BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

AND

BANSI SHAH (01-24462)

DETERMINATION OF A SUBSTANTIVE HEARING
11-15 NOVEMBER 2019

| Committee Members:       | Dr P Ormerod (Chair/Lay) |
|                         | Mr I Crookall (Lay)      |
|                         | Ms S Fenoughty (Lay)     |
|                         | Mr D Cartwright (Optometrist) |
|                         | Ms P Shaw (Optometrist)  |
| Legal adviser:          | Ms L Whittle-Martin      |
| GOC Presenting Officer: | Mr C Hamlet              |
| Registrant present/represented: | Yes and represented |
| Registrant representative: | Mr J Milner (Counsel)   |
|                          | Ms N Wheater (AOP)       |
| Hearings Officer:       | Mr T Yates               |
| Facts found proved:     | Yes                      |
| Facts not found proved: | Found                    |
| Misconduct:             | Found                    |
| Impairment:             | Impaired                 |
| Sanction:               | 9 Months – (With Review) |
ALLEGATION (as amended)

The Council alleges that you, Bansi Shah (01-24462), a registered Optometrist:

1. On or around 25 June 2016 you informed a colleague that you had carried out a dilated fundus examination on Patient A when you had not done so

2. You conduct at 1 above was:
   a) Misleading
   b) Dishonest, in that you knew that you had not carried out a dilated fundus examination on Patient A

3. On or around 25 June 2016 you amended Patient A's records to show that a dilated fundus examination had been carried out on Patient A when it had not been

4. Your conduct at 3 above was:
   a) Misleading
   b) Inappropriate
   c) Dishonest, in that you knew that you had not carried out a dilated fundus examination on Patient A

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

DETERMINATION

Amendment

Mr Hamlet applied to discontinue Particular 4(b), which had alleged that the Registrant’s conduct set out in Particular 3 was “inappropriate”. Mr Milner did not oppose the application.

The Committee accepted the advice of the Legal Adviser, who advised the Committee to consider whether the application was in the interests of justice. The Committee took into account that Particular 4(a) alleges that the conduct set out in
Particular 3 was “misleading”, and Particular 4(c) alleges that the conduct set out in Particular 3 was “dishonest”. In those circumstances the Committee agreed with both parties that it was not in the interests of justice to have a further Particular alleging that the behaviour set out in Particular 3 was “inappropriate”. Further, the amendment could be made without any unfairness to the Registrant.

The Committee therefore it allowed the application to discontinue Particular 4(b).

Hearing evidence in private

In accordance with Rule 25 of the General Optical Council Fitness to Practise Rules 2013 (the “Rules”), the Committee concluded that it would be appropriate for such parts of the proceedings as related to the Registrant’s personal life to be heard in private.

Witnesses

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

- Witness A, the Team Leader at Practice A of Company A at the relevant time;
- Witness B, a residential optometrist at Practice A at the relevant time;
- Witness C, an optometrist at Company A, employed as a Professional Services Consultant, providing a working knowledge of the computer system, “Socrates”, used by Practice A.

The GOC also relied on the agreed witness statements of:

- RH, Optometrist Consultant, whose expert evidence was adduced with the agreement of the Defence;
- Patient A;
- Patient D

The GOC further relied on a bundle of documentation which included a copy of Patient A, D and E’s records and audit trail documentation from 25 June 2017; an attendance note of a conversation with Patient E of 21 October 2017; the notes of the response given by the Registrant when first questioned about the allegation at an internal meeting, and the response provided by the Registrant to the GOC on 6 June 2017.
The Committee heard from the following witnesses called by the Defence:

- The Registrant
- Witness D, the Registrant’s [redacted], to provide character evidence
- Witness E, a friend of the Registrant, to provide character evidence

The Defence also relied on a bundle of documentation which included screenshots of the Socrates system, and a number of witness statements attesting to the Registrant’s good character.

Background

The proceedings related to the events of 25 June 2016, when the Registrant was working as a locum at Practice A. Witness A was the Team Leader that day, and Witness B was working as a fellow optometrist.

The Committee heard that Practice A used a computer system known as 'Socrates' to manage the diary. Periods of time were blocked out in that system for patient appointments to be undertaken. It was accepted that on occasions, if an optometrist was running behind, an appointment period would be blocked to allow them to catch up. The GOC alleged that there was an expectation at this practice that any optometrist who wished to do this would seek permission first.

Witness B gave evidence that the Registrant had a tendency to see a patient and if she was running behind, to block out a further appointment to allow her time to catch up on her notes.

Witness B said that on 25 June 2016, she noticed that the Registrant had booked an additional appointment in the diary for a patient the Registrant had seen earlier in the day, Patient B.

Witness B relayed this information to Witness A in a conversation that took place at around 10.30am to 11.00am. Witness A confirmed that he had not authorised that extra appointment to be put in the diary.

Shortly after this, Witness B said she noticed that an additional appointment for another patient, Patient A, had been booked by the Registrant. The reason for the additional appointment was given as a dilated fundus examination.

Witness B said she knew that the Registrant had just seen Patient A for a sight test, following which Patient A had left the building. Witness B therefore checked Patient A's notes. She saw no record of a dilation examination. She relayed her concern to
Witness A in a conversation that took place approximately 10 minutes after the conversation regarding Patient B.

Witness B then showed Witness A the additional slot booked in Patient A’s name by refreshing the diary. This appeared to show that Patient A had checked in.

Shortly after this, Witness A spoke to the Registrant in her testing room. No-one else was present.

Firstly, Witness A challenged the Registrant about the extra appointment made for Patient B, and told her that this was unacceptable. The Registrant apologised and the appointment was deleted.

Witness A then challenged the Registrant about the additional dilation appointment booked in the name of Patient A. In evidence, Witness A stated that his recollection of events as stated in his witness statement, was clearer than his recollection at the present day. Witness A’s statement read as follows:

"...I asked her whether the dilation drops had been put into Patient A’s eyes and whether the Registrant had carried out the required tests. I made it very clear to the Registrant that the dilation was in relation to Patient A as I stated his name and I showed the Registrant the appointment in the system that stated "arrived for Patient A’s dilation". The Registrant confirmed that she had done this but she was running behind schedule and had not updated his records".

Meanwhile Witness B telephoned Patient A, who confirmed that he had had no drops put in his eyes. He was familiar with the process of dilation due to being a diabetic. Witness B informed Witness A of the outcome of that conversation.

Witness A later noticed that Patient A’s file had been placed next to the shredder.

Witness A spoke to the Registrant again. The passage in his witness statement which dealt with this conversation read:

"I asked the Registrant whether she was 100 per cent sure that she had dilated Patient A. The Registrant confirmed that she had. I informed her that the records for this patient were incomplete as none of the records referred to the dilation."

Witness A said in evidence that he was reviewing Patient A’s records on the system whilst the discussion took place.

Witness A said that the Registrant told him she would make sure that the records were completed before the end of her shift.

Witness A said that approximately 30 minutes later, he observed the Registrant coming out of the testing room and looking through the pile of papers next to the shredder. She took a file, looked through it and returned to the testing room. She
later returned and put the file in the shredding pile. Witness A looked at the file and saw that it related to Patient A.

Witness A said that he then logged onto Socrates and looked at Patient A’s notes. He saw that the records had been updated and a record made that dilating drops had been administered to Patient A.

Witness A said that if dilation of any patient had taken place that morning it would be highly likely that a member of staff would have known. He said the patient would have been in the store for 20 – 30 minutes after the drops had been instilled. Following the re-examination by the optometrist the patient would then require further screening to check the post dilation pressures. He said that the optometrist does not conduct the post dilation pressure test; a shop store member of staff does that.

Witness then reported his concerns to the Store Director and an investigation was commenced.

On 10 July 2016 an internal meeting took place. The Registrant said she had diluted a patient on the day in question but it had not been Patient A. She said she had been in a rush and had accidentally entered the notes relating to the patient she dilated onto Patient A’s record. She said that the patient she dilated was “most probably Patient D or E”.

Following the instigation of GOC proceedings, a formal response was submitted by the Registrant in a letter dated 6 June 2017.

In that response the Registrant represented that she had recorded a dilation examination in Patient A’s notes but that this had been due to an administrative error on her part. Patient A had been scheduled for a sight test at 10:40. The Registrant’s clinic was running late, so she booked an extra appointment for Patient A at 11:00 to avoid another patient being booked in. In doing so, she accidentally selected a dilation appointment instead of a sight test. She accepted that Patient A did not require dilation. During the subsequent conversation with Witness A about Patient A’s dilation appointment and dilation notes, it did not occur to the Registrant that she had made that error. She stated that she was not specifically asked by Witness A about whether she had dilated Patient A. She had not thought when she was speaking with Witness A that he was referring to Patient A. Having performed a dilation on a previous patient that day, the Registrant said she mistook the dilation appointment summary of Patient A for that of this other patient, scanned the barcode from Patient A’s dilation appointment summary and entered her handwritten results from that other patient’s dilation into Patient A’s notes. The dilation notes for the other patient were therefore written up in error in Patient A’s notes. The Registrant was unaware of the error when she left Practice A that day.
In light of the Registrant's response, the GOC employed Witness C to conduct an audit trail of all entries and edits made by various users at Practice A on 25 June 2016. This confirmed that the Registrant accessed Patient A's records between 10:51 and 11:15, when she completed one test record, and then again between 11:47 and 12:02, when a second test record was completed.

The GOC also employed RH to provide an expert report.

In that report RH tabulated the differences between the two sets of records relating to Patient A created by the Registrant. The second record contained additional details that had not been present in the first: “Dilation appt”, “Drug info Time – 11, Drug used – TRO 1.0, Batch No – F8809N, Expiry Date – 12/2016” “Dilated -yes” “Pressure pre-instillation RE 16 LE 17” “Pressure post-instillation RE 17 LE 17” “no DR seen today”.

RH confirmed that the following patients were seen prior to Patient A's notes being amended (in sequence): D, E, F, B, A and C.

RH examined the patient records of Patients D and E. He confirmed that there was no record of dilation, and that there was nothing in the records that would indicate a need for dilation in those patients.

In relation to Patient D, a witness statement was obtained in which Patient D confirmed: “I do not remember having any appointments at Practice A involving drops being put into the eyes. I think this would stand out to me”.

In relation to Patient E, RH saw an email stating that he did not have pupil dilation “back in June 2016 or any other time for that matter”. This was followed up, and Patient E is then recorded as having said that he “really can’t remember”.

RH, who had access to this material, reported that Patient E thought that he had been dilated in the past with eyedrops which give “a yellow tinge”. In RH's opinion these eyedrops were much more likely to be eyedrops used to check eye pressure, or to check the cornea as part of a contact lens episode, than eyedrops used to dilate a patient’s pupils, since these are colourless and do not have a yellow tinge.

RH said that the entry made by the Registrant on the second of the two records relating to Patient A, “no DR seen today”, was a reference to the diabetic retinopathy. He said that Patient A had diabetes, and therefore the absence of diabetic retinopathy was a reasonable note to make in the presence of a normal fundus examination. He said it would be unusual, in his experience, for an optometrist to record “no DR seen today” for the results of a dilation examination of a non-diabetic patient. Patients D and E were not recorded as having diabetes whereas Patient A was noted to have diabetes.

It was RH’s opinion that the post-dilation intraocular pressure readings and the comment about the absence of diabetic retinopathy, as recorded by the Registrant
on Patient A’s second record card, appeared more consistent with a dilated examination of Patient A than a dilated examination note for an appointment with either Patient D or Patient E.

**The Registrant’s evidence**

[REDACTED]

The Registrant said that on the day in question Witness B had been dealing with a family of three first thing, and each member of the family had to be pre-screened. This had a knock on effect for the Registrant’s list, which was delayed. She decided to see Patient D, and then Patient E, without pre-screening.

She said that Patient D’s appointment involved a sight test, and she typed the results into Socrates.

She said that Patient E’s appointment involved a sight test. She said: “I think I might have dilated him”.

She explained that dilation involved putting drops in the eye and waiting for them to work before seeing the patient later. She said that she wrote the dilation test results for Patient E by hand on a piece of paper because the computer records were being used by someone else in the practice. She wrote a quick note of the dilation result and the drugs used and the post pressures. However she did not write Patient E’s name on the paper.

She then saw Patients F and B, who had contact lens appointments, and entered their results contemporaneously on the computer.

She said the whole clinic was delayed that day. There was a blank appointment after Patient A and so she booked in an extra appointment for Patient A to show the staff that she was still seeing Patient A and was running behind. She said she booked this when she was in her test room. In so doing she selected the wrong button, which happened to be the “dilation” appointment button. She explained that at that time she was mostly working with Practice B where the computer system had a different configuration and this might have caused her confusion. She accepted that she did not dilate Patient A. She said he was a diabetic and not due for dilation until the following January.

She said, in relation to Patient B, that he still needed lenses ordering so she booked an additional slot in Patient B’s name to remind herself to do so.

She claimed that it was her practice to book out extra time where she needed it and there had never been any criticism of this previously.
She said that in the conversation with Witness A, he asked her why Patient B had been booked in when Patient B had already been seen. She apologised and explained that she had been reminding herself to order lenses. Witness A then deleted Patient B’s second appointment from the system. She said that she became apprehensive when dealing with this issue as she was not good at dealing with confrontation.

She said that in the second conversation with Witness A, Witness A asked her “have you dilated Patient A and if so his notes are not on the system and so can you write them up”. She said that when Witness A mentioned Patient A it did not occur to her at the time that she had dilated a different patient. She said “he just said a name so I presumed that he was talking about an earlier dilation”. She indicated that she had assured him that all the notes would be written up by the end of the day but she had been referring generally to all of her patients and not specifically to Patient A.

She then proceeded to write up the handwritten dilation notes relating to Patient E that were on her desk. Having scanned the barcode relating to Patient A onto the system she then mistakenly added the handwritten notes relating to Patient E onto the test record for Patient A. She saw the word “dilation” on the record and presumed the record related to the patient she had earlier dilated and so entered the notes relating to Patient E.

She said that Witness A had asked: “are those dilation notes written up”, and she didn’t think he named Patient A.

The Registrant said that she had never been in trouble before and was of good character. She called her [REDACTED], Witness D, Witness E, to give evidence in support of her good character. She also relied on the witness statements of eight further character witnesses.

**Legal Advice**

The Committee accepted the legal advice of the Legal Adviser who reminded the Committee that the burden rested on the GOC to prove the case on the balance of probabilities. She advised the Committee to take into account the Registrant’s good character. She advised that the relevant test for dishonesty was that set out in Ivey v Genting Casinos [2017] UKSC 67, namely:

“When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual’s knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to
be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.”

Submissions

Mr Hamlet submitted that there was no objective evidence that any dilation had taken place on that day and that the Registrant’s evidence was unreliable and untrue. His primary submission was that the Registrant had acted dishonestly by representing that she had dilated Patient A when she had not done so and that she had dishonestly amended the notes to support this assertion when challenged. His secondary submission was that at the very least the Registrant’s actions had been misleading.

Mr Milner submitted that the issue was a narrow one. The Committee had to decide what had been in the Registrant’s mind when she spoke with Witness A and when accessing Patient A’s second test record. The issue for the Committee was whether there had been a genuine belief on the part of the Registrant that what she was doing was dealing with notes in relation to a patient she had in fact dilated. He submitted that the evidence before the Committee supported the contention that the Registrant’s actions had amounted to an innocent mistake, made in the course of a busy day when she had been subjected to both professional and personal pressures.

Decision

In considering the witnesses who had been called in the case the Committee concluded that:

Witness B had been clear in her recollection, was willing to say when she could not remember detail asked of her, was consistent, and credible.

Witness A had been reliable, credible, clear in his recollection, consistent, fair and balanced in that he made concessions, for example by saying that the evidence provided in his statement, made closer in time to the event, was likely to be more accurate than the evidence given by him over three years later.

Witness C provided a useful context within which to understand the procedures in relation to computer records, timescales and other detail relied on in the case.

The Registrant maintained an essentially consistent account but there were important aspects that were not supported by the other evidence and the Committee found that her evidence lacked credibility.
The character witnesses called by the Registrant were impressive, supportive of the Registrant and gave a consistent account of her good character and behaviour.

The Committee understood that it was not for the Registrant to prove her case.

As the Committee had been requested to do, by both advocates, the Committee first considered the narrow question of what was the state of the Registrant's knowledge or belief at the time of the incidents.

It commenced its deliberation by considering the account she put forward, namely, that on the morning in question, she had diluted Patient E.

The Committee concluded that the Registrant did not dilate Patient E.

In reaching this conclusion it took into account the following:

- Witness A had said in evidence that if a dilation test on any patient had taken place, a member of staff would have known; the test involves asking the patient to leave the room for a period of approximately 20 minutes for the drops to take effect and to undergo post-tests by a shop floor member of staff. There was no evidence that this had occurred. To the contrary the evidence provided by Witness B and Witness A was that this had not occurred;

- There was no evidence of any post dilation pressures being done that day other than the entry made by the Registrant in Patient A's notes;

- Patient E's record, which the Registrant accepts she made, indicates that the examination was complete, and that no future dilation was required, in that she entered “Review 24/12” meaning that the patient was to be reviewed in 2 years’ time;

- Patient E's record shows that the Registrant actively entered a record that no dilation had been carried out, namely “Dilated-No”;

- The expert evidence provided by RH was that Patient E’s intraocular pressures were recorded as “right eye 9-10mmHG” and “left eye 10-12mmHg”, whereas the post dilation intraocular pressure recorded on the dilation record for Patient A was “17mmHG” and it was unlikely that this was consistent with Patient E’s pre-dilation pressures. Furthermore, the Registrant had made an entry on Patient A’s second record card for the peripheral retina: “All Quadrants Checked and no DR seen today”. DR is short for diabetic retinopathy. It was the opinion of RH that the post-dilation intraocular pressure reading and the comment about the absence of diabetic retinopathy as recorded by the Registrant appeared more consistent with a dilated examination of Patient A, who had diabetes, than of Patient E, who did not;
• RH said that there was no evidence that dilation was clinically indicated for Patient E;

• The Registrant had written on Patient A’s notes that 11.00 was the time she instilled the drops; at this time she was seeing Patient A, not Patient E, whose appointment had been at 9.40;

• Patient E had indicated that he had been dilated in the past with eye drops that give a yellow tinge, and it was the evidence of RH that this was more likely to reflect eye drops to check eye pressure or the cornea as part of a contact lens episode, since the eye drops used to dilate are colourless and do not have a yellow tinge;

• Whilst the Committee appreciated that Patient E was unsure whether he had been given the dilation drops, the Committee’s view was that had dilation drops been administered he would likely have remembered additional time in Practice A and additional advice that would have been given, such as advice not drive;

• The audit of patient interactions that morning appeared to show the Registrant would have had very little time to re-examine Patient E after any drops had been administered;

• The Registrant said in evidence that she was handed Patient E’s post screening pressures on a paper print out; she said she kept these together with handwritten notes relating to post dilation results of Patient E; if these two records had been kept together as the Registrant described it was implausible that they would then be separated and put into two different patient records.

The Committee then moved on from the issue of Patient E to consider the other evidence in the case.

It was alleged, and was accepted by the Registrant, that at the very least she had represented to Witness A that a patient had been dilated that morning.

The Committee then considered the possibility that the Registrant had dilated some other patient that morning, and mistakenly entered the results of that dilation onto Patient A’s records.

The Committee concluded that there was no evidence, other than the evidence provided by the Registrant, that any dilation had taken place that morning at all; to the contrary, all the evidence pointed to the fact that no dilation had taken place.

The Committee concluded that the evidence supported the assertion made by the GOC that the Registrant had acted dishonestly, both by informing Witness A that she had carried out a dilated fundus examination on Patient A, knowing she had not
in fact done so, and by amending Patient A’s records to show that she had carried out a dilated fundus examination on Patient A, knowing that she had not in fact done so.

In reaching its conclusion the Committee relied not only on the lack of any dilation taking place, but also on the evidence of Witness A. The Committee concluded that Witness A had made it abundantly clear to the Registrant that the patient he had in mind when speaking with her not once, but twice, on the same morning, was Patient A. It was his evidence that he had gone out of his way to visit her more than once to clarify the point. He had had Patient A’s record open at the time of the second discussion. Having listened to the entirety of Witness A’s evidence the Committee concluded that his recollection of events was reliable and consistent with the evidence Witness B and the audit evidence. It was clear that he informed the Registrant on both occasions that he was discussing Patient A rather than any other patient, and the Committee concluded that it was inconceivable that the Registrant could have misread the situation in the way she now described.

The Registrant has said that she was under pressure because she was running very behind. By the time she saw Patient A at 10.50 she was no more than 10 minutes behind and she had only one more patient scheduled before lunch. It was the view of the Committee that she was not therefore under undue pressure of time.

The Committee found the Registrant’s explanation to be lacking in credibility. She has sought to rely on a dilation examination that had not in fact taken place. Further, although the Committee accepts that the Registrant was under significant personal pressure at the time, the Committee concluded that it was, in any event, highly unlikely that a professional person of the Registrant’s experience could have found themselves muddled and confused to the extent that she now suggests in relation to such fundamental points.

In reaching its conclusion the Committee took into account the fact that the Registrant was a person of previous good character. The Committee also took account of the evidence of her character witnesses that a dishonest act would be totally out of character in their experience of her. However the Committee concluded that this was outweighed by the other evidence in the case.

In reaching its conclusion the Committee also took into account the evidence of the Registrant and her character witnesses, that the Registrant dislikes confrontation and does not handle it well.

On the basis of all the evidence, the Committee concluded the Registrant sought to justify her actions by improper means. She had been told by Witness A that it was unacceptable to book the additional slot for Patient B without permission, and she had gone on to repeat that unacceptable behaviour in relation to Patient A, which was also challenged by Witness A. She sought to legitimise her behaviour. She claimed to have carried out a dilation on Patient A, which, to her knowledge, she had
not in fact carried out. She then compounded her lie by adding detailed, false information to Patient A’s records. Her entries gave the impression that she had carried out a dilation in relation to Patient A, when she knew that she had not in fact carried out that examination. Later when challenged and it was obvious that she could not have dilated Patient A she gave a false account of having dilated Patient E.

Having concluded that this was the Registrant’s subjective state of mind at the time of the events relating to Particulars 1 and Particular 3, the Committee had no hesitation in concluding that a reasonable and informed member of the public would regard her behaviour in both regards to be dishonest.

Accordingly, the Committee found Particulars 1, 2b, 3, and 4c proved.

It follows that in those circumstances Sub-Particulars 2a and 4a are inevitably proved because the Registrant’s actions were misleading on both occasions.

Evidence and Submissions on Misconduct and Impairment

The Registrant gave further evidence at this stage. She confirmed that she continues to deny dishonesty. She said that she appreciated the seriousness of the finding. She said she is sorry that she breached the GOC Rules. She said “obviously taking into consideration everything it looks like dishonesty is a serious allegation; that was not my intention; I did not want to be dishonest”. She accepted that honesty is a fundamental tenet of her profession.

She said that since the incident she now makes sure she confirms the name and date of birth of her patients and scans those details into the computer to make sure they match. She ensures that her notes are entered directly onto the computer, rather than making handwritten notes.

She explained the difficult [redacted] circumstances that she now faces.

Mr Hamlet submitted that the Registrant’s dishonesty had been repeated, covered up, and denied. He submitted that this amounted to misconduct. He submitted that the Registrant’s actions had the potential for harm, and that there was a real risk that if faced with the same situation in future the Registrant would act in the same way again. He submitted that a finding of impairment was required to protect the public and was also needed to protect the public interest.

Mr Milner accepted that the Committee’s findings of fact amount to misconduct. He submitted that it may well be that a finding of impairment is required to protect the public interest. However, whilst accepting that dishonesty is difficult to remedy, he submitted that the Registrant had begun to remediate in so far as she could and had demonstrated that she was eager to recover and rehabilitate, and had demonstrated
insight into the gravity of the facts found proved. Consequently, he submitted, a finding of impairment on public protection grounds is not required.

Findings in relation to Misconduct

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 standards required of a registered Optometrist in the circumstances, and whether it would be regarded as deplorable by fellow practitioners. She took 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 concluded that the Registrant had breached the following codes of the GOC Standards of Practice for Optometrists and Dispensing Opticians (April 2016):

“16.1 Act with honesty and integrity to maintain public trust and confidence in your profession

17.1 Ensure your conduct, whether or not connected to your professional practice, does not damage public confidence in you or your profession.”

The Registrant’s behaviour had involved dishonesty whilst acting in her professional capacity as an Optometrist. The Committee concluded that the Registrant’s behaviour could not be described as isolated, but as two interconnected incidents (Particulars 1&2 and 3&4) which had taken place on the same day; the second had been designed to cover up the first. The Committee agreed that this dishonesty fell seriously below the standards expected of a registered Optometrist and would be regarded as deplorable by other members of the profession.

Accordingly, the Committee concluded that in its judgement the facts found proved amounted to misconduct.

Findings regarding impairment

The Committee accepted the advice of the Legal Adviser who set out the criteria in the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Paula Grant [2011] EWHC 927, and encouraged the Committee to ask whether the Registrant:

- Has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or
• Has in the past and/or is liable in the future to bring the profession into disrepute; and/or

• Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the profession

• Has in the past acted dishonestly and/or is liable to act dishonestly in the future

The Legal Adviser also took the Committee to the case of *Cohen v General Medical Council [2008] EWHC 581*, and encouraged the Committee to ask whether the Registrant’s conduct is easily remediable, whether it has been remedied and whether it is highly unlikely to be repeated. She advised the Committee to question whether or not this could be regarded as an isolated incident in an otherwise unblemished career, and to consider whether the Registrant has insight into her misconduct. She advised in accordance with the case of *Yusuff v GMC [2018] EWHC 13 (Admin)* that maintaining innocence in respect of misconduct previously found proved, whilst clearly relevant, does not necessarily equate to a lack of insight. She also advised the Committee to consider the critical public interest issues set out in the case of Grant.

The Committee concluded that as a consequence of her misconduct the Registrant’s fitness to practise as an Optometrist is currently impaired, both on grounds of public protection and public interest.

The Committee concluded that all of the criteria set out in the case of Grant apply in the current circumstances. In dishonestly amending the patient records, the Registrant had acted in a way which had had the potential to put patients at unwarranted risk of harm. She had brought the profession into disrepute, had breached a fundamental tenet of the profession, and had acted dishonestly. Further, the Committee concluded that she is liable to do so in the future, on all four grounds.

The Registrant continues to deny her dishonest behaviour. The Committee understood and accepted the proposition in law that it was possible to demonstrate insight despite continued denial. However, on the facts of this case the Committee found minimal evidence of insight; the Registrant had apologised for breaching the GOC Rules and had recognised that dishonesty was serious. She said that she had put in place certain steps within her working environment. It was submitted that these would reduce any risk that she may have presented to patient safety. However, the Committee was not reassured that the Registrant would act any differently if placed under pressure in future. She had not recognised the nature of her wrongdoing, had inadequately reflected on her past behaviour and had demonstrated minimal insight. The factors she had put forward by way of suggested remediation went largely to points made by her in the course of her defence to the allegation, where she had claimed to make an administrative error. Her suggested remediation had included such steps as avoiding handwritten notes and ensuring she confirmed the identity of
patients. However, the Committee had already rejected the relevance of such factors in reaching its conclusion on the facts, where the Committee had rejected the Registrant’s defence that she had made handwritten notes and entered them onto the computer in error. The Committee concluded that the Registrant’s fitness to practise is therefore impaired on grounds of public protection.

Further, due to the seriousness of the misconduct, as set out in this decision, public confidence in the Registrant and in the profession would be severely undermined were she to be permitted to practise unrestricted. The Committee concluded that a finding of impairment is also required to uphold proper standards and confidence in the Registrant and in the profession.

Accordingly, the Committee concluded that the Registrant’s fitness to practise as an Optometrist is currently impaired.

Sanction

Mr Hamlet submitted that erasure was the appropriate sanction in light of the seriousness of the Registrant’s dishonesty, which had included covering up her actions, together with the Registrant’s continued denial and minimal insight.

Mr Milner submitted that suspension was the appropriate sanction due to the mitigating factors in the case.

The Committee accepted the advice of the Legal Adviser who advised the Committee to consider the range of available sanctions in ascending order of seriousness; to consider any aggravating and mitigating factors in the case; to act proportionately; and to remember that the purpose of sanction is not to be punitive, but is to protect the public, maintain public confidence in the profession, and declare and uphold proper standards of conduct and behaviour. She advised the Committee to take into account the factors set out in the GOC’s “Hearings and Indicative Sanctions Guidance”.

The Committee took into account the following mitigating factors:

- the Registrant’s previous good character
- the positive testimonials provided on the Registrant’s behalf attesting to her ability as a clinician and to the fact that dishonesty is wholly out of character
- the length of time since the misconduct, combined with the lack of any repetition of it
- the Registrant’s personal circumstances at the time of the misconduct and at the present time.
The Committee took into account the following aggravating factors:

- the dishonesty relating to Particulars 3 & 4 was designed to cover up the dishonesty in Particulars 1 & 2
- the Registrant furthered her fabrication during the internal meeting held three weeks after the incident
- the Registrant then continued to fabricate evidence during the hearing
- the Registrant's minimal insight

The Committee concluded that in view of the seriousness of the misconduct, to take no further action would not be sufficient to protect the public or maintain confidence in the profession and the regulatory process.

The Committee concluded that conditional registration would not be sufficient in light of the seriousness of the dishonesty. Further, such an order would not be practicable due to the nature of the misconduct, which did not involve identifiable areas of practice in need of assessment or retraining.

The Committee considered a Suspension Order.

The Committee took into account the fact that dishonesty is a serious matter. Furthermore, in this instance the Registrant’s dishonesty had comprised two interconnected incidents, the second of which had been designed to cover up the first. The Registrant had continued to deny her actions and had not told the truth during the hearing. She had shown minimal insight.

However, the Committee was mindful of the exceptional personal circumstances faced by the Registrant, both at the time of the misconduct and at the present time. Those circumstances, together with the Registrant’s previous good character, her clinical ability, and the lack of repetition since the time of the misconduct in 2016, led the Committee to conclude that suspension was the appropriate sanction in the circumstances. The Committee had found no evidence of harmful deep-seated personality or attitudinal problems. The Committee concluded that a period of suspension would be sufficient to protect the public in light of the mitigating factors identified.

The Committee concluded that a reasonable member of the public, in possession of all the facts, would accept that suspension was the proportionate sanction in the circumstances of the case. The Committee concluded that the public interest would be satisfied by an order of suspension, which would be sufficient to declare and uphold proper standards of conduct and behaviour and maintain confidence in the profession.
The Committee considered erasure but concluded that this was not the only sanction that could protect patients and the public interest in the circumstances of this case. The Committee took into account the wider public interest in retaining the services of a committed Optometrist whose contribution to the profession is recognised by her colleagues. The Committee noted that she spoke with enthusiasm about her chosen vocation. The Committee was of the view that the Registrant should be given time in which to reflect more fully on her actions in the light of the Committee’s findings, which would provide her with the opportunity to develop the minimal insight she had demonstrated thus far.

The Committee gave consideration to the length of the order and concluded that 9 months was the appropriate length, having balanced the seriousness of the dishonesty against the mitigating factors in the case, including her personal circumstances.

The Committee therefore imposes a Suspension Order for a period of 9 months.

A review hearing will be held prior to the expiration of this order. The Committee considered that a Review Committee may be assisted by:

- a written reflection from the Registrant about her dishonest behaviour and the effect of that behaviour on patients, colleagues and the reputation of the profession
- evidence that she has maintained her skills and knowledge, including her compliance with her Continuing Education and Training obligations
- written references or testimonials from persons who can attest to the Registrant’s character, with full knowledge of the Committee’s findings.

**Immediate order**

Mr Hamlet asked the Committee to impose an immediate order of suspension to cover the appeal period or the time taken for any appeal to be determined. Mr Milner did not oppose the application. The Committee accepted the advice of the Legal Adviser.

The Committee decided that an immediate suspension order was necessary to protect the public and the wider public interest in light of its findings.
Chair of the Committee: Dr Pamela Ormerod

Signature .......................................................... Date: 15 November 2019

Registrant: Ms Bansi Shah

Signature .......................................................... Date: 15 November 2019
# 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](http://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.