BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(18)27 & F(18)28

AND

NADEEM SYED (01-19211)

DETERMINATION OF A SUBSTANTIVE HEARING
17-20 JUNE, 15-26 JULY & 19-23 AUGUST, 16-17 and 19-20 DECEMBER 2019, 29 JUNE – 2 JULY 2020, 6 – 10 JULY 2020

Committee Members:	Mr G White (Chair) Mr I Crookall (Lay) Ms C Tetlow (Lay) Mr A Jinabhai (Optometrist) Mr D Cartwright (Optometrist)
Legal adviser:	Ms M Ashworth
GOC Presenting Officer:	Ms A MacDonald (Counsel)
Registrant present/represented:	Present and represented
Registrant representative:	Mr S Thomas (Counsel), Ms S Masud & L Shah (AOP)
Hearings Officer:	Ms B Kayode (17-20 June 2019); Mr T Yates (15-26 July 2019); Ms J Alvarado (19-23 August 2019); Mr T Yates (16-17 and 19-20 December 2019); Mr T Yates (29 June-2 July 2020, 6-10 July 2020)
Facts not pursued by GOC:	1(a), 3(a), 3(b), 3(d), 4(a), 4(d), 6(a), 7(b), 7(c), 10(a), 10(b) and 11.

Facts found proved by admission:	4(b); 4(c); 5(a) and 5(b) in respect of 4(b) and 4(c); 6(b); 7(a) in respect of 6(b); 8(a) to 8(f) inclusive; 9(a) and 9(b) in respect of 8(a) to 8(f) inclusive; 12(a) to 12(g) inclusive; 13 insofar as it relates to failure to record; and 14 insofar as it relates to failure to record.
Facts found proved by Committee:	None
Facts not found proved:	1(b), 1(c), [2 not relevant due to findings on 1(b) and 1(c)], 3(c), 5(c), 9(c), 10(c), 13 (in relation to failed to discuss), 14 (in relation to failed to discuss), 15
Misconduct:	Yes
Impairment:	Yes
Sanction:	Conditional Registration – 12 months with a review
Immediate order:	No

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ALLEGATION

The Council alleges that you, a registered optometrist:

1. Between April 2006 and March 2013, submitted or caused to be submitted GOS3 'H' voucher claims to [REDACTED] Primary Care Trust for payment for prescriptions for "prism controlled bifocals", in relation to the patients set out in Schedule 1, when either:

   (a) the prescriptions and/or voucher claims were not clinically justified; and/or
   (b) "prism controlled bifocals" were not supplied to the patients; and or
   (c) a voucher for a lesser value should have been claimed instead.

2. Your actions, as set out at paragraph 1 above, were:

   (a) inappropriate, and/or
   (b) misleading, and/or;
   (c) dishonest, in that you knew that your claims were inaccurate at the time of submission and were claiming for payment to which you were not entitled.

3. On 7 October 2009 you prescribed Patient DW with "round 24 prism controlled bifocals" and submitted, or caused to be submitted, a GOS 3 'H Voucher' claim for payment, when:

   (a) such a lens does not exist and was not supplied, and or
   (b) the prescription and/or voucher claim was not clinically justified, and/or
   (c) a voucher for a lesser value should have been claimed instead, and/or
   (d) you failed to record any justification for the prescription and/ or voucher claim.

4. On 5 March 2010 prescribed Patient DH with "round 24 prism controlled bifocals" and submitted, or caused to be submitted, a GOS 3 'H Voucher' 0

   (a) such a lens does not exist and was not supplied, and/or
   (b) the prescription and/or voucher claim was not clinically justified, and/or
   (c) a voucher for a lesser value should have been claimed instead, and/or
   (d) you failed to record any justification for the prescription and/ or voucher claim.

5. Your actions as set out in 3 (a)- (c) and 4 (a)- (c) above were:

   (a) inappropriate, and/or;
   (b) misleading, and/or;
   (c) dishonest, in that you knew your claims were inaccurate at the time of submission and were claiming for payment to which you were not entitled.

6. In relation to patients in Schedule X you prescribed frequent changes of spectacles with small changes in prescription, issued with accompanying GOS vouchers, which were:

   (a) not clinically justified and/or
   (b) justification was not recorded.

7. Your actions as set out in 6 above were:

   (a) inappropriate, and/or
   (b) misleading, and/or
   (c) dishonest, in that by prescribing unnecessary and unjustified changes of spectacles you were claiming for payment to which you were not entitled.

8. Your records for the prescriptions issued to the following patients did not correspond with the specification written on the GOS2 form:-

   (a) Patient DP on 6 January 2010
   (b) Patient PP on 8 September 2010
   (c) Patient PF on 6 May 2011
   (d) Patient PG on 21 March 2012
   (e) Patient PH on 23 March 2012
   (f) Patient DD on 14 January 2014.

9. Your actions as set out in 8 above were:

   (a) inappropriate, and/or;
   (b) misleading, and/or;
   (c) dishonest, in that you intentionally recorded and claimed for a more complicated prescription for prisms than was actually issued to the patients as specified in the GOS2 forms and were therefore claiming for payment to which you were not entitled.

10. In relation to patients in Schedule A, you:

    (a) prescribed prisms which were not clinically justified, and/or;
    (b) claimed for a GOS voucher claim of a value that was higher than should have been submitted, and/or;
    (c) failed to record why the prescriptions and/or voucher claims were clinically justified.

11. Your actions as set out in 10 above were:

    (a) inappropriate, and/or;
    (b) misleading, and/or;
    (c) dishonest, in that you intentionally prescribed a more complicated prescription than was actually required by the patient in order to claim for a higher voucher value.

12. In respect of patients in Schedule A, your record keeping was inadequate in relation to recording:-

    (a) patient history
    (b) patient symptoms
    (c) patient ocular health
    (d) patient visual fields
    (e) patient visual acuity
    (f) justification of prescriptions issued
    (g) adequate follow up advice to patients regarding any pathology detected.

13. On or around 23 March 2011 you conducted a sight test on patient DG and failed to discuss or record that you had discussed your finding of cataracts with the patient.

14. On or around 23 August 2011 you conducted a sight test on patient DA and failed to discuss or record that you had discussed your finding of cataracts with the patient.

15. Between 5 March 2010 and 7 January 2013, you conducted several sight tests on patient DH and failed to discuss or record that you had discussed your finding of cataracts with the patient.

AND, in light of the above, your fitness to practise is impaired by reason of your misconduct**.**

DETERMINATION

Background to the allegations

1. The Registrant is an Optometrist registered with the GOC. At all relevant times he was on the Ophthalmic Performers' List. He had a General Ophthalmic Services (GOS) contract with the NHS Central Operations [REDACTED] (COM), which was the body responsible for managing Family Health Services for Primary Care Trusts in the [REDACTED] area. COM was later renamed Primary Care Support (PCS), which, since 1 April 2013, has supported NHS England in its primary care function and provided the financial function for the [REDACTED] and [REDACTED] areas.

2. In 2007, the Registrant had two practices, which were [REDACTED] [Practice 1], and [REDACTED] [Practice 2] (the Practices), the latter of which was later renamed [REDACTED] Opticians. He also administered domiciliary visits to eligible patients in their own homes or in care homes, in the areas of [REDACTED].

3. The NHS operates a GOS scheme, which provides financial assistance to patients who meet certain eligibility criteria. The Registrant was permitted to perform sight tests under the GOS scheme because he was on the Ophthalmic Performers List, and had a contract to do so with his local Primary Care Trust (PCT).

4. Relevant forms available to be completed in respect of a GOS sight test, included a GOS 1 form, which was the claim form for submission to the NHS for payment for conducting the sight test; a GOS 2 form, which was the prescription form required to be handed to the patient following the sight test; and a GOS 3 form, which was the voucher claim form in the event that spectacles were prescribed. The GOS 3 form was required to be completed for patients who were eligible for financial assistance with their appliance (spectacles/contact lenses). The GOS 3 form would entitle the patient to either one or two vouchers ranging from A to H, depending on the types of appliance prescribed. The fixed fee available for each voucher varied, with A having the lowest value and H having the highest. Since 2005, Voucher H's have been worth between £90 - £100 more than the next most valuable voucher.

5. The category of voucher, and the fee applicable would depend upon the type of lens prescribed. This was set out by the National Health Service (Optical Particulars and Payments) Regulations 1997. Guidance for Optometrists has been set out in the publications entitled 'Making Accurate Claims' (published in 2009) and 'Vouchers at a Glance'.

6. A voucher H entitled the eligible patient to a pair of prism-controlled bifocals (PCBs) of any power, or bifocal lenses:

    - Of a spherical power of more than ±14 dioptres with any cylindrical power, or
    - With a cylindrical power of more than ±6 dioptres with any spherical power.

7. The definition of a PCB, according to British Standards (BS 3521-1 (1991) and BS EN ISO 13666 (2012)), is '*a lens whose method of construction permits some independent control of prismatic effect or optical centration of the various portions of the lens*. *Note: this can include a 'slab- off' or bi-prism lens where, for example, the near portion of one lens contains a prism to reduce the vertical prismatic difference that would otherwise occur in anisometropia'.*

8. COM, later renamed PCS, as the financial body responsible, had the responsibility of issuing the payments for GOS 3 voucher claims, recording them on the electronic software system, and auditing the claims to compare the percentage of claims made by individual contractors to the local and national averages.

9. A contractor claiming vouchers above the national expectation was termed by COM/PCS as an 'Outlier'. The Registrant was identified as an Outlier in respect of GOS 3 H vouchers from 2006 onwards. It is alleged that by 2009, the percentage of H vouchers submitted by the Registrant was significantly higher than both the local and national averages. For example, between 1 April 2010 and 31 March 2011, the total number of H vouchers claimed in England was around 2000 and out of these, the Registrant's claims numbered around 250. For Voucher H's claimed in that year, the NHS paid the Registrant in excess of £50,000.

10. [REDACTED] [the Audit Agency] is an affiliate organisation to the NHS providing assurance and advisory services. In June 2011, the Audit Agency was engaged to review GOS voucher claims submitted for payment by all contractors to NHS organisations, including [REDACTED] PCT. The Audit Agency contacted the Registrant to request access to a sample of patient records and clinical notes. The Registrant agreed that the Audit Agency could attend his two practices and take copies of records and notes which were available.

11. As a result of the Registrant being identified as an Outlier, Witness 2, a qualified Optometrist and Ophthalmic Adviser for NHS England [REDACTED]

was asked to conduct an investigation in respect of a number of patients (Patients A to J) who were patients of the Registrant and who had been examined by him and had been issued with an H voucher. In total, 100 patients were written to, 50 of whom responded, and appointments were arranged with ten of them who were willing to be examined along with their spectacles. The appointments were conducted by Witness 2, with Witness 1 present, on 1 August 2011, 26 September 2011, and 3 October 2011.

12. Full sight tests were not conducted because of the GOS rules about early retest and the impact on when the patient's next eye examination would be due. Therefore, Witness 2's methodology was to:

    - Draw up a list of set questions to ask the patients and record their answers. The questions included history, symptoms, medication, and experience of double vision – all of which would potentially be relevant to patients suffering from binocular vision problems, and for whom PCBs may be appropriate. The patients reviewed the answers recorded on the form by Witness 2 and signed the form.

    - Take a number of measurements in relation to the spectacles themselves, and the patient.

    - Examine the patient's spectacles and record the lens type, including any prism present, and the size and model of the frame(s) presented.

13. On 23 April 2013, police accompanied a Fraud Investigator from the NHS Counter Fraud Service to the Registrant's commercial premises at Practice 1. Patient records and associated documents were seized from the premises, under the authorisation of a Notice of Production under the NHS Health Act 2006. The Registrant was then arrested by police for fraud by false representation and interviewed under caution by the Fraud Investigator at [REDACTED] police station.

14. In his police interview, the Registrant denied that his claims for H vouchers were fraudulent, and maintained that each of the ten patients (the subject of Particular 1) had been provided with PCBs. He accepted that he was the only registered Optical Practitioner at the Practices and that he would supervise the dispensing, although others would do the dispensing of lenses/appliances. He explained that [REDACTED] [Company A] was the company which supplied him with the PCB lenses, a company which was owned by his father-in-law.

15. In his police interview, the Registrant said he was aware that he dispensed H vouchers at a level higher than the national average, because he had been

told this by the Primary Care Trust. He said that in 2006, the [REDACTED] PCT had initially refused to pay his claims for PCBs issued under voucher H. He had telephoned the Finance Department of the [REDACTED] PCT and then the Association of Optometrists (AOP) had become involved and liaised with [REDACTED] PCT. He stated that consequently, the matter was resolved, and that he was permitted to continue claiming under voucher H and his claims were paid. He said that in due course he was told by his patients that they were being invited to attend examinations (by Witness 2), so the AOP again liaised with [REDACTED] PCT to inquire about the reasons for the examination requests. The Registrant said he therefore received a letter to say that it was just random testing.

16. The criminal case against the Registrant did not proceed to trial. The Committee was informed that in 2017, a civil claim between the NHS and the Registrant was settled out of court.

17. Subsequent to the Registrant's police interview in 2013, the Registrant continued to make claims under voucher H and [REDACTED] PCT continued to pay them.

18. In a letter to the GOC, dated 19 March 2015, the Registrant set out his position on PCBs and claiming H vouchers. In that letter he stated:

    '…*there are many different types of bifocal lenses that allow a different prismatic correction in the near portion thus creating a prism controlled bifocal. However, the glazing company that I utilise have also found that by rotating a round bifocal lens and hens* [sic] *de-centering its inset can also provide horizontal prism in the reading addition only and inset-de-centration of D segs can also provide prism in the in the near portion of its segment'.*

    'I took the view that in providing this type of correction to patients I was producing a prismatic effect in the near segment which was a prism controlled lens. This allowed for a claim for an H voucher to be made under the regulations. In addition, the booklet entitled Making Accurate Claims which is provided as guidance for the profession states that a voucher H may be used for progressive lenses'.

19. The Registrant's position was that in the cases where he had claimed an H voucher, he had provided a decentred bifocal or varifocal, which met the definition for a prism controlled bifocal (PCB).

20. An expert, Mr Andrew Keirl, a qualified and registered Dispensing Optician and Optometrist, was instructed on behalf of the GOC to go through the patient records which had been given to the GOC. He prepared a report, dated 27 August 2015, upon which the GOC Particulars were based.

21. Particulars1(b) and 1(c) (denied) relate to the ten patients (Patients A to J) who attended the appointments conducted by Witness 2 in 2011. In respect of each patient, it is alleged that the Registrant submitted GOS 3 H voucher claims to [REDACTED] PCT for payment for prescriptions for PCBs, when PCBs were not supplied to the patients and/or a voucher for a lesser value should have been claimed instead. Particular 2 (denied) alleges that the Registrant's actions at Particulars 1(b) and 1(c) were inappropriate and/or misleading and/or dishonest. In relation to dishonesty it is alleged that he knew that his claims for payment of H vouchers were inaccurate when he submitted them and that he knew that he was claiming for payment to which he was not entitled.

22. Particular 3(c) (admitted and found proved) relates to Patient DW, who was eligible for financial assistance under the GOS 3 voucher scheme. The Registrant provided Patient DW with a prescription for 'round 24 PCBs and submitted and claimed for a voucher H. In the joint experts' report, dated 17 June 2019, both experts, Mr Keirl for the GOC and Professor Eperjesi for the Registrant, agreed that '*a voucher for a lesser value than H should have been claimed instead'.*

23. Particulars 4(b) and 4(c) (admitted and found proved) relate to Patient DH, who was eligible for financial assistance under the GOS 3 voucher scheme. The Registrant provided Patient DH with a prescription for 'round 24 PCBs' and submitted and claimed for a voucher H. In the joint experts' report, both experts agreed that, having regard to the patient notes recorded by the Registrant, '*this patient did not have binocular vision and was not complaining of diplopia (double vision). Prisms are not clinically justified for patients who do not have binocular vision and do not complain of diplopia'*. They also agreed that '*the claim for a voucher H was not justified because the prescription was not justified'* and *'a voucher for a lesser value than H should have been claimed instead'.* Particulars 5(a) and 5(b) (admitted and found proved) relate to the Registrant's actions at Particulars 3(c), 4(b) and 4(c) as being inappropriate and misleading. Particular 5(c) (denied) alleges that his actions at Particulars 3(c), 4(b) and 4(c) were dishonest.

24. Particular 6(b) (admitted and found proved) relates to the patients listed in Schedule X, for whom the Registrant prescribed changes of spectacles, issued with accompanying GOS vouchers, without recording the justification for those changes. In the joint experts' report, both experts agreed that, having regard to the patient notes recorded by the Registrant, the justification for the changes in prescription was not recorded. Particular 7(a) (admitted and found proved) alleges that the Registrant's actions in not recording the justification were inappropriate.

25. Particulars 8(a) to (f) inclusive (admitted and found proved) relate to record keeping issues in respect of six patients. In the case of each patient, the analysis of the information in respect of prism recorded in the GOS 2 form, (the patient's prescription), differed from that recorded in the GOS 3 form. In the joint experts' report, both experts agreed that '*the prescriptions issued to the patients…did not correspond with the specification on the GOS 2 form'.*

26. Particular 9 alleges that the Registrant's actions at 8(a) to (f) were inappropriate [9(a) (admitted)] and/or misleading [9(b) (admitted)] and/or dishonest [9(c) (denied)]. In relation to dishonesty it is alleged the Registrant intentionally recorded and claimed for a more complicated prescription for prism than was actually issued to the patients as specified in the GOS 2 forms and was therefore claiming for payment to which he was not entitled.

27. Particular 10(c) (denied) alleges that the Registrant failed to record why the prescriptions and/or specific voucher claims were clinically justified for the patients listed in Schedule A.

28. Particulars 12(a) to 12(g) inclusive (admitted and found proved) allege that the Registrant's record keeping was inadequate for the patients listed in Schedule A in a number of material respects. It is alleged that for each of the patients specified in Schedule A, their clinical records did not include the patients' history, symptoms, ocular health, visual fields, visual acuity, nor the justification for the prescriptions issued or adequate follow-up advice to the patients regarding any pathology detected. Both experts, Mr Keirl and Professor Eperjesi, agreed that in respect of the patients in Schedule A, the Registrant's record keeping was inadequate.

29. Particular 13 (admitted insofar as it relates to 'failed to record') alleges that on or around 23 March 2011, the Registrant conducted a sight to test on patient DG and failed to discuss or record his findings of cataract with the patient. Both experts, Mr Keirl and Professor Eperjesi, initially agreed that if the Registrant did discuss his findings with the patient, there is nothing noted in the clinical records about this discussion.

30. Particular 14 (admitted insofar as it relates to 'failed to record') alleges that on or around 23 August 2011, the Registrant conducted a sight test on patient DA and failed to discuss or record his findings of cataract with the patient. Both experts, Mr Keirl and Professor Eperjesi, initially agreed that if the Registrant did discuss his findings with the patient, there is nothing noted in the clinical records about this discussion.

31. Particular 15 (denied) alleges that between 5 March 2010 and 7 January 2013 the Registrant conducted several sight tests for patient DH and failed to discuss or record that he had discussed his findings of cataract with the patient. Records of sight tests show they were conducted on 5 March 2010, 31 January 2011, 5 January 2012, 7 January 2013.

Particulars of allegation withdrawn by the General Optical Council

32. At the outset of the hearing on day 1, Ms MacDonald, on behalf of the General Optical Council (GOC), indicated that in light of the joint experts' report, dated 17 June 2019, and having taken instructions, the GOC was withdrawing the following factual particulars: 10(a), 10(b) and 11.

33. Following evidence given by the GOC expert witness, Mr Keirl, and having taken instructions, Ms MacDonald indicated on day 17 of the hearing (21 August 2019), that the GOC would no longer be pursuing the following factual particulars of the allegation: 1(a), 3(a), 3(b), 3(d), 4(a), 4(d), 6(a), 7(b), and 7(c). Further, in relation to the wording of particular 10(c), the words: 'the prescriptions and/or' should be removed, so that the particular would read: 'Failed to record why the voucher claims were clinically justified'

Admissions made by the Registrant and formally found proved

34. At the outset of the hearing on Day 2, Mr Thomas, on behalf of the Registrant, provided a written document to the Committee setting out the Particulars which the Registrant admitted. The Registrant admitted the following factual Particulars of the allegation: 4(b); 4(c); 5(a) and 5(b) in respect of both 4(b) and 4(c); 6(b); 7(a) in respect of 6(b); 8(a) to 8(f) inclusive; 9(a) and 9(b) in respect of 8(a) to 8(f) inclusive; 12(a) to 12(g) inclusive; 13 insofar as it related to failure to record; and 14 insofar as it related to failure to record.

35. The Chair announced that those Particulars admitted by the Registrant, were formally found proved.

Defence application to adduce hearsay evidence

36. Mr Thomas, on behalf of the Registrant, applied to adduce hearsay evidence under Rule 40(1), in respect of patients DN and DZ. He submitted that the evidence was relevant in three ways. Firstly, he submitted that the GOC had alleged throughout that the Registrant had either not prescribed prism or prism had not been dispensed. Secondly, he submitted that the evidence was of a 'quasi-character' nature and went to the general clinical care given by the Registrant. Thirdly, he submitted that it was directly relevant to Particulars 13,

14 and 15 in that these were patients who gave evidence about discussions with the Registrant in respect of their clinical care, including the eye conditions cataract (DN) and glaucoma (DZ). He submitted that it was not appropriate for these witnesses to be called to give evidence.

37. Ms MacDonald conceded that it would not be appropriate to require the witnesses to be called. However, she did not accept that the evidence was relevant. She submitted that the patients DN and DZ may have been relevant to Particular 6(a), but that Particular was no longer pursued by the GOC. In relation to Mr Thomas' submissions she submitted that the relevance was marginal.

38. Having heard and accepted the advice of the Legal Adviser, the Committee was satisfied that the witness statements of DN and DZ were relevant, as they gave evidence which may be likely to assist the Committee in resolving the outstanding issues, including character. It was further satisfied that the evidence of DN and DZ was relevant to Particulars 13, 14, and 15, as DN was a patient who gave evidence of her discussions about cataract with the Registrant, and DZ was a patient who gave evidence of her discussions about surgery with the Registrant.

39. The Committee was of the view that it would be unfair to require elderly patients in their 70s to be called to give evidence in the circumstances of this case. Accordingly, the Committee concluded that the hearsay evidence of DN and DZ was admissible, on the basis of being both relevant and fair. The Committee noted that this was not agreed evidence and it was for the Committee to determine what weight, if any, to give to the evidence in due course.

Findings in relation to the facts

40. The Committee was provided with a bundle of documents in support of the GOC case. These included the witness statements of Witnesses 1, 2, and 3; expert reports, dated 27 August 2015 and 31 May 2018, prepared by Mr Keirl; a power point presentation prepared by Mr Keirl; copies of completed GOS forms; patient records; schedules of comparison between local and national H voucher claims and those of the Registrant; the Registrant's police interviews; correspondence between the Association of Optometrists (AOP) and the GOC; correspondence between the Registrant and the GOC; and GOS Guidance on the voucher scheme entitled 'Making Accurate Claims' (2009 and 2014). Mr Keirl produced in evidence 12 sets of lenses/spectacles, illustrating the types of lenses under discussion.

41. The GOC called the following witnesses in support of its case:

    - Witness 1 – an Account and Verification Manager at Primary Care Support (PCS) within NHS England (previously named COM). She provided evidence regarding the GOS system and the local and national average claims for GOS 3 H vouchers and the Registrant's claims in particular. She also attended the investigations conducted by Witness 2 in respect of patients A to J.
    - Witness 2 – a qualified Optometrist and Ophthalmic Advisor for [REDACTED] PCT. She conducted clinical investigations in respect of patients A to J over three dates, 1 August 2011, 26 September 2011, and 3 October 2011.
    - Mr Andrew Keirl – the GOC expert, who examined the patient records the GOS forms and other relevant material to give his expert opinion in respect of PCBs, decentred lenses, and clinical matters, including record keeping.

42. The Committee was provided with a bundle of documents submitted on the Registrant's behalf, including an expert report, dated 4 March 2019, prepared by Professor Frank Eperjesi; his first addendum expert report, dated 21 May 2019; an expert report, dated 12 February 2019, prepared by Dr Glyn Walsh; copies of patient invoices; witness statements of patients DN and DZ; and three character references. During the hearing, but before either the Registrant or Professor Eperjesi gave evidence, Professor Eperjesi produced a second addendum expert report, dated 21 October 2019. The Registrant gave evidence and called as expert witnesses, Dr Walsh and Professor Eperjesi. The Registrant produced a pair of varifocal spectacles, with order form and invoice to illustrate a lens type under discussion.

43. Prior to the hearing, the GOC expert, Mr Keirl and the defence expert, Professor Eperjesi, prepared a joint experts report, dated 17 June 2019. A copy of this joint report was provided to the Committee.

44. The Committee heard and accepted the advice of the Legal Adviser. It considered all of the evidence produced by both parties and the submissions of Ms MacDonald on behalf the GOC and Mr Thomas on behalf of the Registrant. The Committee understood that the burden of proving each contested Particular was on the GOC and the standard of proof required was the civil standard, namely whether it was more likely than not that the alleged fact occurred.

The Committee's Approach

45. The Committee, having regard to the submissions of the parties, identified that the first issue to resolve was whether or not the GOC had proved to the required standard, that a decentred bifocal lens is not a PCB. The primary position of the GOC, simply stated, was that a decentred lens does not fall within the definition of a PCB, according to British Standards, and consequently, none of the spectacles supplied by the Registrant to the patients (identified in the relevant Particulars) was a PCB. The position of the defence, simply stated, was that a decentred bifocal does fall within the definition of a PCB, according to British Standards.

46. The Committee first considered the formal definition of a 'Prism Controlled Bifocal' (PCB). The Committee noted that all three experts agreed that the definition of a PCB, according to British Standards, was contained within Standard BS 3521-1 (1991) and BS EN ISO 13666 (2012) as follows:

> *"A prism controlled bifocal (or multifocal) is a lens whose method of construction permits some independent control of prismatic effect or optical centration of the various portions of the lens. Note: this can include a 'slab- off' or bi-prism lens where, for example, the near portion of one lens contains a prism to reduce the vertical prismatic difference that would otherwise occur in anisometropia"* (the Note was added in 2012).

47. The Committee noted that the three experts were not in agreement about the interpretation of the definition of a PCB, and in particular, whether a decentred bifocal/varifocal lens falls within the definition of a PCB according to British Standards.

48. The Committee had careful regard to the wording of the formal definition of a PCB, according to British Standards. It considered that there were essentially two aspects to this definition. The first was the method of construction of the lens itself and the second was whether that construction permitted some independent control of the prismatic effect of the various portions of the lens.

49. The Committee considered the first aspect of the definition of a PCB, namely the method of construction of the lens.

50. The Committee noted that Mr Keirl's initial position, as set out in his expert report of 27 August 2015, had been that if a lens was made from a plastics material rather than glass, it was not a PCB. Mr Keirl did not consistently maintain this position in his evidence, and at times conceded that PCBs were capable of being made from a plastics material. In examination-in-chief Mr Keirl expressed his opinion that the construction process meant that PCBs were essentially limited to five specific types of spectacles, namely a solid prism segment bifocal lens, a cemented prism segment bifocal lens, a Franklin split lens, a Presto lens, and a 'slab-off' or bi-prism lens. Mr Keirl placed significant emphasis on the word 'construction' for his interpretation of the definition, which he maintained included the purpose of the lens. Mr Keirl stated in examination in chief that the *'construction element takes place during the moulding or casting process'*. He had the following exchange with Ms MacDonald:

> *Ms MacDonald: So just to be clear, do you consider the surfacing to be part of the construction process, or not?*
>
> *Mr Keirl: The surfacing does not affect the reading addition, so if we think about the purpose of a bifocal lens, it is a lens to provide a reading addition. That has been provided during the construction. The surfacing process does not affect the reading addition, so I would not consider that to be part of the construction, that is part of the normal process of any prescription.*

51. However, in cross examination, Mr Keirl confirmed that there was no definition within the British Standards for what the word 'construction' meant and conceded that it was open to interpretation and further debate.

52. Dr Walsh, in his expert report, stated that bifocal lenses have two portions, the upper part of the lens often being called the distance portion and the lower part of the lens often being called the near portion (or segment in all bifocals except the E-line type). Dr Walsh explained that the optical centre of a lens has no prismatic effect, and that the prismatic effect of the lens increases with increasing distance from the optical centre. He explained that decentration is the process of physically moving the lens away from its normal position, or moving the near segment from its normal position in order to achieve a prismatic effect.

53. Dr Walsh, in his expert report explained that surfacing is the process of grinding and polishing a lens surface to its final curves, and the process involves grinding away the material with tools of the same curvature. In his

evidence in chief he clarified that surfacing is the process used to generate the final prescription into the lens.

54. In examination in chief, Dr Walsh said the following in answer to Mr Thomas:

> *Mr Thomas: Is there any common theme of manufacture, or to use the appropriate word, 'construction', is there any common theme of construction amongst these five types of lenses?* [ie. solid prism segment bifocal lens, a cemented prism segment bifocal lens, a Franklin split lens, a Presto lens, and a 'slab-off']
>
> *Answer: Surfacing takes place on all of them.*
>
> *Mr Thomas: But at different stages?*
>
> *Answer: At different stages of the lens production but they are all surfaced and when the surfacing is finished the lens is finished. It is the end of the manufacturing process.*
>
> *…*
>
> *Mr Thomas: but surfacing is certainly in your opinion part of construction of a decentred lens?*
>
> *Answer: Definitely, yes. All surfacing processes I would say are manufacturing processes. There is no real reason to say otherwise.*

55. Dr Walsh explained the process of surfacing a decentred bifocal lens as follows:

> *…The first thing you would do is work where the near needs to be to give the prismatic effect that you want at near. You would then look at the distance power and find out how much moving that to give you that amount of decentration that you want would affect the distance prism…*
>
> *…Once you have done that you would then angle your tool when you are actually finished surfacing the lens so the distance optical centre is exactly where it would have been if you had not moved the segment, so you are not working a prism, you are preventing yourself from giving an unwanted prism.*

56. Professor Eperjesi, in the joint expert report, dated 17 June 2019 expressed his opinion that decentration of a conventional bifocal lens (moving the lens horizontally to induce a prismatic effect) can be described as construction and therefore can be used to produce PCBs. In his oral evidence his opinion was that decentration was part of the construction of the lens. Professor Eperjesi's opinion was that surfacing does form part of the construction process. He said: "*My view is that everything that happens to the lens before it is inserted into the frame is part of the construction."* He confirmed his

opinion that “the bog standard” bifocal lens needed to be surfaced after it had been shunted/decentred.

57. Given that there is no formal definition of the word ‘construction’ within the British Standard, the Committee had regard to the ordinary meaning of the word construction. It noted that the dictionary definition of the word ‘construct’ meant ‘fit together, frame, or build’.

58. The Committee noted that all three experts agreed that the five traditional PCBs fell within the definition of a PCB. They agreed that the Franklin Split, Presto lens, and cemented prism segment bifocal lens did so because there was a process whereby the distance and near portions of the lens were physically joined together so that different magnitudes of prism could be incorporated at distance and near. In relation to the solid prism segment bifocal lens and the Slab-Off all three experts agreed that these also fell within the definition, albeit both are made from one piece of material. The process for creating these two lens types involves either cutting into the back of the lens or working prism over the lower portion of the lens. The Slab-Off allows partial independent control of prismatic effect in the near portion, because it is constructed from a single lens.

59. The Committee concluded that construction of a decentred bifocal is similar to that of a solid prism segment bifocal lens, which is accepted by all the experts as falling within the definition of a PCB. Dr Walsh had explained that a solid prism segment is also “surfaced into the back of the lens”. The prism in a solid prism segment bifocal is created by surfacing. The decentred bifocal lens is surfaced to remove the unwanted prism created by decentration. The creation or removal of prismatic effect in one part of the lens requires a complex calculation to enable the correct surfacing of the lens.

60. Accordingly, the Committee accepted the evidence of Dr Walsh and Professor Eperjesi that surfacing forms part of the construction process and that the surfacing of a decentred bifocal lens has to be adjusted to take account of the decentration, to remove or alter the prism which has been created in that (distance) portion by the decentration of the whole lens, before the lens is ‘glazed’ (fitted into the frame).

61. The Committee accordingly determined that surfacing of a decentred bifocal is part of the method of construction.

62. The Committee next considered the second component of the definition of a PCB, namely whether the construction permits some independent control of the prismatic effect of the various portions of the lens.

63. In cross-examination Mr Keirl accepted that 'partial' independent control or independent prismatic effect could be achieved through decentration. He was involved in the following exchange with Mr Thomas:

> *Mr Thomas: You accept do you not, that some independent control or some independent prismatic effect can be adduced through decentration?*
>
> *Mr Keirl: I do, but as I said, I describe that as partial prism control.*
>
> *…*
>
> *Mr Thomas: partial is the same as some, is it not?*
>
> *Mr Keirl: Yes.*
>
> *…*
>
> *Mr Thomas: We* [on behalf of the Registrant] *suggest that decentration is a method of creating a prism controlled bifocal because it produces or can permit some independent control of prismatic effect or optical centration at the various portions of the lens. It can create some prism at near and a different prism or no prism at all at a distance.*
>
> *Mr Keirl: but it is not a fully controlled prism controlled bifocal.*
>
> *Mr Thomas: … the definition just requires some independent control.*
>
> *Mr Keirl: Yes.*
>
> *Mr Thomas: Decentration does allow some independent control and therefore decentration is prism controlled bifocal, is it not?*
>
> *Mr Keirl: I cannot accept using the term prism controlled bifocal. I would accept partial prism controlled bifocal because of the reasons I have said numerous times before.*

64. In light of Mr Keirl's evidence, Ms MacDonald, during her cross examination of Dr Walsh, accepted on behalf of the GOC, that decentration in certain circumstances did enable some amount of prism at near.

65. The opinion of Dr Walsh was that it is the result or outcome contained within the definition, which is important, namely '*permits some independent control of the prismatic effect…'*. When asked by Mr Thomas why decentred bifocals fell into the definition of a PCB according to British Standards, he said:

> *Because they offer a similar degree of independent prism control to any other lens that you are trying to independently control the prism with, albeit to a slightly lesser magnitude in some cases.*

66. Dr Walsh was candid in his assessment that decentred bifocals fell into the definition of a PCB, according to British Standards, and that this was a loophole which needed resolving. In answer to Committee questions, he said:

> *Now, I freely admit that this prism control issue is a loophole, I would never describe it as anything else, which is why I wanted it either closing or confirming. (...) I freely admit it is a loophole, it is a quirk in the regulations, but I don't think the NHS saw at the time they were [inaudible].*

67. Professor Eperjesi, in his oral evidence, told Ms MacDonald:

> *My view on prism controlled bifocals is that – well, prism controlled spectacles, is that if there is a difference in prism distance and the viewing portion, then that means it is prism controlled. If a shunted* [decentred] *lens produces a difference in prism, in the distance and near portion, then that makes it a prism controlled lens.*

68. In considering the difficulty in interpreting the definition as set out in the British Standard, the Committee noted the evidence of Dr Walsh in which he said: *"I was trying to say the only way this can actually be interpreted in any way that would make sense for an organisation such as the General Ophthalmic Services would be to add in a word such as "intention"… I am not happy with the standard at all. I think the standard is ambiguous to the point at which it is virtually meaningless. I feel that to include the conventional prism controlled lenses it is necessary to make so many… to be so flexible with the standard that it is very difficult not to include all lenses. I have no doubt that was not the intention of those who wrote it."* He also said: *"…you can either get a prism by decentration or you can get a prism by working the prism and it is not distinguished by the NHS".*

69. The Committee considered that all three experts were highly skilled, experienced and eminent in their field. Both Mr Keirl and Professor Eperjesi had reflected on the evidence and their positions over the duration of proceedings, and had developed or varied their opinions as the case had progressed and the evidence had unfolded. In the Committee's view, this did not necessarily undermine or lessen their expertise, but rather reflected the complex nature of the issues involved.

70. The Committee considered Ms MacDonald's secondary position, that even if decentred bifocals could technically fit the formal definition of a PCB, they would not be a PCB unless the finished spectacles were 'usable' for the patient, in the sense that they had the correct prescription and a sufficient reading area.

71. However, the Committee considered that it was constrained by the formal definition of a PCB and also the wording of specific allegations which did not allege that the spectacles supplied were unusable. The Committee noted that the experts were not in agreement as to the interpretation of the formal definition. The Committee did not consider it appropriate to interpret the definition as having an additional implied requirement of an intention to achieve a particular outcome from its construction or of usability of the finished spectacles.

72. Having concluded that surfacing is part of construction, the Committee was of the view that this method of construction does permit some independent control of prismatic effect in the different portions of the lens. Therefore, it concluded that a decentred bifocal lens can be considered as a PCB.

73. In light of all of the above, including the opinions of the defence experts, Dr Walsh and Professor Eperjesi, and the concessions made by the GOC expert, Mr Keirl, the Committee was not satisfied to the required standard that the GOC had proved that a decentred bifocal did not fall within the definition of a PCB, according to British Standards.

Particular 1(b)

Between April 2006 and March 2013, submitted or caused to be submitted GOS3 'H' voucher claims to [REDACTED] **Primary Care Trust for payment of prescriptions for "prism controlled bifocals", in relation to the patients set out in Schedule 1, when either:**

(b) "prism controlled bifocals" were not supplied to the patients;

74. Witness 2 was the only witness who examined and took measurements of the spectacles which had been shown to her by patients A to J. The Committee assessed her credibility and reliability. The Committee was of the view that Witness 2 was an honest witness who was doing her best to assist the Committee. She had adopted a structured approach in creating questionnaires for the patients to answer and had recorded the information the patients had told her, as well as the results of her examination of the spectacles. However, it became apparent to the Committee that she had difficulties in recollection when giving evidence in 2019 about the examinations that she had conducted in 2010/11 and was relying on historic records that she had made at the time. It also appeared to the Committee that at the time of her examinations, she was working on the basis that only the traditional PCBs met the definition of a PCB. Mr Thomas, in cross examination suggested to Witness 2 that it could be inferred from her evidence that she was not recording measurements at the near visual point

but was in fact recording at the geometric centre or at the optical centre of the lens. She agreed that could be inferred but she could not say 'for definite'.

75. The Committee was of the view that the evidence of Witness 2 was confused, particularly in respect of the precise measurements that she was taking, and whether she was measuring for prism in the correct place on the lenses. She also appeared to have been inconsistent with when she would or would not record all the different prismatic effects (both horizontal and vertical) at all the relevant points on each pair of spectacles. The Committee concluded that her evidence in respect of whether or not she had discovered all prism in the spectacles she was examining was not reliable. In reaching this conclusion, the Committee had regard to the evidence of Mr Keirl, the GOC expert, who, in his capacity as an expert, had been listening in to the evidence of Witness 2. Following the completion of her evidence, Mr Keirl carried out his own calculations, based on Witness 2's measurements, to determine whether or not a prismatic effect would be evident at the near visual point. Mr Keirl had the following exchange with Mr Thomas:

Mr Thomas: You produced a document which we went through yesterday, which shows that Witness 2 fails to record prisms at the near visual point. That is right, is it not?

Mr Keirl: In some of the cases that would appear to be the case. Some cases were closer to the calculation, some did not correspond.

Mr Thomas: You yesterday, when you were giving your evidence with regards to that document said 'in practice some of these prisms would have been within tolerance' but Witness 2 was not conducting a sight test, was she?

Mr Keirl: No.

Mr Thomas: She was not issuing prescriptions, was she?

Mr Keirl: No.

Mr Thomas: She was investigating whether prisms were present.

Mr Keirl: Correct.

Mr Thomas: So she should have recorded every prism that was present, should she not?

Mr Keirl: At the distance visual point and the near visual point.

Mr Thomas: Your document showed that she failed to record prisms at the near visual point.

Mr Keirl: Yes.

…

Mr Thomas: You then heard her give evidence and be cross-examined. That is right, is it not?

Mr Keirl: I did.

Mr Thomas: It would be fair to say, and of course this is a matter for the Committee, but it would be fair to say that her evidence was somewhat confused?

Mr Keirl: Yes.

Mr Thomas: After hearing her evidence, there was yet more reason to consider that Witness 2's evidence was not reliable, after having heard her evidence and her cross-examination.

Mr Keirl: Yes.

Mr Thomas: Given that all of the conclusions with regards to Patients A to J are almost exclusively based on Witness 2's evidence, which is unreliable, you cannot draw any conclusion, can you? You cannot present any real concrete opinion to this committee with regards to Patients A to J can you?

Mr Keirl: That is correct. We do not know exactly what the spectacles were that were being measured. We know that they do not correspond to the dates on the GOS vouchers. We have no documentation to confirm what was supplied to the patient.

76. Professor Eperjesi, in his capacity as an expert, had also listened into the evidence of Witness 2. He too agreed that he could not rely on Witness 2's evidence to determine whether or not the Registrant supplied PCBs to patients A to J.

77. In light of this, the Committee concluded that it would need to treat the evidence of Witness 2's measurements and findings with caution, and in so doing, that it should have regard to the calculations undertaken by the GOC expert, Mr Keirl.

78. The Committee then considered whether or not the GOC had proved that any of the patients A to J (in Schedule 1) were not supplied with PCBs, either as traditional PCBs or PCBs in the form of decentred bifocals/varifocals. The Committee considered each patient separately. The Committee noted that both experts agreed that in the absence of the patient records, it was not

possible to conclude that a prescription for differential prism/PCBs, in relation to each patient, was not clinically justified. Further, for some of the patients A to J, the presenting symptoms, as recorded by Witness 2, indicated that differential prism/PCB's may have been clinically justified.

79. As identified earlier, Ms MacDonald had raised the question of whether the spectacles dispensed were, in fact, usable for the patient. There was evidence recorded from some of the patients seen by Witness 2 that they had difficulty in using their spectacles; it was recorded in some of the questionnaires that some patients no longer used their spectacles either wholly or in part and some had to return to the Registrant's practice for adjustment. Mr Keirl had expressed the opinion that some of the patients' spectacles may not be usable as the positioning of the near vision segment of the lens would mean that patients would not be able to use the optimum part of the near segment, or in some cases any part of the near segment and Professor Eperjesi said they may be difficult to use. This observation was noted particularly in relation to varifocals where the tolerance for the varifocal to be 'swung' was small. However, in the Committee's opinion, the question to determine was whether the spectacles supplied to each of the patients were PCB's in accordance with the British Standards definition. The Committee concluded that the evidence showed that the spectacles met the definition; the fact that some patients had difficulty in using them was not material to the issues to be resolved by the Committee.

Patient A

80. The Committee finds Particular 1(b) not proved in respect of Patient A.

81. The Committee noted that there were two GOS3 forms for Patient A. One was dated 21 May 2010, and the other was dated 8 February 2011. Patient A attended the meeting with Witness 2 on 1 August 2011, and had brought with them a pair of spectacles and two lenses not in a frame. Witness 2 had recorded on the questionnaire that Patient A told her that new lenses had been put in an old frame which were six months old, and the lenses which were out of the old frame were eight months old. The first question for the Committee was whether or not either of the GOS3 forms corresponded to the spectacles/lenses. In relation to the spectacles, the Committee considered that the GOS3 form, dated 8 February 2011, was more likely than not to correspond with the date Patient A said she had received the spectacles, albeit there were slight differences in the measurements of the cylindrical and reading addition powers.

82. Witness 2 did not discover any prism in respect of the lenses which were in the spectacles, whereas Mr Keirl, when he looked at her recorded measurements, had calculated 0.3 dioptres of vertical prism at the near visual

point (NVP) for the right eye, and 0.83 dioptres of vertical prism at the NVP for the left eye. Mr Keirl was of the view that any reasonably competent Optometrist would be able to measure 0.5 dioptres of prism or above. Given Mr Keirl's findings, the difficulty for the Committee was whether Witness 2 had not found prism because it was not there, or whether it was because she had missed it. Particularly in relation to the left eye, and mindful of Mr Keirl's opinion that a reasonably competent Optometrist should be able to measure at least 0.5 dioptres of prism, the Committee did not consider that Witness 2's measurements were sufficiently accurate to be relied upon. In all the circumstances, the Committee was not satisfied to the required standard that PCBs had not been supplied to Patient A.

Patient B

83. The Committee finds Particular 1(b) not proved in respect of Patient B.

84. The Committee noted that there were two GOS3 forms in respect of Patient B. One was dated 21 August 2009, and the other was dated 8 September 2010. Patient B attended the meeting with Witness 2 on 1 August 2011, and had brought with them one pair of spectacles. Witness 2 recorded on the questionnaire that patient B had said that her last sight test had taken place in August 2010. The Committee was satisfied that it was more likely than not that the GOS3 form, dated 8 September 2010, corresponded to the spectacles Patient B had brought to the meeting.

85. Witness 2 did identify that there was prism within the lenses of Patient B's spectacles, but did not find any differential prism. Her findings were that the prism found was the same for near as it was for distance. Mr Keirl, in his calculations, had identified differential vertical prism of almost 1 dioptre, according to Witness 2's measurements. Witness 2 had not identified any vertical prism. Mindful of Mr Keirl's opinion that a reasonably competent Optometrist should be able to measure at least 0.5 dioptre of prism, the Committee did not consider that Witness 2's measurements were sufficiently accurate to be relied upon. In all the circumstances, the Committee was not satisfied to the required standard that PCBs had not been supplied to Patient B.

Patient C

86. The Committee finds Particular 1(b) not proved in respect of Patient C.

87. The Committee noted that there were two GOS3 forms in respect of patient C. One was for 24 February 2010, and the other was for 25 February 2011. Patient C had attended the meeting with Witness 2 on 1 August 2011, and had brought with them two pairs of spectacles. Witness 2 recorded on the

questionnaire that patient C had said that their last sight test had been performed a few months before, possibly May (2011). The Committee considered that the dates of the GOS3 form for 25 February 2011, were sufficiently proximate to correspond with the 'latest pair' of spectacles brought by Patient C and examined by Witness 2.

88. Witness 2 did identify that there was prism within the lenses of Patient C's spectacles, but did not find any differential prism. Her findings were that the prism found was the same for near as it was for distance for both the left and right eye. Mr Keirl, in his calculations, had identified vertical differential prism of 0.78 dioptres between the eyes at the NVP, according to Witness 2's measurements. The Committee also noted that Mr Keirl's calculations indicated that Witness 2 had missed differential prism of 0.67 dioptres in the other pair of spectacles. Mindful of Mr Keirl's opinion that a reasonably competent Optometrist should be able to measure at least 0.5 dioptre of prism, the Committee did not consider that Witness 2's measurements were sufficiently accurate to be relied upon. In all the circumstances, the Committee was not satisfied to the required standard that PCBs had not been supplied.

Patient D

89. The Committee finds Particular 1(b) not proved in respect of Patient D.

90. The Committee noted that there was only one GOS3 form in respect of Patient D and it was dated 24 July 2009. Patient D had attended the meeting with Witness 2 on 26 September 2011 and had brought with them two pairs of spectacles. Witness 2 recorded on the questionnaire that Patient D had said that their sight test had taken place in August 2011. Of the spectacles, Witness 2 had recorded Patient D as saying that one of the pairs was 5 to 6 weeks old and the other pair was one year old. The Committee noted that these dates did not correspond to the GOS 3 form, nor to the prescription. In these circumstances, the Committee could not be satisfied to the required standard that the GOS3 form related to either pair of spectacles which Witness 2 examined.

Patient E

91. The Committee finds Particular 1(b) not proved in respect of Patient E.

92. The Committee noted that there were two GOS3 forms in respect of Patient E. One was for 26 March 2010 and the other was for 5 April 2011. Patient E had attended the meeting with Witness 2 on 26 September 2011 and had brought with them two pairs of spectacles. Witness 2 recorded on the questionnaire that patient E had said that their last sight test was in May/June

2011, following which a pair of spectacles had been prescribed and supplied by the Practice. The second pair of spectacles was recorded as being two and a half years old and did not correspond to the dates for either of the two GOS3 forms. The Committee noted the answers which Witness 2 had recorded on the questionnaire in relation to the latest pair of spectacles. Patient E had described the latest pair of spectacles as varifocals and had been told that prism would be put in them. A narrative was recorded of their answer to the question about when they received the spectacles as follows:

> *~ 2 weeks after test. When first put on didn't feel right tried for few days + returned (non tolerance). [Dispenser] was going to check lenses + straighten them. No better so had another appointment with same optician. Told "prescription was right but felt a problem with lenses because difficult to get prism in varifocals". Remade + were perfect then.*

93. In relation to varifocals, Witness 2 stated that she was unaware that it was possible to measure prism at the NVP, and thought that it was only possible to measure prism at the prism reference point. She had not identified any prism at either distance or near for either eye. Mr Keirl confirmed that the NVP and the prism reference point were not in the same place on the lens, and his calculations identified a prismatic effect at the NVP for both eyes at both distance and near. In light of Witness 2 not understanding that it was possible to measure prism at the NVP, the Committee did not consider that Witness 2's measurements were sufficiently accurate to be relied upon. In addition, the Committee noted that, as it was recorded that Patient E had said that the spectacles had to be re-made, there may be a disconnect between the GOS3 form for 5 April 2011, and the apparently re-made spectacles which Witness 2 examined. The Committee was not satisfied the GOS 3 related to the re-made spectacles. In all the circumstances, the Committee could not be satisfied to the required standard that Patient E had not been supplied with prism controlled bifocals/multifocals.

Patient F

94. The Committee finds Particular 1(b) not proved in respect of Patient F.

95. The Committee noted that there was one GOS3 form in respect of Patient F, which was dated 23 October 2009. Patient F had attended the meeting with Witness 2 on 3 October 2011 and had brought with them two pairs of spectacles. Witness 2 had recorded on the questionnaire that Patient F had said their last sight test had taken place in October 2010, and the latest pair of spectacles had been prescribed and supplied on that occasion. The Committee noted that would have been one year after the GOS3 form. In relation to the second pair of spectacles, Witness 2 had recorded that Patient

F had described them as being three years old. The Committee noted that that would have been one year before the GOS3 form.

96. Witness 2 did identify that there was prism within the lenses of Patient F's spectacles, but did not find any differential prism. Her findings were that the prism found was the same for near as it was for distance in both the left and right eyes, whereas Mr Keirl, in his calculations, had identified differential prism.

97. The Committee did not consider that there was a sufficient degree of connection regarding the dates, between the GOS3 form and either pair of spectacles brought in by Patient F and examined by Witness 2. In these circumstances, the Committee could not be satisfied to the required standard that either GOS3 form related to the pairs of spectacles which Witness 2 examined.

Patient G

98. The Committee finds Particular 1(b) not proved in respect of Patient G.

99. The Committee noted that there was one GOS3 form in respect of patient G, which was dated 23 April 2010. Patient G had attended the meeting with Witness 2 on 3 October 2011 and had brought with them three pairs of spectacles. Witness 2 had recorded on the questionnaire that Patient G had said that their last sight test had been 'a few months ago' and a pair of spectacles had been prescribed and supplied as a result. The second pair of spectacles was recorded as having been supplied one year before, and they were varifocals. The third pair of spectacles was recorded as being three to four years old. The Committee considered that the dates of the second pair supplied corresponded with the GOS3 form, and the prescription was very similar.

100. The Committee noted that for this patient, Witness 2 had recorded a vertical prism, whereas she had not in relation to some of the earlier patients. The Committee also noted that in her witness statement, Witness 2 stated that the second pair (varifocals) had "no prism", which contradicted her recordings that she had found vertical prism. Her recordings indicated that she had found differential prison at distance and near. Mr Keirl in his calculations had identified a differential vertical prism of 1.44 dioptres. He opined that the prism recorded by Witness 2 was assumed to be thinning prism and therefore he had ignored it in his calculations. In all the circumstances, the Committee did not consider that Witness 2's measurements were sufficiently accurate to be relied upon. In all the circumstances, the Committee was not satisfied to the required standard that PCBs had not been supplied.

Patient H

101. The Committee finds Particular 1(b) not proved in respect of Patient H.

102. The Committee noted that there was one GOS3 form in respect of patient H, which was dated 7 May 2010. Patient H had attended the meeting with Witness 2 on 3 October 2011 and had brought with them two pairs of spectacles. Witness 2 had recorded on the questionnaire that Patient H had said that their last sight test had taken place in May 2011, which was when the latest pair of spectacles had been prescribed and supplied to them. The second pair of spectacles had been prescribed and supplied in May 2010. The Committee considered that the date of the GOS3 form corresponded to the second pair of spectacles.

103. Witness 2 did identify that there was prism within the lenses of Patient H's spectacles, but did not find any differential prism. Her findings were that the prism found was the same for near as it was for distance for both eyes. Mr Keirl, in his calculations, had identified differential vertical prism of 2.64 dioptres. The Committee was of the view that this was an amount of differential prism which should not have been missed by a reasonable competent Optometrist. Consequently, the Committee did not consider that Witness 2's measurements were sufficiently accurate to be relied upon. In all the circumstances, the Committee was not satisfied to the required standard that PCBs had not been supplied.

Patient I

104. The Committee finds Particular 1(b) not proved in respect of Patient I.

105. The Committee noted that there was one GOS3 form in respect of patient I, which was dated 27 April 2010. Patient I had attended the meeting with Witness 2 on 3 October 2011 and had brought with them one pair of spectacles. Witness 2 had recorded on the questionnaire that Patient I said that their last sight test had taken place in April 2011, which was when the spectacles had been prescribed and supplied to them.

106. The Committee did not consider that there was a sufficient degree of connection regarding the dates, between the GOS3 form and the pair of spectacles brought in by Patient I and examined by Witness 2. In these circumstances, the Committee could not be satisfied to the required standard that the GOS3 form related to the pair of spectacles which Witness 2 examined.

Patient J

107. The Committee finds Particular 1(b) not proved in respect of Patient J.

108. The Committee noted that there was one GOS3 form in respect of Patient J, which was dated 27 April 2010. Patient J had attended the meeting with Witness 2 on 3 October 2011 and had brought with them one pair of spectacles. Witness 2 had recorded on the questionnaire that Patient J had said that their last sight test had been carried out in approximately August 2010, which was when the spectacles had been prescribed and supplied.

109. The Committee noted that the date of the GOS3 form and the recorded date of obtaining the spectacles differed by around four months. The Committee also noted that a number of the components of the prescription within the GOS3 form, including prescribed prism, did not correspond to the measurements recorded by Witness 2. The Committee did not consider that a sufficient link had been established between the GOS3 form and the examined spectacles, to satisfy it that the GOS3 form corresponded to those spectacles. In these circumstances, the Committee could not be satisfied to the required standard that the GOS3 form related to the pair of spectacles which Witness 2 examined.

Particular 1(c)

Between April 2006 in March 2013, submitted or caused to be submitted GOS3 'H' voucher claims to [REDACTED] **Primary Care Trust Full payment for prescriptions for "prism controlled bifocals", in relation to the patients set out in Schedule 1, when:**

(c) a voucher for a lesser value should have been claimed instead.

110. The Committee finds Particular 1(c) not proved.

111. The Committee had regard to the Guidance entitled Making Accurate Claims, issued in respect of the GOS and Optical Voucher Scheme (2009). In paragraph 3, entitled Supplying and Claiming (General), it states:

> *…The voucher is not intended as payment for one part of a pair of spectacles. Restricting the use of the voucher in that way would be a breach of the regulations. In other words, there is no stipulation as to which part of the price of the dispensed appliance a voucher can be used for, whether frame, lenses or the professional dispensing fee.*
>
> *… As long as the retail price for the completed appliance – however it is made up – exceeds the total value of the voucher plus any supplements, then the patient is entitled to spend the full value of the voucher and the practice is entitled to claim the full value of the voucher.*

112. In paragraph 22, entitled Choosing Correct Voucher Values, it states:

Prism-controlled bifocal lenses for patients entitled to a full voucher are classed as voucher H in all cases regardless of the distance or reading power.

… the amount that you can claim for a GOS3… is the lesser of the voucher value or the retail price of the appliance provided.

113. The Committee had regard to the evidence of Dr Walsh. It was his opinion that a GOS3 voucher H may be claimed in relation to a decentred prism controlled bifocal as this accords with the British Standard. The Committee acknowledged that the Guidance, Making Accurate Claims, may have been drafted on the assumption that only traditional PCBs, which were expensive to manufacture, were included within the British Standards definition. However, the Committee was of the view that this was not what the Guidance actually set out. The Committee concluded from all the evidence that the Registrant was entitled to claim an H voucher in respect of the spectacles prescribed for patients A to J because it had not found that PCBs had not been supplied. It then went on to consider whether within that H voucher, he should have claimed a lesser amount than the full value of the voucher.

114. In evidence, the Registrant explained that he had very few private customers. In relation to the retail value of decentred spectacles and specifically his pricing structure for them, he said that his pricing structure was whatever the NHS voucher value was at the time, and that his pricing structure went in line with the NHS voucher values. The Registrant had accepted in evidence that the cost of manufacturing the decentred lenses themselves was far lower than the full value of an H voucher. The Committee noted that the GOC had not provided evidence to challenge the Registrant's explanation of his retail pricing. As the Guidance was specifically drafted in terms of 'retail price', rather than actual cost price, the Committee concluded that this permitted the retailer to set the prices for spectacles, which may include components of frame, lenses, professional dispensing fee, and profit.

115. In all the circumstances, the Committee was not satisfied to the required standard that a voucher for a lesser value should have been claimed instead.

Particular 2

116. This Particular falls away as a result of 1 the findings in Particular 1.

Particular 3

On 7 October 2009 you prescribed Patient DW with "round 24 prism controlled bifocals" and submitted, or caused to be submitted a GOS3 'H Voucher' claim for payment, when:

3(c) a voucher for a lesser value should have been claimed instead

117. The Committee finds Particular 3(c) not proved.

118. The Committee noted that both Mr Keirl and Professor Eperjesi, in the joint expert report, dated 17 June 2019, agreed that the prescription for prism controlled bifocals was clinically justified. Mr Keirl accepted in his evidence that there was a clinical justification for the issue of a GOS3 H voucher.

119. Professor Eperjesi was also of the opinion that the claim under voucher H was clinically justified. In evidence he confirmed that the prescription which had been recorded in respect of Patient DW could be made up as a prism controlled bifocal, and that if it was made up as a prism controlled bifocal, then the Registrant was permitted to claim a voucher H. In his addendum report he had stated:

> *I maintain my position that the prescription of prism controlled bifocals was clinically justified on the basis that Patient DW was complaining of diplopia* (double vision).
>
> *… As a voucher H was clinically justified it is not my opinion that a voucher for lesser value should have been claimed instead.*

120. In light of the evidence of Mr Keirl and Professor Eperjesi, the Committee was not satisfied to the required standard a voucher for a lesser value should have been claimed.

Particular 4 – on 5 March 2010 prescribed patient DH with "round 24 prism controlled bifocals" and submitted, or cause to be submitted, a GOS3 H voucher claim for payment, when: (b) the prescription and/or voucher claim was not clinically justified, and (c) a voucher for a lesser value should have been claimed instead (both admitted and therefore announced proved).

Particular 5(c)

Your actions as set out in [4(b) and 4(c)] above were:

dishonest, in that you knew your claims were inaccurate at the time of submission and were claiming for payment to which you were not entitled.

121. The Committee finds Particular 5(c) not proved.

122. Mr Keirl and Professor Eperjesi, in the joint expert report, both agreed that on the balance of probabilities, Patient DH did not have binocular vision and was not complaining of diplopia. Further they agreed that prisms were not clinically justified for patients who do not have binocular vision and who do not

complain of diplopia. The experts also agreed that a voucher for a lesser value than H, should have been claimed instead, and by claiming a voucher H the Registrant would have made an unjustified financial gain.

123. Mr Keirl and Professor Eperjesi had agreed that the Mallet Unit test was an appropriate test for measuring whether a patient had a 'fixation disparity', which in turn, would indicate that a patient may benefit from having prism prescribed. The Committee considered the Registrant's evidence in which he explained that he had made a mistake when examining the patient in that he had been using the Mallet Unit incorrectly. He said that he had not known at the time that he was using the wrong part of the Mallet Unit test, but had discovered his mistake as a result of this case, from Professor Eperjesi. The Registrant had the following exchange with Mr Thomas:

> *Mr Thomas: [referring to the patient record of DH for 5 March 2010] … you have accepted the allegation in relation to this, that the prescription or voucher claim was not clinically justified and/or the voucher for a lesser value should have been claimed instead. You have Professor Eperjesi's evidence and in fact it is the joint evidence of both experts that in fact this patient, Patient DH, did not have binocular vision and therefore could not have benefited from prism controlled…*
>
> *Registrant: Yeah.*
>
> *Mr Thomas: You can see on the right-hand side [of the patient record] that you obtained a fixation disparity for this patient?*
>
> *Registrant: Yes.*
>
> *Mr Thomas: How and did you obtain a fixation disparity for this patient?*
>
> *Registrant: When I was – when we were discussing this with Professor Eperjesi he asked me the same question and I said I used a – if a patient can't see the 'OXO' on the Mallet Unit I'll direct their attention to the larger one and that's when he said "But that is for something totally different" and at that point I was – that's when I was thinking I don't know how – where that came from. I don't know where I've read it or why it was in my mind that if somebody couldn't see the smaller OXO you then direct their attention to the larger OXO…*

124. The Committee considered whether the Registrant had made a genuine mistake at the time of conducting the sight test, or whether it was more likely than not that he was now deliberately and untruthfully describing his actions as a mistake. The Committee noted that the Registrant's findings of a fixation disparity were recorded on the patient record at the time, so the face of the record itself demonstrated the incorrectness of a finding of fixation disparity

when compared with the other information recorded on the Patient's record card. The Committee also acknowledged that the Registrant had accepted that he had, in effect, been clinically incompetent in his use of the Mallet Unit test on this occasion and his actions had been both inappropriate and objectively misleading. The Committee accepted the Registrant's explanation that he had made a mistake in his use of the Mallet Unit test.

125. In all the circumstances, the Committee was not satisfied to the required standard, that the Registrant had submitted the GOS3 Voucher H form, knowing that it was not clinically justified, as opposed to it being a negligent mistake. The Committee was of the view that a negligent mistake of this nature in respect of this one patient (DH), would not be considered dishonest by the standards of ordinary and decent people. Accordingly, the Committee was not satisfied to the required standard that he had been dishonest.

Particular 8 – your records for the prescriptions issued to [patients DP, PP, PF, PG, PH, DD] did not correspond with the specification written on the GOS2 form (admitted and therefore announced proved).

Particular 9(c)

Your actions as set out in 8 above were:

dishonest, in that you intentionally recorded and claimed for a more complicated prescription for prisms then was actually issued to the patients as specified in the GOS2 forms and were therefore claiming for payment to which you were not entitled.

126. The Committee finds Particular 9(c) not proved.

127. The Committee acknowledged that there was a mismatch between the six GOS2 forms and the corresponding patient records and GOS3 forms. The GOS2 form contained the prescription resulting from a sight test, which was required to be given to the patient, who was entitled to go to any Opticians to have the prescription made up into spectacles. Broadly speaking, the prescriptions in the GOS3 forms and patient records matched each other, whereas those in the GOS2 forms differed. The GOS3 forms and patient records contained a prescription for prisms that differed in magnitude for distance and near which could be made up as a PCB, whereas the GOS2 forms did not. The Committee was mindful that the GOC case on this Particular was predicated on the basis that it was more likely than not that GOS2 forms represented the correct and accurate record as to what was prescribed to the patient, whereas the GOS3 forms and patient records were wrong, on the basis that the Registrant had intentionally added a prescription

for differential prism to them which had not been prescribed, in order to claim the more valuable H voucher.

128. The Committee was not satisfied on the evidence before it, that it was more likely than not that the GOS2 form was the accurate prescription and the GOS3 form and corresponding patient record was not. The Committee noted that the experts, in the joint expert report, had agreed that according to GOS Regulations, a GOS3 voucher if appropriate, should be issued along with the GOS2 prescription to the patient at the conclusion of the sight test. In light of this, the Committee concluded that it was not appropriate to infer that the differences between the GOS2 and GOS3 forms were in order to conceal that there had been no prescription for prisms whose magnitudes differed for distance and near.

129. The Committee had regard to the Registrant's evidence, in which he admitted that he had been lazy when it came to completing the GOS2 forms, particularly as the patients would not bother to take the GOS2 form with them or would throw it away. The Committee considered that such actions of laziness were inappropriate and would lead to forms which were objectively misleading, as the Registrant accepted. However, in relation to the six patients, the Committee did not consider it demonstrated a pattern of behaviour, which would be considered dishonest by the standards of ordinary honest and decent people. Accordingly, the Committee was not satisfied to the required standard that he had been dishonest.

Particular 10

In relation to patients in Schedule A, you

10(c) failed to record why the voucher claims were clinically justified.

130. The Committee finds Particular 10(c) not proved.

131. The Committee noted that the Registrant accepted that he had not recorded why voucher claims were clinically justified, the issue was whether he was under a duty to record this information and so had failed to do so.

132. The Committee had regard to the College of Optometrists' Guidance in respect of record keeping. It noted the responses of Mr Keirl in cross examination, accepting that the Guidance did not specify a requirement to record the clinical justification for a particular voucher. In relation to the joint expert report, although the experts had not specifically addressed the issue at Particular 10(c) of whether there was a duty to record the clinical justification for a specific voucher, the Committee noted that they had addressed the same issue in relation to a different Particular no longer

pursued (Particular 4(d)). In relation to that Particular, the joint expert report stated:

> *The experts agree that the Registrant did not record a justification for the voucher claim. The experts agree that the voucher code should be written on the record but also agree that there is a small body of responsible optometrists who would not record any justification for a voucher claim…*

133. In light of this, the Committee concluded that whilst it may have been good practice to record the clinical justification for a specific voucher on the record card, the absence of such a record did not amount to a culpable failure on the part of the Registrant. In all the circumstances the Committee was not satisfied to the required standard that the Registrant was under a duty to record the clinical justification for a voucher claim.

Particular 13

On or around 23rd March 2011 you conducted a sight test on patient DG and failed to discuss or record that you had discussed your finding of cataracts with the patient (admitted and announced proved in relation to 'failed to record')

134. The Committee finds Particular 13 proved only in so far as the Registrant failed to record that he had discussed his finding of cataracts with the patient.

135. The Committee noted that the Registrant, by his admission, accepted that there was a duty on him to record any discussion with a patient regarding a finding of cataract. The Committee inferred from his admission, that if there was a duty to record any such discussion, then he accepted that there must also be a duty to have such a discussion in the event of finding cataract.

136. The Committee noted that in the joint expert report, Mr Keirl and Professor Eperjesi agreed that the Registrant may have discussed his findings of cataract with patient DG but if he did there was nothing noted in the clinical records about this discussion. In evidence, the Registrant stated that he would have discussed his findings of cataract with Patient DG, as he would with all patients for whom he found cataract. He said that the fact that he had noted in 'ocular history' on the left hand side of the form, "lens opacity", indicated information provided by the patient and told him that he had had some discussion about cataract with the patient.

137. In his addendum report, Professor Eperjesi acknowledged that this was an area in which his opinion had changed. Having reviewed the clinical records of Patient DG for 23 March 2011, he identified in the 'history' section that the Registrant had recorded: "R+L LOs". Professor Eperjesi was of view that this was an abbreviation for "right and left lens opacity", and that lens opacity was

another way of describing a cataract. The Registrant in his evidence confirmed that this was the correct interpretation of the clinical note entry. Professor Eperjesi's opinion in his addendum report was that in order for this note to appear in the history section of the record card, cataract must have been discussed with patient DG by the Registrant.

138. In light of all the evidence, the Committee was not satisfied to the required standard, that the Registrant had failed to discuss his finding of cataract with the patient.

Particular 14

On or around 23rd August 2011 you conducted a sight test on patient DA and failed to discuss or record that you had discussed your finding of cataracts with the patient. (admitted and announced proved in relation to 'failed to record')

139. The Committee finds Particular 14 proved only in so far as the Registrant failed to record that he had discussed his finding of cataracts with the patient.

140. The Committee noted again from the joint expert report, that the experts agreed that the Registrant may have discussed his findings of cataract with patient DA, but if he did there was nothing noted in the clinical records about this discussion. The Registrant's position in evidence was similar to that of for patient DG, namely the information recorded in the ocular history of the record card, told him that he would have had a discussion about cataract with the patient.

141. In his addendum report, Professor Eperjesi acknowledged that this was another area in which his opinion had changed. Having reviewed the clinical records of Patient DA for 23 August 2011, he identified in the 'history' section that the Registrant had recorded: "R+L LOs". For the same reasons as for Particular 13, Professor Eperjesi's opinion in his addendum report was that in order for this note to appear in the history section of the record card, cataract must have been discussed with patient DA by the Registrant.

142. In light of all the evidence, the Committee was not satisfied to the required standard, that the Registrant had failed to discuss his finding of cataract with the patient.

Particular 15

Between 5 March 2010 and 7th January 2013, you conducted several sight tests on patient DH and failed to discuss or record that you had discussed your finding of cataracts with the patient.

143. The Committee finds Particular 15 not proved.

144. The Committee noted that there were clinical records available of sight tests for Patient DH for the following dates between the timeframe alleged within Particular 15, namely 5 March 2010, 31 January 2011, 5 January 2012, and 7 January 2013. The Committee had copies of these record cards and noted that the Registrant's handwriting and annotations were difficult to decipher. This was a feature that was evident throughout the Registrant's record cards.

145. The Committee noted again from the joint expert report, that the experts agreed that the Registrant may have discussed his findings of cataract with patient DH, but if he did there was nothing noted in the clinical records about this discussion. In cross-examination, Mr Keirl accepted that "LO SURGERY REFUSED" was, in fact, written by the Registrant on the record card for 7 January 2013. He accepted that was an indication that the patient had been spoken to about cataract surgery and refused that cataract surgery.

146. The Registrant's position in evidence was similar to that for patients DG, and DA, namely the information recorded in the ocular history section of the record card, told him that he would have had a discussion about cataract with the patient. In addition, in respect of the record card for 7 January 2013, in the section to be completed on the right hand side of the notes, following the examination, he had written: "LO SURGERY REFUSED", indicating that there had been discussion about cataract and he had recorded the outcome of that discussion.

147. In cross-examination, Mr Keirl was specifically taken through the record card of 5 March 2010 and had the following exchange with Mr Thomas:

> *Mr Thomas: On the left hand side [of the record card]… you can see the history and symptoms and that's the bottom you can see "shingles 10 weeks". Do you see that?*
>
> *Mr Keirl: Yes:*
>
> *Mr Thomas: That what have been reported by the patient, would it not?*
>
> *Mr Keirl: Yes.*
>
> *Mr Thomas: Underneath there is "L" and "R" and what looks to be "LOS". Is that right?*
>
> *Mr Keirl: Yes.*
>
> *Mr Thomas: The right/the "R" is "LOS" which is "lens opacities". Is that right?*
>
> *Mr Keirl: Yes.*

Mr Thomas: Next to the "L", next to the "left" I am guessing is "IOL" and what does "IOL" stand for?

Mr Keirl: "Intraocular lens".

Mr Thomas: An intraocular lens is a surgery that comes as a result of cataract, is it not?

Mr Keirl: It is.

148. Mr Keirl conceded that if the record card of 5 March 2010 was the first examination of Patient DH by the Registrant, then from the face of the record, there would have been some discussion about previous ocular history which would include cataract and previous surgery. The Committee noted that this record card was the earliest in time which had been provided to it for this patient, so there was no evidence before the Committee that there had been a previous examination of this patient by the Registrant.

149. In his addendum report, Professor Eperjesi acknowledged that this was another area in which he had changed his opinion and had identified references to lens opacity, and therefore cataract, in the ocular history section for each of the four record cards. Consequently, his opinion was that it could be inferred that cataract must have been discussed with Patient DH by the Registrant on each occasion.

150. In light of the evidence, the Committee considered that it was evidentially proper to infer from the each of the four record cards that a conversation about cataract had taken place between the Registrant and patient DH, albeit the narrative of the conversation was not recorded in detail. Further, on at least one occasion within the timeframe of the Particular (7 January 2013), the Committee considered that the outcome of the discussion of having surgery in respect of cataract, had been recorded in that the surgery had been refused. Consequently, the Committee was not satisfied to the required standard that the Registrant had failed to discuss or record that he had discussed his findings of cataract with the patient.

Findings in relation to misconduct

151. Having announced the facts, the Committee agreed to Mr Thomas' request, on behalf of the Registrant, to consider and announce a decision on misconduct and then, if necessary, to consider current fitness to practise after that. His reasons for this were that he could make submissions on misconduct, and if the matter proceeded to consideration of impaired fitness to practise, additional evidence may then be called on the Registrant's behalf. Ms MacDonald indicated that the GOC was neutral on whether misconduct and impairment should be heard together or considered separately. Having heard the advice of the Legal Adviser, the Committee was satisfied that it was fair and appropriate to consider misconduct and impairment separately.

152. Ms MacDonald explained that she, on behalf of the GOC, was only making positive submissions in relation to Patient DH, who featured in particulars 4(b), 4(c), 5(a), and 5(b). In relation to the other particulars found proved [6(b), 7(a), 8(a) to (f), 9(a) and (b), 12(a) to (g), 13 and 14], she explained that the experts in the joint expert report had concluded that these particulars fell below the expected standard, as opposed to far below. In light of the case of *Shodlock v GMC [2015] EWCA Civ 769,* Ms MacDonald explained that she was not able to positively submit that these incidents should be taken together to cumulatively amount to misconduct.

153. In relation to Patient DH, Ms MacDonald explained that the experts in their joint expert report had agreed that the Registrant's actions fell far below the expected standard. She submitted that the incident in respect of Patient DH had been particularly grave, in light of the Committee's finding on the facts, which included that the Registrant had admitted that he had been clinically incompetent in his use of the near Mallet Unit. She also invited the Committee to consider that the Registrant had accepted in evidence that it was fair to say he had used the near Mallet Unit incorrectly a number of times.

154. Ms MacDonald submitted that in relation to Patient DH the Registrant by his actions had breached core duties under the relevant Code of Conduct (2005), namely Standard 8 – keep professional knowledge and skills up to dated; and Standard 9 which was to recognise the limits of his professional competence.

155. Mr Thomas referred the Committee to the cases of *Rao v GMC [2002] UKPC 65* and *Silver v GMC [2003] UKPC 33,* which were cited in the case of *Calhaem.* He submitted that the Registrant's actions in respect of DH were, in effect a single isolated incident, which although falling below those expected standards, did not fall so far below those standards as to amount to misconduct. He submitted the Registrant's actions in respect of all the Particulars were not so serious as to amount to misconduct.

156. The Committee heard and accepted the advice of the Legal Adviser. She advised the Committee in respect of a number of cases, including *R (Remedy UK Ltd) v GMC [2010] EWHC 1245 (Admin); Calhaem v GMC [2007] EWHC 2606 (Admin); Rimmer v GDC [2011] EWHC 348;* and *Shodlock v GMC [2015] EWCA Civ 769.* The Committee was aware that any finding of misconduct was a matter for its independent judgement. In assessing whether the facts found proved amounted to misconduct, the Committee had regard to the over-arching objective of protecting the public, which involves the following: to protect, and maintain, the health, safety, and well-being of the public; to promote and maintain public confidence in the professions; and to promote and maintain proper standards and conduct for members of those professions.

157. In the Committee's judgement, the Registrant's actions in respect of Patient DH were very serious. Although this was a single patient for whom the Registrant had prescribed PCBs which were not clinically justified, this was in the context of his admitted lack of clinical knowledge and understanding regarding the correct use of the near Mallet Unit to detect fixation disparity. Both Mr Keirl and Professor Eperjesi had agreed that this patient did not require PCBs as the patient did not have diplopia (double vision) nor did they have binocular vision. Although acknowledged by the Committee to have been a negligent mistake, the Committee considered that it was particularly grave, and had the potential to cause patient harm (as noted by Professor Eperjesi), in the form of eye ache and/or headache, albeit this was not permanent. Further, the Registrant acknowledged in his evidence to the Committee that his lack of clinical knowledge in the use of the near Mallet Unit had persisted until a late stage in the current proceedings, when Professor Eperjesi explained to him that he had been using it incorrectly. The Registrant had also conceded in evidence that he had done this a number of times. He stated in evidence, in answer to the question of why he thought he prescribed so many prisms: "*It's a few factors. One, I do – I use a Mallet Unit on everyone".* The Registrant's actions were both inappropriate and misleading.

158. Further, although this was a single unjustified claim for payment, the Committee considered that the context in which it occurred was serious. The Registrant had not understood how to use the near Mallet Unit correctly and had conceded in evidence, that he did not check the finalised PCBs with the Patient. In the Committee's view, the claim was made for payment, without the Registrant having checked the accuracy of the spectacles against the Patient's prescription (noted on the patient's record) to ensure that they were satisfactory to be dispensed to the Patient. When asked about checking the spectacles which came back from Company A, he said: "*I never checked*

them. Again a mistake, my mistake." The Registrant's actions were both inappropriate and misleading.

159. In relation to Patient DH, the Committee considered that the Registrant had breached the following Standards of the Code of Conduct:

- *8 – keep professional knowledge and skills up to date;*
- *9 – recognise the limits of his or her professional competence.*

160. In all the circumstances, the Committee determined that the Registrant's actions in respect of Patient DH fell far below the expected standards of an Optometrist and were so serious as to amount to misconduct.

161. The Committee noted the position of the GOC that no positive submissions were made in respect of the other admitted facts [6(b), 7(a), 8(a) to (f), 9(a) and (b), 12(a) to (g), 13 and 14], and misconduct. However, the Committee considered that these Particulars related to an important part of the day to day practice of an Optometrist, namely record keeping. Therefore, in the Committee's judgement, it was appropriate, and in accordance with the case of *Calhaem,* to consider the admitted acts and omissions in respect of the Registrant's record keeping cumulatively in order to determine whether they were so serious as to cross the threshold for misconduct. The Committee also noted that Patient DH was one of the patients listed in Schedule X (of Particular 6(b), and Schedule A (of Particular 12(a) to (g)), in respect of whom there had been record keeping issues.

162. Particulars 6(b) and 7(a) related to a total of 49 patients, in respect of whom the Registrant had not recorded the clinical justification for prescribing new spectacles with small changes in prescription over a number of years. The absence of recording a rationale for these changes could, in the Committee's view, have a potential impact on continuing patient care especially for other optical practitioners who might care for the patient. The Registrant had admitted that his actions were inappropriate. The Committee considered that these omissions in record keeping were widespread, persistent, and therefore, serious.

163. Particulars 8(a) to (f) and 9(a) and (b) related to six patients for whom the Registrant had inaccurately recorded clinical information. The information on the GOS2 forms did not correspond with either the GOS 3 form or patient records. The Committee noted that the time span for these record keeping issues was from January 2010 to January 2014. The Registrant's explanation for not completing accurate records, was 'laziness'. In the Committee's view this indicated a casual approach to the expected standards. The Registrant had admitted that his actions were both inappropriate and objectively

misleading. The Committee considered that a Registrant, who did not complete required records accurately over a period of years due to laziness, did not promote confidence in the profession or promote proper standards and conduct, and this was, therefore, serious.

164. Particular 12 related to a total of 25 patients, in respect of whom the Registrant admitted that his record keeping was inadequate in a number of respects, namely, patient history, symptoms, ocular health, visual fields, visual acuity, justification of prescriptions issued and adequate follow-up advice regarding any pathology detected. The Committee considered that this was a significant number of patients and a wide range of important areas in which the Registrant's record keeping was inadequate and was therefore serious.

165. In light of the Committee's view that the findings in Particulars 6/7, 8/9, and 12 were in themselves serious, and covered several areas of record keeping, it did not consider that assessing these Particulars cumulatively offended against the observations in the case of *Shodlock*, that a series of non-serious findings should not normally be added together in order to amount to misconduct.

166. The Committee had regard to the College of Optometrists Guidance in respect of patient records which had been included within Professor Eperjesi's initial report of 4 March 2019. The key points for the rationale for maintaining accurate records were listed as:

- *Full records are essential to facilitate the clinical management of the patient and continuity of care.*
- *You must keep full records to protect yourself in case of complaints.*
- *You must keep full, accurate and clear patient records, made at the time of the examination, which provide a history of patient care, including referrals.*

167. Given the importance of full and accurate records to facilitate the clinical management of patient care, the Committee considered that such a large number and wide range of inadequate, inappropriate and/or misleading records had the potential to place patients at risk of harm, and so were serious. The Committee also noted that the Registrant's record keeping issues had persisted, notwithstanding three standard Ophthalmic Contract visits to the Practice undertaken by Witness 2 on 5 May 2010, 29 September 2010, and 12 August 2011 to review the practice. On each occasion, it was identified that aspects of record keeping were insufficient.

168. The Committee was of the view that the omissions in record keeping, given their range and extent, breached Standard 6 of the Code of Conduct (2005), which was to maintain adequate records.

169. In all the circumstances, the Committee determined that the Registrant's actions in respect of record keeping fell far below the expected standards of an Optometrist and were so serious as to amount to misconduct.

170. Therefore, the Committee found that the admitted facts found proved were so serious as to amount to misconduct.

Finding on Impairment

171. Having found misconduct, the Committee went on to consider whether the Registrant's fitness to practise is currently impaired. The Committee had regard to the submissions of Ms MacDonald on behalf of the GOC and Mr Thomas on behalf of the Registrant. The Committee accepted the advice of the Legal Adviser.

172. The Committee was provided with a further bundle of documents, submitted on behalf of the Registrant. These included computerised records relating to four patients, randomly selected by Practice 1, the independent practice where the Registrant is working 2 to 3 days a week as a locum; a Contractor audit of Performer Records, dated 18 November 2019, undertaken by the independent practice; a Clinical audit, dated 20 January 2020, of patient records undertaken by the Store 1, for whom the Registrant is working once a week as a locum; and CET records covering 2013 to 9 July 2020.

173. The Registrant gave evidence. He explained that he was no longer a practice owner, but acted as a locum for his former practice, Practice 1 (2-3 days a week), the Store 1 (one day a week) and the Store 2. In relation to Patient DH and his incorrect use of the near Mallet Unit, the Registrant explained that his method of prescribing prism had now changed. He acknowledged that he used to rely heavily on the fixation disparity test using the near Mallet Unit Test, whereas he now used a patient's symptoms, recovery from the cover test and fixation disparity, placing most importance on the patient's symptoms.

174. In relation to his record keeping, the Registrant said that the main thing he had changed was the legibility of his records, conceding that even he had had difficulty reading his own handwritten patients' notes. He explained that in each of the practices where he works, the patient records are all computerised, and he would generally record a narrative of any discussions he had with a patient. In answer to Ms MacDonald's questions, about the four record cards provided in evidence, he accepted that there was room for improvement in his record keeping.

175. The Committee acknowledged that the Registrant had admitted all the Allegations which were found proved, and that this in itself demonstrated some insight. From his own evidence at this impairment stage, the Committee considered that the Registrant continued to reflect on his practice leading to further developing insight, which was continuing. However, in the Committee's view his insight was not fully developed at this stage.

176. The Committee considered that this ongoing developing insight demonstrated a willingness on the part of the Registrant to remedy his misconduct and improve his practice. The Committee considered that the facts amounting to misconduct were potentially remediable.

177. Regarding the misconduct in relation to Patient DH, whilst this was a single incident which occurred 10 years earlier, the Committee had previously noted that the lack of clinical knowledge underpinning this misconduct had persisted until a relatively late stage of these proceedings, when Professor Eperjesi had told him that he was using the near Mallet Unit wrongly. The Registrant had conceded in evidence that he may have incorrectly used the near Mallet Unit a number of times. He had stated in evidence, in answer to the question of why he thought he prescribed so many prisms: "*It's a few factors. One, I do – I use a Mallet Unit on everyone".*

178. The Committee noted that in his police interview in 2013, it had been put to the Registrant that he may be prescribing PCBs when they may not be necessary. His answer at that stage was: *"If you've got a fixation disparity, why are you going to ignore fixation disparity?... you can get an optician that'll say, you know what why are you correcting somebody who doesn't necessarily complain that they are getting loads and loads of headaches and stuff like that but why don't you just give them a bit more comfort?"*

179. The Committee was concerned that the Registrant had thought he knew how to use the near Mallet Unit test correctly for a sustained period of time. He knew that he was an 'Outlier' in terms of prescribing GOS 3 voucher H's, and the possibility that he may have been prescribing unnecessary prism based on fixation disparity was raised with him in the police interview in 2013. However, the Registrant had not challenged himself or rigorously scrutinised his practice in order to satisfy himself that his clinical knowledge was accurate and up-to-date and that his prescribing of prism was appropriate for the patient.

180. The Committee also noted that the Registrant had undertaken relevant CET training in binocular vision on 18 October 2013, 8 August 2014, 19 June 2015, 22 December 2016, 15 April 2019, 23 April 2019, and 14 May 2019. It was apparent to the Committee that the Registrant had not sustained and built on his learning from this training, all of which pre-dated the start of this hearing. The Committee was not reassured that he now fully understood how to use the near Mallet Unit Test correctly, or use it as one part of the process of determining whether a patient would benefit from prism.

181. In all the circumstances, the Committee inferred that the risk had remained that the Registrant may have used the near Mallet Unit Test incorrectly

between 2010 and 2019, the point at which he discovered that he had been using it incorrectly. Further, the Committee noted that, following this realisation, the Registrant had read up about the Test, but had not undertaken any additional relevant training. In the absence of recent relevant training, or other confirmation that the Registrant was now correctly using his recently acquired knowledge of the near Mallet Unit test within his practice, the Committee was not satisfied that the Registrant had fully remedied his misconduct in relation to patient DH.

182. Therefore, in the Committee's judgement, it could not rule out the risk of repetition that the Registrant may use the near Mallett Unit Test incorrectly and/or give a prescription for prism which was not clinically justified.

183. In relation to the misconduct relating to record keeping, the Committee had regard to the four patient records, the audits and the Registrant's own evidence. The patient records related to September and October 2019. The Registrant had explained in evidence, and the Committee accepted, that these record cards were an improvement on his record keeping standards between 2010 and 2014. However, he accepted that there were still aspects which were capable of being further improved.

184. The Committee noted that it had not been provided with record card examples, from either Store 1 or Store 2, nor any recent examples of record keeping cards from Practice 1, to support the Registrant's position that his record keeping standards had further improved, since October 2019. The Committee noted that the Contractor Audit of Performers Records, dated 18 November 2019, was undertaken by Optical Advisers who were not qualified Optometrists. The Committee noted from the CET record that the Registrant had undertaken some record keeping training in November 2018, but was of the view that this training had not been sustained nor that it had been consistently put into practice in his record keeping examples of September/October 2019. In the absence of recent record cards to demonstrate the continued improvements the Registrant said he was making, the Committee was not satisfied that the Registrant had fully remedied his practice in respect of record keeping.

185. Therefore, in the Committee's judgement, it could not rule out the risk that the Registrant may not consistently meet the expected standards of record keeping.

186. In the Committee's judgement, public confidence in the profession would be undermined if no finding of impairment was made in this case. In reaching this conclusion, the Committee bore in mind the Registrant's persistent lack of knowledge and understanding of the near Mallet Unit Test, and his

persistent and wide-ranging record keeping deficiencies. In the Committee's view it is paramount that the public can be confident that a Registrant has the clinical knowledge and understanding to underpin his practice and prescribing, and the diligence to ensure that full and accurate records are maintained.

187. Accordingly, the Committee concluded that the Registrant's fitness to practise is currently impaired on both public protection and public interest grounds.

Sanction

188. Having determined that the Registrant's fitness to practise is currently impaired by reason of his misconduct, the Committee next considered whether it was impaired to a degree which required action to be taken on his registration. Ms MacDonald and Mr Thomas presented an agreed position to the Committee, that conditional registration was the appropriate and proportionate sanction in this case. To that end, they provided the Committee with a set of proposed conditions, about which they were broadly in agreement, albeit they were not in agreement about the length of the order, or the breadth of the proposed second audit.

189. The Committee has accepted the advice of the Legal Adviser and exercised its independent judgement. It had regard to the Indicative Sanctions Guidance (the Guidance) and considered the sanctions in ascending order of severity. The Committee was aware that the purpose of a sanction is not to be punitive but to protect members of the public and to safeguard the wider public interest which includes upholding standards within the profession together with maintaining public confidence in the profession and its regulatory process. The Committee was also mindful that any sanction must be proportionate both for the public and the individual Registrant.

190. The Committee first considered whether any sanction was necessary. Given the Committee's findings that the Registrant had not yet fully remedied his misconduct, the Committee concluded that some form of sanction was necessary to protect the public, to promote and maintain public confidence in the profession and to promote and maintain proper standards in the profession. The Committee did not consider that a financial penalty was appropriate in the circumstances of this case.

191. The Committee next considered whether conditional registration was the appropriate and proportionate response. The Committee has previously found that the Registrant's misconduct is capable of being remedied. The Committee had regard to the Guidance, in particular paragraph 33.9, which identified factors which may make conditional registration appropriate. The Committee was satisfied a number of these factors were present as follows: that there are identifiable areas of the Registrant's practice in need of assessment or retraining (paragraph 33.9 b); potential and willingness to respond positively to retraining (paragraph 33.9 d); and that it is possible to formulate appropriate and practical conditions to impose on his registration and make provision as to how they will be monitored (paragraph 33.9 g).

192. In terms of length of order, the Committee concluded that the order should be for a period of 12 months. The Committee acknowledge that these proceedings have been ongoing for a long time, through no fault of the Registrant. However, the Committee did not consider that the six months

proposed by Mr Thomas would give the Registrant sufficient time to demonstrate that he had incorporated the necessary training and development consistently into his practice.

193. The Committee did consider whether a suspension order was required, but concluded that such an order would be entirely disproportionate and punitive given the findings in this case.

194. Accordingly, the Committee determined to impose conditional registration for a period of 12 months, with a review.

195. A review hearing will be held between four and six weeks prior to the expiration of this order. The Review Committee will need to be satisfied that the Registrant is fit to resume practice either unrestricted or with further conditions.

Immediate order

196. The Committee has heard submissions from Ms MacDonald on behalf of the Council and from Mr Thomas on behalf the Registrant. It has accepted the advice of the Legal Adviser.

197. The Committee has decided not to impose an immediate order for conditional registration, as it did not consider that the requirements for imposing an immediate order were met. It was not of the view that an immediate order was necessary to protect the public, nor was it required in the public interest. The Committee noted that the Registrant had been practising throughout these proceedings without restriction.

Chair of the Committee: Mr Graham White

Signature *Graham White* **Date: 10 July 2020**

Registrant: Mr Nadeem Syed

Signature present via video **Date: 10 July 2020**

List of conditions

NO.	CONDITION
1.	Mr Syed must identify and engage an independent and suitably qualified person (*'the Assessor'*) to assess 25 of your patient records, which were completed between October 2019 and March 2020, such Assessor to be approved by the GOC. The Assessor can adopt a suitable methodology to allow for a selection of a sample across the entire period. The records should be assessed for overall quality, detail and accuracy based upon the guidance provided by the College of Optometrists. This patient record audit should be completed within 28 days of this order coming into effect, and should highlight any concerns within the sample, but particular focus should be directed towards: (a) Patient history (b) Symptoms (c) Ocular health (d) Visual fields (e) Visual acuity (f) Justification of prescriptions issued (g) Adequate follow-up advice regarding any pathology detected (h) Reasons for changes of spectacles (with or without GOS voucher) where there is a small change in prescription.
2.	Mr Syed must meet with the Assessor (either in person or through a virtual meeting) to discuss the findings from the patient record audit. Mr Syed must discuss with the Assessor areas of concern, if any, and potential methods for improving the patient records in relation to these areas.
3.	Mr Syed must produce a performance development plan (PDP) taking into account the feedback of the Assessor in relation to condition 2 above. The PDP must address: (a) Binocular vision and patient assessment, with a particular focus on the function and use of the Mallet Unit Test; (b) Maintaining adequate and accurate records;

	(c) The training and development to be undertaken by Mr Syed and how this is to be incorporated in his practice. The PDP must be provided to the General Optical Council (GOC) within 2 months of the start of this order.
4.	Mr Syed must complete the actions identified within the PDP so that the PDP outcome can be submitted for the consideration of the GOC approximately one month before the first substantive review of the conditions.
5.	Mr Syed must identify specific training in relation to: (a) Binocular vision addressing in particular binocular vision anomalies and the function and use of the Mallet Unit test; (b) Record keeping. This training must be provided by a certified CET provider and the relevant points must have been accepted in advance of the first substantive review of the conditions.
6.	No later than 6 months after the first audit, the Assessor should conduct a second audit of patient records (at least 25) focusing on items (a)-(h) in condition 1 and any area of concern identified within the first patient record audit. The second patient record audit must be provided to the GOC approximately one month before the first substantive review of the conditions. The second patient record audit should include a report from the Assessor highlighting areas of improvement and whether any areas of concern remain.
7.	Mr Syed should provide a reflective piece detailing his learning points drawn from the patient record audits; discussions with the Assessor; the PDP; and the relevant training; and his learning from the outcome of these proceedings. The reflective piece should be available for the Committee at the first substantive review of the conditions.
8.	Mr Syed should provide the Committee at the first substantive review with 10 patient records, to be randomly selected by the Assessor, for consideration within the review hearing.
9.	The GOC will enter these conditions against your name in the register save any conditions which relate to your health. You must allow the Registrar to share any information, including confidential information, with any

	employer, supervisor, professional colleague or any organisation for which you provide ophthalmic services for the duration of your conditional registration.
10.	You must notify the Registrar within 14 days of commencement of any professional appointment you accept whilst you are subject to these conditions (this includes any teaching posts) and provide contact details of your employer and if providing NHS ophthalmic services, the NHS Body on whose ophthalmic performer or contractor list you will be included (this includes any equivalent employer in the EC).
11.	You must inform the Registrar within 14 days of any criminal convictions, police cautions or formal disciplinary proceedings taken against you from the date of this determination.
12.	You must inform the Registrar: (a) If your work takes you out of the UK for a significant period of time; or (b) Of any employment you apply for outside of the UK (and in which countries) as conditions of registration only apply to practice undertaken in the UK (you must consider whether your time out of work or out of the UK will allow you to fulfil the conditions during the period of conditional registration). The Registrar may inform the relevant competent authorities in that country of your current conditions of UK registration.
13.	You must continue to fulfil the CET requirements under the GOC CET scheme to secure appropriate points for continued inclusion on the GOC register.
14.	You must inform the following parties that your registration is subject to conditional registration: (a) Any organisation or person employing or contracting with you to undertake ophthalmic services (to include any locum agency); (b) Any prospective employer (whether within the UK or EC); (c) The NHS Body in whose ophthalmic performer or contractor list you are included or seeking inclusion.

15.	You must ensure that your GOC registration is renewed by 15 March annually while you are subject to the GOC conditional registration procedures. Should you fail to renew your registration a review hearing will be arranged immediately.

NOTICE TO REGISTRANT:

- The GOC will enter these conditions against your name in the register save for any conditions that disclose information about your health.
- In accordance with Section 13C(3) of the Opticians Act 1989, the GOC may disclose to any person any information relating to your fitness to practise in the public interest.
- In accordance with Section 13B(1) of the Opticians Act 1989, the GOC may require any person, including your learning/workplace supervisor or professional colleague, to supply any information or document relevant to its statutory functions.

FURTHER INFORMATION
Transcript
A full transcript of the hearing will be made available for purchase in due course.
Appeal
Any appeal against an order of the Committee must be lodged with the relevant court within 28 days of the service of this notification. If no appeal is lodged, the order will take effect at the end of that period. The relevant court is shown at section 23G(4)(a)-(c) of the Opticians Act 1989 (as amended).
Professional Standards Authority
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). Further information about the PSA can be obtained from its website at www.professionalstandards.org.uk or by telephone on 020 7389 8030.
Effect of orders for suspension or erasure
To practise or carry on business as an optometrist or dispensing optician, to take or use a description which implies registration or entitlement to undertake any activity which the law restricts to a registered person, may amount to a criminal offence once an entry in the register has been suspended or erased.
European Alert
The General Optical Council is required by Regulation 67 of the European Union (Recognition of Professional Qualifications) Regulations 2015 to inform all European competent authorities of any restrictions or prohibitions on a dispensing optician or an optometrist's practice. 'Competent authority' effectively means the relevant regulator for each EU member state. The GOC is the competent authority for all opticians registered in the United Kingdom (UK).

If you have been made subject to either a suspension or conditions of practice order (whether interim or substantive), or to an erasure order, we hereby notify you of the following:

- Within 3 days of the Fitness to Practise Committee decision taking effect you will be the subject of an alert sent under article 56a(1) of the Directive;
- You have the right to appeal the decision to issue the alert or to apply for rectification of the decision; and
- You have the right to access remedies in respect of any damage caused by false alerts sent to other competent authorities.

The alert is sent securely via the Internal Market Information (IMI) system. The alert will include the following details:

- Your identity (full name and date of birth);
- Your profession;
- Your GOC registration number;
- The fact that the GOC is the national authority which adopted the decision on the restriction or prohibition of your professional activities;
- The scope of the restriction or prohibition;
- The period during which the restriction or the prohibition applies.

If you wish to appeal the decision to issue this alert then please see the information sheet below. Please note that this relates to your right of appeal against the issuing of the alert – see above regarding your right of appeal against a substantive decision.

A copy of the alert may be obtained via the contact details at the end of this document.

Please see the attached information sheet for further information.

Contact

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.

European Alert – Information Sheet

Please see the below Frequently Asked Questions (FAQs) which have been developed to assist you with this process and explain your options.

1. Why has the General Optical Council (GOC) sent this alert?

With effect from 18 January 2016 the GOC is legally required to issue alerts concerning all registrants whose practice has been prohibited or restricted – this includes all determinations of suspension, conditions or erasure issued by a Fitness to Practice Committee (FTPC), whether interim or substantive, and any extensions ordered by the High Court.

This legal requirement is placed on us by article 56a of Directive 2005/36/EC on the recognition of professional qualifications ('the Directive'). This article was adopted into UK legislation via Regulation 67 of the European Union (Recognition of Professional Qualifications) Regulations 2015. All other Member States must also comply with the provisions of the Directive and participate in the alert mechanism.

2. What is the purpose of these alerts?

The purpose of these alerts is to ensure public protection across all Member States. The intention is that each member state will be notified of any restrictions or prohibitions placed on UK registrants so that they are able to check this against their own registers and applicants. We will also be notified of any restrictions or prohibitions handed down to European optical professionals. This will assist us with safeguarding the public and maintaining the integrity of our registers.

3. Why was I not consulted before the alert was sent?

The terms of the Regulations are very strict; the alert must be issued within three days of the panel's decision coming into effect. The notification must be issued at the same time the alert itself is sent.

4. Who will see the alert?

The alert is sent securely via the Internal Market Information (IMI) system to the competent authority in each Member State.

In the UK, statutorily regulated health and social care professionals have to be registered with, and show that they meet the standards of, the relevant regulatory body, in order to practise their profession. The regulators control access to regulated professions, professional and vocational titles and professional activities which require specific qualifications, and are subject to national law. The European Commission term these organisations the 'competent authorities' although the exact duties of the competent authorities vary across member states, they are effectively the regulator (in the same way the GOC is) for each member state.

A competent authority has been defined by the European Commission as: *any authority or body empowered by a Member State specifically to issue or receive training diplomas and other documents or information and to receive the application and take the decision, referred to in Directive 2005/36/EC.*

5. If there is a mistake in the alert can I apply for it to be corrected?

If you notice a mistake in the alert (such as a typing error or incorrect information) then please contact the GOC and we will consider your request to amend the alert. Please note the GOC is not able to remove an alert at your request, see next question for further information.

6. What if I disagree with the alert being sent?

If you disagree with the sending of an alert then you have the right of appeal to the County Court. If you merely consider there to be a mistake within the alert then please refer to the above question.

Please note that the GOC is required to send the alert under European Law. With this in mind, and if you still wish to appeal to the County Court, then you may find the following government website useful: https://www.judiciary.gov.uk/you-and-the-judiciary/going-to-court/county-court/

If you attended the hearing and were given the FTPC decision document by hand, then the period for submitting an appeal with the County Court is 28 days from the date you were handed the document. If the FTPC decision document has been sent to you by post, the appeal period is 30 days from the date the decision document was posted to you (there is an additional 2 days allowed to cover postage time).

7. Can the GOC assist me with my appeal against the issuing of an alert?

The GOC is unable to help you with your appeal – we strongly advise that you seek independent legal advice.

8. If I appeal an alert being sent, what effect will that have on the substantive decision made in relation to my registration?

There will be no effect on the decision made by the GOC affecting your registration. This would be an appeal against the issuing of the alert and not the substantive decision – they are two separate things, and each have different appeal routes. If you require details on how to appeal the substantive decision (i.e. the erasure, conditions or suspension) then please refer to the separate guidance sheet enclosed with the decision letter regarding your substantive GOC case.

9. If I successfully appeal the issuing of an alert, what will happen to the alert itself?

While your appeal is ongoing the alert will remain on the IMI system but with a qualification to say that an appeal has been lodged.

On appeal the County Court may:

- Dismiss your appeal;
- Allow your appeal and direct the alert be withdrawn or amended accordingly.

If the County Court decide to allow the appeal, then the GOC has a duty to delete the alert (or amend as appropriate) within three days of this decision.

10. What happens if the order made by the FTPC is revoked?

When an order is revoked by the FTPC (or the High Court) and that order was the subject of a European alert, we will close the alert within 3 days of the decision to revoke the order. When an alert is closed, all personal data is removed from the alert system.