BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(19)22 & F(16)27

AND

NICOLA MOSS (01-12695)

DETERMINATION OF A SUBSTANTIVE HEARING
9-11 DECEMBER 2019

| Committee Members:          | Ms A Johnstone (Chair/Lay) |
|                            | Mr N Pilkington (Lay)      |
|                            | Ms C Tetlow (Lay)          |
|                            | Mr C Dutton (Optometrist)  |
|                            | Ms G O’Rourke (Optometrist) |

| Legal adviser:             | Ms L Whittle-Martin        |

| GOC Presenting Officer:    | Mr B Albuery               |

| Registrant present/represented: | Yes and represented |

| Registrant representative: | Ms E Sanderson (Counsel) |

| Hearings Officer:          | Mr T Yates                 |

| Facts found proved:        | 1, 2, 3.                   |

| Facts not found proved:    | 4, 5                       |

| Misconduct:                | Found                      |
ALLEGATION (as amended)

The Council alleges that you, Nicola Moss, a registered optometrist:

1) On 7 September 2010 you carried out a sight test for Patient A and you:
   a. Failed to conduct and/or record an intraocular pressure test despite this being clinically indicated.
   b. Failed to conduct and/or record a visual fields test despite this being clinically indicated.

2) On 6 February 2013 you carried out a sight test for Patient A and you:
   a. Failed to conduct and/or record an intraocular pressure test despite this being clinically indicated.
   b. Failed to conduct and/or record a visual fields test despite this being clinically indicated.

3) On 4 July 2015 you:
   a. Failed to observe and/or record the cupping in Patient A's left eye.
   b. Failed to observe and/or record the asymmetry between the cupping in each eye.

4) Between 28 April 2017 and 4 May 2017, amended records for the following patients
   a. Patient D
   b. Patient E
c. Patient F  
d. Patient H  

5) Your actions at 4 above were:  
   a. Inappropriate  
   b. Misleading  
   c. Dishonest

AND by virtue of the facts set out at 1 and/or 2 and/or 3 and/or 4 and/or 5 above your fitness to practice is impaired by reason of misconduct.

DETERMINATION

Amendment

Mr Albuery applied to amend the particulars of the allegation, by removing particular 2c, in the light of evidence that had now been provided by Professor Bruce Evans, and by limiting particular 4 to the four patients (D, E, F and H) whose records had been examined by the handwriting expert, Dr Christopher Davies. The Registrant's representatives had been given notice of this application and supported the amendments being made.

The Committee accepted the advice of the Legal Adviser and concluded that it was in the interests of justice to allow the application.

Admissions in relation to the particulars of the allegation

The Registrant admitted particulars 1, 2 and 3 of the Allegation and the Chair announced these particulars found proved.

Witnesses

The Committee heard from the following witnesses called by the GOC:

- Professor Bruce Evans, an expert in optometry;
- Dr Christopher Davies, a handwriting expert.
The Committee was also provided with a witness statement from Person A, an optometrist who had worked at the Practice at the relevant time and had referred this matter to the GOC.

The GOC further relied on an Agreed Statement of Facts and a bundle of documentation which included a copy of the original complaint, patient documentation from the Practice, patient documentation from [REDACTED] NHS Foundation Trust and patient records relating to patients D, E, F and H.

The Registrant gave evidence at the impairment stage.

The Registrant also relied on a bundle of documentation consisting of references from four professional colleagues who attested to the Registrant's clinical practise and four of the Registrant's patients; two CET statements dated 2016-18 and 2019-21; and ten reports provided by her current supervisor, a consultant ophthalmologist. These had been submitted to the GOC as part of a supervision requirement that had been imposed on the Registrant’s ability to practise for the past 3 ½ years following the making of an interim order in proceedings before the GOC in 2016.

Background to the allegations

In summary it was alleged that the Registrant examined patient A in September 2010, February 2013 and July 2015 and that each of these examinations was inadequate as a result of the failures set out in particulars 1, 2 and 3.

It was further alleged that at a later date, in May 2017, the Registrant amended clinical records for four patients and in doing so acted in an inappropriate and/or misleading and/or dishonest manner, as set out in particulars 4 and 5.

The alleged facts were that on the 16 June 2015, Person A, an optometrist, was working as a locum optometrist at the Practice, when she tested Patient A's sight. She found that his intraocular pressure (“IOP”) was markedly different in each eye and she therefore examined previous records, which had been completed by the Registrant, for comparison. She found that there were no results for IOP relating to the previous two sight tests in 2010 and 2013, and that no visual field tests had been performed in 2010 and 2013. She referred Patient A to the Hospital Eye Service who confirmed that he was subsequently treated for glaucoma.

The GOC instructed Professor Bruce Evans, an expert optometrist, to prepare a report upon the Registrant's examinations of Patient A. Particulars 1, 2 and 3 of the Allegation were based upon his findings.
In relation to the sight test on the 7 September 2010 (particular 1), Professor Evans noted that no test of intraocular pressure or visual fields had been undertaken for Patient A, whose age and known family history of glaucoma meant that such tests had been clinically indicated. Professor Evans clarified that these tests would assist an optometrist in detecting glaucoma. He concluded that the sight test conducted by the Registrant was ‘therefore both unsafe and exceptional …. and falls far below the standard required’.

Professor Evans reached the same conclusion, with the same reasoning, in relation to the sight test conducted by the Registrant on the 6 February 2013 (particular 2).

In relation to the follow up appointment conducted by the Registrant on the 4 July 2015 (particular 3), Professor Evans concluded that ‘the failure of the Registrant to detect both the marked cupping in the left eye and the asymmetry falls far below the standard of a reasonably competent optometrist’.

Professor Evans gave evidence. It was suggested to him by Ms Sanderson on the Registrant’s behalf, that the behaviour alleged and admitted by the Registrant in particular 3 fell below, but not far below, the standards expected of an optometrist. He disagreed and maintained the stance he had taken in his expert report.

In relation to particulars 4 and 5, it was alleged by the GOC that the Registrant had amended patient records relating to patients D, E, F and H.

The records had been sent to a forensic document examiner, Dr Davies, for examination by him.

As a result of a report compiled by Dr Davies dated 8 March 2018, it was alleged by the GOC that the Registrant had made notes in the patient records after the event in order to give the impression that tests which she had failed to undertake had in fact been undertaken by her.

In his report, Dr Davies concluded that in relation to the patient records for Patients D, E, F and H, he had detected entries in the examination notes that had been written in different inks.

Dr Davies gave evidence before the Committee and referred to the relevant entries.

Dr Davies stated in his report that he had been unable to establish a date when the relevant entries had been made, with the exception of one of the records relating to patient E, namely record E2. In relation to this entry he had been able to establish that an entry was made on or after 15 October 2016. He said in his report, and in
giving evidence before the Committee, that he had deduced this from the fact that he
had detected impressions on a form dated 15 October 2016, namely form E4, which
indicated that it was likely to have sat underneath record E2, dated 19 July 2014, at
the time of E2’s alleged amendment.

It was accepted that the Registrant had an unblemished career hitherto.

Application of no case to answer in relation to particulars 4 and 5 pursuant to
Rule 46 (8)

At the close of the case for the GOC, Ms Sanderson submitted that there was no
case to answer in relation to particular 4 and particular 5.

Ms Sanderson submitted that the evidence that had been adduced was insufficient
for a Committee, properly directed, to conclude that the records relating to Patients
D, E, F, and H, had been amended between 28 April 2017 and 4 May 2017 as
alleged.

Ms Sanderson’s primary submission was that in relation to three sets of records,
namely those relating to Patients D, F, and H, there was no evidence that the
disputed entries amounted to “amendments” at all, in that there was no evidence to
support the contention that the disputed entries had been made non-
contemporaneously. She submitted that the expert’s evidence, at its height, was that
the disputed entries had been written in a different pen. As such, the expert could not
assist the Committee as to whether or not the entries had been written at the time of
the relevant appointment. Accordingly, the Committee could not, on the state of the
evidence, conclude that it was more likely than not that the disputed entries were in
fact “amendments” made on subsequent dates.

In relation to the fourth set of records, namely the records relating to Patient E, Ms
Sanderson’s primary submission was that the evidence at its height was that a
record on which an imprint had been found, namely record E4 dated 15 October
2016, was likely to have sat underneath record E2 dated 19 July 2014, at the time of
E2’s alleged amendment. However, she submitted that there was no evidence to
support the expert’s assumption that the record E4 had been placed in the file in
2016. Indeed, there was no evidence as to the provenance of E4 at all.

Accordingly, Ms Sanderson submitted that there was no case to answer in relation to
any of the patient records, on the grounds that there was insufficient evidence to
conclude that the disputed entries on the records relating to Patients D, F, H, and E
were non-contemporaneous “amendments”.

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Ms Sanderson’s secondary submission, in the alternative, was that should the Committee be against her primary submission, and should the Committee find there to be evidence that any of the records relating to Patients D, F, H and/or E had been amended non-contemporaneously, there nonetheless was no evidence that any of those amendments had been made between the dates of 28 April 2017 and 4 May 2017 as alleged.

She submitted that in relation to the records relating to Patients D, F and H, the expert could not assist as to the date when any amendments may have been made. In relation to records relating to Patient E, and in particular record E2, the expert evidence at its height, and relying on an assumption unsupported by evidence, was that E2 appeared to have been amended at some point on or after 15 October 2016 (the date of record E4).

However, Ms Sanderson submitted, there was no evidence regarding the state of the records as at 28 April 2017, when they were taken away, and as such, no evidence that the records did not already contain the alleged amendments at that date. She submitted that it was equally, if not more, probable that the disputed entries had already been present at that time. The evidence was that the Registrant had worked in the Practice for a period of 11 years.

Ms Sanderson submitted that there was no evidence as to any subterfuge in the records being taken, such as to give rise to a permissible inference that they had been taken for inappropriate reasons. Indeed, the evidence was that the Registrant left a careful paper trail to allow others working at the Practice to identify exactly what had been taken. Further, there was no complaint as to four further sets of records that had been taken at the same time.

Ms Sanderson submitted that even if the Committee concluded that the records for Patients D, F, H and/or E had been amended subsequent to the relevant appointments, there was insufficient evidence for the Committee to conclude that the amendments had taken place during the particular week alleged in particular 4 of the Allegation.

Mr Albuery accepted that there was no direct evidence regarding the date that the relevant amendments had been made. He submitted, however, that it was open to the Committee to draw an inference from the facts which would allow the Committee to overcome the relevant threshold. He submitted that it was agreed that on 28 April 2017 the Registrant attended the Practice having sought permission to take the records away, and on that basis, it was open to the Committee to make an inference regarding the dates when the amendments that had been identified by the handwriting expert had been made.
The Committee accepted the advice of the Legal Adviser, who reminded the Committee of Rule 46 (8) which states:

“Before opening the Registrant’s case the Registrant may make submissions as to

a. Whether sufficient evidence has been adduced upon which the disputed facts could be found proved;

b. Whether the facts, whether they are disputed or proved, could support a finding of impairment.”

The Legal Adviser reminded the Committee of the leading case of *Galbraith [1981] 1 WLR 1039*, as adapted to a regulatory setting by the case of *Sharaf v GMC [2013] EWHC 332*, which clarified that the test in regulatory proceedings is whether, taking the evidence presented by the regulator at its highest, a tribunal could find the facts proved on the balance of probability.

The Committee accepted Ms Sanderson’s secondary argument that, at the very least, the Committee had been provided with no evidence that the Registrant had amended any of the relevant records between 28 April 2017 and 4 May 2017. On that basis the Committee concluded that there was no case to answer in relation to particular 4.

In those circumstances, in the light of the way particular 4 has been drafted, the Committee did not consider it necessary or appropriate to decide whether there was a case to answer in relation to any other time period.

It followed from the Committee’s finding in relation to particular 4, that there was also no case to answer in relation to particular 5.

**Findings in relation to Misconduct**

Mr Albuery referred the Committee to the evidence and expert report of Professor Evans and submitted that the three admitted failures regarding the care of Patient A represented a serious departure from the standard that could reasonably have been expected of an optometrist. The failures related to standard tests that should have been undertaken to detect glaucoma, a condition which if left untreated could result in visual impairment. Recognising the clinical requirement for these tests in these circumstances is a core competency for an optometrist.

Ms Sanderson accepted on behalf of the Registrant that in relation to each allegation the Registrant’s behaviour had fallen below the standard expected of her. In relation to particulars 1 and 2, she accepted that the Registrant’s behaviour had fallen far
below the standard expected, whereas in relation to particular 3 it was only accepted that the Registrant’s behaviour had fallen below the standard expected.

The Committee accepted the advice of the Legal Adviser, who advised that in considering misconduct the Committee should ask whether, in its judgement, the Registrant’s behaviour had fallen seriously below the standard required of a registered Optometrist in the circumstances, and whether it would be regarded as deplorable by fellow practitioners. She referred the Committee to the cases of Roylance v General Medical Council No 2 [2001] 1 AC 311 and Nandi v GMC [2004] EWHC 2317.

The Committee took into account the evidence provided by Professor Evans that Patient A had two risk factors for glaucoma: he was older than 60 and had a family history of glaucoma (his mother), and in those circumstances intraocular pressure and visual field tests should have been conducted and recorded. Further, the Committee took into account Professor Evans’ conclusions in relation to both the 2010 examination reflected in particular 1, and the 2013 examination reflected in particular 2, that the sight test conducted by the Registrant had been “both unsafe and exceptional…and falls far below the standard required”. It also took into account Professor Evans’ conclusion in relation to the appointment in 2015, reflected in particular 3, that “In addition to failing to observe the cupping in the left eye, the Registrant also failed to detect the asymmetry between the cupping in each eye which the Complainant and the hospital staff detected. I consider that the failure of the Registrant to detect both the marked cupping in the left eye and the asymmetry falls far below the standard of a reasonably competent optometrist”.

In considering the sight test carried out by the Registrant on 7 September 2010, the Committee accepted that Patient A’s age and family history of glaucoma meant that intraocular pressure and visual field tests should have been conducted and recorded by the Registrant. In exercising its judgment, the Committee concluded that the fact that the Registrant had not conducted and recorded these tests fell far below the standard expected of her in the circumstances and amounted to misconduct.

In considering the sight test carried out by the Registrant on 6 February 2013 the Committee reached the same conclusion as it had reached in relation to the sight test on 7 September 2010, for the same reasons.

In considering the examination carried out by the Registrant on 4 July 2015, the Committee took account of the fact that she had not purported to provide Patient A with a full sight test on this occasion, but nonetheless she had examined the optic nerve. The Committee considered that in so doing she had failed to observe and record the cupping in Patient A’s left eye and the asymmetry between the cupping in each eye. The Registrant had recorded “discs don’t look cupped”. It was the
judgement of the Committee that this fell far below the standard expected of her in the circumstances and amounted to misconduct.

Accordingly, the Committee concluded that in its judgement the facts relating to particulars 1, 2 and 3, both individually and collectively, amounted to misconduct.

Findings regarding impairment

The Registrant gave evidence. She took the Committee through her employment history. She explained that she had been the subject of Interim Order of Conditions for the past 3 ½ years, imposed by the GOC. She explained that as part of those Interim Conditions she had been supervised whilst working part time as a clinician within the eye department of [REDACTED], where she had assessed and monitored glaucoma patients. She produced copies of the reports, which stretched from August 2016 to October 2019, and had been compiled by her supervisor for the purpose of the Interim Order proceedings. These stated that there had been no concerns regarding the Registrant’s clinical practice in that time.

The Registrant said that if faced with the same situation in future, she would carry out the tests that she now admitted she should have conducted. She said that she “felt dreadful” and “gutted” about her actions. She said that she had used the opportunity to learn from her mistakes. She said that she had never wanted to let patients down.

Mr Albury reminded the Committee of the legal criteria relevant to the issue of impairment, including that impairment is a matter for the judgment of the Committee.

Ms Sanderson submitted that the Registrant’s fitness to practise is not currently impaired as she had remediated her misconduct in the course of abiding by Interim Order of Conditions which had been imposed for the past 3 ½ years, and which had focussed on treating and monitoring glaucoma patients. She drew the Committee’s attention to the fact that the reports expressed no concerns regarding the Registrant’s current clinical practice. She also drew the Committee’s attention to the extensive CET undertaken by the Registrant over the past 3 ½ years and the positive testimonials provided, including those of her professional colleagues and her consultant supervisor. She submitted that in the circumstances it could not be suggested that the Registrant posed a risk to the public, and that the public would be satisfied by knowing that the Registrant had been subject to Interim Order conditions for the past 3 ½ years, culminating in the current public hearing.
Declaration

The Committee makes a formal declaration that the Registrant’s fitness to practise is not currently impaired.

In reaching its decision, the Committee has taken into account the GOC guidance on impairment within the “Hearing and Indicative Sanctions Guidance”, and has accepted the advice of the Legal Adviser, who referred to the case of CHRE v NMC & Grant [2011] EWHC 927, as set out earlier in this determination, and the case of Cohen v General Medical Council [2008] EWHC 581 in which it was said that ‘…It must be highly relevant in determining if a registrant’s fitness to undertake training is impaired that first his or her conduct which led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated.’ The Legal Adviser reminded the Committee of the need to consider the protection of the public, and also the wider public interest, which includes the need to declare and uphold proper standards of behaviour and to maintain public confidence in the profession.

The Committee has taken into account the references and reports that have been provided on the Registrant’s behalf, and in particular the reports that have been written by the Registrant’s supervisor for the purposes of the Interim Order Proceedings, whilst working in eye department of the [REDACTED]. In particular, the Committee has taken into account the following passages:

- 18 August 2016: “[Mrs Moss] works as a clinician within the eye department primarily treating and monitoring glaucoma patients. She also works as a research optometrist for the department. Her clinical workload primarily entails seeing new and follow-up glaucoma patients in the eye clinic, assessing clinical findings, making clinical decisions and working in close co-operation with her medical colleagues of whom I am the clinical lead and her direct clinical supervisor...........

Since Mrs Moss’s [interim] conditional order I have reviewed at least 10 cases per month with Mrs Moss, usually 3 to 5 cases a week. We have discussed these verbally and I have also examined a significant number of these cases myself. I have had no concerns....

I have had a close working relationship with Mrs Moss for the past eight years and I have to say that I have found her to be a very good colleague. She examines patients thoroughly and carefully and her clinical findings are accurate. She shows compassion to patients, good communication skills and follows up on clinical issues with diligence. She always makes sure that the patient’s safety and clinical care comes first and she communicates well with
medical colleagues from other specialities if required. I have no concerns myself about Mrs Moss’s clinical practice”.

- 19 March 2017: “She is meticulous about measuring intraocular pressure accurately and has excellent clinical skills in the assessment of the optic nerve and visual fields”.

- 4 October 2019: “I confirm that I have been supervising Mrs Moss for the period July to September 2019. During this period of time she has reviewed approximately 80 cases, all over 40 years of age, 60 of these patients had primary open angle glaucoma or primary angle closure glaucoma, 15 had ocular hypertension and 5 were glaucoma suspects. I have discussed and reviewed the vast majority of these cases and, as before, I continue to have no concerns about Mrs Moss’s clinical acumen, personal integrity, record keeping and clinical decision-making. She has my full confidence”.

The Committee has taken into account a final reference prepared by the Registrant’s supervisor dated 27 November 2019, who stated:

- “I have worked with Mrs Moss for over 10 years…….Throughout this entire period I have not had any doubts about Mrs Moss’ competency, integrity and honesty. I have found her to be highly competent and more knowledgeable than most optometrists about the management of glaucoma”.

The Committee has taken into account the Registrant’s unblemished career hitherto. The Committee concluded that the Registrant’s fitness to practise is not currently impaired. In abiding by the Interim Order of Conditions that have been imposed for the past 3 ½ years, which concentrated specifically on work with patients suspected of glaucoma, the Registrant has been able to demonstrate that she is highly unlikely to repeat her misconduct. It is clear to the Committee that the misconduct in this case was capable of remediation and has been remediated in full. The Committee could think of little else that the Registrant could have done to demonstrate remediation. She had accepted her behaviour amounted to misconduct and had shown insight when giving evidence before the Committee. The Committee is satisfied that the Registrant’s fitness to practise is not currently impaired on public protection grounds.
In considering the wider public interest, the Committee accepted the argument put forward by Ms Sanderson that the public interest is satisfied by the Registrant’s adherence, over the past 3 ½ years, to Interim Order of Conditions which had been tailored to the misconduct which the Registrant had recognised and accepted. Whilst this could not be described as a case that had concerned an isolated incident, it is a case that had involved a single patient. The Committee concluded that a member of the public, on being informed that Interim Order of Conditions had been in place for the past 3 ½ years, with good effect, and on learning that the Registrant had appeared before her regulator to admit and apologise for her misconduct, would not demand more to mark the seriousness of the misconduct in this case. In those circumstances the Committee concluded that public confidence in the Registrant and in the profession, and that maintenance of standards within the profession, would not be adversely affected by a finding of no impairment.

Accordingly, the Committee finds no current impairment of the Registrant’s fitness to practice.

Mr Albuery submitted that as the objectives of the regulator had already been met it would be disproportionate to request a warning. The Committee agreed with this submission.

The Committee revoked the Interim Order given in March 2016.

Chair of the Committee: Ms Anne Johnstone

Signature ......................................................... Date: 11 December 2019

Registrant: Ms Nicola Moss

Signature ......................................................... Date: 11 December 2019
## FURTHER INFORMATION

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

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