BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

AND

MS SONIA PELAN – (01-20766)

DETERMINATION OF A SUBSTANTIVE HEARING
20-22 MAY 2019

Committee Members: Mr J Kellock (Chair/Lay)
Ms R O’Connell (Lay)
Ms A Robertson-Rickard (Lay)
Ms L Troy (Optometrist)
Mr K Gohil (Optometrist)

Legal adviser: Mr D Clark

GOC Presenting Officer: Mr G Micklewright

Registrant present/represented: Present and represented

Registrant representative: Mr S Thomas

Hearings Officer: Mr T Yates and Ms V Desai

Facts found proved: Particulars 4c(i), 7a, 7b, 8a(i) and 8a(ii) (all by admission)

Facts not found proved: Particulars 1i(a), 1i(b), 2i(a), 3i(a), 4a(i), 4b(i), 4c(ii), 5, 6, 8b(i) and 8b(ii)

Misconduct: No misconduct (thus no impairment)
Ms Sonia Pelan (“the Registrant”) is an Optometrist who was first registered with the General Optical Council on 13 February 2004. At the material times, she was working as a locum at Redacted (“the Practice”). An allegation has been made against the Registrant that her fitness to practise is impaired by reason of misconduct. The allegation relates to her assessment of a patient, referred to in these proceedings as Patient A, her record keeping, and her making of retrospective entries in the patient notes. The proceedings are governed by the Opticians Act 1989 (“the Act”) and the General Optical Council (Fitness to Practise) Rules Order of Council 2013 (“the Rules”).

The original Allegation is set out below:

**Original Allegation**

The Council alleges that you Sonia Pelan, a registered optometrist, whilst employed at Redacted:

1. On or around 20 February 2017 you conducted a sight test on Patient A and failed to conduct an appropriate assessment of Patient A's eyes in that you:
   i) Failed to detect signs of peripheral retinal detachment in Patient A's right eye, despite:
      a. Patient A's field vision test detecting a defect in the right eye;
      b. Patient A stating that he had a "semi-transparent curtain-like obstruction", or words to that effect, in his right eye;

2. On or around 27 February 2017 you conducted a sight test on Patient A and failed to conduct an appropriate assessment of Patient A's eyes in that you:
   i. Failed to detect signs of peripheral retinal detachment in Patient A's right eye, despite:
      a. The defect in Patient A's field vision worsening; and/or
      b. Patient A stating "the curtain is getting bigger" or words to that effect, and/or;
      c. Patient A stating his right eye felt "irritated as if there was a permanent grain of sand in it" or words to that effect;

3. On or around 3 March 2017 you conducted a sight test on Patient A and failed to conduct an appropriate assessment of Patient A's eyes in that you:
   i. Failed to detect signs of peripheral retinal detachment in Patient A's right eye, despite: The defect in Patient A's field vision worsening; and/or
      a. Patient A stating that she had been "experiencing floaters" in his right eye, or words to that effect;

4. Your record keeping was inadequate in that:
a. On 20 February 2017 you:
   i. Failed to record your findings during or shortly after Patient A's sight test;
   ii. Failed to routinely record essential clinical information during or shortly after Patient A's sight test;
   iii. Failed to routinely record essential history information during or shortly after Patient A's sight test;
   iv. Failed to routinely record essential symptoms information during or shortly after Patient A's sight test;

b. On 27 February 2017 you:
   i. Failed to record your findings during or shortly after Patient A's sight test;
   ii. Failed to routinely record essential clinical information during or shortly after Patient A's sight test;
   iii. Failed to routinely record essential history information during or shortly after Patient A's sight test;
   iv. Failed to routinely record essential symptoms information during or shortly after Patient A's sight test;

c. On 3 March 2017 you:
   i. Failed to record your findings during or shortly after Patient A's sight test;
   ii. Failed to routinely record essential clinical information during or shortly after Patient A's sight test;
   iii. Failed to routinely record essential history information during or shortly after Patient A's sight test;
   iv. Failed to routinely record essential symptoms information during or shortly after Patient A's sight test;

5. On or around 20 February 2017 and/or 27 February 2017 and/or 3 March 2017 you failed to appropriately refer Patient A to the hospital eye service for further investigation of the signs for peripheral retinal detachment;

6. On or around 20 February 2017 and/or 27 February 2017 and/or 3 March 2017 you failed to carry out additional tests which were clinically indicated, including:
   a. A dilated retinal examination;
   b. A pachymetry;

7. On or around 18 March 2017 you amended Patient A's records in that you replaced:
a. 'Eye Exam Floaters -1' with 'Eye Exam Floaters 0';
b. 'Tonometry Left Drops Drops 0' with 'Tonometry Left Drops Drops 1'
c. 'Eye Exam Tonometry Notes – empty' with 'Eye Exam Tonometry – iop with perkins 9, 9 r and l'
d. 'Eye Exam Driver 0' with 'Eye Exam Driver 1'
e. 'Eye Exam Anaesthetics Used -1' with 'Eye Exam Anaesthetics Used 0'
f. 'Eye Exam Flashes -1' with 'Eye Exam Flashes 0'
g. 'Tonometry Right Drops Drops 0' with 'Tonometry Right Drops Drops 1'
h. 'Tonometry Left Drops Notes - empty' with 'Tonometry Left Drops Notes – oxy'
i. 'Eye Exam Contact Lens Wearer 0' with 'Eye Exam Contact Lens Wearer 1'
j. 'Tonometry Right Drops Notes - empty' with 'Tonometry Right Drops Notes – oxy'
k. 'Eye Exam info on Drops Given -1' with 'Eye Exam info on Drops Given 1'
l. 'Tonometry Right Fields -1' with 'Tonometry Right Fields 1'
m. 'Tonometry Left Fields -1' with 'Tonometry Left Fields 1'
n. 'Eye Exam HA's -1' with 'Eye Exam HA's 0'

8. Your actions at 7 above were:
   a. Misleading in that you:
      i. Were aware that Patient A did not attend for an appointment on 18 March 2017; and/or
      ii. Did not date the amendments; and/or
      iii. Did not record that the amendments had been made at a later date;
   b. Dishonest in that you:
      i. Were aware that Patient A had not attended for an appointment on 18 March 2017; and/or
      ii. Were aware that Patient A had been diagnosed with peripheral retinal detachment; and/or
      iii. Were aware at the time of amending Patient A’s records that you were representing that the records were made during or shortly after the relevant sight test.

And by virtue of the facts set out above, your fitness to practise is impaired by reason of misconduct.
Application to amend the Allegation

At the beginning of the hearing, Mr Micklewright, on behalf of the Council, asked the Committee for further time to consult with the Council’s expert witness, Professor Simon Barnard. For reasons which appeared to the Committee to stem from an administrative error on the part of the Council, a witness statement submitted by the Registrant in September 2017 had not been provided to Professor Barnard until a few days before the hearing. In addition, the Registrant had provided a document last week in which she explained her understanding of the electronic record system. Mr Micklewright wanted to confer with Professor Barnard to clarify the extent to which the new information impacted upon his evidence.

By lunchtime on the first day of the hearing, the Committee was provided with two short additional reports from Professor Barnard, in which he commented on the new information and made revisions to his original report. As a result, Mr Micklewright applied to amend the allegation. Some of the amendments were to correct factual errors (such as the date upon which certain events occurred) or typographical errors (such as the use of ‘she’ instead of ‘he’). Most of the proposed amendments were more substantive. They sought to reduce the number of specific factual allegations. In particular, the extent to which the Registrant was said to have made misleading and dishonest alterations to the records was significantly reduced. Mr Micklewright explained that the amendments more accurately reflected the evidence, and in so far as they related to misleading and dishonest practice in relation to record keeping, the allegation now focused only on those parts of the notes which could properly be said to be capable of misleading other practitioners. Mr Thomas, on behalf of the Registrant, did not oppose the application to amend.

The Committee accepted the advice of the Legal Adviser, to the effect that Rule 46(20) of the Fitness to Practise Rules gave the Committee the power to amend the particulars of allegation if this could be done without injustice. The Committee bore in mind that it had a duty to ensure cases were not under-prosecuted and that factual allegations were not allowed to drop away for the sake of expediency. The Committee was disappointed that the Registrant’s statement had not been provided to Professor Barnard at an earlier stage in the case, but it agreed that the proposed amendments did better reflect the evidence in the light of Professor Barnard’s additional reports. Therefore the Committee allowed the application to amend.

The revised particulars of allegation are set out below:

**Allegation (as amended)**

The Council alleges that you Sonia Pelan, a registered optometrist, whilst employed at Redacted:

1. On or around 20 February 2017 you conducted a sight test on Patient A and failed to conduct an appropriate assessment of Patient A’s eyes in that you:
   i. Failed to detect signs of peripheral retinal detachment in Patient A’s right eye, despite:
a. Patient A's field vision test detecting a defect in the right eye;

b. Patient A stating that he had a "semi-transparent curtain-like obstruction", or words to that effect, in his right eye;

2. On or around 27 February 2017 you conducted a sight test on Patient A and failed to conduct an appropriate assessment of Patient A's eyes in that you:
   i. Failed to detect signs of peripheral retinal detachment in Patient A's right eye, despite:
      a. Patient A stating "the curtain is getting bigger" or words to that effect.

3. On or around 6 March 2017 you conducted a sight test on Patient A and failed to conduct an appropriate assessment of Patient A's eyes in that you:
   i. Failed to detect signs of peripheral retinal detachment in Patient A's right eye, despite:
      a. Patient A stating that he had been "experiencing floaters" in his right eye, or words to that effect;

4. Your record keeping was inadequate in that:
   a. On 20 February 2017 you:
      i. Failed to record adequately Patient A's complaint of, "a small, semi-transparent curtain-like obstruction at the top left-hand side of his right eye's field of vision", or words to that effect.

   b. On 27 February 2017 you:
      i. Failed to record adequately Patient A's complaint of, "the curtain is getting bigger", or words to that effect.

   c. On 6 March 2017 you:
      i. Failed to record adequately the name of the drug used for dilation; and/or
      ii. Failed to adequately record Patient A's complaint of floaters.

5. On or around 20 February 2017 and/or 27 February 2017 and/or 6 March 2017 you failed to appropriately refer Patient A to the hospital eye service for further investigation of the signs for peripheral retinal detachment;

6. On or around 20 February 2017 and/or 27 February 2017 and/or 6 March 2017 you failed to carry out a dilated retinal examination.

7. On or around 18 March 2017 you amended Patient A's records in that you replaced:
   a. 'Eye Exam Floaters -1' with 'Eye Exam Floaters 0';
   b. 'Eye Exam Flashes -1' with 'Eye Exam Flashes 0'

8. Your actions at 7 above were:
a. Misleading in that you:
   i. Did not date the amendments; and/or
   ii. Did not record that the amendments had been made at a later date;

b. Dishonest in that you:
   i. Were aware that Patient A had been diagnosed with peripheral retinal detachment; and
   ii. Were aware at the time of amending Patient A’s records that you were representing that the records were made during or shortly after the relevant sigh.

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

DETERMINATION

Admissions in relation to the particulars of the allegation

The Registrant admitted particulars 4c(i), 7a and 7b of the allegation. The Committee therefore found those particulars proved, in accordance with Rule 46(6) of the Rules.

At the conclusion of the Council’s case, and having heard evidence from Professor Barnard, the Registrant further indicated that she now admitted particulars 8a(i) and 8a(ii). Therefore, the Committee also found those particulars proved on the basis of the Registrant’s admission.

Background to the allegations

Patient A attended the Practice on 20 February 2017 for a routine eye test, prompted by his feeling that his sight had deteriorated. He had previously visited the Practice in 2012. As part of the eye test, he underwent field of vision testing. This was initially carried out by an optical assistant, and the results were passed on to the Registrant. She then saw Patient A for a consultation. The Registrant repeated the field of vision test for the right eye, which showed a similar result. This indicated a superior nasal defect, which the Registrant wanted to investigate further. Her initial hypothesis, which she shared with Patient A, was that he may be suffering from glaucoma. The Council alleges that, at this first consultation, Patient A told the Registrant that he had noticed a “semi-transparent curtain-like obstruction” in his right eye. The Registrant’s case was that this was not said, at that or at any other consultation.

Arrangements were made for Patient A to return to the Practice on 27 February 2017. The Registrant said that this was for the purposes of a more detailed field of vision test, and that this was carried out. It confirmed the defect in the right eye, but did not show any deterioration from the first set of tests on 20 February 2017. After
the test, the Registrant saw Patient A briefly and explained that she wanted to investigate further. Patient A’s account was that the Registrant carried out the same tests that she had carried out during the first visit. It was the Council’s case that Patient A told the Registrant on 27 February 2017 that the curtain was getting bigger. This was denied by the Registrant.

Patient A returned to the Practice for a third time on 6 March 2017. On this occasion, the Registrant carried out a wider range of tests. The field of vision test was repeated, and the results were similar to those obtained previously. One additional test involved the administration of anaesthetic drops so that the pressure of the eyes could be examined. The Registrant said that she also dilated the pupils of both eyes and carried out a detailed examination. She did not detect any retinal abnormality. She decided to refer Patient A to a specialist and prepared a referral letter in which she detailed the results of her examination. She remained of the view that glaucoma was the likely diagnosis. Patient A did not think his pupils had been dilated at this visit. He said that he had noticed floaters in his vision prior to this third visit to the Practice, although he could not remember specifically whether he mentioned this to the Registrant. It was the Council’s case that he did tell the Registrant about the floaters. The Registrant disputes this. It was common ground that the Registrant advised Patient A to contact the Practice if his vision deteriorated before he was seen by the specialist.

After the third visit, Patient A was troubled by the irritation and floaters to such an extent that he contacted the Practice but could not be accommodated with an early appointment. After contacting the NHS24 service, he attended Queen Elizabeth University Hospital on 11 March 2017. He was examined, but no dilation was carried out because he was driving. An urgent appointment was made for him to attend the Eye Hospital at Gartnavel General the following day. He attended that appointment and was diagnosed with a retinal detachment in the right eye which required immediate surgery.

The Registrant learned of the diagnosis of retinal detachment on 18 March 2017. She accessed Patient A’s records and added entries to the electronic notes for the appointment on 6 March 2017. The Council’s case was that this was done dishonestly, in order to give the impression that the notes had been made at the time. The Registrant’s case was that she was doing no more than clarifying the notes and ensuring that they reflected the tests undertaken and were consistent with the referral letter. She denied any intention to mislead, whilst accepting that, objectively, her actions may have been misleading. She denied that she had acted dishonestly.

**Admissibility of evidence from Interim Order hearing**

The Committee was made aware by the parties that the Registrant had been subject to an order for interim conditional registration in relation to the allegation against her. The interim order was imposed on 11 September 2017 and was later revoked. Mr Thomas invited the Committee to rule that certain evidence contained within the determination of the Committee which originally imposed the interim order was
admissible as positive testimonial evidence, relevant to the issue of dishonesty. In its determination, that Committee had commented on the ‘probity’ allegations (now particulars 7 and 8) and had declined to make the interim order on the basis of those allegations “in the light of the Registrant’s witness statement, the contents of which the Registrant is now committed to. It also took account of the testimonials provided on her behalf. The Committee did not find that the fact of retrospective entries, without more, was sufficient in this case to establish a case of lack of probity.” Mr Micklewright opposed the application, arguing that the views of the Committee hearing an interim order application could not be relevant to these proceedings.

The Committee accepted the advice of the Legal Adviser. It reminded itself that Rule 40(1) of the Fitness to Practise Rules required evidence to pass the tests of relevance and fairness in order to be admissible. The Committee concluded that the views expressed by a previous Committee, which had not heard any evidence itself and which was conducting a risk assessment rather than making factual findings, could not be relevant to its decision-making. The Committee noted that the Case Examiners must have found that there was a case to answer on the probity allegations, as they were before the Committee at this substantive hearing, in contrast with the views expressed by the previous Committee. With respect, however, the opinion of the Case Examiners would be no more relevant at this hearing than that of the previous Committee. Therefore, the Committee refused the application made by Mr Thomas.

Findings in relation to the facts

The Committee heard evidence from Patient A and from Professor Barnard on behalf of the Council. The Registrant also gave oral evidence. The Committee accepted the advice of the Legal Adviser.

The Committee considered Patient A to be an honest witness who was doing his best to recollect events and give truthful answers to the questions he was asked. At no stage did the Committee feel that he was trying to mislead or embellish his evidence. The Committee noted that in several key areas, his evidence differed substantially from that of the Registrant. The Committee also found the Registrant to be a credible witness.

The Committee considered Professor Barnard to be credible and reliable as an expert. He was very balanced in his assessment of the Registrant’s actions, making critical comments at times but conceding the validity of her approach where appropriate. His evidence was not substantially challenged by Mr Thomas. However, Professor Barnard was not a witness of fact and so he was unable to assist the Committee in resolving conflicts between Patient A and the Registrant. The Committee therefore looked at factors such as the extent to which the evidence given by Patient A and the Registrant was internally consistent (in other words, did they give different accounts on different occasions); whether their evidence was
consistent with any written records that were made at the time; and the inherent probability or improbability of their accounts.

In terms of internal consistency, Patient A made a detailed written complaint to the Council on 5 May 2017. He explained to the Committee that this was the earliest he had felt able to do so after his operation and period of recovery. He said that he had had to lie in a prone position for much of the time in the weeks after his operation, but had also had to return to hospital for follow-up appointments and, on occasions, because he was concerned about his eye. His witness statement made to the Council for the purposes of these proceedings, dated 1 July 2017, was based on and was largely consistent with, his earlier complaint. One significant discrepancy was that, in his complaint of 5 May 2017, he made no reference to seeing floaters until the period after his last consultation with the Registrant on 6 March 2017, whereas in his written statement to the Council he said he noticed them before that final consultation although he could not remember if he had mentioned them to her at the consultation. He said in oral evidence that he was not aware of the term “floaters” until a discussion with his wife, who is a doctor, after the final consultation. In another material respect, there was a noticeable discrepancy between what he said in both of his written accounts, on the one hand, and in his oral evidence on the other. In his written evidence he said that he told the Registrant about the “curtain-like obstruction” to the vision in his right eye at the first and second consultations, whereas in his oral evidence he said it may have been at the second and third appointments only.

With regard to consistency with contemporaneous records, the Committee was provided with a copy of Patient A’s hospital notes. These recorded that he attended the Accident and Emergency Department of Queen Elizabeth University Hospital during the afternoon of 11 March 2017. He was examined by a doctor at around 8.20pm and the history records that he said he had been seeing floaters (or “black fly”) for the past 1-2 days and that, over the same short period, there had been an increase in loss of vision “like curtain”. This appeared to be inconsistent with his evidence that he had noticed those symptoms at an earlier stage.

The Committee considered the inherent probability and improbability of the accuracy of each witness’s account. Patient A said that he did not believe his eyes had been dilated at the appointment on 6 March 2017. He explained that he had dilation subsequently at hospital and the effects were much more dramatic; he likened it to being intoxicated, and to having to shield his eyes from light. The Registrant explained that she had dilated his eyes at that consultation, and this was recorded in the referral letter she prepared the same day although she did not record the name of the drug she had used in the dilation. She said that she had dilated because she was continuing to explore the possible diagnosis of glaucoma. She also explained that, by dilating a patient’s eyes, the practitioner is able to spend more time with the patient and thus carry out a more detailed investigation, as well as giving themselves time to consider their findings and next steps. It was her practice to dilate a patient when she was intending to refer. Professor Barnard said that the strength of the drug used for dilation by the Registrant (0.5% tropicamide) was significantly weaker than
the drugs used in hospital. In his opinion, this could have accounted for Patient A’s different experiences of dilation. Both Patient A and Professor Barnard stated in evidence that the Registrant appeared to be a caring and conscientious practitioner. In the Committee’s view, it was more likely that she would have carried out dilation in these circumstances than that she would have failed to do so, but then record in the referral letter that she had.

The Committee also considered the inherent improbability of an otherwise caring and conscientious practitioner failing to act appropriately on being told about symptoms such as a curtain obstructing vision. Both the Registrant and Professor Barnard said that this was a “red flag” symptom which would require immediate referral because of the potential risk to sight. Professor Barnard said that it was ingrained in all practitioners to record and act upon symptoms such as flashes, floaters and curtains in vision. The Registrant told the Committee that if Patient A had mentioned a curtain obstructing his vision at any of the consultations, it would have “stopped her in her tracks” and she would have acted upon it. The Committee accepted her evidence on that point.

The Committee additionally took note of the fact that the Registrant was a person of good character with no previous regulatory findings against her. She provided testimonial evidence from a number of sources which commented favourably on her honesty and integrity. She told the Committee that she had personally approached the authors of the testimonials and had informed them of the nature of the allegations she faced. The Committee recognised that good character cannot provide a defence to allegations such as those faced by the Registrant, but it was a factor the Committee added into the balance in her favour when assessing both her credibility and her propensity to act in the manner alleged.

The Committee bore in mind that the burden of proving factual allegations lies with the Council. It concluded that it could not rely on Patient A’s evidence as a reliable account where it differed in material respects from the evidence of the Registrant. The Committee is not critical of Patient A in this regard, but it appears that his recollection of the events may have become confused. This is not surprising, given the traumatic nature of those events and the shock and disruption they must have caused him.

Having carried out that analysis of the credibility and reliability of the witnesses from whom it had heard, the Committee then considered the factual particulars of allegation.

With the exception of particular 1i(a), the sub-paragraphs set out in particulars 1-3 all depended on the Committee accepting the evidence of Patient A to the effect that he had told the Registrant about the curtain-like obstruction and the floaters. Even on his own evidence, he could not specifically recall telling her about the floaters. In any event, for the reasons set out above, the Committee did not consider that Patient A’s evidence was sufficient to discharge the burden of proof. In relation to particular 1i(a), both parties accepted that the field of vision test revealed a defect in the right eye. However, the Committee was not satisfied that the Council had adduced...
sufficient evidence to establish that the Registrant had failed to detect signs of retinal detachment at the first consultation. Therefore, the Committee found particulars 1-3 not proved. The Committee found the disputed sub-paragraphs of particular 4 not proved, in light of its finding that Patient A had not reported the symptoms as alleged.

In relation to particular 5, this required the Council to establish that the Registrant should have referred Patient A for further investigation of the signs for peripheral retinal detachment. It was the Registrant’s evidence that she was investigating a possible case of glaucoma, although she was looking for any abnormal signs when examining Patient A’s eyes. She did not see any sign of detachment even on 6 March 2017, when she had dilated. Professor Barnard explained to the Committee that there was nothing in the field of vision tests which might have led the Registrant to believe that there was a retinal detachment, and the stability of the test results over the three visits tended to support the Registrant in this regard. He said that retinal detachments are not always apparent on examination. He could not comment on how Patient A’s eye may have appeared at the various consultations, and therefore could not assist the Committee in its decision as to whether the Registrant should have seen the signs of retinal detachment. Professor Barnard’s evidence was that, if Patient A had not told the Registrant about the curtain and the floaters, her working hypothesis of possible glaucoma was not unreasonable and he would not be critical of her for not referring the patient for a possible retinal detachment. On the basis of its decision on particulars 1-3, and the evidence of Professor Barnard, the Committee found particular 5 not proved.

The Committee found particular 6 not proved. There was nothing in Patient A’s presentation on 20 February or 27 February 2017 to suggest that a dilated retinal examination was required. It was not part of the standard eye test and the Committee accepted that the visit on 27 February was specifically for the purpose of carrying out a more detailed field of vision test. For the reasons explained above, the Committee concluded that it was more likely than not that the Registrant had carried out a dilated retinal examination during the visit on 6 March 2017.

In considering the allegation of dishonesty in particular 8b, the Committee bore in mind the submissions of the parties and the advice it had been given about the test set out in *Ivey v Genting Casinos [2017] UKSC 67*. The Committee considered the Registrant’s state of mind. The Council’s case was that the Registrant had added details to the electronic notes, that she had not stated in the additions that they had been made retrospectively, and that she had done this in order to make her treatment of Patient A appear more favourable to her than it would otherwise have appeared. The Registrant’s case was that she had been focused on the referral letter on 6 March 2017 rather than the electronic notes and, on learning about the retinal detachment, she revisited the notes to see if there were any learning points. At this stage she realised that, although the referral letter had been scanned onto the electronic system, no specific eye examination notes had been made for that appointment. The Registrant then transferred the information from the referral letter into the electronic record. She knew that any changes would be date-stamped,
although she accepted that this would not be immediately obvious to a casual reader of the notes who did not go through an audit process.

In the Committee’s view, the Council has failed to establish on the balance of probabilities that the Registrant was acting with any intention to mislead. She accepted that, objectively, her reference to the absence of flashes and floaters could be misleading because she had only asked if there had been any change. She had not explicitly asked the question on 6 March 2017 as to whether Patient A had such symptoms. However, her motivation is more likely to have been to ensure there was consistency between the referral letter and the electronic notes. The Committee accepted the Registrant’s explanation for her actions. Based on this finding, the Committee was not satisfied that an ordinary decent person would regard her actions as being dishonest. Therefore, the Committee found particulars 8b(i) and 8b(ii) not proved.

Findings in relation to misconduct

The Committee invited submissions from Mr Micklewright on behalf of the Council and from Mr Thomas on behalf of the Registrant on the issue of misconduct. Mr Micklewright told the Committee that the Council was neutral on the question of whether the admitted facts amounted to misconduct. He submitted that the Registrant’s actions breached Standard 8.1 of the Council’s Standards of Practice for Optometrists and Dispensing Opticians (“the Standards”), which requires the maintenance of “clear, legible and contemporaneous patient records”. He accepted that a breach of the Standards does not necessarily lead to a finding of misconduct, and that the breach must be serious. Mr Thomas submitted that the Registrant’s actions were not sufficiently serious to attract the moral opprobrium of being labelled professional misconduct.

The Committee accepted the advice of the Legal Adviser.

The Committee recognised that, when making a decision on misconduct, it was exercising its judgement and was not applying a burden or standard of proof. The Committee did take the view that the Registrant’s actions breached Standard 8.1, in that her records were not all made contemporaneously; and the records were not clear, as they were potentially misleading as to the time when they were made and they lacked an important detail regarding the drug used for dilation.

However, when considered in context, the Committee concluded that the breaches were not sufficiently serious to cross the threshold of professional misconduct. The failure to record the drug was an isolated slip by the Registrant. Her amendment of the electronic records was, at its highest, an error of judgement but was not intended to mislead and, in reality, was unlikely to mislead.

The Committee found that the admitted facts do not amount to misconduct. Consequently, there can be no basis for a finding of current impairment.
Chair of the Committee: James Kellock

Signature ………………………………………………… Date: 22 May 2019

Registrant: Sonia Pelan

Signature ………………………………………………… Date: 22 May 2019
## FURTHER INFORMATION

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<th>Transcript</th>
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<td>A full transcript of the hearing will be made available for purchase in due course.</td>
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<th>Professional Standards Authority</th>
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<td>This decision will be reported to the Professional Standards Authority (PSA) under the provisions of section 29 of the NHS Reform and Healthcare Professions Act 2002. PSA may refer this case to the High Court of Justice in England and Wales, the Court of Session in Scotland or the High Court of Justice in Northern Ireland as appropriate if they decide that a decision has been insufficient to protect the public and/or should not have been made, and if they consider that referral is desirable for the protection of the public. PSA is required to make its decision within 40 days of the hearing (or 40 days from the last day on which a registrant can appeal against the decision, if applicable) and will send written confirmation of a decision to refer to registrants on the first working day following a hearing. PSA will notify you promptly of a decision to refer. A letter will be sent by recorded delivery to your registered address (unless PSA has been notified by the GOC of a change of address).</td>
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Further information about the PSA can be obtained from its website at [www.professionalstandards.org.uk](http://www.professionalstandards.org.uk) or by telephone on 020 7389 8030.

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<td>If you require any further information, please contact the Council’s Hearings Manager at 10 Old Bailey, London, EC4M 7NG or, by telephone, on 020 7580 3898.</td>
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