLR 512, the overall approach in regulatory proceedings is not to punish the registrant for past mistakes, but to protect the public against the acts and omissions of those who are not fit to practise, and to maintain the reputation of the profession and public confidence in it. In considering Mr Staite's fitness to practise today, you will take into account the misconduct which you have found proved. Those events happened in February 2009. Mr Staite retired from practice in August 2009, as was confirmed in his witness statement at tab H, page 226. There is, therefore, only a period of six months during which Mr Staite continued to practise after the events giving rise to these allegations.

I would ask you now to turn to tab H. He confirms in paragraph 2 that he retired in August 2009 at the age of 65. Then at paragraphs 15 and 16 of his witness statement, at pages 228-229 he comments there on the case of Patient A and expresses sympathy for her. He goes on to say that he has always been very committed to patient care, he wishes to apologise and in paragraph 16 he makes some observations there about his practice up to that point. He had never previously been notified to the GOC before, he has only ever received one complaint during his entire career. He states: "During my time as an optometrist, I have carried out eye examinations for a great number of patients" and so on. He says: "I often identified signs of eye conditions, sometimes of a rare nature".

What he says there, and what is said in the many testimonials which I presume you have in the bundle at tab I, relates to events that happened prior to these allegations. It was only for a period of six months that he continued to practise afterwards. You have no information currently before you as to any steps taken by Mr Staite to remedy his practice, so that the misconduct that occurred in 2009 does not reoccur. I am sure you will be familiar from many cases you hear where you get a lot of detail about training, reading or other steps that the optometrist has taken to make sure that the failings that have occurred in the past do not occur in the future. Because of the timing of this, you do not have that evidence before you, as Mr Staite has retired.

As I said on the issue of misconduct and as you have found, this represents serious failings on the part of a professional, and you have nothing to

reassure you that those failings would not reoccur if Mr Staite returned to practise. He says in his statement that he has retired and that he has no intention of practising again. That may well be the case but, as long as he remains on the Register, he is free to return to practise at any stage. It may be that he would want to undertake locum work, there are all sorts of situations in which he may consider that he wants to return to practise. Therefore, my submissions are that you should exercise your professional judgment and make a finding of impairment of fitness to practise. Madam, those are my submissions unless I can help you any further.

**Lady Wall:** Are there any questions to put Ms Bromley? [*No questions*] Thank you.

**Ms Mishcon:** Can I call Mr Staite to give evidence?

**Lady Wall:** Yes.

**MR ROGER JOHN STAITE called and affirmed  
Examination-in-Chief by MS MISHCON**

**Q.** Would you give your full name and address please?

**A.** Roger John Staite of The Grange, Llanon, Ceredigion.

**Q.** Mr Staite, how long have you practised as an optometrist?

**A.** In total, 42 years.

**Q.** Can you give us some idea how many patients you will have seen in that time – how many patients do you see in a week?

**A.** Until I retired, I was working full time and was, generally speaking, pretty much fully occupied, so I would have seen 14 patients a day, 70 patients a week, for 44-45 weeks a year, which is about 3,000 a year or something like that.

**Q.** In that time, have you had any other complaints about your professional practice?

**A.** Only one that was settled in-house in Aberystwyth, about eight or nine years ago.

**Q.** Some concern has been expressed as to whether you might return to practise as an optometrist. We know that you have retired. Have you attempted to remove your name from the Register?

**A.** Yes. I have not paid my subscription twice, I indicated that I did not want to renew my registration and in each case I was told that I had to remain on the Register until this hearing.

**Q.** Because of this hearing.

**A.** I believe I have been taken off the open Register.

**Q.** Do you have any intention of returning to practise as an optometrist at all?

**A.** None whatsoever.

**Q.** Also, it has been said that we have no evidence of what might have happened in the six months after the alleged incidents here. Can I apologise, we thought that Mr Staite's CV was attached to his witness statement in the bundle but we have realised this morning it is not? I shall have this photocopied; we only have one that has just been sent through. Looking at this, in your last full year of employment before you retired, did you carry out any further education – how many CET points did you get?

**A.** I am required to do a rolling 12 CET points over a three-year period, so 36 in three years. In the year before I retired, I did 28.

**Q.** If we look at the facts, the allegations that have been made, may I ask you to tell the Committee what your normal practice would have been when you see a patient? You have accepted that you did not record everything that you did. What would have been your normal practice?

**A.** My normal practice, first of all, would be to make the patient relaxed. Then I would ask them why they were there, was there a problem. If a problem was presented, I would normally question them further: when did it arise, had it arisen suddenly, had there been some event that had triggered it, was there any medical history that might explain it or be background to it? I would then proceed, first of all, to carry out a refracted sight test, both the unaided sight and then fully corrected with spectacles. I would normally go on to measure intraocular pressure. We had an instrument called a Pulsair 2000 which would give a pretty much instant result. I would then do direct ophthalmoscopy and, if anything then arose from that, I would move on to do other examinations. One of the symptoms that Patient A mentioned was a gritty eye, so I did and would have done a slit-lamp examination to check the anterior surface of the eye. Because of the mention of the shadow, which I from the ophthalmoscopy assumed was the floater, I also would have checked the anterior vitreous for evidence of what is commonly called tobacco dust, which is an indication that there is inflammation of the retina. It was also fairly standard practice then to ask for a field test. I don't know whether you want me to expand?

I do not know what happened with the field test. Normally, I would have finished the examination, the lady would have left to take the field test which is done in a separate room upstairs, one of the assistants would have done that. Then I would be presented with the result. If the result was completely clear and there had been no other problems, the patient may well have gone but the record should then have been put in a daily file that I kept where all the examinations that day would be kept. At the end of the day, I would go through the file and check each one to make sure they were complete. I don't know what happened, I did not see that field test.

**Q.** Did you discover at a later stage whether or not the field test results taken on 11 February were put in your daily record?

**A.** I did not discover what had happened to the record until the lady came back on the 16<sup>th</sup>.

- Q.** Before we get to the 16<sup>th</sup>, may I ask you when she went to have the field test, would you have been expecting her to come back, or would you see another patient while she was doing the field test?
- A.** There would have been another patient waiting.
- Q.** As far as you know, did Patient A wait to see you?
- A.** No.
- Q.** Did you see her field test results on 11 February?
- A.** No.
- Q.** Now that you have seen them, had you seen them on 11 February what would you have done?
- A.** I would have referred her. It was fairly plain from the field test that there was a significant problem.
- Q.** It has also been said that you did not carry out a dilated examination on that day. Can you explain what the usual series of events would have been?
- A.** I would not, as a general rule, carry out a dilated examination on patients unless there is reason to assume there is a problem, partly because of time. As a routine, to dilate someone you have to administer the drops, wait 15 minutes, then re-examine the patient. If you have a full clinic, in order to do that you would have to delay the patient who may have other problems, you would have to delay your subsequent patients, although if I had serious concerns, I would have fitted her in somewhere. I would fit a patient into my lunch hour or whenever. One of the other problems with dilation is that sometimes patients react badly to them, sometimes it causes them disturbance of vision. Therefore, generally speaking, if I was going to dilate a patient who had never been dilated before, I would warn them that they might be advised to bring sun-glasses in case the weather was bright, or to be accompanied so that, if their vision were disturbed, someone could take them back.
- Q.** If you were going to carry out a dilated examination, would you normally wait until after the field test results had been seen by you?
- A.** Yes.
- Q.** When the patient came back again on 16<sup>th</sup>, we can see that you carried out a further visual field test on that day.
- A.** Yes.
- Q.** As a result of that, you considered that this might be a detached retina, we can see that from the referral. Do you now accept that you should have referred her straight to the ophthalmologist rather than to the GP?
- A.** Yes. I have beaten myself over the head over that one every day for the last two years. I wake up every morning at the crack of dawn and the first thing I think is why did I not refer that lady as an emergency? I still don't know why I didn't. This is only conjecture, it is not fact, but I was almost certainly confused by the fact I had not seen the field test in the first place. I was taken aback. The lady had not booked an appointment as such for the 16<sup>th</sup>. The

first I knew there was a problem was when I was told that the record had been filed away. As soon as I saw it –

**Q.** Are you talking about the field test that was done on the 11<sup>th</sup>?

**A.** Yes.

**Q.** You were told on that day that it had been filed away

**A.** In permanent records, basically. So I was taken aback and that was probably partly what I was confused about.

**Q.** When you referred her to the GP after the 16<sup>th</sup>, how long did you expect it would be before she would be referred to an ophthalmologist?

**A.** Given that the GP's practice was in Aberystwyth, the ophthalmic clinic is also in Aberystwyth, I expected that she would be seen within three or four days. When I subsequently found out that it had been three or three and a half weeks, I was taken aback, it still should have been an emergency referral.

**Q.** You set out in your witness statement how much you regret what happened in your treatment of Patient A. Is there anything that you would like to say to the Committee today about what happened with this patient?

**A.** Only that I am – I shouldn't use the word – gutted. I understand how traumatic and painful it has been for this lady, and I am horrified that, to some extent, I was to blame for that. I should have referred her as an emergency. I should have followed up on the day that I didn't see the field test so in that respect I was to blame, and I am so sorry for that lady but it is too late to do anything about it.

**Q.** We know that the letter of complaint to the GOC was after you had retired and that the first letter that was sent by the complainant was in the month that you were due to retire. At that stage, did you know what had happened to her before the first letter of complaint?

**A.** No.

**Q.** So in the six months that you continued practising after February until August, it was not until August that you were aware that anything had gone wrong?

**A.** No.

**Q.** Had you continued practising after that complaint had come through, how would that have changed, if at all, the way you approached your practice?

**A.** In one sense, the change had already been made in that they now produce a list of all the patients for that day that is given to the practitioner, so that when he or she reassesses the records, they have a list of everyone they have seen and can check against the records that they have that they have seen all of those.

**Q.** Was that initiated as a result of you suddenly realising that you had not seen them?

**A.** No, it was simply tightening up on our procedures. That was not instigated by me but, if it had not been, it would have been, if you know what I mean. If that change had not been made and I had still been practising, I would have made

certain it was instigated so that we could keep a closer check on exactly what happened. This is not an excuse but in a busy day when you have 14 patients, one every 30 minutes, if something passes and is not picked up, by the end of the day it is gone. The one thing I would do is make absolutely certain that a record was checked at the end of each day to make sure that everything had been seen and annotated. As to recognising conditions, I have in the past diagnosed retinal detachment and, when I have diagnosed it, I have referred appropriately. I still do not know why I did not refer her as an emergency that day – I have done it in the past.

**Q.** Thank you. I don't know if there are any other questions for Mr Staite.

**Cross-examined by MS BROMLEY**

**Q.** Just a few questions, Mr Staite. I think you said that you have in the past diagnosed detachment, was it?

**A.** Yes.

**Q.** How long ago was that?

**A.** I cannot remember exactly when it was.

**Ms Mishcon:** It is page 246, the last page of the bundle, and it was in 2006. I shall refer you to this document again when I address you. [*discussion about page numbers*]

**Lady Wall:** My bundle ends at 244.

**Ms Bromley:** There are the two extra ones.

**Ms Mishcon:** I shall refer you to this but it is a patient where a detached retina was diagnosed in 2006 by Mr Staite on a Tuesday and by Friday of the same week, he was undergoing an operation. It is page 246.

**Lady Wall:** We should all have copies of this.

**Ms Mishcon:** Yes, because when I address you on impairment, I shall refer to that document. I did not realise that you did not have it, it was sent in.

**Lady Wall:** Is there anything else you think we should have which we might not?

**Ms Mishcon:** I don't think so. If you go up to page 244, I think you have everything apart from those two last pages. There is the CV also.

**Lady Wall:** Perhaps you should give that to Mr Henley. I don't know how long it will take him to do it but perhaps we should take five minutes while this is all done.

[*Hearing adjourned at 12.41*]

[*Hearing resumed at 12.49*]

**Lady Wall:** Thank you for these documents. We have read them and we shall designate the CV as R1 and, although it is probably not strictly necessary, the statements from Mr Jones and Mr Fisher as R2, because they were not included in the bundle, even though they are paginated and clearly intended to be in the bundle.

**Ms Mishcon:** Can I apologise that they did not get into the bundle? We had thought that they had been sent.

**Lady Wall:** It was an oversight that has been remedied.

**Cross-examination by MS BROMLEY (contd.)**

**Q.** Mr Staite, I was asking about the last time you had diagnosed a retinal detachment and I believe the answer is 2006, is that right?

**A.** Yes.

**Q.** Is that the only previous occasion when you have had to diagnose a retinal detachment in all your years of practice?

**A.** No, I have probably diagnosed three or four cases.

**Q.** And that includes the one in 2006?

**A.** Yes.

**Q.** You said in examination-in-chief that you have accumulated 28 CET points in your last full year of employment?

**A.** Yes.

**Q.** So that was from August 2008 to August 2009, is that right?

**A.** I am not sure whether it is that or whether it is the CET year, as it were.

**Q.** Right. If it is the CET year which is the calendar year, you might be talking about 2008 might you?

**A.** I might be, yes, but I am not certain.

**Q.** Okay. Of those CET points, how much was relevant to the situation you faced with Patient A, so identifying and diagnosing retinal detachment?

**A.** Specifically diagnosing retinal detachments, I can't think of one that was specific to that.

**Q.** So none specifically related to diagnosing retinal detachment. Were any of the CET points of any relevance to the situation you faced with Patient A?

**A.** Specifics I cannot give you but they would have been on points of referral, use of certain types of instrument such as slit lamp examination, things like that, and record-keeping.

**Q.** Do you accept it might be that Patient A's retinal detachment was present on 11 February?

**A.** Yes.

- Q.** So it was there to be seen but you simply failed to pick it up, is that right?
- A.** No, I failed to see the field test that would have indicated there was a retinal detachment. I was not convinced that there was a retinal detachment. In fact, I would have said that, if the field test had been plain, I would have been certain that there wasn't one. She did not complain of all the symptoms of retinal detachment. There was no mention of flashes, floaters or anything like that – well, floaters but not flashes and you tend to associate the two together. You get the flash and then you get the floater as the retina is being tugged and irritated. Therefore, you would expect flashes at least to be associated. Floaters are very common in older people, they are very common in high myopes, they can happen spontaneously even in younger people. They are very, very common. If I referred every patient who ever had a floater, there would be queues half a mile long outside the hospital. Floaters are common. The half moon, yes, that I should perhaps have picked up on. There were no flashes. As far as the mention of irritation, a gritty feeling, there are no sensations of gritty feelings in retinal detachment, that is not a symptom of a retinal detachment, which is why on the record there is a point where it says TBUT, which is tear break-up time. A five-second tear break-up time would indicate a marginally dry eye, which would explain the gritty sensation.
- Q.** Do you not accept that, leaving aside the visual field, there were sufficient indications such as a half moon of darkness, her age, being a very high myope, floaters, to indicate that you should have had retinal detachment on your radar?
- A.** In retrospect, yes, but only in retrospect.
- Q.** You retired six months after Patient A's two incidents in February. Apart from the fact that you have 28 CET points, none of which relate to retinal detachment, did you undertake any steps to ensure that would not happen again in the six months before you retired?
- A.** No, because I did not know it had happened, if you know what I mean.
- Q.** You have said that you have no intention of going back to practise but do you accept that things can change and that intention might change in the future? One cannot see into the future.
- A.** Obviously, I cannot see into the future but have no intention. I would not say that my health is poor but I do suffer from angina, I have high blood pressure. I have five children, four and a half grandchildren, 23 nieces and nephews who are all approaching marriageable age. This year alone there are three weddings that I shall be attending. I am not going to have the time to go back to work. I have no intention of going back to work. If, for whatever unforeseen reason, it was considered that I wanted to go back to work, I would have to undergo training before I could do so anyway because I have not continued with CET points. My registration has lapsed because I have not paid my fees as I had no intention of doing it, so I would have to reapply for registration and I would have to prove that I had undertaken CET points. As part of that, I would make certain that, if I were ever to consider it, those CET points would include recognition of retinal detachment, points as to when one should dilate and so on.

**Q.** Okay, I have no further questions.

**Lady Wall:** Do we have any questions?

### **Questioned by the Panel**

**Professor Hirji:** Good afternoon, Mr Staite. Your counsel mentioned that you had one patient complaint which was settled eight to nine years ago?

**A.** Yes.

**Q.** Do you recall what that was about?

**A.** Vaguely. It was an elderly lady in her 80s whom I examined. Some months afterwards, she developed an eye infection and in the course of the treatment for that, she was diagnosed as a chronic glaucoma sufferer. The complaint was that, if I had seen her three or four months previously, I believe it was, why had I not referred her? Her pressures were borderline when I saw her of somewhere in the high teens, low 20s, an average reading of about 20. She had a cup/disc ratio of about 0.6 and had a full field test.

**Q.** When did you plan to review her?

**A.** I had asked for an early referral, six months, but she was diagnosed before.

**Q.** What was the outcome? Were you taken to task about it and did you provide any compensation, or was it just dropped?

**A.** I think it was just dropped. A letter came to me which I passed on to our professional services and the case was just dropped.

**Q.** Thank you. My next question is you mentioned in your evidence that you looked to see if there was any tobacco dust, is that correct?

**A.** Yes.

**Q.** However, tobacco dust on an undilated eye is difficult or nigh impossible to see even if it is present. That bothers me in the sense that you did not dilate, you looked for tobacco dust but it was not recorded?

**A.** I looked only directly as part of the slit lamp examination. I would have used a very narrow beam to look, for example, for flare in the anterior chamber and then beyond it just as par for the course, as it were. I would not have been looking specifically for tobacco dust, it would have been part of the look.

**Q.** So you didn't look for tobacco dust effectively, because there was no reason to do so, you had not suspected a detachment?

**A.** This is true.

**Q.** I also notice on your record cards, and I asked Dr Harper this question as well, that if you look at the record card on page 55 in front of you – that is your record card?

**A.** Yes.

**Q.** Have you noticed that the section where it says "pupils" is blank?

- A.** Yes.
- Q.** I wonder why you decided not to examine the pupils at all in view of that fact that it would have given you a lot of information.
- A.** As a general rule, in an examination, I would simply pass a light over both pupils and only note if I saw an abnormality.
- Q.** In the presence of a detachment, would you expect to see an abnormality?
- A.** I would expect there to be a more sluggish reaction to the pupil, in one eye compared to the other.
- Q.** There is a section in here for an RAPD on the right-hand side at the top. If you remember, I pointed out that later on the hospital were able to determine quite clearly –
- A.** There was a relative afferent pupil defect, yes.
- Q.** You did not check for that at that particular time?
- A.** I must not have done.
- Q.** I also want to ask you what advice did you give this patient when you finished the examination, because the records do not state any advice at all.
- A.** Because I did not see the field test, my advice was not complete. As best as I can recall, I would probably have said something like: I cannot find anything obviously wrong, there is no significant change in the spectacle prescription, but we will have a field test anyway just to be certain and that is where it ends, because I did not then see the field test and when I came out of the sight test of the next patient who came in, the lady had gone. So I did not have the opportunity to make a final advice statement.
- Q.** I understand that and the reason why I asked you that is because it is normal practice to address the presenting symptoms at the advice stage, isn't it?
- A.** Yes.
- Q.** She was complaining of gritty eyes and half moon loss of vision, and I was looking for when you wrote down or gave advice, 'you have half moon loss of vision because –' or 'you have gritty eyes because –' and I did not see that on the record card?
- A.** As I said, because there wasn't that final ending, the lady mentioned that I said to her she had gritty eyes because of a gland dysfunction, which would have been part of the conversation.
- Q.** I understand. I suppose that the same applies to the recall date that, because you had not finished the examination process as far as you were concerned, that is not recorded?
- A.** That is right.
- Q.** Is my understanding correct that, subsequently, you now have a process placed in your practice where that could not happen? In other words, you are forced to review every case that has been seen?
- A.** Yes.

**Q.** On the day?

**A.** Yes.

**Q.** Thank you very much.

**Ms Jeyasingham:** I have one question. Following the original complaint letter from Patient A in August, what happened at the practice: were you asked to recall that case? It does not say how it was dealt with at that time, I am just curious?

**A.** I forwarded the complaint immediately on to –

**Q.** - the GOC.

**A.** Not to the GOC, to Dollond & Aitchison's own personnel department.

**Q.** And how did they process it?

**A.** They looked it and I believe the answer they gave in reply to the lady was that they thought that, because I had referred as a matter of urgency, I had fulfilled my obligation.

**Q.** But nobody came to interview you, or you weren't asked for a statement?

**A.** I was asked to provide the records but I was not interviewed.

**Lady Wall:** I have two questions. One relates to the mechanics of this visual field test. My understanding is from what you have said that somebody else is doing that?

**A.** Yes.

**Q.** Who is it?

**A.** It would have been one of the staff who was trained by me in the use of the equipment but not a qualified optician. It is a computerised programme and one of the staff would have carried it out.

**Q.** Right. What was the arrangement under the Boots management for this test to be undertaken: was it before you saw the patient, after you saw the patient?

**A.** That is open to individuals. I believe now the practice is that field tests are carried out as a pre-treatment, before the patient is seen by the practitioner, so that he has the record before he starts the examination. In my case, perhaps in retrospect it was wrong, I preferred to see the patient first so that I could state which particular programme I wanted. Because it is a computerised programme, there are separate programmes that you can use, so I preferred to say for this patient I want programme 4 or programme 3 or whatever. It was not Boots Opticians then, it was Dollond & Aitchison. All of this has taken place at a time of change within the practice anyway. However, now I believe it is standard that a field test is carried out on every patient before they see the practitioner.

**Q.** Okay. You would select the computerised programme that you thought was appropriate?

- A.** Yes.
- Q.** Then somebody who was not qualified but adequately trained would put the person in front of the computer and what happened then to the read-out?
- A.** What should have happened is that the record with the print-out would come back and be placed immediately outside my test room, so that when I came out from the next test, the record would be there if there was any problem with it, if there were any points missing. If it was a completely full field with no defects, and the patient was not having spectacles, that record would be put in the end-of-day file that I mentioned that I would then normally look at at the end of each day.
- Q.** So when you did not find the record outside your room –
- A.** - I assumed that there was no fault found on the record, and that it has been put in my end-of-day file.
- Q.** Right, I understand.
- A.** Because I did not have a list of all the patients, I went through the records that were there and did not connect that the one that I really ought to have seen was not there.
- Q.** When did this system change?
- A.** About two months after that.
- Q.** And do you think that it changed as a result of this complaint?
- A.** No, the system was changed to tighten it up, not because of that event because we still did not know that event had happened.
- Q.** I am just trying to work out why it had changed. Was it a change in management? Was it a difference between Dollond & Aitchison and Boots?
- A.** I cannot answer that one, I don't know. I don't know whether I should say this but I believe it was partially commercial as well, so that we could look to see had this patient been prescribed spectacles, was there a change in prescription, had they been prescribed varifocals or sunglasses. It was to put in a more detailed one. It also tightened up the system so that each patient was recorded as being seen and you had the record to match it.
- Q.** Going back a little while, how long had this practice been using visual field tests?
- A.** It has used visual field tests of some kind since before I joined it 25 years ago although they were much more primitive when I first started practising. However, we have used both central and peripheral field tests all of my career.
- Q.** You have been very honest with the Committee and you have said that for the last two years, you have asked yourself everyday why you did not refer her. We have to set that against a very long career of 42 years with only one other complaint. What is your own explanation for why you did not refer her on the first occasion?
- A.** On the second occasion?

- Q.** On the first occasion, with the half moon of darkness?
- A.** I assumed that the half moon of darkness was the floater and I indicated on the record that I saw it. A floater on its own I would not have referred for. I have seen many, many floaters. On the second occasion, I don't know why I did not refer her as an emergency. It is a difficult one. I was almost certainly confused by the fact that I had not seen the field test, that threw me completely. When the lady came the second time, it was not a booked appointment, she simply walked in. Then there was a bit of a flap because we could not find the record as it had been filed. When we found it, there was obviously a field defect. I was at a loss to know what had happened I think, and wanted perhaps to examine that in more detail as to what had happened, to try to find out who had done the field test.

Because it was five days previously and we had a staff of about seven or eight part-time and full-time, no-one was acknowledged as being the person who had done the field test. So I was thrown by that. The only other thing, and I don't know whether it is wrong to say this – I am probably cutting my own throat – was that the previous sight test the lady had done, not by me, had indicated that she was very deeply amblyopic, had a lazy eye, and she had not been prescribed a lens to correct the vision in that eye. Because of the big difference between the two prescriptions, she almost certainly could not tolerate the difference in the two sets of lenses, so she was simply prescribed what is called a balance lens, a lens of the same weight and thickness so that it did not look odd. The vision recorded on her record was light perception only.

I don't think that was the reason why I did not refer her as an emergency but it may somehow, subconsciously, have said this is not so urgent, because it is a very poor eye anyway. The main reason, and I believe I am being honest here, was simply because I was confused by the sequence of events as to why I had not seen the field test in the first place. I wanted to try to find out what had happened. I cannot give a better answer than that.

- Q.** Thank you very much. As I said, you have been extremely candid, which has been very helpful to us. Any more questions?

**Professor Hirji:** One more if I may. Mr Staite, following on from what you said to our Chairman, why then at the second referral point did you not send her to the emergency?

- A.** I don't know exactly why I did not send her as an emergency, and I acknowledge that I should have done so, which is why I have admitted it. I think it is because I was, to some extent, confused, baffled by the sequence of events as to why I had not seen the field test in the first place and what had happened to that. It is just that I was confused I think. All this is trying to look back in retrospect to an event that happened six months before I knew it had happened, if you know what I mean. It is difficult to try to give an explanation for something you did six months ago, but I suspect it was a combination of being confused over the missing field test and the missing record, and possibly – just possibly – by the fact that that eye was light perception only.

Also, to be fair, I did not expect three and a half weeks from referral to appointment. I had assumed that it would have been three or four days.

**Q.** Thank you very much.

**Lady Wall:** There are no further questions from the Committee. [*The witness stood down*]

**Ms Mishcon:** Can I ask you, first of all, to forgive me if I remind you of a couple of paragraphs from established authorities on impairment? I shall do so briefly as I am sure you know them already. The first is from the case of *Cohen v GMC* [2008] EWHC 581 (Admin) where it says:

“In my view at stage two when fitness to practise is being considered, the task of the panel is to take account of the misconduct of the practitioner and then to consider it in the light of all the other relevant factors known to them in answering whether, by reason of the doctor’s misconduct, his or her fitness to practise has been impaired. It must not be forgotten that a finding in respect of fitness to practise determines whether sanctions can be imposed. I must stress that the fact that stage two is separate from stage one shows that it was not intended that every case of misconduct found at stage one must automatically mean that the practitioner’s fitness to practise is impaired.

There must always be situations in which a Panel can properly conclude that the act of misconduct was an isolated error on the part of a medical practitioner, and the chance of it being repeated in the future is so remote that his or her fitness to practise has not been impaired. Indeed, the rules have been drafted on the basis that once a Panel has found misconduct, it has to consider, as a separate and discrete exercise, whether the practitioner’s fitness to practise has been impaired.

Second, the reasoning of the Panel which I set out above suggests that, having found the misconduct proved against the appellant, they considered that it automatically followed” – this is the criticism that I am just making – “that his fitness to practise was impaired, without looking at the other relevant factors such as, first, the appellant’s long, previous, unblemished record.”

They then go on to talk about conduct since this incident, which we cannot really look at in this case.

As has already been pointed out to you, usually when arguing whether a practitioner’s fitness to practise is impaired, the Committee is invited to look forward from the events which amounted to misconduct to see (a) whether the practitioner has insight into his conduct, and I hope that what he said to you will assure you that has considerable insight and remorse, and (b) what, if

any, steps have been taken to remedy the conduct to ensure that it will not happen again.

Unusually, in this case we cannot really ask you to look forward because Mr Staite retired almost two years ago within a few months of the index events, and has not practised as an optometrist since August 2009, and you have heard that he has no intention of doing so again. Therefore, I invite you to look back from the events to 42 years of an otherwise unblemished career.

As you have heard, there has never been any other complaint to the GOC and only one other complaint in 42 years has ever been made about his treatment by any patient, which was dealt with on the basis of a letter of complaint which was taken no further.

The testimonials also attest to his professional capabilities. I shall ask you to look again at the testimonial, which I know you have looked at recently, at what is now called R2, although it is numbered 246. It says that in 2006 Mr Staite correctly and promptly diagnosed a detached retina and referred the patient urgently to hospital.

It is also important to look at this testimonial, because not only was the patient operated on within three days of the diagnosis, but the patient talks about the level of support that was given by Mr Staite to the patient, offering to drop other appointments to fit him in if he was having any other problems about his retina. He says:

“Of all the healthcare professionals I met during the week following my diagnosis, Mr Staite was by far the most supportive and I am extremely grateful for the prompt action that he took. At the time, I was unaware of the seriousness of a detached retina. Now I am absolutely certain that Mr Staite’s prompt intervention saved the sight in my right eye.”

I hope that all of the testimonials will persuade you that this was in fact an isolated departure from Mr Staite’s usually meticulously careful and caring approach to his professional practice and his patients.

Could I also remind you of a very short passage from the more recent case of *Cheatle v GMC* [2009] EWHC 645 (Admin)?

“There is clear authority that in determining impairment of fitness to practise at the time of the hearing regard must be had to the way the person has acted or failed to act in the past. As Sir Anthony Clarke MR put it in *Meadow v General Medical Council*:

‘In short the purpose of [fitness to practise] proceedings is not to punish the practitioner for past misdoing but to protect the public against the acts and omissions of those who are not fit to practise. The FPP thus looks forward not back. However, in order to form a view as to the fitness of a person to practise today, it is evident that it will have to take account of the way in

which the person concerned has acted or failed to act in the past’.”

That obviously also refers to the misconduct but it also must look back, especially when you have an example of such a long and otherwise unblemished career.

It goes on:

“In my judgment, this means that the context of the doctor’s behaviour must be examined. In circumstances where there is misconduct at a particular time, the issue becomes whether that misconduct, in the context of the doctor’s behaviour both before the misconduct and to the present time, is such as to mean that his or her fitness to practise is impaired. The doctor’s misconduct at a particular time may be so egregious that, looking forward, a panel is persuaded that the doctor is simply not fit to practise medicine without restrictions, or maybe at all. On the other hand, the doctor’s misconduct may be such that, seen within the context of an otherwise unblemished record, a Fitness to Practise Panel could conclude that, looking forward, his or her fitness to practise is not impaired, despite the misconduct.”

Although the allegations relate to two separate days five days apart, I ask you to consider this as one incident for the purposes of making your decision about Mr Staite’s fitness to practise.

You have heard that he did not see the visual field test results on 11 February, and he fully accepts responsibility for the fact that he did not see them when he should have done. However, when Patient A returned on 16 February, he repeated the tests and he immediately recognised that she had a possible detached retina, we can see that from the referral letter, and he referred her as a matter of some urgency to the GP. Again, he fully accepts that he should have referred her straight to an ophthalmologist but he could not have foreseen that it would have taken three weeks before the patient was seen for what was an urgent referral.

Patient A was one patient out of probably many thousands whom Mr Staite treated successfully over 42 years. He is genuinely and extremely sorry for Patient A and the effect that this has had on her. He has, I would submit to you, shown considerable insight. In not seeking to detract in any way from what she has suffered, he, therefore, has not sought to challenge any of the allegations of misconduct, despite the authorities saying that negligence does not necessarily amount to misconduct.

Again, please have patience with me as it is something that you probably know extremely well, that is the GOC guidance about fitness to practise:

“Optometrists and dispensing opticians must demonstrate safe and competent practice. To do this, they must establish and maintain proper and effective relationships with patients and colleagues alike.

Their position in society as a respected professional gives them access to patients from all walks of life, including those who may be vulnerable, and therefore trust from both parties is paramount but should that trust be brought into question through the registrant's conduct, it may be considered that he should not continue to work in unrestricted practice ...

The Fitness to Practise Committee should consider the relevance of testimonials, mitigating circumstances, remorse and apologies in relation to the primary issue of fitness to practise ... Persuasive evidence of rehabilitation and a credible commitment to high standards in the future will be directly relevant to the question of fitness to practise..."

We cannot do that in the future but I hope you will look to the past in order to make your decision.

The testimonials, I would submit, paint a picture of a caring, conscientious practitioner who always endeavoured to put his patients first. It was notable when I looked at them how many times the words "integrity", "honest" and "trust" were used by the people who were asked to give testimonials on his behalf. There are 16 testimonials before you, there could have been many, many more than that but, since he retired two years ago, Mr Staite has not had access to patient records. Therefore, the only people whom he could ask to give testimonials were those people whom he knew how to contact, so he was somewhat limited, one should say, as to how many people he could contact to ask for that.

I ask you to read them all very carefully, I know you have read them already, when you retire to consider your decision. Again, I ask for your patience if I read just a few passages from some of those that I think are important and that I would like to highlight to you.

I had already asked you to look at the final one which we have looked at already. The other one that came in with that is also an important one, and it is the one that is marked R2 but has page 245 in the bottom right-hand corner. This is written by Mr Staite's line manager who worked with him for over three years in his capacity as Branch Manager. What he is says is this:

"Roger was a highly valued member of the team and greatly respected within the larger company. What set him aside from the other optometrists was his desire to always put the customer first. This could range from altering the test to accommodate specific needs, or just listening to a patient who does not see many people. During his time in Aberystwyth, Roger built up a very large loyal customer base of patients who would only see him. Some had seen him as a child with their parents and now wanted to bring their children to see Roger. The level of honesty with patients is what separated Roger from other optometrists. He would gladly see people in his lunch break, stay late for an emergency appointment; and in rare, unfortunate cases, phone

through to the eye clinic for an instant referral. It was with enormous difficulty that we found a new optometrist who suited the Aberystwyth practice.

During the time I have known and worked with Roger, I have never had reason to question his clinical knowledge or ability. He readily passed on knowledge and explained in detail the results of an eye examination to patients and staff alike. I have never known him cut a corner or do a short test for his or anyone else's benefit. I have seen him refuse to see people as there was insufficient time to carry out a sight test before the next patient.

Roger was a very large loss to the branch when he retired. Some patients only wanted to see him and we have lost some of those patients to the competition. The reason he was so respected is based on his attitude towards patients and all things clinical. He built up an impeccable reputation during his years of testing."

At page 236 in the bundle is a testimonial from Dr Balsom who had been a patient of Mr Staite from the mid-1980s until he retired, and his wife and daughters had also been patients.

"At all times, he was most professional, considerate and thorough. Furthermore, in one of my routine examinations, he spotted a rare but potentially very serious condition, namely central serous retinopathy (CSR). He referred me immediately to my GP and to specialist units both in Shrewsbury and Wolverhampton Hospitals.

Given that this was a very unusual CSR presentation for someone of my age and had probably been affected by a bee sting many weeks earlier, Mr Staite displayed outstanding diagnostic qualities as a healthcare professional that resulted in a successful outcome by very prompt investigation and referral. I should add that the specialist hospital consultants had been particularly impressed that this uncommon condition had been picked up in a routine high street optician's examination."

Two pages before that at page 234 is another testimonial towards Mr Staite's diagnostic qualities. This is someone who had been a patient for nine years, a boxer who attended for yearly examinations as had been required.

"I had initially been diagnosed with shingles in the left eye by my GP and medication had brought no relief. The symptoms became progressively worse and very painful, including a degree of blindness. Late on Friday, 16 July 2004, I felt concerned and contacted Mr Staite for advice. He insisted I went to see him immediately at his practice, though it was after his usual working hours. After examination, Mr Staite immediately sent me to Accident and Emergency and arranged for a further specialist to examine my eye. In the hospital, I received immediate treatment and my doctors informed me that had I not

received the prompt medication and treatment, I may have permanently lost the sight in my left eye. After many months of intensive treatment my eye made a full recovery and I regained my boxing licence. Personally, I feel without Mr Staite's prompt action, I would not have achieved this."

Over the page, he says:

"In my opinion, Mr Staite is highly professional and thorough. He would always warn me of the dangers that boxing could do to my eyesight. I felt he had a genuine professional concern for my wellbeing. When under his care, I never once considered the need to see another optician."

At page 238 is a testimonial from a professional photographer who writes:

"As a professional photographer, my eyesight is obviously most important and I can state that Roger Staite has always provided me with treatment of the highest levels of professional care and thoroughness and, as I am someone with more than a passing knowledge of optics, also kindly took the trouble to answer fully and honestly all my questions regarding the quality of my eyesight. He also has been personally responsible for the eyecare for my wife and also both my children who are now in their mid thirties from a young age. In particular, his early diagnosis and treatment of my daughter Tanya's chronic astigmatism was extremely thorough and rigorously monitored. For the past few years Tanya has lived in Australia and early on received laser treatment there to correct her condition, and such was Roger's professional concern that on her next visit home, he insisted on fully testing her to confirm the quality and success of the treatment. This kindness and concern I submit is a measure of the professionalism and responsibility that he considers appropriate to his profession."

Finally, although there are many, I would ask you to read the one at page 230 as that is from a fellow optometrist at Dollond & Aitchison. I would like to end with the final sentence on page 233 which is Professor Tecwyn Jones's testimonial:

"... we do not know of anyone within his field of expertise more competent, caring and conscientious than Mr Roger Staite. He is a professional to his very marrow and a person of highest integrity."

Mr Staite is truly sorry for what happened to Patient A, and he deeply regrets his shortcomings in relation to his treatment of her in February 2009. However, the same mistake is unlikely to occur again, first because Mr Staite has considerable insight and has learned from his mistakes. Secondly, the testimonials, especially the last one, show that he is perfectly capable of diagnosing a detached retina and making the appropriate referral. Others show his diagnostic skills in relation to other conditions. He has honestly told

you that he really does not know why he did not refer her as a matter of emergency when he did realise that this was a detached retina. He did diagnose it when he saw the visual field test and he has questioned himself, as you heard, every day since as to why he did not refer her urgently on that occasion. Thirdly, he is no longer practising as an optometrist and will not do so in the future.

I ask you to take into account his deep regret and the testimonials when you are making your decision. It would be a great shame if this long and caring career should end with a finding of impairment against him. I, therefore, urge you to find that his fitness to practise is not impaired.

**Lady Wall:** Thank you very much. [To Legal Adviser] Would you like to give us any further advice?

**Mr Marshall:** Yes, certainly. The question for the Committee at this stage is to decide whether on the basis of the facts found proved, the registrant's fitness to practise is impaired by the misconduct you have found. The law at present is that, on this issue, there is no burden of proof to be discharged. The question is one for your judgment. Although you have found misconduct, that does not mean that fitness to practise is automatically impaired; they are separate questions.

The question is whether fitness to practise is currently impaired. In deciding that question, you must consider both the events that gave rise to this hearing, and any subsequent matters. In relation to misconduct, the process was explained by Cranston J in a recent case concerning doctor *Cheatle v GMC*. Miss Mishcon has already read the passage that I was going to refer to, so I shall not repeat it.

I would simply remind you that, if you find that fitness to practise is not impaired, you do have the power to give a warning under section 13F(5) of the Opticians Act 1989. If you exercise this power, you should consider whether the warning should expire and, if so, when. That is my advice.

**Lady Wall:** Thank you very much. That is the end of this part of the hearing and it is now 13.40, we have gone on much longer, we would normally have taken a break sooner. Following the pattern of the hearing, it seemed very much better for you to complete your case and Mr Staite's evidence. Accordingly, we now all need lunch and then we shall have a discussion as to the matter of impairment, and we shall provide reasons for our decision. I doubt whether we shall complete all of that before 14.30 or 15.00 is probably more reasonable. So shall we meet again at 15.00?

[Hearing adjourned at 13.40]

[Hearing resumed at 15.07]

**Lady Wall:** These are our findings regarding impairment.

The Committee found that the fitness of Roger Staite to practise as an optometrist is not impaired.

The Committee heard evidence from the registrant and found him to be frank and insightful. His answers were candid and honest. The Committee was impressed by the way he has questioned himself rigorously over these matters. He has clearly agonised over the lapses of judgment that he made. He cooperated fully with the GOC's investigation and willingly came to the hearing to give evidence, which assisted the Committee, even though he is now retired from practice and does not intend to practise in the future. Because of his planned retirement on 19 August 2009, which coincided with the letter of complaint on 7 August 2009, he has not had the opportunity to undertake further training or other remedial steps. However, the Committee considers that if his career had been continuing, he would have taken all necessary steps to avoid such an error in the future.

The Committee heard that the registrant has been practising for 42 years with no findings against him and no significant complaints. It has seen a number of impressive testimonials from patients, colleagues and others who are aware of these allegations. Several of these references speak of his diagnostic skill which is the issue in this case.

Part of the background to the misconduct was that the results of a visual field test examination were not available to the registrant. He did not seek to absolve himself of responsibility for this in any way. Nevertheless, there seems to have been an administrative failing in ensuring that Mr Staite was able to review the test results. This failing helps to explain, but does not excuse, the misconduct that took place in relation to this patient. It is important for members of the profession to remember that delegation of tests to unqualified staff does not absolve them of professional responsibility. Mr Staite is fully aware of this.

The Committee is satisfied that this episode was a quite uncharacteristic lapse on the part of a competent and conscientious practitioner who has given great service to the public over many years. Had he remained in practice, the Committee would not have felt that there was a risk of repetition.

For these reasons, the Committee has concluded that the misconduct in this case does not mean that the registrant's fitness to practise is currently impaired.

The Committee is aware that it has a power to issue a warning, but it does not consider it appropriate to do so. The registrant is fully aware

of his professional responsibilities and the respects in which, in relation to this patient, he failed to meet them.

Thank you everybody.

*[Hearing concluded at 15.10]*