General Optical Council

F(06)10

BEFORE THE FITNESS TO PRACTISE COMMITTEE OF THE GENERAL OPTICAL COUNCIL

ANTHONY VAUGHAN JONES
(01-9489)

Tuesday, 20 March 2007
&
Wednesday, 21 March 2007

General Optical Council

FITNESS TO PRACTISE SUBSTANTIVE HEARING:
ANTHONY VAUGHAN JONES (01-9489)
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Fitness to Practise Committee:	Mr P North (Chair) Professor N Hirji (Optometrist) Ms L O'Donoghue (Optometrist) Mrs G Huka (Lay member) Mr R Varley (Lay member)
Legal Adviser:	Mr D Swinstead
Hearings Manager:	Mr D Henley BEM
For the GOC:	Mr J Foster Mrs C Withall
For the Registrant:	Mrs S Kapila

[*The hearing commenced at 10.17 a.m.*]

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

At the desk in front of the Committee, to my left, is the transcriber who will be keeping an official record of all that is said today during the sessions of the hearing at which the parties are present. Next to the transcriber is Mr Henley, the Hearings Manager, who will provide administrative assistance to the Committee. The remaining persons sitting in the hearing room rather than in the public and press areas are members of the respective legal teams.

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

Do we have any applications at this point?

Mr Foster: No sir, but it may assist, sir, that I have prepared some bundles here which I would like to be handed up to the Committee and made available to the witness. My friend has one. These are bundles for the facts stage, and I would be assisted if the Committee limited their consideration of the papers to this bundle until they have made their decision on the facts, sir.

Mr North: Thank you; Mrs Kapila, you are aware of this?

Mrs Kapila: Yes, I have seen this one.

[*Documents distributed*]

Mr North: Are there any admissions in relation to the particulars set out in the allegations?

Mrs Kapila: Yes, sir, there are a number of admissions. These admissions are made purely as matters of fact and not in any way as failures or as any indication of deficient professional performance, and the admissions that are made are as follows:

A (i) Mr Jones on 6 January when he examined Patient A did not carry out indirect ophthalmoscopy through a dilated pupil;
(ii) He did not carry out dynamic assessment of the anterior vitreous;
(iii) He did not perform a visual field test examination on Patient A; and
(iv) He did not refer Patient A.

I would reiterate that these admissions are made purely as factual admissions.

Mr North: Thank you; Mr Foster?

Mr Foster: Sir, you may wish to have the allegation read out into the transcript? I am sure Mr Henley would be happy to do that.

Mr North: Would you do that?

Mr Henley: The allegation:

"On 6 January 2005 Mr Jones examined Patient A and he:

(i) Did not carry out indirect ophthalmoscopy through a dilated pupil.
(ii) Did not carry out dynamic assessment of the anterior vitreous.
(iii) Did not perform a visual field test examination on Patient A.
(iv) Did not enquire as to the full history of any recent ocular symptoms, including details about any flashes and floaters.
(v) Did not refer Patient A.
(vi) Did not sufficiently note details of Patient A's symptoms and history on the record card.
(vii) Did not note details of ophthalmoscopy on the record card.

And by reason of the facts set out above, Mr Jones is guilty of deficient professional performance."

Mr North: Thank you.

Mr Foster: Thank you, sir. As you have heard that is the allegation against Mr Jones. It is very clear, and I am sure your learned Legal Adviser will tell you, that the burden of proving those facts rests on me as solicitor appointed by the Council to present their case, and that the standard to which they must be proved is so that you can be certain so as to be sure that the facts alleged took place.

Clearly in relation to the admitted facts under (i) (ii) (iii) and (v) you can be certain that those facts took place because they are admitted, but as my learned friend tells you it is on the basis that these tests were not carried out, and not on the basis that Mr Jones had a duty to carry out these tests. That is not accepted; although that is part of the Council's case that remains something that I will have to prove today, and as such, it is something on which I intend to lead evidence to have the witnesses

speak to regardless of the fact that admissions have been made in respect of those particulars.

Having determined so that you are certain that those facts took place, if you do make that determination, you will then be faced with a new stage of the proceedings which is to determine in your professional judgment whether those facts amount to a deficient professional performance, and you will seek advice and submissions on that at the appropriate stage. Should you determine that those facts do amount to a deficient professional performance, it will be for you to determine in your judgment whether such a deficient professional performance amounts to an impairment of Mr Jones' fitness to practise, and again you will receive advice and submissions at the appropriate stage.

What I intend to do now is to summarise the evidence that I intend to call in order to put it into context for you, hopefully to assist you in determining whether or not you feel that the matters raised took place.

All facts alleged involve Patient A, as you have heard. Patient A is a 56-year-old shop assistant from Abergavenny. Patient A attended an eye examination on 6 January 2005. At the beginning of that eye examination Patient A informed Mr Jones that there was something wrong with her right eye. She told him that if she looked left everything was grey. She described this problem as "shading".

Mr Jones examined Patient A's eyes. Due to the fact that Mr Jones was aware of Patient A's history involving vitreous floaters he looked for signs of retinal detachment. He did not however dilate Patient A's pupil or use indirect ophthalmoscopy. He also did not carry out a dynamic assessment of the anterior vitreous. He did not use a slit lamp in order to look for Shafer's Sign, which you will hear is a predictive sign of a problem with the retina, a possible tear or detachment.

Having examined Patient A's eyes Mr Jones noted that there were no signs of detachment on her records. Mr Jones did not ask Patient A whether she was suffering from flashes, another symptom which may indicate that there is a problem with the retina. He advised Patient A that he could see a mass of floaters, but explained to her that as she had always had floaters there was nothing to worry about. At the end of the examination Mr Jones told Patient A that everything was fine. He gave her a new prescription for her spectacles and advised her to return in two years' time for another check-up.

Some three weeks later, on 24 January 2005, Patient A was still very concerned about the "shading" that she was experiencing, so she returned to her opticians and this time she was seen by one of Mr Jones' colleagues. On this occasion Mr Jones' colleague recognised the symptoms of a possible retinal tear or detachment and referred Patient A immediately to possible. Patient A attended the Royal Gwent Hospital that day and on the next day, 25 January, having been transferred to the University of Wales Hospital in Cardiff, she underwent surgery to repair an acute retinal detachment.

You will hear from two witnesses of fact today: Patient A will give evidence regarding the examination on 6 January; in addition you will also hear from Dr Nick Sheen. Dr Sheen has considered the evidence relating to Mr Jones' examination of Patient A on 6 January, and you will that in Dr Sheen's expert opinion Mr Jones ought to have dilated Patient A's pupils and performed binocular indirect ophthalmoscopy. The reason, you will hear, for this is that direct ophthalmoscopy is essentially a two-dimensional process, you can see two dimensions. The retinal tear often occurs in

the third dimension, it may be coming towards you, and because of that you need a test that involves three dimensions and that is binocular indirect ophthalmoscopy. In addition, because it is important to look for Schafer's Sign, it is also important to do a dynamic assessment of the anterior vitreous. You will hear that in Dr Sheen's opinion this is the minimum that a reasonably competent optometrist concerned about the possibility of retinal detachment is expect to undertake. You will hear Dr Sheen explain why it is not possible to rule out the possibility of retinal detachment by direct ophthalmoscopy alone.

You will also hear that in Dr Sheen's opinion, Mr Jones' history-taking and his record keeping were also deficient. You will hear that by failing to enquire fully about Patient A's history and by failing to conduct the bare minimum of required examinations, Mr Jones essentially robbed himself of the opportunity to ensure that Patient A was not suffering from a retinal tear or detachment, and by failing to keep proper records he also failed to give Patient A the care that she was entitled to.

As I have said, facts must be certain. You will then go on to determine whether as a matter of your judgment this amounted to a deficient professional performance. I bring the case, and clearly it is the Council's case that it did but that will be a matter for you.

Sir that is all I intend to say by way of opening remarks. If you have no questions of me I would ask that I call my first witness, Patient A.

Mr North: I am grateful.

Patient A called and sworn
Examined-in-chief **by Mr Foster**

Mr Foster: Good morning. This morning when I talk to you, and indeed when my colleagues or the Committee speak to you, we are going to be referring to you as Patient A. This is to protect your anonymity, so that is the only name that I will be saying.
Patient A: Right.

Q. There are a lot of people here who have to hear the evidence that you have to give, so I would be grateful if you could keep your voice up when you answer questions. Can you help the Committee by letting us know your age?
A. Fifty seven.

Q. I am grateful; and what do you do for a profession, Patient A?
A. I work in a newsagents - WH Smith.

Q. And where is that?
A. In Abergavenny.

Q. I see you are wearing spectacles; how long have you been wearing spectacles for?

Mr North: It might be helpful if Patient A identified herself on paper, I think.

Mr Foster: Certainly sir. If you would just write your name for the Committee, that would be helpful. [*Patient A writes her name on paper which is passed to the Committee*] Thank you. I apologise.

Mr North: Would you like to continue?

Mr Foster: Thank you, sir. You were telling us how long you had worn spectacles for.
Patient A: Since a child.

Q. And why is it that you have spectacles.
A. I am astigmatic.

Q. And apart from your astigmatism do you suffer from any other conditions in your eye? How is your sight?
A. It is not bad; it is okay.

Q. Are you long-sighted, short-sighted?
A. Short-sighted.

Q. I am grateful. You are aware that this hearing involves Mr Jones?
A. Yes.

Q. Have you been to Mr Jones' practice as a patient?
A. Yes.

Q. On how many occasions?
A. Twice.

Q. Can you tell me about the first occasion you went to see him?
A. It was 2003.

Q. And why did you decide to go and see Mr Jones then?
A. It was just a routine check-up.

Q. The optometrist that he works from, was this your opticians?
A. The company you mean? Yes.

Q. Can you tell us the name of that?
A. Rayners.

Q. Rayner Opticians; and when you went to see the opticians in 2003 had you known you were going to see Mr Jones, or was he the optometrist who was working on that day?
A. I had booked with him because he was recommended at that time.

Q. Can you tell us what happened in the eye examination in 2003?
A. He referred me to a check for diabetes.

Q. Did he tell you why?
A. He wasn't certain, but just as a precaution I presumed.

Q. Did he tell you on that day in 2003 whether there was anything wrong with your eyes?
A. No.

Q. When he told you that he was going to refer you for a diabetes check did he explain why that was?
A. Just a precaution as far as I was aware.

Q. Did you suffer from any sight problems at that time?

A. Nothing at all, no. Nothing untoward.

Q. When you had finished the examination in 2003, apart from telling you that he would refer you for a diabetes check did he tell you that you ought to come back and see him again?
A. Yes, in two years' time.

Q. And did he give you any sort of prescription?
A. Yes, they always give a written prescription.

Q. I am grateful. I would like you to have a look if you may at page 55 of the bundle that is in front of you. Do you see that page in front of you?
A. Yes.

Q. Is this the prescription that you were given?
A. Yes.

Q. Can you tell us what date it says on the bottom?
A. It is dated 16 January 2003.

Q. And slightly above that date and above the signature of the optometrist, can you tell us where it says "I recommend your next eye examination" what the date of that is?
A. January '05.

Q. January '05, so from this prescription you are telling us that you knew you should return in January 2005?
A. Yes.

Q. Did you return in January 2005?
A. Yes, I did.

Q. And in January 2005 were there any problems with your eyes?
A. Yes.

Q. Can you tell us what the problem was with your eyes then?
A. It was just my right eye; if I looked directly forward or to the right everything was fine, but if I looked to the left there was like a shading.

Q. What do you mean by "shading"?
A. It just looked grey, and it was just sort of from there over, nothing else. Everything was fine, but it was just that looking to the left was the grey shading.

Q. I am grateful. How long prior to your appointment in January 2005 had you been experiencing this particular problem?
A. I am not certain. It was only days.

Q. Did that affect the reasons why you made the appointment at all for that time?
A. That was the only reason.

Q. And you attended the surgery on 6 January 2005 that is accepted.
A. Yes.

Q. When you were examined by Mr Jones what symptoms did you tell him you were suffering from?
A. Exactly what I have told you now, that I had the shading to the left of my eye.

Q. And did you use the phrase "shading"?
A. Yes.

Q. Did Mr Jones ask you what you meant by that?
A. I am not certain.

Q. Do you yourself remember whether you elaborated on what "shading" meant at all?
A. I think, as far as I can remember, all I said was that I had this shading to the left, and I think that was it, and then he proceeded with the examination.

Q. Once you had told him that can you tell us what you remember he did in terms of an examination?
A. A normal routine eye examination.

Q. When you say that, how many times have you undergone an eye examination in your life?
A. Oh, lots.

Q. What do you mean by a "normal routine eye examination"?
A. Well, you just look at the board, read the letters, then they look in your eyes with the thing.

Q. When he looked into your eyes, when he examined your eyes, prior to doing that did he put drops in your eyes?
A. No.

Q. Have you ever been examined by having drops put in your eyes?
A. Yes.

Q. What do you understand happens when drops are put in your eyes?
A. They dilate the pupils.

Q. So you have experienced that?
A. Yes.

Q. But it didn't happen on this occasion?
A. No.

Q. Did he use an instrument to look in your eye at all?
A. Yes, it is – like a glorified torch that sort of whirrs a bit or something.

Q. I am grateful; and following that did Mr Jones ask you any questions about what you had been seeing, about your visual history?
A. Nothing other than I had floaters which I have always had. I have had floaters for quite a few years but nothing other than that, that I am aware.

Q. Did he ask you whether you had floaters or did he tell you that you had floaters?
A. I think – I have to think now. I had had floaters before but I think there may be even more floaters.

Q. Did he ask you whether there were more floaters or did he tell you that there were more floaters?
A. I think he told me.

Q. Did he ask you whether the floaters had been noticeably worse for you?
A. No.

Q. Did he ask you whether you had any other symptoms?
A. I don't think so.

Q. Had you had any other symptoms?
A. No.

Q. What did Mr Jones tell you at the end of the examination about your eyes?
A. Everything was fine, and I was to come back in two years.

Q. Did this put your mind at rest?
A. Yes, at the time.

Q. Why was that?
A. Because I had gone to an optician and as far as I was aware he had checked my eyes so there couldn't be a problem.

Q. And we know that you had been given a prescription because you have shown it to us; did that affect the spectacles that you were wearing?
A. There wasn't a great deal of difference as far as I recollect.

Q. But it was a new prescription for new glasses?
A. Yes.

Q. I am grateful. So you left at the end of 6 January; did you continue to experience the symptoms of shading that you have described?
A. Yes, it was exactly the same.

Q. What did you do about that?
A. Initially nothing, until I went back.

Q. And when did you go back.
A. I have forgotten the date – 24 January.

Q. I am grateful; and why did you go back on that date?
A. Because the shading was still there and although I had been told that there was nothing wrong it just niggled.

Q. When you went back on that date did you see Mr Jones again?
A. No.

Q. Do you remember who you saw?
A. Ruth Barnet.

Q. And did Ruth Barnet examine your eyes?
A. Yes.

Q. And what did she tell you about your eyes?
A. She thought I had some retinal tears.

Q. So as a result of that what did she do?
A. She contacted the hospital and it was all dealt with very, very quickly.

Q. Which hospital did you attend?
A. Initially the Royal Gwent in Newport.

Q. Was that on the same day or on a different day to -?
A. Same day.

Q. On the same day; what did they tell you at that hospital?
A. They said it was definitely retinal tears.

Q. And what happened as a result of that?
A. I had to go then to the University Hospital of Wales in Cardiff.

Q. When did you go there?
A. The following morning.

Q. What happened at the University of Wales?
A. They operated that morning.

Q. Was that operation successful?
A. Yes.

Q. Was that to repair the retinal detachment?
A. Yes.

Q. I am grateful; I have no further questions for you Patient A, but I am sure that my learned friend will and I am sure at some stage the members of the Committee will.

Mr North: Thank you; Mrs Kapila?

PATIENT A cross-examined **by Mrs Kapila**

Mrs Kapila: I am sorry I have to address you as Patient A, for obvious reasons. You told us that you saw Mr Jones in 2003?
Patient A: Yes.

Q. In fact he did tell you then, didn't he, that you had vitreous degeneration and increased short-sightedness?
A. I don't recall that.

Q. He also told you that he was therefore referring you to your GP, also because he wanted you tested for diabetes.
A. Yes, he recommended me to go to my GP to test for diabetes, yes.

Q. He asks you to return to his practice within a year.
A. No.

Q. You were sent reminders from the practice after a year to come in for a routine examination.
A. No.

Q. When you came in for your examination you came in on a purely routine basis.
A. Which examination?

Q. The examination on 6 January 2005.
A. No.

Q. You had no symptoms of shading.
A. I did.

Q. You gave Mr Jones no symptoms of shading.
A. I did.

Q. Mr Jones took a history of your visual symptoms.
A. I'm sorry?

Q. Mr Jones took a history of your visual symptoms; he asked you about an increase in floaters and you gave him a reply in the negative.
A. No.

Q. He asked you about whether you had experienced any flashes, and you gave a reply in the negative.
A. I don't recall Mr Jones asking me about flashes.

Q. You complained to Mr Jones about a deterioration in the vision of your right eye.
A. No.

Q. You have told us that you had shading in your eye.
A. Yes.

Q. And that it was only on looking to the left -
A. Yes.

Q. - that you noticed the shading.
A. Yes.

Q. You are absolutely sure of that?
A. Yes.

Q. So only when you looked to the left did you see the shading?
A. Yes.

Q. At the time these events were taking place did you see Mr Jones on a daily basis or regularly in your work?
A. Yes, he used to come into the shop occasionally.

Q. When you went away from his practice you have just told us that you were satisfied that there was nothing wrong with your eye until a little bit later. When you met him when you were at work did you not think to mention to him that your eye was still having problems?
A. I can't recall whether I saw Mr Jones through that period. He doesn't work in Abergavenny very often.

Q. But he is a regular visitor to WH Smith where you work?
A. Yes, but I am not on the shop floor all the time.

Q. I see. When you continued you say to experience these symptoms of shading, why did you wait until 24 January to go and see your optometrist again?
A. Because I had been to an optician and I thought that what he said was correct so there was no need to go, but as time when on and it didn't improve I thought I needed to go back.

Q. Are you saying that your symptoms were exactly the same on 24 January as they were on the 6th?
A. Yes.

Q. So all that time with this shading, this bit in your eye that you couldn't see, you just let it be for two weeks?
A. Yes.

Q. Your symptoms of shading developed on or around 24 January when you went back to the practice.
A. No.

Q. When you saw Mr Jones these symptoms simply did not exist.
A. They did.

Q. You are absolutely sure of that now?
A. Absolutely positive.

Q. So it is no longer a question of whether you recall or you are not sure or you don't think so, you are absolutely sure now?
A. On 6 January I had the shading on my eye.

Q. Are you looking to seek compensation from Mr Jones?
A. Not at all.

Mr North: Can we just stick to the facts of the matter Mrs Kapila, if you don't mind?

Mrs Kapila: It is just a question, Chairman, which I feel might be pertinent to the evidence that you are hearing today. It will also be a matter of fact. I have no further questions for Patient A.

Mr Foster: I have just one short question, sir.

PATIENT A re-examined **by Mr Foster**

Mr Foster: Why is it that you remember what happened in that examination?
Patient A: I was there. I don't know. I just went because I had the shading, because I could see clearly straight in front and to the right it was just that small piece to the left, it wasn't a large amount, but it was just that little something. Then Mr Jones said it was okay, there was nothing wrong, so I went home and 'Right, I've had my eyes tested, end of story', so I didn't do any more about it – but then it just stayed there.

Q. I am grateful. I have no other questions, but the Committee may.

Mr North: Thank you, Mr Foster. Legal Adviser, are there any matters you would like to explore, or bring to our attention or draw up?

Mr Swinstead: No sir, thank you.

Mr North: Colleagues, do you have anything?

PATIENT A questioned by the **COMMITTEE**

Professor Hirji: Yes, I do have a question. Can you recall the time you spent in 2003? How long did the examination process take?
A. Quite a while. Mr Jones seemed to be very thorough.

Q. Can you give me an estimate – half an hour, 45 minutes?
A. [*Pause*] Half an hour, possibly? I am not certain.

Q. That would be the first visit in 2003?
A. Yes.

Q. Was it the same amount of time in the second visit in January 2005? Was it shorter or longer?
A. I am just thinking now; when I say half an hour that was 2005, sorry.

Q. Oh, right.
A. Sorry, I got my dates muddled there.

Q. So you first went in 2003?
A. Yes.

Q. How long was that visit?
A. I would probably think about the same?

Q. About the same?
A. Yes.

Q. And the final visit with a different optometrist, how long was that?
A. She was quite quick actually. From the time I went in and spoke to her in the Reception area and then in she seemed to know exactly what the problem could be.

Q. So the decision was fairly quick -
A. Very quick.

Q. - and the process was fairly quick?
A. Yes, but she did have a good look as well.

Q. And she dilated the eye?
A. Yes.

Q. And you think about 15 minutes, or 30 minutes again?
A. Yes – yes, quite quick.

Q. Fifteen?
A. At the most.

Q. Thank you very much.
A. Okay.

Ms O'Donoghue: Did you experience any flashing lights when you went on 6 January?
A. I don't know. I can't be honestly certain when I saw the flashes. The first time I saw the flashes was one morning when I woke up and I was lying quietly in bed, and then

– they weren't that conspicuous. They weren't easy to see. You couldn't see them just like this; it was only when I was sat quiet or lying down or something.

Q. Thank you.

Mrs Huka: Mrs A, could you tell us whether you think that your symptoms got worse between 6 January and 24 January?
A. As far as I could tell they were exactly the same.

Q. Thank you.

Mr North: Mrs A, if I could just follow up on the flashes point, can you pinpoint in the sequence of events when you first became consciously aware of those flashes?
A. It would probably be about halfway between the 6th and the 24th.

Q. So about halfway between the dates?
A. I would think so. They could have been there before or not, I don't know.

Q. But you consciously between the 6th and the 24th -
A. Yes, somewhere in there. It was one morning when I woke up and I could – you know.

Q. And for how long had you experienced the greying episode in your eye? You will have to excuse my questions I am a lay member and am perhaps not as well informed as my learned professional colleagues.
A. Somewhere between the New Year and 6 January.

Q. Between New Year and 6 January?
A. Yes, because it was a day or two before I actually went to the optician.

Q. So in effect before you went back to work?
A. I went back to work on 2 January.

Q. Okay, that has been very helpful, thank you very much indeed. Do any of my colleagues have any further questions? [*No*]

Mr Foster: You may want to ask Mrs Kapila if she has any questions arising out of your questions.

Mr North: I was just about to ask her that.

Mr Foster: Sorry to jump the gun!

Mr North: I was going to ask whether any of our representatives have any matters.

Mrs Kapila: I may have one or two questions arising from the Committee's questions; if you could bear with me for just one minute? [*Confers*]

PATIENT A re-cross-examined **by MRS KAPILA**

Mrs Kapila: Patient A, you were asked a few minutes ago about when you had the symptoms that you are complaining of. Are you aware that there is a medical record, which I can show you but which you might well have seen in the context of your other medical records that talks about an "acute onset retinal detachment in the right eye"?
Patient A: Yes, I think so.

Q. And you still maintain that you had these symptoms between the 1st and the 6th of January?
A. Yes.

Q. Thank you, I have no further questions.

Mr Foster: I have no further questions, thank you, sir.

Mr North: Just one point on which I should like some clarity if I may, Patient A. The reason you went for the initial appointment in 2005, was that also the anniversary of the two year period?
A. No.

Q. It was not?
A. It was slightly before.

Q. It was slightly before?
A. Yes.

Q. Fine, thank you. Do my colleagues have anything further? [*No*] Thank you very much Patient A, you have been very helpful.
A. Thank you.

[*The witness stepped down*]

Mr Foster: Sir, I should be grateful if I could now call Dr Nicholas Sheen.

DR NICHOLAS SHEEN called and sworn
Examined-in-chief by **MR FOSTER**

Mr Foster: Could you give your full name for the Committee?
Dr Sheen: It is Nicholas John Leyton Sheen.

Q. Could you help us with your qualifications, Dr Sheen?
A. Yes. I qualified from Cardiff University with a degree in optometry; I then did my pre-registration year to obtain my membership of the College of Optometrists. I then worked in practice for some years - it was two-and-a-half to three years - before going to Bristol Eye Hospital to do a Masters in ophthalmology and optometry. After that I worked for three months in practice before going back to Cardiff University to do a PhD in retinal imaging.

Q. What is it that you do now?
A. At the moment my working life is split between two things: I am a lecturer at Cardiff University, and I am also responsible for the accreditation and evaluation of practitioners in Wales for the Welsh Eyecare Initiative.

Q. I am grateful for that. You have had a chance to consider the patient records in this case haven't you?
A. Yes.

Q. Having looked at those records can you first of all help us with what you believe Patient A may have been suffering with on 6 January, if anything?
A. The patient records note that there was deterioration in the right eye. Patient A mentions that she had shading. The shading would have raised alarm bells just in

order that a more thorough examination should be carried out. It could have raised one's index of suspicion as a retinal problem, not necessarily but that is certainly something that along with the myopia, the previous vitreous degeneration and the age of the patient that a reasonably competent optometrist would have in their mind.

Q. I am grateful for that; and when you say "a retinal problem", what sort of retinal problems are we talking about?
A. One retinal problem that you would obviously be looking out for is a retinal detachment or a tear.

Q. And help me, I am not an optometrist and I know that some of the members on the Panel are not optometrists; why is that a bad thing?
A. The retina basically transmits the image that you see to the brain and enables that to take place. If the retina peels away from where it should be then obviously you lose your ability to portray an image in that part of the eye.

Q. Is that serious?
A. Yes; depending on where the retina peels off from and how far it gets it can lead to blindness.

Q. It can lead to blindness; how does one avoid it leading to blindness?
A. One avoids it leading to blindness by spotting the potential problem and then there is treatment that can be given at hospital, depending on how advanced it has become, which usually involves laser surgery and often then surgery to put the retina back by use of a gas bubble in the eye and some pushing mechanism to force the retina back on to where it should be.

Q. So if I understand this correct, it is your opinion that it is important to spot a possible retinal detachment as early as possible?
A. It is imperative, yes.

Q. In order to avoid the necessity for the most extremely invasive treatment?
A. Yes, that would be correct. The later the problem is spotted the more likely it is that the surgery will be more invasive.

Q. Is it an easy thing to spot a retinal detachment?
A. A retinal detachment and the ease with which one can spot it depends in a sense on how far advanced it is or where it starts to occur. Often these things happen in the far periphery of the eye which can be difficult to see. That is often where they start, which is why further investigative techniques are often employed by optometrists to look at the periphery so that you can spot them. Those techniques obviously require some skill, but it is a skill which the vast majority of optometrists do have.

Q. I am grateful. So if I understand this, what you are saying is that Patient A's symptom that she described of "shading" would lead an optometrist to suspect the possibility of a retinal detachment, is that right?
A. I certainly think the symptom of "shading" would lead to raise your index of suspicion along with the other things that were present. I would think it is not a classic presentation of a detachment but certainly along with the other things should have warranted a further investigation.

Q. When you say "the other things", what other things would they be?
A. The other things being that the patient is short-sighted, that it has been noted previously that she has vitreous degeneration which often is a forerunner to

problems, or potential problems, of retinal detachment or tears. Along with the shading that should have alerted one to do a further examination.

Q. So your evidence is that a patient who has vitreous degeneration in her history may be someone where one ought to be concerned about the possibility of a retinal detachment, is that right?
A. Yes; it is a little bit complex, but with the ageing complex the jelly in the back of the eye tends to shrink, and with that process in some people as it shrinks it can pull off bits of the retina with it. So if you are already seeing some form of shrinkage then that would make you think that perhaps this patient is at the right time for a retinal detachment, the right time in their life and their eye for a retinal detachment to occur.

Q. So would it be right to say that is one risk factor?
A. Yes.

Q. And another one that you have described is short-sightedness. Is that also a risk factor for retinal detachment?
A. Yes, primarily because the short-sightedness tends to cause more changes within the jelly of the eye because the eye is longer. Because you are short-sighted the eyeball itself tends to be a little bit longer, so you often get changes to the jelly, and myopes it has been shown are much more likely to have retinal detachments than people who do not wear spectacles, or people who wear spectacles for long-sightedness rather than short-sightedness.

Q. So we have the risk factor of vitreous degeneration, we have the risk factor of short-sightedness, and there is a risk factor associated you say with the symptom of shading as well?
A. The symptom of "shading" as I say is not a classic presentation I would not say of retinal detachment, but it would certainly with these other things make a reasonably competent optometrist think of doing further investigations to rule out the possibility.

Q. I am grateful. Having a patient present with those symptoms, would there be questions that an optometrist ought to ask?
A. Again with the other risk factors as well it would be important to ask questions of whether they have noticed any new floaters or any flashing lights.

Q. Why would that be important?
A. Because those are good predictors of retinal detachment or retinal tears.

Q. So you would expect an optometrist in that situation to ask those questions?
A. I would, yes.

Q. And should the optometrist note the questions and the answers on the patient's records, or not?
A. Yes, definitely.

Q. Would that include whether the answers were in the negative?
A. We are often told and recently there has been a lot of press to that effect, that you should always record your negatives as well.

Q. Why would that be?
A. Well, if anyone is going to look at those records again it is important to know the history, so it is important to know what the patient experienced previously even if that is in the negative, saying 'There was not this at this time, and perhaps there was now'.

Q. To take you back to the original question that you were asked about your expert opinion of the condition that Patient A was actually suffering, would such a full history assist you now in determining whether Patient A was suffering a particular condition?

A. I certainly think it would have helped a lot if we had known whether they had flashes at that point or extra floaters at that point.

Q. So one of the sets of people whom full documentation would assist would be in fact this Committee and you in coming to your expert opinion about what the condition might have been?

A. Absolutely, yes.

Q. Do you, in your expert opinion, feel that Mr Jones' records were adequate in that regard?

A. I think they certainly should have noted something - especially considering the other factors we have discussed, the other risk factors – about any flashes or floaters.

Q. Where would these generally have been noted on a patient record?

A. In the 'Symptoms' section.

Q. I am grateful. If I ask you to turn up page 53 in our bundle, is this the eye examination record in regard to Patient A's consultation on 6 January that you considered?

A. Yes, it was. There is a note there of "No other symptoms".

Q. Can you tell us where that is?

A. Under 'Symptoms' it does say "No other symptoms" but it does not specify exactly what those were or what questions were asked, so it is very difficult to ascertain from that exactly what questions were asked.

Q. Is that section where you say the questions asked and the answers given ought to have been noted?

A. Yes.

Q. I am grateful for that. So we have reached a stage where a patient presents to an optometrist and where certain risk factors that are identified, or certain questions, might raise in the mind of the optometrist the possibility of a retinal problem, whether a detachment or a tear; is that a concise exposition of what you have just said?

A. Yes.

Q. At that stage what ought a reasonably competent optometrist to do?

A. I would expect a reasonably competent optometrist to then dilate the pupil with some drops and look with binocular indirect ophthalmoscope, rather than using a direct ophthalmoscope.

Q. I am going to take you through what you have just said, partly for my own benefit because I have some understanding of it but not a complete one by any means. You have said first of all that you would dilate the pupil; why would one do that?

A. Purely because if your pupil reacts to light in a normal fashion then the moment you shine a light in it, it constricts and that constriction affords you less field of view of what you want to look at, so in order to have a better field of view, because as I mentioned often detachments occur in the periphery, you would want to put drops in to make the pupil big so you can see as far out as you possibly could.

Q. Just for my own clarity, the different instruments that optometrists use, the direct ophthalmoscope and the indirect ophthalmoscope, all shine light into the eye in order to facilitate the examination, is that right?
A. They do, yes.

Q. And you are saying that when that light is shone into the eye, if the pupil is not dilated it will become smaller, so the area you are looking at to determine whether or not it is healthy will be smaller and therefore harder to look at?
A. Yes, that is correct.

Q. I am grateful; so once you have dilated the pupil you say that you would use binocular indirect ophthalmoscopy. What do you mean by that?
A. It is a process – there are a couple of different methods of doing it but certainly the most common method used by optometrists is using the slit lamp in conjunction with a lens which is held in front of the eye to view the back of the eye.

Q. And why is that better than using a direct ophthalmoscope?
A. A couple of reasons; one of the reasons, and an important reason, is because again the binocular indirect method gives you a wider field of view, and also it affords you a stereoscopic view which can be useful in retinal detachments. Because retinal detachments or tears invariably involve the retina falling forwards into the eyeball, into the centre of the eyeball, it is easier to see that because that is projected in three-dimensional space with an instrument that affords you a three-dimensional view. But it is also very important in terms of the field of view. The field of view is much better with a binocular indirect ophthalmoscope than with a direct ophthalmoscope, and if we are talking about wanting to see as far out as possible then that would be the best method to use.

Q. May I summarise this, and please help me if my summary is not correct, but from my understanding of what you are saying there seem to be a number of advantages. One of them is you get to see more of the retina using that method, is that right?
A. Yes. The image that you see shows you more in terms of field of view than you would get with a direct ophthalmoscope, particularly in a myopic patient such as Mrs A.

Q. And excuse me if this is very much in layman's terms, but the retinal tear, the retinal detachment, could be happening anywhere on the retina, is that right?
A. It can be, but the predilection for where it occurs is often in the periphery, because that is where the jelly is attached most strongly to the back of the eye.

Q. And is that easy to see or difficult to see, the periphery compared to the remainder of the retina?
A. If you have a dilated pupil and you are using an indirect ophthalmoscope it is possible to see to the far periphery.

Q. But not possible through a direct ophthalmoscope?
A. You can still see in the periphery with a direct ophthalmoscope, but it does not allow you to see as far out.

Q. I am grateful; so you get a wider field of vision, which you are saying as I understand it is important because you need to check as much of the retina as possible, as much of the periphery of the retina as possible, is that right?
A. That is correct.

Q. And in addition the image you are seeing may well have a problem moving either in directions up and down that you could see in two dimensions or in a dimension that is effectively towards the viewer in the third dimension, which you would only be able to see through binocular indirect ophthalmoscopy?
A. That is correct, yes.

Q. So that is one of the tests that you feel that ought to have been performed?
A. In these circumstances and considering the risk factors, yes.

Q. Is that a test which a reasonably competent optometrist would be able to perform?
A. It is.

Q. I am grateful; were there any other tests that you felt a reasonably competent optometrist ought to perform when they are concerned about a retinal break or tear?
A. Yes, often in a retinal break or tear because the retina comes away it sheds some cells into the jelly of the eye, and the only way to look for those is to look at the vitreous itself, which is then looking for little spots.

Q. What are the spots called?
A. The spots are often called tobacco dust.

Q. Are they often known as Shafer's Sign?
A. The actual sign itself is known as Shafer's, yes.

Q. Shafer's, I apologise. What is the point of looking for Shafer's Sign?
A. It is a very good indicator of a retinal detachment occurring, so if it is there it tells you that it is extremely likely that there is a detachment present, or a tear.

Q. How do you look for Shafer's Sign?
A. Using a slit lamp.

Q. Not direct ophthalmoscopy?
A. No, you wouldn't be able to see it with direct ophthalmoscopy. You certainly would not be able to see it.

Q. And when one uses a slit lamp should the pupil be dilated or not?
A. Yes, it should be.

Q. For the same reasons as -?
A. For the reason that it makes it much easier to see, yes.

Q. Are there any other tests that a reasonably competent optometrist ought to perform himself if he is concerned about retinal breaks or tears?
A. Specifically the tests that we have mentioned are the two that they would really concentrate on for retinal detachments or breaks.

Q. Now, it is very important to distinguish between the gold standard, between what the best of all possible optometrists might seek to do, and the bare minimum, the requirement on a reasonably competent optometrist. These two tests that you describe; are they the gold standard or are they the bare minimum when one is concerned about retinopathy?
A. I would suggest that they are the bare minimum in the present times.

Q. I am grateful. In the event that an optometrist, for whatever reason, was not able to perform these two tests because they were not capable of it or for any other reason,

what ought that optometrist to do in that circumstance if they are concerned about a retinal break or tear?

A. If they really were not able to do it then they should refer on to a hospital eye department if they have sufficient concerns that there is a detachment or tear present.

Q. If someone has concerns that there may be a retinal break or a retinal tear, can they close down those concerns by simply using a direct ophthalmoscope and examining an undilated eye?

A. No.

Q. I would be grateful if you would have another look at page 53. I would like you to tell me whether you feel in your expert opinion there is sufficient detail on this record regarding Patient A's symptoms and history?

A. As we mentioned I would expect to see a finding to the negative or positive of whether there were any flashes or floaters in this case.

Q. Are you able to determine any details of ophthalmoscopy that have been recorded?

A. There are certainly details of ophthalmoscopies that have been recorded.

Q. Can you show us where they are?

A. In the bottom right of the page, you have a series of boxes there with some notes within under 'Internal', and also under 'Medication' and 'Fields' there are indications of ophthalmoscopy.

Q. Is this sufficient detail in your opinion?

A. No, I would expect to see something written or recorded on there about the state of the peripheral retina.

Q. Why?

A. Purely for the reasons that we mentioned, that often retinal tears and detachments occur in the peripheral retina, so if you were looking for them that is how you would normally record it.

Q. So just for my understanding again, and I am sorry if I reduce this to very simple terms, if someone is looking at the retina to determine whether there are detachments, you would expect them to describe what it is they see, is that what you are saying?

A. Basically, yes.

Q. I do apologise for labouring this but it is my way of understanding it. Without description of the periphery that has been examined, is it your opinion that this is an adequate record?

A. Not with what is written on there, just saying "No sign of any detachments!" I would want to know what signs were looked for.

Q. You have given evidence to this Committee about the bare minimum in your opinion of the tests that ought to be performed by an optometrist who is concerned about the possibility of retinal detachment. Is that just your opinion or is that a widely-held opinion within the profession?

A. I would state that it is a widely-held opinion within the profession, particularly as time has gone on it has become more and more the accepted standard.

Q. I am grateful; could you help us then by telling us in your opinion, if an optometrist believed that they could determine whether or not a patient was suffering from a

retinal detachment by only using direct ophthalmoscopy, would you say that was safe practice?

A. No, I would say that is unsafe.

Q. I am grateful. I have no further questions for you at this stage, but I imagine my learned friend will and I imagine the Committee will.

Mr North|: Yes, I think it would be helpful if we were to pause for 10 minutes at this point, as we have had a session of over an hour-and-a-half. [*Addressing witness*] Can I just remind you that during the recess you must not discuss any details of the case with any person outside.

[*Hearing adjourned at 11.27 a.m.*]

[*Hearing reconvened at 11.48 a.m.*]

Mr North: Mrs Kapila?

DR SHEEN recalled
Cross-examined by **MRS KAPILA**

Mrs Kapila: Dr Sheen, you have given us your qualifications and experience. Can you tell us, are you currently in practice?

Dr Sheen: I do a day a month in practice, yes.

Q. A day a month?

A. Yes.

Q. Just turning to your report, would you say Dr Sheen that your report, when it talks about the standards of Mr Jones falling below that of a reasonably competent practitioner, is based on the symptoms as allegedly given by Patient A?

Mr North: Just before Dr Sheen answers, are we referring to a document in the bundle?

Mrs Kapila: We are referring to Dr Sheen's report.

Mr North: Is it actually in the bundle?

Mr Foster: It is not in your faxed bundle, sir, and I think my learned friend can put points from the report to this witness. I do not imagine that these are previous inconsistent statements are they?

Mrs Kapila: No.

Mr Foster: I think she is just asking the questions she is asking. I would prefer it if she deals with him by asking the questions, but if you would prefer to have the report it could of course be supplied to you.

Mr North: Legal Adviser, what do you think?

Mr Swinstead: We have two rather complicated issues here. I am aware, and I think the parties are aware, that the Committee will have in fact because they were served with the bundle seen the report, but they have I think been invited as it were to put that to one side and to rely upon the evidence that they hear. Now, that is what they have been invited to do. Mrs Kapila, as far as you are concerned, what you are

doing is questioning the witness on the evidence that he has given, or on his report, or on both?

Mrs Kapila: On both.

Mr Swinstead: Right; would you like the Committee when you are asking questions about the report to specifically refer to the parts of the report, which in fact they have, so they can see the point you are seeking to make?

Mrs Kapila: I think it would be very useful, yes.

Mr Foster: I have no objection to that, sir, no.

Mr Swinstead: Well, sir, to that limited degree if the Committee could refer to the report, and if you, Mrs Kapila, could tell the Committee which paragraph or which page you are referring to? I was just looking at it, but am I right in thinking that Dr Sheen has not specifically numbered his paragraphs?

Mrs Kapila: No, he has not.

Mr Swinstead: So if you could refer to them –

Mrs Kapila: I will have to try.

Mr Swinstead: If the Committee could simply then refer to the report and to the paragraphs they are referred to so that Mrs Kapila's points can be fairly made and Dr Sheen can fairly answer them?

Mrs Kapila: Page 2 of your report, Dr Sheen. You have said in about the sixth paragraph, three-quarters of the way down the page:

> "This indicates that on the basis of Patient A's symptoms, Mr Jones' examination of Patient A on the 6th January 2005 was not of the extent or quality expected of a reasonably competent practitioner."

So again we are talking about the basis of the symptoms. Again in your report at page 3, and in fact the third paragraph on page 3, you have stated:

> "There is some discrepancy over Patient A's symptoms on 6th January 2006." – although I think you mean 2005 – "Mr Jones had recorded in his records that Patient A was complaining of deterioration in the right eye with no other symptoms."

Then you have said:

> "This alone would not necessarily make an optometrist of similar competency to Mr Jones think of a retinal detachment as a cause of the reduction in vision."

A. Yes. That refers to the fact that Patient A was in the records of Mr Jones and the symptoms referred to, or what was written down on the record card, was "deterioration of right eye".

Q. Yes, as opposed to any shading?
A. Any shading, yes.

Q. Further on the same page, that is page 3 of your report, this is the sixth paragraph, you state:

> "If the vitreous degeneration was stable without any other further symptoms or suspicious history, other than a slight deterioration in one eye, then it is reasonable to suggest that a dilated BIO fundal examination would not be performed provided the pupil size was large enough to give an adequate view."

A. Yes. That refers specifically to the symptoms and not to the other matters, the other risk factors.

Q. Yes, so just correct me if I am wrong but from what I gather from what I have just read out from your report, you were saying that if the symptoms were as presented by Patient A as she says, then Mr Jones fell short of the standards of a reasonably competent optometrist because he did not carry out the indirect ophthalmoscopy, the dynamic assessment, the visual fields and the referral, am I correct?
A. Could you rephrase the question, please?

Q. Yes; I am sorry, I am going to have to go from your report and pick from it. Would I be correct in saying that where you have alleged in terms of the examination of Patient A that Mr Jones fell short of the standard of a reasonably competent optometrist, you are basing that view on the symptoms as allegedly given to Mr Jones by Patient A?
A. I am, yes.

Q. But would you agree with me that there is no extraneous evidence on the record card of those symptoms?
A. That is correct.

Q. Could I take you to the point about the patient records? You have said that the patient's records do not contain sufficient details of the patient's symptoms. Is that because it doesn't say 'No flashes, no floaters, no this nor that'? Is that what you would expect the practitioner to have done?
A. Certainly in light of the symptoms and the previous history one would expect a negative finding to be recorded of 'No flashes, no floaters'.

Q. But you would agree that there is a recording of "No other symptoms"?
A. I would agree, yes.

Q. With respect to the details of ophthalmoscopy, I think you did state in evidence that there were details of the ophthalmoscopy but if it was being suggested that Mr Jones did an indirect, then there were insufficient details of the ophthalmoscopy, am I correct?
A. I would suggest that there is insufficient detail of any recording of ophthalmoscopy *per se*, whether it was direct or indirect.

Q. But there is some detail?
A. There is some detail, yes.

Q. But not according to you as much as you would have liked?
A. As much as I would expect of a reasonably competent practitioner.

Q. From the record card I think you would agree, Dr Sheen, that you cannot be sure merely from a non-recording that Mr Jones did not enquire as to the full history of any recent ocular symptoms and details about flashes and floaters?
A. Only as far as there are no specific questions recorded, or what the answers to the questions would be.

Q. Dr Sheen, there is no dispute that had these symptoms been presented as alleged by the patient, it would have been necessary for Mr Jones to carry out a proper examination through a dilated pupil, an indirect ophthalmoscopy. However in respect of the fact that you say the records did not sufficiently note details of the symptoms and did not note details, it is really a question of best practice isn't it? They are still within the range of reasonably competent optometrists' records?
A. I would argue with you on that point regarding the patient and the risk factors for the symptoms, and regarding the ophthalmoscopy. I think a reasonably competent practitioner should have noted more than Mr Jones did in this case.

Q. So you are saying that the lack of those details put him out of the range of a reasonably competent optometrist?
A. That is my opinion, certainly in this case.

Q. That is your opinion?
A. Yes.

Q. Could I just ask you, if we were for a moment to say that Patient A did not present with those symptoms, based on what you are telling us about the lack of details of ophthalmoscopy and the patient records you state that Mr Jones' performance would be deficient?
A. I think the pertinent thing is that from what I read of Mr Jones' statement and what was written on the record card that he was actively looking for signs of detachments.

Q. Right, so we are looking then at the words "No sign of any detachments!" on the record card?
A. Yes and the statement of Mr Jones.

Q. I see; so if Mr Jones were to give any other explanation for that particular line on his record then obviously there would be debate as to whether or not he was suggesting that he had done a full examination?
A. Sorry, if he -?

Q. Perhaps you could explain to the Committee what your reading of "No sign of any detachments!" says, please.
A. I find it hard to make a qualified judgment on what "No sign of detachments" means, because -

Mr Swinstead: Mrs Kapila, I think in fairness if Mr Jones is going to give an explanation for those words then in proper fairness to Dr Sheen, if your instructions are that Mr Jones is going to say 'This is the reason I wrote it' – whatever it is, you should make those clear so that this witness can then answer it, because at the moment you are sparring as it were.

Mrs Kapila: Yes, I was about to do exactly that, because I could see the difficulty obviously Dr Sheen would have with my previous question. Let me put it another way then Dr Sheen: if that statement "No sign of any detachments!" related more, whether or not it is in the correct place on the record card, to symptomatology rather than examination then your views would be different?

A. I can't imagine they would ever relate to symptomatology.

Q. Well, if the practitioner was talking more about evidence or indications of detachment the situation becomes somewhat more different doesn't it?
A. If they had said 'No signs of any detachments' and recorded that in the findings of their investigations I would expect some form of positive or negative findings rather than just that statement, i.e. were there no tears or detachments.

Q. That is if the practitioner had in fact done a full examination to detect a retinal detachment.
A. Yes, but it just said "No sign of any detachments!" and I thought that would mean -

Q. You took it at its face value.
A. Well, I assumed from the evidence "No sign of any detachments!" suggests that he was specifically looking for signs of detachments, but I am not sure what he did to elicit that statement.

Q. Would you expect an optometrist who is PEARS accredited - and you run the scheme do you not?
A. Yes.

Q. Would you expect such an optometrist to ignore a symptom of shading?
A. Not with the other mis-factors involved, no.

Q. Would you expect such a PEARS-accredited optometrist, bearing in mind that their clinical skills may be somewhat superior to the average optometrist, not to carry out the sort of examinations starting from indirect ophthalmoscopy if symptoms of the retinal detachment were presented?
A. No, I would say they would carry out those tests.

Q. Would you just give me a minute please? [*Pause*] I have no further questions for this witness.

Mr North: Any re-examination Mr Foster?

Mr Foster: Very briefly sir yes, thank you.

DR SHEEN re-examined by **MR FOSTER**

Mr Foster: Dr Sheen, it may help if we look again at page 53, because the small amount of re-examination I have will flow naturally from there. You were directed to the note that says "No sign of any detachments!" on the basis that Mr Jones' side of the story was to be put to you. I am not sure if I understand what Mr Jones' side of the story is but that is something I can examine with him, but from your point of view as an expert and as an optometrist what could "No sign of detachments!" possibly mean other than you have gone looking for signs of detachment and found none?
Dr Sheen: I really don't know.

Q. Have you ever in your practice or experience seen anyone write such a statement on a patient record if they do not mean that they have done some sort of examination to determine there is no sign.
A. No, I can't say I have.

Q. Would you say that is a safe thing to write on a patient record if you haven't done any examination yourself to determine that that is in fact the case?

A. Sorry, can you say that again?

Q. Would you say that is a safe thing to write down on a patient record if you haven't yourself looked at that patient's eyes to determine if there are any signs of detachment?
A. No, it is not safe to write that down without having done -

Q. Why is that not safe?
A. If you are writing – I am getting a bit bogged down with this I must admit, but if you are writing "No sign of detachments" then that seems you have done an examination to look for signs of detachments and you would write down what those examinations were and what your findings were, rather than just a statement.

Q. So in the event where, for example, Mr Jones was tragically run over by a bus and you were the next optometrist to examine this patient, could you think that there was anything that this statement could possibly mean other than that he had looked at her eyes and found no signs of detachment?
A. Well, no. I would assume he had done the necessary tests but they are not recorded themselves.

Q. I am grateful. Now, you talk about the tests right at the beginning of your report. You have been directed to your report, and I am not going to direct you to particular sections of it but I am going to put this to you and you can tell me if I am right or not: from your evidence and from your report you have said that when somebody is concerned about the possibility of a retinal detachment these are the tests they ought to perform', is that correct?
A. Yes.

Q. So although you go on in your report to talk about the presence or absence of presenting symptoms, in fact those presenting symptoms are only an indicator of whether you ought to do these tests or not?
A. Yes.

Q. If you have already decided that you are looking for a retinal detachment the presence or absence of presenting symptoms is not going to change your mind is it?
A. No. If you decide that you are going to look for them then you would -

Q. Conduct these tests?
A. Yes.

Q. And if you see any signs of retinal detachment you would note it down, and if you do not see any signs of retinal detachment you would note it down?
A. Yes.

Q. I am grateful. I have no further questions for you.

Mr North: Mrs Kapila, anything further?

Mrs Kapila: No.

Mr North: Legal Adviser, any points at this stage?

Mr Swinstead: No.

Mr North: Does the Committee have any points?

DR SHEEN questioned by the **COMMITTEE**

Mr Varley: Dr Sheen, I am a lay member and I am getting a bit confused. Let me just see if I can get this right: you say in your report that the symptom of shading should have prompted a reasonably competent optometrist to perform two particular tests, is that correct?

A. That is correct, yes.

Q. There is no mention of shading on the patient's record, is that correct?

A. That is correct.

Q. It is agreed that the patient suffered from vitreous degeneration and myopia?

A. Yes.

Q. Now, would the presence of those lead any reasonably competent optometrist to perform the two tests that you have indicated, without the presence of shading?

A. I would suggest, and I put this in my report, it does not necessarily mean that they would do these further tests if there was just vitreous degeneration and this level of myopia.

Q. Right.

A. It was just the written part of "No sign of detachments!" that is somewhat confusing.

Q. The other thing is, there were a lot of medical articles attached to your report. Did you put them in?

A. Yes, I think there were four.

Q. One of them was *Optometrists' examination and referral practices for patients presenting with flashes and floaters*. I do not pretend to understand a great deal of this, but I just did underline something on the introduction which said, and there has been a lot of talk about flashes and floaters:

> "Flashes and floaters are common symptoms, occasionally indicative of the development of a retinal tear with or without retinal detachment."

So can you put a percentage for me on what "occasional" would mean in there? Would it be 5 per cent, 10 per cent?

A. I think it is roughly 10 per cent of those symptomatic who go on to develop -

Q. So 10 per cent of patients with those symptoms would have a retinal tear or a displaced retina?

A. Yes.

Q. Thank you.

Professor Hirji: Dr Sheen, you answered the question from my colleague saying that if there was just vitreal detachment then it was not unreasonable, if it was all recorded and a history well understood, for a reasonably competent optometrist not to dilate and not necessary to do a slit lamp examination in the absence of symptoms?

A. Yes.

Q. That is what you suggested?

A. That is correct.

Q. Would you expect in that situation a reasonably competent optometrist to query anything further before writing down something like "No sign of detachments"?
A. Well, I certainly think the symptoms should have been listed, were there further floaters, flashes.

Q. So the fact it says "No other symptoms" is not adequate according to you?
A. That is correct.

Q. And that is the problem you face?
A. That, with the statement which to me means that he was obviously looking for detachments for some reason, and just stated -

Q. Can I take you to pages 53 and 54 on the record cards? I just want your opinion, and I am sure the other expert witness may have a view as well, and that is at the bottom there is the IOPs.
A. Yes.

Q. If you look at the IOPs, which are the inter-ocular pressure fillers I am not familiar with, there is a difference.
A. There is.

Q. And it is on two occasions; however on the last occasion there is only one measurement so we can't really tell, if we look at the last measurement before referral? It was 16 on one so we can't really tell what happened to the other eye. Does that suggest anything else that one should be concerned about in any way?
A. Yes, you are right. A difference in inter-ocular pressure between two eyes can indicate that a retinal detachment or tear has occurred if the pressure is lower in the affected eye. There is a difference of 3 mmHg in this case, and the reason I did not mention it is because I felt it was possibly within normal measurement range.

Q. So you don't think the difference is significant there?
A. I guess it is another indicator if you like that there may have been a problem there, but I would not be happy to say that that is -

Q. In your opinion is this a further risk factor or is it not?
A. It is a further risk factor, yes, in light of everything else.

Q. So we now have four risk factors?
A. We do, yes; the only problem with the IOP as I see it is that because there is such range between I did not feel it was particularly -

Q. So we should not really take that into account?
A. I think the small amount that it is, which is 3 mm Hg, could just be normal variation – but in light of everything else, you know -

Q. It is 4 on the next one.
A. It is 4 on the next one? Which one is that, sorry?

Q. It is the one on 16 January.
A. A difference of 4.

Q. So that was the previous one.
A. That was 2003. Which was the difference of 4, sorry?

Q. If you look at 16 January 2003 that was the first visit, but there is an asymmetry there anyway.
A. Yes, there was, slightly.

Q. So it is less likely -
A. Yes, it is less likely to be -

Q. Thank you, Dr Sheen. Mr Chairman.

Ms O'Donoghue: I would like to ask your opinion about what you said about Mrs A's symptom of shading, that it was not a classic presentation of a retinal tear or a detachment. She had the vitreous degeneration and that is not disputed; do you feel that her symptom could have been caused by vitreous degeneration or not?
A. It is possible.

Q. In the absence of any retinal tear?
A. Yes.

Q. Thank you.

Mr North: I have no further questions. Do either of the parties wish to comment on anything before the witness is dismissed?

Mrs Kapila: No.

Mr Foster: I have one further question arising out of the Committee's questions.

DR SHEEN further re-examination by **MR FOSTER**

Mr Foster: You have given your evidence extremely clearly and very fairly, but this may actually be a problem with the way I have put the questions so I want to be as clear as possible. It is my understanding that if you take the situation where the optometrist knows nothing about the patient whatsoever and she presents with symptoms but does not mention shading and does not mention any acute symptoms, it has been your evidence both in your report and in chief that in that situation the optometrist may not need to perform these tests. Is that right?
Dr Sheen: That is correct.

Q. And that is because the shading and any other acute symptoms may raise in the optometrist's mind the possibility of a retinal detachment, is that right?
A. It is.

Q. But if for any reason the optometrist is concerned about the possibility of retinal detachment they must do these tests regardless of whether or not there are any presenting symptoms, is that right?
A. Yes.

Q. If that optometrist has decided for themselves, based either on the patient's history or just as a gut feeling 'I would like to check for retinal detachment', the only way to check for it is through the tests that you have pointed out, is that correct?
A. That is correct.

Q. And I think you said in answer to one of my friend's questions that not only did you consider the record you also considered a response made by Mr Jones to the Council, in the form of a statement which is in the bundle, and it is certainly evidence

that could be brought in chief, that he accepts he was looking for the signs of retinal detachment.

A. Yes.

Q. I am grateful, I have no further questions.

Mr North: Was that a reference, Mr Foster, to the letter that appears at pages 14 and 15 in the revised bundle?

Mr Foster: It is indeed, sir.

Mr North: Thank you for that clarification, it is very helpful. There having been no further matters from either party, I think we can thank Dr Sheen for his helpful contribution to the proceedings today.

[*The witness stepped down*]

Do you propose to call any further witnesses Mr Foster?

Mr Foster: No sir that would be the Council's case.

Mr North: In that case would it be helpful to both parties if we adjourn for lunch now and came back at, say, five past one? [*Agreed*] Thank you very much.

[*Hearing adjourned at 12.18 p.m.*]
[*Hearing reconvened at 1.08 p.m.*]

Mr North: Thank you, ladies and gentlemen. Mr Foster, I understand that you have finished presenting your evidence, and if I may I shall turn to Mrs Kapila.

Mrs Kapila: Chairman, I will be calling Mr Jones to give his evidence now.

MR ANTHONY JONES called and sworn
Examined-in-chief by **MRS KAPILA**

Mrs Kapila: Mr Jones, could you give the Committee your full name and address please?
Mr Jones: Anthony Vaughan Jones, 4 Park View, Llandew, Brecon.

Q. Would you tell the Committee how long you have been an optometrist?
A. Thirty years.

Q. And what have you been doing in those 30 years in that respect?
A. I have been a community optometrist working in a mixture of private practice and for a company.

Q. You are a PEARS-accredited optometrist?
A. Yes.

Q. Could you explain to the Committee what that means and involves, please?
A. A PEARS accreditation is Primary Eyecare Acute Referral Scheme. One has to go through an accreditation process. It is a process of increasing knowledge and clinical skills within optometry. It is Welsh scheme.

Q. Do you recall Patient A?
A. Yes, I do.

Q. Do you recall seeing her in January 2003?
A. Yes.

Q. Could I take you to the bundle in front of you at page 54? Is that a record of your examination of the patient on 16 January 2003?
A. Yes.

Q. What was the outcome of this visit?
A. I advised Patient A to attend her GP because I was slightly suspicious that her blood sugars might be raised. On question she had reported some thirst, and she also had some vitreous floaters which concerned me a little, so I referred her to her GP.

Q. Did she have any increase in her myopia at that visit?
A. Yes, she did.

Q. And is page 56 a copy of your referral letter?
A. Yes.

Q. When you saw Patient A again on 6 January – sorry, I am leading on facts which I believe are not in dispute here – 2005, what was the reason for her visit?
A. It was a routine review.

Q. When had you asked her to return after the examination in January 2003?
A. I had asked her to come back in 12 months.

Q. You have heard Patient A give evidence that the prescription actually said two years; can you comment on that?
A. It was a clerical error.

Q. Would Patient A have been sent any reminders from the practice?
A. The system would have been triggered by the 12 month recall on the record card, and yes, my understanding is that she would have been sent reminder cards.

Q. What did Patient A complain about when she saw you on that second visit?
A. On 6 January 2005?

Q. That's right, yes. The record card appears at page 53.
A. She complained to me about what she described as a slight change in prescription in the right eye, otherwise she did not complain of anything at all.

Q. So if we look at Symptoms, you've got two year review but complains of deterioration right eye, no other symptoms?
A. Yes.

Q. Can you explain 'two year' there please?
A. It was the time interval that she had attended.

Q. I see. If we go to the record on page 54 could you take us to where you referred to the one year recall please?
A. I am sorry I don't understand what the question is.

Q. You asked her to come back after a year.
A. Yes.

Q. Could you take the Committee to that section of your record please?
A. Bottom right-hand corner.

Q. Where it says 12/12?
A. Yes.

Q. So going back again to the record on page 53 of this bundle, we've got there "No other symptoms". You have heard the patient state in evidence that she complained of shading. Did she complain of shading?
A. She did not.

Q. What would you have done if she had complained of shading?
A. An entirely different sort of eye examination prompted by her symptoms.

Q. Could you tell us in terms of your record, did you do an external examination?
A. Yes.

Q. Did you take her inter-ocular pressures?
A. Yes.

Q. What was the result of these two examinations?
A. The inter-ocular pressures were normal, within normal range, and compared reasonably to the previous. There were no external signs of any pathology.

Q. Did you carry out ophthalmoscopy?
A. Yes.

Q. And are the results of that ophthalmoscopy in the bottom right-hand corner of that record card?
A. Yes, the bottom quarter.

Q. What did ophthalmoscopy reveal?
A. In the right eye she had vitreous degeneration, which looking at my previous notes I had made a note of. There was more vitreous degeneration in the right eye than in the left eye. There was still some present in the left, but the vitreous degeneration in the right eye was I felt consistent with what it had been before.

Q. Did you ask the patient if she had any flashes or floaters?
A. Yes.

Q. What was the patient's response?
A. She had not.

Q. Had she had flashes and floaters what would you have done in terms of your record card?
A. I would have written it down as a positive finding.

Q. And what would you have done in terms of your examination?
A. At that point I would have considered the risk of retinal detachment, because flashes and floaters do sometimes present as such. It is one of the things we are aware of, so I would have conducted a dilated examination.

Q. Can you explain the words "No sign of any detachments!" on your record card?
A. I have used the wrong words for that. I have mixed up 'signs' and 'symptoms'. I should really have put 'There are no symptoms of detachments'.

Q. And why did you think of putting that statement down on the record card?
A. Because I was mindful of the fact of it being more myopic in the right eye and with some vitreous degeneration that she might be at some risk, but in the absence of symptoms then that is what I wrote.

Q. Why do those words appear in that part of your record card?
A. I am afraid I write things in different parts of the record card, possibly according to the time that I do them.

Q. Could you tell us whether or not you had the patient's record cards before you when you were carrying out this examination?
A. Yes, on the desk.

Q. Just give me a minute. [*Pause*] Mr Jones, did you enquire about the full history of any recent ocular symptoms other than flashes or floaters which you have already told us you enquired about?
A. Yes, I did.

Q. Was there any history of any recent ocular symptoms?
A. None, which is why I wrote "No other symptoms".

Q. I have no further questions for Mr Jones.

Mr North: Thank you; Mr Foster?

MR JONES cross-examined by **MR FOSTER**

Mr Foster: Good afternoon, Mr Jones, I am going to ask you some questions on behalf of the Council. You have told us you have been an optometrist for 30 years?
Mr Jones: Yes, sir.

Q. And that you have done a significant amount of training in that time and are accredited, so I would be very interested to hear your view on the purpose of a patient record first of all. What do you say they are actually for, these records?
A. In my view a background to what a patient has experienced in the past, complained of in the past, a record of vision, prescription to see if there is any change, and other related pathologies.

Q. When do they come in hand in terms of your practice? When are they useful records? Are they useful at the time that you are making them or are they useful later, would you say?
A. At all times. It is a written record so one can refer to them at whatever point.

Q. For example now you are being asked to think back to a time in January 2005 aren't you?
A. Yes, sir.

Q. Can you remember word-for-word the entire conversation that you had with Patient A on that day?
A. I have fairly good recall, especially when you know the patient. Perhaps somebody I haven't seen before, unless there is something very striking, but when you have seen someone and had a rapport with them for many years you do get to know them and you remember things. I find so.

Q. So in terms of that date for example, obviously that is the date we are all talking about and I presume having looked at these records you have thought quite carefully about what was said on that day, when the patient first came into the office prior to the examination did you ask her any other questions, about how her day was or any normal interaction questions?

A. Yes. I have known this patient for a number of years and we have always engaged in conversation where she works, so although I had not tested her since 1990 I have known her that long.

Q. Can you tell us for example: what was the first thing that you said to the patient when she walked in, your actual words?

A. My usual wording would be 'Hello [Patient A], how are you today, take a seat; now, can you please tell me if you have any problems, is this a routine eye examination or are you worried about something?'

Q. I am very interested in this answer because it is very important in the context of this case I think, and it is important in the context of you understanding the questions that you are being asked. I asked you what were the words you used and you have told me what the usual words you would use are. Are you saying every single time a patient comes in you only utter that script, or are you saying it would be something along those lines?

A. Something along those lines. I wouldn't say the words were exactly similar each time, no.

Q. Do you remember the exact words you used on that day?

A. No, sir.

Q. No and presumably what is important about that is that when you make a record such as this the record will help you to remember the things that you did, the things that were said, is that correct?

A. Yes, but one writes clinical information rather than just ordinary talking to the patient.

Q. What is important in terms of this hearing is that you are being asked about things that were said, things that happened. You can project back into the past and think what is likely to have been said, what you would have said or what you would have liked to have said, but to be fair unless you write it down you can't be sure, can you, of the words that were used during that meeting?

A. Because it is not written down I can't prove it, but given the patient's history I would have asked the pertinent questions.

Q. Absolutely, and obviously it is clear to you is it not that you are not here to have to prove anything, the job of proving things is up to me, but writing it down allows you to be sure, doesn't it, after the event that particular questions were asked and particular answers were given. How many patients do you see in a week in general, sir?

A. In a working week I would approximate to 12 a day five days a week, so 60 patients a week.

Q. So I am sure that you would accept would you not that for somebody who sees 60 patients a week it is even more important to write down what happened in a particular circumstance, so that you don't accidentally think 'This is what was likely to be said' when in fact you were thinking of one of the other 60 patients that you had seen?

A. I focus on the patient in question, and I do write down the clinical details.

Q. Absolutely, and it is for that reason is it not, so that you can look back later in time and know what was said and know what was done?

A. Yes, sir.

Q. I am grateful. Now, the patient is in a different situation to you isn't she? She comes along to that eye examination and it is quite a rare moment in her life, so she has much more reason to remember what happened that you would because she is not doing 60 identical examinations in a week is she?
A. Yes.

Q. And the patient says you didn't ask her about flashes, you didn't ask her about floaters. What do you say about that?
A. I did ask her but I didn't write it down, because it was a negative.

Q. No, what I am trying to work out, and I would like to be very clear about this, is whether you are saying that you would have done, or whether you are saying you actually did.
A. I did, because it is my way.

Q. So why didn't you write that down?
A. I think we are getting back to the writing down of negatives, which I am guilty of not doing.

Q. Okay, thank you very much; and would you accept that is quite a dangerous practice, in that when you come back to determine whether or not the question was asked, as you said before you can't be sure?
A. Yes.

Q. I am grateful. Now, you said in your evidence-in-chief that you did ask about flashers and floaters and that the patient answered in the negative about flashes and floaters, is that right?
A. I asked her about flashes and floaters generally, but the patient already had floaters so having looked at her I then said 'Are the floaters any worse?'

Q. This is very important, because of course this is not something you volunteered in chief. When you were asked by my friend when she was asking you questions in chief she said 'Did you ask about flashes and floaters' and you said 'Yes', and she said 'Did the patient say she had any' and you said 'No'. Now you are telling us a slightly different thing, which is 'I asked generally about them and she already had floaters so I talked about them'. Why didn't you mention that when you were asked a couple of moments ago?
A. I am not sure how to answer that, sir.

Q. I sympathise with your difficulty, because if you look at the record that you did create in respect of this patient, while you say you never write things down in the negative of course you did write down "No sign of any detachments!" which is a negative, isn't it?
A. It is a negative, but that is a mindset negative rather than asking the patient something and them saying 'I have got no this, no that'.

Q. This brings us on to what the patient was actually doing in the surgery, because my friend has been keen to stress throughout this hearing that it is very important what symptoms the patient presented with, for obvious reasons, but regardless of the symptoms you were looking for whether or not she had a retinal detachment, weren't you?
A. I had a mindset that she was slightly more at risk.

Q. It went a bit further than that, though, didn't it? You knew she had a history of vitreous degeneration, is that right?
A. Yes.

Q. And because of that you looked carefully to see if there was any sign of retinal detachment, isn't that right?
A. I looked with direct ophthalmoscopy, yes.

Q. Did you find with direct ophthalmoscopy?
A. No, sir.

Q. So was that how you satisfied yourself that there was no sign?
A. At the time, yes, because there were no symptoms.

Q. Okay; now I would like if I may to take you to look at page 14 in the bundle before you, just to clarify this point, just to put it to you and give you the opportunity to comment on it. This is a letter from you, isn't it?
A. Yes, sir.

Q. This is a letter to the General Optical Council sent in February 2006, isn't it?
A. Yes, sir.

Q. And if you look down to the fourth paragraph – sorry, maybe the fifth paragraph, the very large paragraph second before the end, near the end of it where you say:

> "Having previously referred [Patient A] for vitreous floaters I was careful to look for signs of retinal detachment and on my records noted 'no sign of any detachments'."

Do you stand by that?
A. Yes, sir.

Q. Okay; I am going to suggest to you that because you were looking for retinal detachments it didn't matter what symptoms the patient presented with, you were left with a series of tests that you ought to have done in order to determine whether or not there were retinal detachments. What do you say about that?
A. I was mindful of it, but because she didn't have any symptoms, she didn't have any flashes, she didn't have the shading, I didn't proceed with the dilated examination.

Q. Why did you bother doing an undilated direct ophthalmoscopy then, if you felt that there was no possibility that she had a retinal problem?
A. One has to do an undilated examination under the regulations.

Q. So when you said in your response "I was careful to look for signs", what you were actually doing was doing the minimum examination that you were required to do by law because she had turned up in your surgery, is that right?
A. No symptoms, sir.

Q. Do you accept that is not an adequate method for determining whether or not she had signs of retinal detachment?
A. Given the circumstances I think so. With hindsight perhaps not.

Q. I am grateful, because of course this Committee at some point may have to consider whether or not you are a safe practitioner. First of all they are going to have to consider whether you had a duty to conduct these tests, but if they feel you did have

such a duty they are going to have to go on to consider what you would do in this same circumstance again.

A. Yes, sir.

Q. If you were presented with an identical set of circumstances, what tests would you now perform?

A. I would perform dilated bulk fundoscopy.

Q. I beg your pardon?

A. A dilated examination.

Q. And would that be direct or indirect?

A. In addition to direct, not instead of.

Q. Would you do anything else?

A. Yes, visual fields.

Q. And would you also carry out a dynamic assessment of the vitreous?

A. Yes, sir.

Q. For Shafer's Sign?

A. That is done at the same time as one would do indirect ophthalmoscopy with a patient on the slit lamp.

Q. I am grateful; so if Patient A were to turn up to you today you say you would do all of those things; would you also make a clear note on your record of all the things you had done and observed?

A. Yes, sir.

Q. I have no other questions.

Mr North: Thank you; Mrs Kapila?

MR JONES re-examined by **MRS KAPILA**

Mrs Kapila: Mr Jones, Mr Foster has asked you at length about the significance of the word "sign" and you have told us in your evidence earlier what that particular sentence on your record card meant. Could you clarify for us that letter that you wrote to the Council, where you have said:

> "I was careful to look for signs of retinal detachment and on my records noted 'no sign of any detachments'."

And:

> "However, there was no evidence of any retinal tears or detachment".

Could you explain please what those words mean?

Mr Jones: I think in essence I have got very mixed up with 'signs' and 'symptoms'. I should really have put 'symptoms' or 'evidence of'.

Q. Did you think that the patient's symptoms as presented to you indicated a retinal detachment?

A. Not in January 2005.

Q. You were also asked at some length about the number of patients you examine in practice. Do you see retinal detachments in practice?
A. Yes.

Q. Are you familiar with the symptoms of retinal detachment?
A. Yes.

Q. You were also asked about the exact words that you used when questioning this patient. I will simply ask you once again, did you take a visual history from this patient, and did you ask her if she had flashes and floaters?
A. Yes, I did.

Q. You have told us in evidence and upon questioning from Mr Foster that you were talking about an increase in floaters. Why would that be the case?
A. The floaters had not increased significantly in the right eye compared to the previous visit in 2003, although there was a difference in floaters between the right and the left.

Q. And is that shown on your record card by the words "As before"?
A. Yes.

Q. You told us under questioning from Mr Foster that you knew this patient quite well compared to some of the other patients. Did you see this patient regularly outside of your practice?
A. Yes, I saw her where she worked.

Q. Could you just explain to the Committee where she worked?
A. The lady works in Smiths, which is directly opposite the practice. It is where I buy my newspaper first thing in the morning, and usually a magazine at lunchtime, so I tend to see her probably twice on the days that I was in the practice.

Q. Did you see her after your examination on 6 January 2005?
A. Sorry?

Q. Did you see her in your workplace after your examination of 6 January 2005? Did you see her at her in WH Smith?
A. Between the 6th and the 24th.

Q. Yes; I have no further questions.

Mr North: Thank you, Mrs Kapila. Legal Adviser, do you have any questions?

Mr Swinstead: Not at this time, sir.

Mr North: Are there any questions from the Committee?

MR JONES questioned by the **COMMITTEE**

Mrs Huka: I have a question, Mr Jones. Looking at your eye examination record, and bearing in mind what you said about knowing this patient fairly well, could you explain to us how any of your colleagues would have known if anything had changed in the record if you had not been around? I hear what you say about you knowing this patient very well, but what if for any reason you were not around and one of your colleagues had actually seen Mrs A, how would they know if anything had changed around her eye examination since the last time you saw her?

A. The records show the level of vision, the visual acuity, they show the prescription, so that would be able to be determined if there was any change. My record shows the vitreous degeneration as being worse in the right eye than the left eye, eye pressures also. I don't think I can answer any more than that, I am sorry.

Q. Thank you.

Ms O'Donoghue: I have just one question. On your examination in 2003 you wrote on the letter that went to the general practitioner about the vitreous floaters. Was that a referral or a notification to the GP about those?
A. At that time it would have been a notification to the GP.

Q. Thank you very much.

Mr North: Professor?

Professor Hirji: Mr Jones, I just want to clarify that I understand your position in your evidence, and that is that use of the word 'sign' is incorrect on the record card and should really be 'symptom'?
A. Yes, sir.

Q. But you have written it down on the internal section on the record card, and that is because you do things as you feel?
A. I am afraid I do write in different parts of the record, not entirely conforming to where they should be.

Q. This is also what you mean in the last sentence in your letter that one of my colleagues referred to, Mr Foster referred to I think, that you were "careful to look for signs". Are you saying that you were careful to look for 'symptoms'?
A. I am afraid I used the wrong word, yes.

Q. Thank you that clarifies that position for me. I just have one question which I hope you can answer for me. I notice that there is no indication of any pupil reflexes at all. As you said if they are normal you tend not to record them, is that the case?
A. Yes, sir.

Q. Thank you that answers the question.

Mr Varley: I am a lay person so you will have to excuse me if this is really obvious, but you say in your letter to the GOC that you looked for retinal tears. Are you saying that the retinal tears would have occurred after your examination of her on the 6th and before the examination by Ruth Barnet on 24 January, or were they were present but because of the tests you could have done you had not identified them?
A. I am saying that with the test that I did do I couldn't see any, sir.

Q. And that is as far as you are going?
A. Yes, sir.

Mr North: Are you content with your answer?

Mr Varley: Yes.

Mr North: Mr Jones, I have a couple of questions which I hope will be helpful. Why did Patient A come to see you on 6 January?

A. It was a purely routine eye examination. It was a recall. She had had reminder cards and when I had met her in Smiths on previous occasions she would tell me she must come in for an eye examination, she must come in, she had had reminder cards. It was a culmination of those chats and previous meetings.

Q. Had she noticed anything about her eyesight?
A. She didn't tell me, sir.

Q. So it was purely routine?
A. She did mention that she wanted new spectacles and when she could afford it then she would come in.

Q. The other thing that might help me is what is a "slight media haze"?
A. When one looks into the eye the picture is not quite as sharp or as clear as it could be. It is just slightly hazy.

Q. Was that with both eyes?
A. Yes.

Q. Both of them?
A. Yes.

Q. I'm just going to Enclosure 14, the third paragraph, I just notice there that:

> "[Patient A] informed me that she had noticed a slight deterioration in her right eye".

A. Yes, sir.

Q. So she did in fact tell you that?
A. Yes, sir.

Q. That is helpful. Let me get this clear, it was the right eye where there was a considerable amount of vitreous degradation?
A. Yes, sir.

Q. Right, I see.
A. The change was a slight change of prescription, where the vision with that new prescription was brought up to what it was in 2003.

Q. Okay. Again excuse me, I am a lay person, but if vitreous degradation continues what is the outcome?
A. Ultimately decreasing vision. If it were to go further one can get problems because of the shrinkage.

Q. What would those problems be?
A. It would be usual to have a posterior vitreous detachment, which in many cases is quite without incident, in very rare cases can give rise to a tear in the retina.

Q. Did you say detachment in there?
A. Yes, sir.

Q. You did?
A. Yes.

Mr North: Okay, fine. Thank you, that has been very helpful. With regard to the questioning by the Panel do either of the representatives wish to put further points?

Mr Foster: Very briefly, and they come out of those questions, and I am sure my friend may afterwards.

MR JONES re-cross-examined by **MR FOSTER**

Mr Foster: Very, very briefly, and actually you said this in chief as well as in response to one of the Committee member's questions but you said them in two slightly different ways; you told the Committee members she had been sent reminders, and you said in chief that the system would have generated reminders. You didn't send the reminders yourself, did you?

Mr Jones: No sir, I have nothing to do with that.

Q. You didn't see the reminders being sent did you?

A. No, sir.

Q. So actually what you said in chief was right, you assumed that they had been sent rather than they had been sent?

A. Yes, sir.

Q. That is one of the assumptions that you make, and obviously as we all know assumptions can be dangerous. I would like to talk to you very briefly about this 'signs' and 'symptoms' dichotomy. Can you tell me, you said in chief and you said in response that you had noticed more floaters in Patient A's eyes; is that because Patient A had told you there were more floaters or because you had seen more floaters?

A. Because I had seen them.

Q. You had seen them? Just to help me, because I don't really know the difference to be honest, is a floater in this context a sign or a symptom?

A. A floater is a symptom.

Q. A symptom? So if you are saying you were very careful to look for symptoms and note them, can you just tell me where you have noted down that symptom on page 53, 'more floaters'?

A. 'Lots of vitreous degeneration'.

Q. "(As before)"?

A. "(As before)".

Q. It doesn't really suggest there is more does it? That suggests there is the same amount.

A. It is important to differentiate she had more vitreous degeneration in the right than in the left.

Q. I just put this last point to you before my friend asks you some questions: the floaters themselves are signs and symptoms aren't they? They are symptoms but they are also signs that may point to a retinal detachment?

A. Yes.

Q. So what you noted there actually would make sense of "I was careful to look for signs". How would you look for symptoms?

A. My word usage was not very good on this occasion.

Q. So it is not only 'signs' that you got wrong, it was 'look' as well. Is "careful" wrong? [*Pause*] Looking back on it, do you think you were actually careful in determining whether or not there was a retinal detachment in this case, or do you think that is another word that probably ought not to be there?
A. Given the circumstances of the time I feel that I did what I should have done, but in retrospect perhaps "careful" was not a good word to use.

Q. I have no further questions.

MR JONES further re-examination **by MRS KAPILA**

Mrs Kapila: I have some questions on what you have just answered. We have gone between 'signs' and 'symptoms' and I think perhaps you have explained what you have to say about that. Could you look at page 53 please, Mr Jones? Can you explain what you mean by "Lot of vitreous degeneration (as before)"?
Mr Jones: It means there was more vitreous degeneration in the right eye than the left eye, and that that was the case previously.

Q. So could you tell us the relationship between the issue of floaters and vitreous degeneration please?
A. Essentially they are one and the same. Vitreous degeneration is in my view a slightly greater manifestation than floaters; floaters tend to be smaller, rather singular.

Q. So when you say "Lot of vitreous degeneration (as before)", are you talking about floaters?
A. It is the change within the mass of jelly part of the eye.

Q. Does that include floaters?
A. There would be floaters there, yes.

Q. So if you say 'as before' are you talking about the same amount of floaters?
A. I am really talking about the general appearance of the vitreous. It may have been helpful if I had written 'the appearance of the vitreous looks the same as last time'.

Q. Did the patient complain of floaters?
A. She didn't complain of floaters, she mentioned them; 'complain' suggests a change.

Q. You talked about the symptom of deterioration in the right eye; can you tell us what her visual acuities were like on the day that she saw you on 6 January, please?
A. It is important to remember that visual acuity is a measure of the best vision that one can get with corrective lenses, so the visual acuities were in the right eye the same in 2003 and 2005.

Q. What were her visual acuities on the day she was referred, which was 24 January 2005 if you look at page 61 of the records?
A. Much worse, three or four lines worse depending on the chart.

Q. Just one last question; you were asked about not yourself sending reminders. I think you have already said this in your evidence did the patient speak to you about receiving reminders before she saw you?
A. She did, yes.

Q. I have no further questions.

Mr North: Yes; Legal Adviser?

Mr Swinstead: Mr Jones, I know this has been touched upon but I don't think it is absolutely clear and it may assist the Committee if you just clear it up. On your examination record on page 54 you noted that you wanted to see Patient A in 12 months from 2003?

A. Yes, sir.

Q. We know if we look at page 55 that in fact as far as her prescription is concerned, and that is a document she would see, it said "2 years".

A. Yes, sir.

Q. And you have said that was a clerical error.

A. Yes, sir.

Q. Obviously you do not have personal knowledge of exactly what happened, but as far as you know of your firm's system firstly would a reminder go out based upon your examination record or on her prescription?

A. The examination record, because staff know reference to what is written on the prescription when she brings it out to them.

Q. Do I understand, and do the Committee understand therefore, that reminders would have gone out at some time towards the end of 2003, perhaps December or early January 2004? About when would the reminder go out before the due date?

A. My understanding is approximately a fortnight before the patient is due.

Q. So we are talking about the end of December?

A. Yes, sir.

Q. So 2003 into 2004, but the evidence the Committee has heard is that she didn't come then at all?

A. No.

Q. Would she have received any further reminder at the end of 2004 to come in 2005?

A. Yes sir, from the initial 12 month reminder she would have been sent further reminders at a set interval, which I am not sure about but I think it is after several months. So she would have had several.

Q. So if somebody doesn't respond to your original reminder, it is your firm's policy to go on sending at intervals further reminders?

A. Yes, sir.

Q. You have told the Committee that in the course of seeing her when she was at work she spoke to you about coming to see you again.

A. Yes, sir.

Q. Can you help the Committee as to when that was in terms of when she actually came to see you for the second time in 2005?

A. She mentioned to me on several occasions that she had had reminders, and that she was wanting to come in to have some new spectacles.

Q. Can you place a time on that?

A. It was mentioned more than once.

Q. But are we talking for example in June of 2004, are we talking September? Can you give the Committee some help as to when those conversations might have taken place?
A. Given that the first reminder would have been issued at the start of '04, throughout 2004.

Q. Right; you can't be more specific than that?
A. No, because there would be more than one reminder and she used to say to me 'I must come in, I've had some reminders, I have had another reminder', and that was the sort of rapport that we had.

Q. But you are unable to say when the last reminder would have gone out from your firm before she actually came to see you in January 2005?
A. No, sir.

Q. Sir, thank you, I have no further points.

Mr North: That was most helpful, thank you.

Mr Varley: Could I just ask something else?

Mr North: Yes, Mr Varley, if you wish.

Mr Varley: Just to nail this finally, you said in your letter to the GOC that:

> "Her visit on 6 January 2005 was therefore overdue by two years",

but in fact it was one year wasn't it?
A. Yes, I am sorry about that.

Q. Right, I am with you. Thank you.

Mr North: Anything further Mr Varley? [*No*] Colleagues? [*No*] Representatives? [*No*] Thank you.

Professor Hirji: Can I ask something? I am a little confused, because I think I am hearing two different stories and I just want to make sure in my mind that I am clear. You said to Mr Foster that you noticed an increase of floaters on 6 January?
Mr Jones: Yes, sir.

Q. So you noticed an increase in floaters relative to the previous visit?
A. No, I noticed that there were more floaters in the right eye than the left eye.

Q. But that was the case as last time?
A. It increased compared to the left eye but not increased compared to the last visit.

Q. Thank you.

Mr North: Anything arising? [*No*] Right, Mr Jones, thank you, that has been most helpful.

[*The witness stepped down*]

Mrs Kapila: Sir, I have one more witness of fact, and before I call her I would like to pass to the Committee a bundle of documents in which her very brief witness statement appears.

Mr North: Are you content with that Mr Foster?

Mr Foster: It rather depends on who this witness of fact is. I do have a statement; I think it is from the Practice Manager?

Mrs Kapila: Yes, that is the only statement that we are using.

Mr Foster: Is it that one? [*Indicating*]

Mrs Kapila: It is, yes. It has been already served on Mr Foster some time ago.

Mr North: And this statement is being handed up rather than -?

Mr Swinstead: Are you calling the witness, Mrs Kapila, or do you want the statement to stand? Are you calling the witness?

Mrs Kapila: I am calling the witness.

Mr Swinstead: And you want the Committee to see the statement as well?

Mrs Kapila: Well yes, just for completeness' sake. It has already been served on Mr Foster and if it is before the Committee it just makes it easier.

Mr Foster: Sir, I am not sure that I have any particular objection to this three-line statement being shown; however it should not necessarily be in the context of this entire bundle. I would prefer rather normally for her to be examined and for the statement to be put to her if it need be, but what I would object to is that bundle contains a lot more than this statement.

Mrs Kapila: If there is an objection to that then I will ask her to read that statement, and since it is such a brief statement it can go in your notes. I do not wish to raise an issue on this statement. She is coming here to give evidence so she will tell you what you need to hear.

Mr Foster: I have no objection to that, sir. The Committee will of course see everything in that bundle at the appropriate time.

Mr Swinstead: I would suggest, Mrs Kapila that it would be better if you are calling the live witness – I can't see any objection to her reading her short statement so I think that would be better.

Mrs Kapila: I am more than happy to proceed in that manner.

Mr North: Is that all right, Mr Foster?

Mr Foster: It is, sir.

Mr North: We are content to proceed in that manner then.

MS NICOLA ANNE REES called and sworn
Examined-in-chief by **MRS KAPILA**

Mrs Kapila: Ms Rees, could you give the Committee your full name and address please?
Ms Rees: Nicola Anne Rees, 5 Croesonen Park, Abergavenny, Monmouthshire.

Q. Could you read the brief statement that you prepared and signed, please?
A.

> "In January 2005 I was employed as the Practice Manager at Rayners Opticians in Abergavenny.
>
> I had been working there in that capacity for about 13 years and knew [Patient A]."

Q. Sorry, could you not mention her name, say 'Patient A' instead?
A. Right:

> "On 16 January 2005 [Patient A] came in for a routine and overdue appointment."

Q. Could you explain the last statement that you made, please?
A. Right; just as far as I was aware Patient A booked in for a routine eye examination. That is all that was marked in in the diary and that is all she came in for as I was aware. She had her eye examination and then prepared to order glasses.

Q. Can you tell us what the practice was in respect of reminders at Rayners Opticians?
A. A patient had a reminder. The reminders were always put on to a computer system with regard to what was written on the record card, and the patient would have in the region of five reminders before the computer stopped mailing them.

Q. And where would the computer take the date for sending of the first reminder from?
A. It would be inputted into the computer from the record card, the patient's record card, following the sight test.

Q. Had Patient A been sent the routine reminders?
A. Yes.

Q. I have no further questions for this witness.

Mr North: Thank you; Mr Foster?

MS REES cross-examined by **MR FOSTER**

Mr Foster: Ms Rees, I am asking questions on behalf of the Council. Who asked you to prepare this statement?
Ms Rees: I was contacted by the AOP and asked to prepare it.

Q. And then you kindly supplied them with this statement?

Mrs Kapila: I am sorry, I should clarify; I perhaps misused a word there. I prepared the statement based on what -

Mr Foster: All right; it is a very short statement and you have given your evidence on oath haven't you -
A. Yes.

Q. - that it contained the truth?
A. Yes.

Q. You have been asked about the reminders which are sent out to patients and you have said they are obviously dependent on dates which are presumably fed into the computer by you and your colleagues?
A. Yes.

Q. Presumably, regardless of the fact that those reminders are generated and sent out, human error can still creep in, can't it?
A. Human error can creep in, but there are measures in place.

Q. To avoid that?
A. Yes.

Q. Are you good on dates?
A. Fairly good on dates.

Q. Very good?
A. Fairly good, I think.

Q. Are you one of the measures in place to make sure mistakes are not made?
A. Yes, I would have been at the time, yes.

Q. Would it surprise you to learn that nobody else apart from you thinks that Patient A went in on 16 January 2005?
A. Actually it was the 6th, not the 16th.

Q. I have no further questions.

Mr North: Thank you. Mrs Kapila?

Mrs Kapila: Chairman, perhaps I should add that I should have pointed out that there was a typographical error.
A: Yes, I did notice it actually but I was just reading from here, so I did notice that.

Mrs Kapila: It is something that I should have pointed out as the maker of that statement.

Mr Foster: Just in reply to that as it is a further point, can I just ask you should you have noticed that when you signed it?
A. Yes, I should have noticed that.

Q. I am grateful.

Mr North: Thank you Mr Foster. Do any members of the Committee have questions?

MS REES questioned by the **COMMITTEE**

Professor Hirji: I have a question, again just to make sure that I understand this point. You said when the appointment was made for Patient A that she did not complain of anything.
A. No.

Q. There was no indication of an urgency -
A. No.

Q. - or a need to see an optometrist?

A. No, it was just booked in as a routine eye examination. We used to have practices put in place where if it was anything away from a routine eye examination it would be marked down in the diary to allow extra time.

Q. Can you give me an example of such a thing?
A. Example, if somebody comes in as an ocular emergency complaining of flashes, floaters or even post-cataract patients, it would all be noted down what they were coming in for.

Q. Thank you.

Mrs Huka: Could you bear with me and just for my own peace of mind tell me how you knew that Patient A came in for just routine examination? How did you know this?
A. Because of the way our appointment system worked, the diary, and it was just written as a routine eye examination. I made it my business to know what was going on in the practice on a daily basis, and if it had been anything other than that, you know if any other members of staff knew it was anything different, then I would have known about it.

Q. Because you keep on saying 'were' and 'the way the system worked' as if it is in the past tense.
A. I am not longer the manager there now. That is the only reason I am using 'were'.

Q. Thank you.

Mr North: When did Patient A come in to book the appointment?
A. I wouldn't be able to tell you the date that she came in to book the appointment. We didn't have a system of marking down when the date was, but myself and all of my staff knew that if somebody came in as an urgency with a complaint, with any sort of symptoms, then it would be treated as an urgency and they would be seen at the nearest available slot if we had a test that day, if we had somebody in that day, if not they would have been advised to go to a hospital.

Q. Is that the case with Patient A?
A. Yes. Yes, as far as I am aware. There is nothing written that indicates anything different.

Q. Thank you very much, that has been very helpful.

Mrs Kapila: I have no further questions.

Mr Foster: No, thank you sir.

Mr North: Thank you very much, it was a great help.

[*The witness stepped down*]

Mrs Kapila: My next witness is my expert witness; I don't know if you are looking for a short break before that?

Mr North: I think 10 minutes or so might do us all some good. Thank you.

[*Hearing adjourned at 2.08 p.m.*]
[*Hearing reconvened at 2.24 p.m.*]

Mrs Kapila: Chairman, I am calling Dr Barnard who is our expert witness, and I would also like at this stage to pass to you Dr Barnard's report which has already been served on Mr Foster.

Mr Foster: I have no objection to that. [*Document circulated*]

DR SIMON BARNARD called and affirmed
Examined-in-chief by **MRS KAPILA**

Mrs Kapila: I am going to ask Dr Barnard to read from his report, simply because I see that as a convenient way of going through his evidence. I will stop him where I seek clarification on any points. Of course I will not ask him to go through every detail at the beginning but to move to the actual issues, so therefore it is not hopefully going to take any additional time. Dr Barnard, if we turn to your report, just briefly could you read out the section which is basically a summary of your experience, which says 'Dr Simon Barnard' and your qualifications and your practical experience? That is in the very front of your report.

Dr Barnard: My name is Simon Barnard. I am currently an optometrist in primary care practice. I am Director of Ocular Medicine at the Institute of Optometry in London. I am a Visiting Associate Professor at the Department of Optometry, School of Health Sciences, Hadassah College, Jerusalem. I am a Visiting Lecturer at the Department of Optometry & Visual Science, City University, London, and I am a member of the Board of Examiners of the European Council of Optometry.

Q. And on page 4, if I could ask the Committee to have a brief look through Dr Barnard's qualifications and experience? I do not intend to go through all of them but they are listed there if the Committee wish to have a quick look through them, and I am sure you will look at them again when you consider this matter further. [*Pause*] Dr Barnard, are you currently in practice?

A. I am indeed. I spend I would suggest about 90 per cent of my time in primary care practice.

Q. On page 5 of Dr Barnard's report we have a summary of the records that were seen, and these are the records dated 16 January 2003, 6 January 2005 and 24 January 2005. I do not think that it should be necessary for us to go through those records as we have already looked at them, but they are there. I will ask Dr Barnard to read from page 6 of those, which is "Opinions relating to issues". Obviously should you wish to refer back to those records then please do so.

A. Okay:

> "Firstly, I have read the Expert Witness report of Dr Sheen submitted on behalf of the General Optical Council and would agree with most or all of his statement **if Patient A had definitely reported a shadowing in her vision** when she presented to Mr Jones on 6 January 2005. My comment is not a reflection on Patient A's testamentary reliability but rather points out that the proviso that Patient A had reported this symptom is of importance with regard to certain aspects of this case.
>
> Patient A asserts in her statement that the reason she came to see Mr Jones was because she had observed "shading" in her right eye when she looked to the left.
>
> This compares to Mr Jones' record that states she had reported a deterioration in her right eye.

Patient A does recall informing Mr Jones that her eyesight was not getting any better and that her eyesight had deteriorated as a whole.

Patient A does not know if on this occasion she reported flashes to Mr Jones. She states that she had experienced flashes, but could not recall when she first noted flashes.

Therefore, in conclusion, I note that there is agreement between Patient A and Mr Jones that she had reported a deterioration in vision (whether it be generally or in the right eye). Mr Jones did not record that Patient A had noticed flashing lights and Patient A cannot recall whether she had flashing lights at the time of presentation. Therefore, the frank difference between record and memory is that of the "shadowing".

If Patient A had reported this symptom of shadowing in her right eye then this should have been recorded by Mr Jones. I would then also agree with Dr Sheen that Patient A should have been examined with binocular indirect ophthalmoscopy under mydriasis.

However, as stated above, there is a clear difference between Mr Jones and Patient A over their respective record and memory.

A question arises as to whether, if Mr Jones had **not** been made aware of symptoms other than that of deterioration in vision, he should have in any event dilated Patient A's pupils to examine her retinas with binocular indirect ophthalmoscopy under mydriasis.

In the UK optometrists rarely routinely dilate every patient. This is not the optimum mode of practising as the profession, as a body, would detect more retinal disease than it presently does if peripheral retina were to be examined routinely as some would argue it should be.

The current situation is that the average, reasonably competent optometrist would make a decision to dilate those at increased risk due to symptoms or other risk factors.

I am in agreement with the statement of Dr Sheen (Page 3 of his report) that, "*If the vitreous degeneration was stable without any further symptoms or suspicious history, other than a slight deterioration in one eye, then it is reasonable to suggest that a dilated BIO fundal examination would not be performed …*"

Q. Can I just stop you very briefly there Dr Barnard? So we are linking that then, are we, to what you have stated above that quote, other risk factors. Are we then talking about the vitreous degeneration and myopia that was present in this patient?
A. Yes, I am particularly interested in new symptoms when it comes to risk factors.

Q. Sorry, please continue.
A.

"I would also agree with Dr Sheen that a full history should be taken. Indeed, it would have been useful to have seen recorded, particularly because Mr Jones had observed vitreous changes previously, something to the effect that no floaters were visible to the patient. Having said this, the patient had not reported floaters on 16 January 2003 nor, it appears, had Patient A noticed floaters by the time of her visit to Mr Jones on 6 January 2005.

Patient A was at relatively increased risk of peripheral retinal disease compared to someone who is emmetropic but in the absence of symptoms I would suggest that the average, reasonably competent optometrist is likely to have not dilated the patient.

In this instance Mr Jones had previously diagnosed vitreous floaters but it appears that on the day he saw Patient A she was neither suffering yet from additional floaters nor flashes of light. Had the latter been reported then this would have meant undoubtedly that Mr Jones should have then carried out further investigations. I would also agree that if Patient A had indeed reported "shadowing" then this should have alerted Mr Jones to a possible problem that required investigating.

With regard to the allegations:

Mr Jones' decision making was dependent upon the symptoms he understood were being reported by the patient.

In the UK a reasonably competent optometrist would not usually dilate routinely a patient's pupils. From Mr Jones' record card he understood that Patient A was attending for a routine check. He had recorded this with those words but with the addition that Patient A had reported the vision in her right eye had deteriorated.

I would conclude that with the benefit of hindsight, Mr Jones' decision to carry out routine ophthalmoscopy turned out to be clinically incorrect. However, as he was acting upon the symptoms he understood the patient to be reporting, it was a decision that the average, reasonably competent optometrist might have done in the same circumstances.

I would agree with Dr Sheen that there should have been recorded any history of flashes or floaters. However, I would point out that the patient does not appear to have been experiencing these symptoms at the time of her visit in 2005. I do not believe that the average reasonably competent optometrist records "*no flashes*" and "*no floaters*" in every case even though I would agree that it is a good clinical habit to do so.

I would agree that additional clinical details such as the status of the peripheral retina and blood vessels should be recorded.

I would agree with Dr Sheen that visual fields might have been carried out and the results recorded because Patient A was over 40 years [of age]. In fact, it is my belief that a visual field screening should be carried out routinely on all adult patients. However, it is also my understanding and experience that this is not the clinical habit of the majority of optometrists in the UK whether they be reasonable competent or not unless there is a risk factor of certain diseases, for example, open angle glaucoma.

In my opinion it cannot be concluded that a retinal detachment was present when Mrs Jones saw Patient A. Nor may it be concluded that a retinal tear was present when Mr Jones examined Patient A. Indeed, when she was seen by Mrs Connolly three weeks later, Mrs Connolly did not detect a retinal detachment despite a dilated examination but rather a **possible** retinal tear.

If Mr Jones had decided to routinely dilate, I suspect that he may well have detected peripheral vitreo-retinal changes that are very common amongst myopes. Such changes, which may well have been present, may have led to vitreo-retinal traction, subsequent tears and then retinal detachment. I reiterate that peripheral retinal changes are very common amongst myopes and as such is a reason why, arguably, all myopes should be dilated and the peripheral retinas examined routinely at regular intervals. However, this is not presently the habit, protocol or routine for either the vast majority of optometrists in the UK or the average, reasonably competent optometrist.

Additional general comments

I wish to point out two general observations concerning Mr Jones' clinical skills that are for me a pointer towards his general level of competency with this particular patient.

The first is his decision, following the examination in 2003, to refer the patient for a blood sugar check. This was taken on the basis of the patient's reported symptoms (volunteered information by the patient), change in refraction (clinical sign) and reported thirst (presumably elicited from the patient by further, subsequent questioning. I believe this pathway demonstrates the action of a reasonably competent optometrist.

Secondly, Mr Jones carried out a Perkins applanation tonometry on 6 January 2005. I would suggest that the vast majority of optometrists in the UK carry out non-contact tonometry. Perkins applanation tonometry demands the use of a topical anaesthetic and skill in carrying out a procedure whereby the instrument is placed in physical contact with the cornea whilst the reading of intraocular pressure is determined. I would also conclude that the ability to carry out together with the use of this procedure is also evidence that Mr Jones is a reasonably competent optometrist."

Q. Perhaps I could ask you just a few questions in relation to your report. Could you comment on the issue of the pressures in relation to this patient?

A. Yes. Professor Hirji raised an issue of difference in pressure between the two eyes, and I would just like to point out the refraction of the patient. The spherical component of the right eye is something like minus 3.5 whereas the left is almost zero, so this suggests that the right eye is probably a bigger eye and therefore a difference in pressure may just be a physiological variation.

Q. Could you comment on the significance of the visual acuity findings at the visit on 6 January and the referral visit of 24 January?

A. The fact that there had been a significant drop in visual acuity suggests that there had been a substantial change in the physiology or pathophysiology of that patient's eye.

Q. At that time with the record that we have already referred to which refers to the acute onset of the retinal detachment?

A. Yes. It may well do. When there is peripheral retinal disease, and the prevalence is very high; if we take in all types of peripheral pathology probably 50 or 60 per cent of myopes have something wrong with the edge, the very anterior part of their retina. That predisposes them to a retinal tear if the jelly as it detaches pulls on the retina, and this can be very acute, it can be an overnight thing, and a retinal tear can lead to a retinal detachment within a day or a few days.

Q. In respect of the visual fields point that you have made in terms of it being something that is not done routinely by the vast majority of optometrists, can you give the Committee any indication on current practice or how matters stand today on visual fields?

A. There are two points I would like to make. Firstly, and I am an advocate of doing visual fields on every patient over 40, but a central field examination is of very little significance whatsoever in determining whether a patient has a retinal tear in the periphery of their retina. Again, the second point I would like to make is being an advocate of visual fields routinely, just Monday last there was the annual conference of the College of Optometrists and there was a debate between two eminent advocates, one suggesting that visual fields should be done on all patients over 40 and the other suggesting not and only when there are symptoms or risk factors, and those advocating the latter actually won the vote. So it seems to me that currently the profession as a whole has still decided amongst its own body that visual fields are carried out not routinely on every patient over 40.

Q. Obviously we have heard from you when reading your report, Dr Barnard that you would have liked to have seen a fuller history of recent ocular symptoms including details about any flashes or floaters. Would you say though that the absence of that does not mean that no enquiry was made on those factors?

A. I have to listen to Mr Jones. I am of a similar age and practising experience in terms of length to Mr Jones, and I can think back 15 years when we all used to write very little down and would only write if we did see something that was wrong. Things have been changing over time, and most of the profession are slowly tightening up their record keeping. It is interesting to note that newly-qualified practitioners are probably much more thorough at writing down 'no flashes' and 'no floaters' on every patient than those of us who have been qualified for longer.

Q. With regard to your comments on the details of Patient A's symptoms and history and the details of the ophthalmoscopy, would you say that the records that have been presented in this case, the record in question being the one of 6 January 2005, falls below the level of a reasonably competent optometrist?

A. I would not. Mr Jones has described the optic nerve head. He could have made further descriptions about that and he could have been more specific about the ocular media, but he has made some comments and descriptions for both. It is not as though he has written nothing down at all. I would suggest that the fact that he has not written down for example cup/disc ratio and the arteriovenous ratio does not mean that he is not a reasonably competent optometrist.

Q. I have no further questions Dr Barnard.

Mr North: Thank you; Mr Foster?

DR BARNARD cross-examined by **MR FOSTER**

Mr Foster: Dr Barnard, you will be relieved to you know I am not going to cross-examine you on your qualifications as your expertise goes before you, and in any event you appear to agree in the main with what Dr Sheen said, so I would like to examine that agreement a bit more carefully if I may. You agree for example that Mr Jones ought to have written down what it was he saw when he looked at Patient A's retina, don't you?

Dr Barnard: But he has; for example he made a qualification about the optic nerve, and that is an observation.

Q. So you agree; the question I am asking is that he ought to have written down what he saw. You are saying he has, but do you think that is something he ought to have done?
A. Absolutely.

Q. And part of the reason he ought to have done that is for example when someone like yourself comes later on to examine the records that he has made in order to determine, for example, whether Patient A was suffering from a retinal detachment, the answers to those questions would have assisted you wouldn't they?
A. Yes.

Q. And indeed had he carried out the tests that he is charged with not having carried out, that also would have assisted you greatly in determining whether or not Patient A had a retinal detachment on that day wouldn't it?
A. The fact that he has only done direct ophthalmoscopy, and that not being the optimum manner by any stretch of the imagination of looking at the peripheral retina, tells me that he cannot have examined the very periphery of the retina.

Q. And if he examined the very periphery of the retina and recorded the results of that examination, would it be easier for you now to say whether or not Patient A was suffering from a retinal detachment on that day?
A. To be frank what it would have been more likely to have told me is that he did not detect any retinal tears or peripheral retinal pathology, but a retinal detachment progresses from a tear and will very often be detectable with direct ophthalmoscopy.

Q. Right; now, we heard this from Dr Sheen and I want to take myself through it rather gently so that I can understand it. The process leading up to a retinal detachment is a process that takes place in time and the sooner you spot that process the better it is for the patient, would you disagree with that?
A. I would not disagree with that, but may I just mention some statistics here?

Q. I am sure my friend will take you back to anything you want to answer, but I am going to ask you a series of questions and I would be grateful if you would answer them.

Mr Swinstead: Just pause there, because if you ask the witness a question and he wishes to answer it in a particular way, with respect I think you should allow him to answer.

Mr Foster: I agree, as long as it is in relation to the question.

Mr Swinstead: Well, I am sure he will advise me if it is not.
A. It is, yes – I believe it is, I hope it is.

Q. Well, with respect he is the expert, and if you ask him a question –

Mr Foster: I thoroughly agree, sir, and we want the expert to give as full an answer as he can. My difficulty is up until now I have asked a question and there has been a slightly different answer, so I am really just asking Dr Barnard to answer the question I am asking rather than answer a different one that he refers; but if the statistics go to the question I am asking -
A. Would you be kind enough to put the question again to me, please?

Q. Certainly, let me put it again please. If you are looking for anything to do with a retinal problem, the earlier you begin looking for it the better? That was the question.
A. Correct; however by the age of Patient A, 30 per cent of the population have a condition called posterior vitreous detachment – 30 per cent, and 10 per cent of

those go on to lead to a retinal tear, and probably about 10 per cent of those roughly go on to lead to retinal detachment. What this actually means is that the profession as a whole, if it is 30 per cent of the population so one in three, should be dilating every single patient and looking in the peripheral retina for the earliest signs of retinal tears – but, whether it is right or wrong, we don't do that. We instead are directed by patient symptoms to determine whether there is an additional risk factor suggesting we should dilate. That was my point.

Q. And I am grateful for your answer. I think it may have strayed into confirming my suspicions slightly, so let me examine your answer. Do those statistics tell you it is better to look early, or not?
A. Of course it is better to look early.

Q. And when you are looking early for anything associated with a possible retinal detachment, you would not disagree that the way to do that is through indirect ophthalmoscopy and through the dynamic assessment of the anterior vitreous, would you?
A. I would totally agree with that.

Q. I am grateful; and not only do you agree with Dr Sheen on that, it seems that Mr Jones also agrees with Dr Sheen on that, that if you are looking for retinal problems that is the way to do it.
A. Yes.

Q. So it doesn't actually matter what symptoms the patient presents with, does it? If you have already decided 'I am going to look carefully for signs or symptoms of a retinal detachment', you would still have to conduct those tests wouldn't you?
A. Yes; if one has set upon the path of determining the health of the peripheral retina, one needs to dilate the patient and look indirectly.

Q. I am grateful; and if one had set upon that path with a direct ophthalmoscope, would that be safe practice if the end of that path could lead to the possibility of a retinal detachment?
A. Direct ophthalmoscopy will invariably not be able to detect a retinal tear in the extreme periphery of the retina. What it will be able to do, even with an undilated pupil as long as the pupil is not too small, is probably detect a retinal detachment that is already happening.

Q. So if it is very, very bad it might be big enough to see through a direct ophthalmoscope?
A. That is correct.

Q. But you would likely miss the smaller signs that would lead you to be able to do something about it early enough?
A. Yes, you would invariably I would say – probably 90 per cent of the time – miss a peripheral tear that is way out in the extreme periphery, and 90 per cent of tears are not visible by direct ophthalmoscopy.

Q. Help me again if you would, sir, because this is very helpful for my understanding at least: Shafer's Sign. Can you tell us about Shafer's Sign? We have been told that is something that happens when the tear begins and it leaves a sign; is that right?
A. That is correct. When the retina tears there is traction pulling on the layer under the retina, that is called the retinal pigment epithelia, full of pigment, and that will cause pigment cells to migrate from that layer under the retina through the hole into the jelly, and they will be floating around in the vitreous. They will be visible when one

looks with a slit lamp microscope at the anterior vitreous and they appear as little tiny brown dots, hence the term 'tobacco dust' or Shafer's Sign.

Q. And help me if I am getting this wrong, because I am not a medical professional at all, but because they happen as a result of the tear they are symptom of the tear aren't they?
A. They are a sign of the tear.

Q. A sign of the tear? Can you help me with the difference between 'signs' and 'symptoms'?
A. Yes; it is really who is reporting it, so a sign is what the practitioner observes, a symptom is what the patient complains of.

Q. Sorry, I am confused by that. I do not disagree with you - that was my understanding – but you would not therefore be able to go out looking for symptoms would you? You would ask the patient and they would answer you.
A. That would not be my normal terminology, but there is confusion and I can recall times when I have been giving a lecture on this, that or the other and I ask 'What are the signs of retinal detachment' for example, and someone in the audience will put their hand up and say 'Spots in front of the eyes', because there is a rather loose and incorrect usage of terminology.

Q. Of course we would not want to take any advantage by that usage, so let's look at this very carefully. The patient would not be able to see Shafer's Sign would they?
A. Well, they wouldn't see Shafer's Sign but when that break occurs and as the retina tears, some little blood vessels will be torn at the same time releasing particles of blood into the jelly as well, and they see those as little floaters, as little black spots.

Q. So if you were looking for Shafer's Sign would you ask the patient or would you look through a slit lamp and try and see it for yourself? Or you might do both?
A. You might do both. You would look for Shafer's Sign because it is a sign, but the patient will report spots of a different nature from a different cause, meaning blood.

Q. So as a safe practitioner, if you are concerned about the possibility of a retinal detachment, would you look through a slit lamp or ask the patient about floaters or both? Which would be the safe course?
A. If you were concerned because you suspected symptoms of a retinal detachment, or more likely if the patient came in saying 'I've woken up this morning and I've got spots in front of my eyes', that is the more likely scenario. 'I can see spots in front of my eyes', then that symptom reported by the patient would raise the index of suspicion enough for you to want to dilate the pupil and look for the signs.

Q. Very helpful, and you have said that in your report and you have said that before; you agree that if Patient A did, as she says she did, report the shading Mr Jones should have done everything he was charged with. You have been clear on that haven't you?
A. Yes, I have.

Q. What I am asking you is even if she didn't report any signs at all, if for any reason you as an optometrist were concerned about the possibility of a retinal detachment, would you conduct indirect ophthalmoscopy, would you look through a slit lamp looking for Shafer's Sign, would you ask about the possibility of floaters, or would you do one of those and not the others? What would you do?
A. If I was concerned from the symptoms of the patient -

Q. Well, you have talked about the symptoms of the patient, but the question is if for any other reason you were concerned about the possibility of a retinal detachment, leaving aside the presenting symptoms – let's say for example the patient was a mute and could tell you nothing, if you for any reason went to look for retinal detachment, which one of these tests would you do?
A. If I was looking for retinal detachment I would have to dilate the pupil and use indirect ophthalmoscopy.

Q. And if you were looking for retinal tears, for signs of a possible eventual retinal tear?
A. The same thing, same procedure.

Q. So regardless of what the patient told you, if you were looking for this the only way to carefully look for it, the only way to safely look for it, is the way you have described using indirect ophthalmoscopy using a slit lamp to look for Shafer's Sign?
A. Yes, if I was suspicious the patient had a peripheral retinal problem that might be progressing.

Q. And it is not possible therefore to 'carefully' look for the signs of retinal detachment by simply asking the patient whether or not they have seen floaters?
A. No, I would agree with you there.

Q. I am grateful for that. I am going to take you to something you say in your report now, sir, which I don't entirely understand. You said on page 8, and this is the third paragraph down on page 8:

> "I would agree with Dr Sheen that there should have been recorded any history of flashes or floaters. However, I would point out that the patient does not appear to have been experiencing these symptoms at the time of her visit in 2005."

Now, I presume from what you have told me about the difference between symptoms and signs that you are saying 'The patient didn't say anything about it', although of course we know from Dr Jones that he saw floaters on that date. Is that the reason that you have said very specifically "the patient does not appear to have been experiencing these symptoms", i.e. the symptoms of floaters?
A. In fact I was interested to hear this morning Patient A actually appearing never to have experienced flashes or floaters. She said that the only symptom she ever noticed was a shadow.

Q. But the question I am asking you is did you not take into account the fact that Mr Jones saw floaters when he examined the patient when you said "the patient does not appear to have been experiencing these symptoms"?
A. The term 'floater' is a layman's term. What Mr Jones was seeing, observing, was the sign of vitreous degeneration, which is almost universal in a myope of this age.

Q. And the point about vitreous degeneration, and I am sorry if I am reducing this to a level that I understand, is that if the patient experiences it as a symptom or if the practitioner sees it as a sign it is a possible risk factor in eventual retinal detachment.
A. Particularly if it is a new symptom from the patient. Now, when we observe a myope of this age invariably – <u>invariably</u> – there is vitreous degeneration. As we get old the jelly becomes less jelly-like, it becomes liquefied and what one sees, the best way of describing it is as sort of mucus floating around in fluid, and you see it in most patients.

Q. But if it gets worse that is a bad thing?

A. It is going to get worse. As we grow older the vitreous degeneration continues until in the end our jelly is completely liquefied and completely detached from the retina, but in the vast majority of patients that does not lead to any problems.

Q. So what is the point in looking for this vitreous degeneration in terms of retinal detachment?

A. It is an observation, in the same way that we look not only at the vitreous we look at the lens, looking for cataracts, and we look at the retina. Vitreous degeneration is part of the ageing process.

Q. As you say degeneration gets worse over time; are you telling us that if the degeneration gets markedly worse between two observations that is a bad thing in terms of retinal detachment?

A. It may sound strange but actually we want it in the end to degenerate completely and in an uncomplicated fashion, and by 'uncomplicated' I mean this: that the jelly itself fills the eye and lies on the retina. It is very loosely attached to the retina. As the jelly becomes liquefied there is a very strong chance, and by this age 30 per cent of the population, the jelly has come away cleanly from the retina, but in a small percentage of patients during that process there is a little area that just catches for some reason way out in the periphery because there are peripheral problems there, and as it comes away it causes a tear. We actually want the jelly to become completely detached in an uncomplicated manner, and in fact when somebody comes along complaining of a new floater or flashes of light, it is invariably not a tear but is invariably a posterior vitreous jelly detachment. There is a six week time period over which time that jelly normally comes away completely, and in fact a good protocol is at that point with the new symptom of a floater or flashes to dilate the patient, look for tears, there is nothing there, get the patient back six weeks later and do exactly the same. That is what will happen with some optometrists and in an eye hospital.

Q. So if Mr Jones has got his direct ophthalmoscope and he is having a look at the vitreous degeneration through that, are you saying that actually has no effect at all, that there is no point in him doing that?

A. It is not going to tell us anything about the peripheral retina, but I would just come back to the body of the profession who do not dilate patients routinely, and the only way of determining which patients have got peripheral retinal disease – because some patients with peripheral retinal disease never experience symptoms, unfortunately there is a small percentage of patients who have full-blown retinal detachments with no symptoms in the early stages, none at all.

Q. And when you say that it puts me in mind of people who speed in their motor cars. There are lots of people who do that too, but it doesn't help very much when they are stopped by the police to say 'Lots of other people were doing it'.

A. I agree with you.

Q. I am grateful. The last point is that you have said to the Committee 'It cannot be concluded that a retinal detachment was present when Mr Jones saw Patient A', the truth is it cannot be concluded either way can it?

A. I would say that if she had had a retinal detachment at that time, three weeks later she would have lost her eye. Her eye would have been gone.

Q. And are you saying you have sufficient information on the patient records provided to you to make that judgment to the standard that this Committee can be certain so as to be sure of that?

A. I can't be absolutely certain of course, but the position of the tear that was found was superior temporal, and when you have a superior tear there is a great danger of fluid

getting under the retina and by gravity filling up the space underneath and lifting the whole retina off. That is the worst place to have a retinal tear.

Q. So we are looking at likelihoods, but when we come to saying whether we are sure or not we cannot be sure either way can we?
A. I will use the term 'probability' rather than 'likelihood'.

Q. But we can't be sure either way?
A. We cannot be certain.

Q. I am grateful. I have no further questions, sir.

DR BARNARD re-examined by **MRS KAPILA**

Mrs Kapila: Just one point of clarification; Dr Barnard, you have been taken through a great deal of evidence related to symptomatology, signs, indirect ophthalmoscopy and the like. When it comes to your report and Dr Sheen's report, which is the premise upon which the question is set out, is it accurate to say, Dr Barnard that your agreement with Dr Sheen in terms of what Mr Jones should have done is based on the symptomatology of shadowing that the patient is alleged to have given? Let me put it another way: if the patient did give that symptom then you agree with Dr Sheen that he should have carried out the indirect ophthalmoscopy and the requirements set out in the allegations, in terms of the examination? Is that the basis of your evidence?
Dr Barnard: Yes.

Q. Is it also correct to say that if the patient did not present with those symptoms, then Mr Jones acted, as indeed it is suggested by Dr Sheen, as a reasonably competent optometrist in not carrying out that indirect ophthalmoscopy and the rest of the examination as set out in the allegations?
A. I do believe so.

Q. I have no further questions.

Mr North: Thank you. Legal Adviser, have you any points? [*No*] Colleagues, do you have questions?

DR BARNARD questioned by the **COMMITTEE**

Professor Hirji: Can I ask you to tell me what you would record in the history and symptoms section of the record card, in those two bits of information? You qualified at about the same time as Mr Jones; what would you record there?
A. Let me just find it and compare it to what he recorded – on 6 January 2005?

Q. Yes.
A. I would have written probably exactly the same thing, a routine examination but complains of a deterioration in the right eye. That is probably the primary symptom that the patient complained of. I am afraid I am amiss here; I am not in the habit of writing 'No flashes, no floaters' on every patient. Whether I would write 'No other symptoms', I might sometimes but not at other times.

Q. But you would mention something about general health, history -
A. Yes, I would.

Q. So you think that is a perfectly adequate record?

A. I think it is not perfect by any means; the general health and medications and family history is not recorded.

Q. Would you expect a competent practitioner to have recorded it?
A. I would expect a reasonably competent optometrist to record it in most cases. We are all human and there are times when we don't always record everything.

Q. Would the vast majority of practitioners record it?
A. Yes, I think the vast majority of practitioners would put down general health, family history.

Q. Similarly, what would you record under fundal details?
A. I am in the habit of recording quite a lot now, but I record the cup/disc -

Q. In 2005 what would you have recorded?
A. I would record the cup/disc ratio; I would also record something about the quality of the media. Now it may be just non-specific, 'media clear', or it may be 'early cataract' for the lens and 'vitreous change' – I would probably use the term 'vitreous changes' in that regard.

Q. Thank you.

Mrs Huka: Can I just ask, are retinal tears usually painful?
A. They are never painful.

Q. Never painful?
A. There are no painful tears in the retina.

Q. Right, thank you.

Mr North: Dr Barnard, I was just interested in something that you have written on page 8 of your report. It is the second paragraph about "Mr Jones' decision to carry out routine ophthalmoscopy" – I am a lay member, you will have to excuse me, some of these words are rather difficult, and "he was acting upon the symptoms", and "it was a decision that the average, reasonably competent optometrist might have [taken] in the same circumstances". Is that the thrust of what you are saying?
A. Yes.

Q. Where do you think professional judgment and the interests of the patient and appropriate investigations in the circumstances would fit within that rather narrow definition?
A. Unfortunately it is a matter of clinical judgment. When there is a choice of whether one does additional tests or not it has to come down to clinical judgment, and this is why I use the term "hindsight", because it is only after we know that we have missed something that we realise that we have not acted in the patient's best interests on this occasion.

Q. What puzzles me is your rationale for that is that the registrant was acting on the symptoms he understood the patient to be reporting. Where was the professional initiative and judgment in the course of action that was taken?
A. Well, Mr Jones does say that he did ask various questions to the patient, and it is not the habit of optometrists in the United Kingdom as a whole to carry out these additional tests unless there is an indication to do so, and in his clinical judgment he did not see the need to do those tests. In hindsight that may not have been the correct decision. I would also add though that it is very possible that if he had dilated

the patient and looked with a Volk or a fundus lens he may have found no retinal tears at all at that point.

Q. So it is safe to proceed on the basis of what the patient tells you?
A. I think that we have to listen to patients very carefully. Of course it is important to try and elicit symptoms. One has to draw the line at some point and different practitioners draw the line in different places.

Q. But your suggestion in that paragraph on page 8 that "he was acting upon the symptoms", and I see no mention of clinical judgment nor of in a sense proactive investigation. The decision was acting upon the symptoms reported, and you say that is acceptable for an average reasonably competent optometrist?
A. I have a view myself on what the profession should do, but when one looks at what the body of the profession does - most of whom are reasonably competent - they do not dilate every patient.

Q. No, no, no – sorry, answer my question, please.
A. Would you please put it again to me?

Q. All right; really the thrust of what I am saying is would an average reasonably competent optometrist reach a clinical decision based solely upon what the patient told him?
A. Not solely upon what the patient told him, no, but on what the patient -

Q. Sorry to interrupt you, but you have said in your paragraph "as he was acting upon the symptoms he understood the patient to be reporting". I do not see any mention of the other professional skills, judgment, clinical judgment. I do not see any of those mentioned there. It is represented to me there as a response to what the patient told him.
A. Yes, but there is a certain level of eye examination that is carried out when a patient comes in and says they have come in for a routine examination for example. Yes, there are questions that one should ask the patient and often that leads one along a path to carry out other tests, but most practitioners generally draw the line at doing all the tests in the interests of the patient.

Q. In your opinion was Mr Jones sufficiently proactive in terms of his diagnosis?
A. In retrospect it would have been better for him to have routinely dilated this patient and looked in the periphery of the retina, but I would also qualify that again; at that time he may have found absolutely nothing in the periphery of the retina in the way of a tear.

Q. Thank you, we will leave it at that.
A. May I just – it might just help the Committee; I recently had an experience of a patient who came to see me who came in complaining of a mild visual disturbance. He just was not seeing so well in one eye. I dilated him, I mean I do dilate a lot, and found a large flap tear. Now, he did not complain of flashes or floaters, and I sent him down to Moorfields that day and he was operated on that day. The letter I got back from the consultant said 'Thank you for referring this patient with a flap tear' and retinal detachment by then, by late afternoon it was developing into a detachment, 'who had been complaining of flashes and floaters for the last three days'. But I know very well that he had not told me that because I had questioned him very firmly.

Q. I see. Well, thank you, that has been helpful Dr Barnard. Any further questions arising out of Committee questions from either representative?

DR BARNARD further cross-examined by **MR FOSTER**

Mr Foster: I have an extremely brief one and it comes out of the previous conversation, sir. I will not take too long about it. The idea that you suggest in your report you have just said is that Mr Jones was acting in his clinical judgment on the symptoms. Can I ask you to look at page 14, please? Where Mr Jones says, "I was careful to look for signs of retinal detachment and on my records noted 'no sign of any detachments'.", presumably this was a matter of his clinical judgment in much the same way as that story that you have just told us, regardless –

Mrs Kapila: Chairman, sorry – I think there is a certain point here that I need to make; obviously it is up to the advice you will receive on this, but Dr Barnard is being questioned on something written by Mr Jones, and the opportunity to question Mr Jones has been and passed. I wonder if it is now right for questions which I cannot see have risen out of the examination of the Committee are now put to Dr Barnard as an expert witness? I just cannot see where the connection is. This is a matter surely of evidence given by Mr Jones?

Mr North: Mr Foster, what would you say to that?

Mr Foster: The reason I am putting the question, sir, is because you put it and because I am not sure that I understood throughout Dr Barnard's evidence exactly what his position is on this, because on the one hand he seems to be very clear that if you are looking for retinal detachment you should do the tests charged, and on the other hand he is saying that he made a clinical decision not to perform these tests based on the symptomatology, but we know from Mr Jones himself that he was looking for signs of retinal detachment. Really I am just hoping that Dr Barnard can clarify this, especially in light of his very interesting and informative story that on occasion when he is not given any symptoms he still goes on and performs these tests and there is a very important reason for so doing. But certainly sir, if you feel the point has been made -?

Mr North: It is an interesting point; perhaps the Legal Adviser could assist here? Could you give us some professional guidance?

Mr Swinstead: It seems to be a reasonable point, although as far as I understood the evidence what Mr Jones actually said when he used the words in the letter "signs of retinal detachment" he was actually talking about symptoms. I therefore think that you should be cautious in asking the question, because certainly I understood Mr Jones to be referring to symptoms, and I think you should bear that in mind when you are asking the question.

Mr Foster: Certainly; might I rephrase it on that basis?

Mr Swinstead: Certainly. That is my advice.

Mr Foster: Thank you.

Mr North: So if you will rephrase it, Mr Foster I think we can allow it.

Mr Foster: I am grateful for the opportunity. Dr Barnard, is it a clinical judgment to look for symptoms of retinal detachment?

Dr Barnard: It is a clinical judgment to look for signs of retinal detachment. Now you can look for retinal detachment with a direct ophthalmoscope, you can find retinal

detachment with a direct ophthalmoscope, but it is not the optimum method of looking.

Q. So when Mr Jones says in his evidence 'I used a direct ophthalmoscope to look for symptoms of retinal detachment', it is your evidence that that doesn't really mean anything is it?
A. I think he is using – we often find even with academic people they often need to change the term 'prevalence' and 'incidence' as a lot of people do not really understand the difference.

Q. Maybe we can assist then if we step back from that, because I take on board that Mr Jones might not know the difference between 'signs' and 'symptoms', when he picks up his direct ophthalmoscope and looks in the patient's eye for something, is that a clinical judgment in your opinion?
A. He is carrying out what he would normally routinely carry out on a patient, on a routine patient who is not complaining of any symptoms.

Q. I am not sure that I understand that, but I am grateful.
A. Can I explain further?

Q. Please.
A. Many optometrists still use a direct ophthalmoscope and they do not dilate patients, but when they pick up their direct ophthalmoscope they are looking for signs of any eye disease to the limit that that direct ophthalmoscope will allow them to do so.

Q. So when he uses the words "retinal detachment" at all in the sentence, it is completely irrelevant?
A. Well, if he was looking for a sign of retinal detachment it is perfectly permissible to look for a retinal detachment with a direct ophthalmoscope, and you will find them; but it is not the optimum way by any means of finding the very earliest retinal detachment, or the very earliest retinal tear, or the precursor to either of those two problems.

Q. One final question, just to clarify this for me: if you looked at a patient record of a patient you had not seen and saw the words "No sign of any detachments!" with an exclamation mark written on that record, would that mean to you that someone had done the tests and therefore determined there were no signs, or that they had done the basic routine direct ophthalmoscopy that the law requires that has nothing at all to do with retinal detachment?
A. I would much prefer to have seen for example 'No sign of any retinal problems' or 'No sign of any retinal detachment by direct ophthalmoscopy'.

Q. And in answer to the question that I asked you, if you look at a patient record and see "No sign of any detachments!" written on it, what would you believe that meant?
A. If the practitioner had used direct ophthalmoscopy I would know that the patient did not appear to have any retinal detachments to the limit that was examinable by that instrument, which is not the optimum way.

Q. If for example the practitioner had been run over by a bus, as we have already posited once, and all you had was this document, what would "No sign of any detachments!" mean to you?
A. I don't understand that -

Q. If you do not have a practitioner to tell you whether he had used direct or indirect ophthalmoscopy or what test he had done in coming to the determination that there

was "No sign of any detachments!", what would the words "No sign of any detachments!" indicate to you as a practitioner?

A. I would actually read that this was direct ophthalmoscopy because there is no drug written down and there is no binocular BIO written down, the letters BIO, and I know that the vast majority of optometrists, or certainly the majority of optometrists now, use direct ophthalmoscopy only routinely.

Q. And would you write down "No sign of any detachments!" to mean 'I have done a bit of direct ophthalmoscopy'?

A. I would not write that down.

Q. I am grateful. I have no further questions.

Mrs Kapila: Chairman, just one point of clarification?

Mr North: Mrs Kapila?

DR BARNARD further re-examination by **MRS KAPILA**

Mrs Kapila: Dr Barnard, you have been asked repeatedly about the signs of detachment and so on and I will not go into that again, you have given your evidence on that, but you have also been asked about the optometrist unfortunately falling under a bus or whatever. Can you clarify - is a hospital reliant upon the optometric records of the optometrist when it comes to looking for retinal detachment or deciding on symptoms of a retinal detachment?

Dr Barnard: I think when a patient presents for the first time to a hospital they are going to treat that patient as a new entity. It could be helpful if there are previous records of visual acuity but retina itself is a moving feast. You can have nothing there one day and a retinal tear the next.

Q. So in effect whoever is going to look at this patient next in the absence of further symptoms or not, that record is not going to be definitive is it?

A. I don't think it is going to assist or otherwise the practitioner who is going to diagnose a condition.

Q. I have no further questions.

Mr North: Colleagues, any further questions?

DR BARNARD further questioned by the **COMMITTEE**

Mrs Huka: Just a brief question, Chairman. In a situation where you have a patient over 50 and there are no floaters, and the patient has come in and said 'I've got this haze or whatever over my right eye', what would you do? Would you consider that a person who has come in for a routine examination given the state of knowledge that I put to you?

A. Did you say a pain?

Q. No. A patient is over 50, and the optometrist knows that they have floaters and the patient has said 'My right eye does not appear to be functioning properly', would you consider that somebody who has come in for a routine examination?

A. Actually yes. If a patient says 'My right eye has deteriorated' usually what it means and what it turns out to be is that there has been a change in prescription, and as long as having done the refraction the visual acuity is as it was before then the

deterioration that the patient was alluding to was most likely just to be due to the change in refraction and the new power of lenses required.

Q. That is why I put visual acuity cumulatively and not individually. What I am talking about is not somebody who came in and just said 'It is my eye', it is somebody who is over 50 and somebody who is known to have floaters, so taking the three things together would you say that it was routine?
A. That is still routine I would say, yes, particularly if they are coming in at regular intervals.

Q. Thank you.

Mr Swinstead: I am just a bit concerned; in the question you asked, you asked it in two different ways because when you put the question you did not refer to change. Did you mean to refer to change?

Mrs Huka: I meant change.

Mr Swinstead: Exactly, and I think the witness answered you in a general tone talking about deterioration, which may have a distinction between that and shading. I don't know whether you want to pose the question?

Mrs Huka: I do in that case.

Mr Swinstead: Because I think he was answering the other question.
A. Thank you; if a patient of any age comes in and says 'I noticed shading' then that is no longer a purely routine examination.

Mrs Huka: And if it is no longer routine, what would you do as opposed to what you would have done if it had been routine?
A. If I may apply that to the reasonably competent optometrist out in practice, they would dilate the patient and look with a binocular indirect ophthalmoscope, and probably I would argue would do a visual field as well.

Q. Thank you.

Mr North: There being I think no further questions, thank you Dr Barnard, you have been most helpful this afternoon. You may stand down.

[*The witness stepped down*]

Mrs Kapila: Chairman, I have no further witnesses. Obviously we now come to the point when you have to look at the facts and whether or not they are proved to the requisite standard, and I will in that context seek to direct your attention to a number of references that I wish to put forward for Mr Jones, and I would also tell you why I seek to put them forward at this point in time. I don't know what the Committee wishes to do in terms of procedure but that would be my next act.

Mr North: Are we going to have final submissions at all?

Mr Foster: Yes, sir. I think my learned friend is saying that under the normal course of circumstances the references from both professional and lay people would be given to you at a later stage of proceedings - at the mitigation stage - should you reach that stage of proceedings.

Mrs Kapila: I am terribly sorry to interrupt, but that is not quite what I am saying. Perhaps some of it might be mitigation at a later stage but I do not argue the point on the later stage yet. I am merely saying that for this particular stage, which is the factual fact-finding stage, I would be referring to them on a particular basis, and that is where I limit my argument at this point.

Mr Swinstead: Mrs Kapila, you want to put evidence before the Committee of good character, is that right?

Mrs Kapila: That is right.

Mr Swinstead: And you want therefore to refer the Committee to certain testimonials which go, or attest to, Mr Jones' good character?

Mrs Kapila: Yes.

Mr Swinstead: And you will be inviting the Committee to take those into account when they consider the facts at this stage?

Mrs Kapila: Yes, certainly.

Mr Swinstead: With respect I think it would be helpful if you are going to put, as it were, a bundle of documents before them that you pause, and if necessary discuss with Mr Foster, which of those goes specifically to the point so you can say to the Committee 'I refer to the letters on pages 1, 3, 5 and 6 and I specifically refer to the second paragraph', or the third paragraph, whatever it happens to be. But rather than just putting them in front of the Committee and as it were trying to get the Committee to work out for themselves which bit they want to rely on, I do not think that would be helpful to them.

Mrs Kapila: No, I was not intending to do it that way. I was in fact intending to sift the references according to –

Mr Swinstead: I don't know if you have agreed which particular documents you wish to rely on, and whether you have discussed them with Mr Foster but, sir, my advice to the Committee would be that that ought to be done so there is agreement which documents the Committee should be invited to see now.

Mr North: Is this the *Campbell* judgment?

Mr Swinstead: No, sir, this is even pre-*Campbell*, but it is a *Campbell* point. I would simply invite you that in due course you should look at these documents at this stage simply from the point of view of character, attesting to Mr Jones' good character, and you will be invited to weigh that in the balance. You should not look at the documents for any other reason, and that is why it would be helpful if you could be directed to the specific bits and then you would not have to read anything else. There is a broad capital point but in a sense almost we have not got that far, if you see what I mean.

Mr North: I do.

Mrs Kapila: Just one point if I may make it? Of course the purpose of putting in the character references at this stage is because there is a serious point here about credibility, and they are put in for that purpose in terms of Mr Jones' credibility. The facts that you are being asked to decide hinge on credibility therefore that is the basis on which I put them forward.

Mr Swinstead: Mrs Kapila, it follows from that would you wish me to give the Committee a good character direction formally, basing it upon the criminal good character direction in *Archbold* and amended to, as it were, be appropriate for this Committee – which goes to the two points, firstly – well, I will prepare it and if necessary discuss it with you, but would you wish me to do that?

Mrs Kapila: Yes, after I have submitted the –

Mr Swinstead: Yes, of course, when I come to say to the Committee –

Mrs Kapila: Yes, that would be a good way to go.

Mr North: Mr Foster, are you content with that?

Mr Foster: Entirely. I accept that it may well be potentially possible that something within these letters does go to character, but it would be good if that could be pointed out first and then we could come to an agreement on that.

Mrs Kapila: I am more than happy to do that.

Mr North: All right. [*Confers*] Would 15 minutes be helpful at this point to discuss this point?

Mrs Kapila: That should be fine, thank you.

[*Hearing adjourned at 3.31 p.m.*]
[*Hearing reconvened at 3.52 p.m.*]

Mr North: Right, I hope that short delay was helpful and we can proceed with closing submissions.

Mr Swinstead: Sorry, sir; pausing there, if you are proposing to put in evidence of good character then with respect that should happen before – you have not formally closed your case?

Mrs Kapila: No.

Mr Swinstead: I think you should put it in now in evidence and then speak to it when you make your submissions, but you should perhaps make clear what evidence you are going to put in now. How do you want to deal with it? I am sorry, perhaps I should have asked.

Mrs Kapila: I do have a bundle here that now includes evidence that you have seen other than the references. The references I intend to refer to are only those that go towards good character, and I have confirmed that with Mr Foster, so I will only direct the Committee to those particular pages and references.

Mr Swinstead: And you just have one bundle that is prepared for the Committee? Would you have other bundles?

Mrs Kapila: We have bundles for the Committee, so that they can go to the relevant pages and indeed the relevant sections of those particular references.

Mr Swinstead: Right.

Mr Foster: I have seen the parts of these references that my friend wishes to read to the Committee and I have no objection to that.

Mr Swinstead: Are you therefore happy for the Committee to have the bundle now?

Mr Foster: It is a matter for the Committee. They are going to be very short, and I would imagine my friend could read them because they are no more than a couple of lines, but if the Committee wish to have the bundle I have no objection to that.

Mr Swinstead: Mrs Kapila, you are just intending to read them are you?

Mrs Kapila: I would very much like the Committee to have the bundle because I think it would be helpful for them to see the reference that I read from.

Mr Swinstead: Very well.

Mr Foster: I have no desire to prevent the Committee, but it really is a matter for the Committee.

Mr North: Yes; I think in fairness it would be interesting to know the source and the quotations that you wish to use, but I think to make the bundle entirely available to the Committee at this point would not be appropriate.

Mrs Kapila: Well, you now have heard the expert evidence which was part of the bundle. You heard evidence on the medical record - that is part of the bundle. You have heard from the witness whose statement is part of the bundle. The vast majority of the references are going to be referred to now in terms of the character, and then there is a CET record, on which I don't think there will be any objection, which is not going to be used at this stage and which you will not be asked to look at. So really all you will be looking at, and directed to look at, is that part of the references that are relevant at this stage.

Mr Swinstead: Sir, as long as the Committee understand that they should only look at, and good note should be taken of exactly what they should look at, I do not see any objection unless Mr Foster takes it.

Mr Foster: I would follow the advice.

Mr Swinstead: Let's have it handed in.

Mr North: Could we indicate in the record that the Committee will be directed solely to those items which are identified by Mrs Kapila in relation to this aspect and proceedings.

Mrs Kapila: Yes.

Mr Swinstead: I think possibly, Mrs Kapila, at this stage while you are still dealing with Mr Jones' case you should perhaps either list the pages and paragraphs which you wish to the Committee to refer to, so would you like to do that?

Mrs Kapila: Would you like me to do that prior to reading from them?

Mr Swinstead: You are going to read from them?

Mrs Kapila: Yes, very briefly. I will be identifying exactly.

Mr Swinstead: Fine, thank you, and we will take note.

Mr North: If we are content then we can continue, thank you.

Mrs Kapila: The first reference appears on page 11 of the bundle, prefaced by four zeros for which I apologise but it is page 11. This is from Brenda Sheridan, JP., RN., SCM and she states that:

> "I have known Anthony Jones for over 20 years, initially as an optometrist and professional colleague and latterly as a neighbour and friend".

and the bit I am going to direct you to is in the second paragraph, first sentence:

> "I can confirm that he is a man of great integrity".

I then turn to page 12; this is a reference from a Mrs Kinsey and she states that she has known Mr Jones for nearly 40 years and has always found him to be a reliable person. [*Slight pause*] Sorry, I was about to read something in error.

Mr Foster: Do you want to tell them the sentence they ought to consider?

Mrs Kapila: Just the fourth sentence down; page 14 –

Mr Swinstead: Which is:

> "I have always found him to be a courteous, considerate and reliable person."?

Mrs Kapila: Yes, I apologise. Page 14, this is a reference from Mr O'Connor Davies, an optometrist:

> "I have known Anthony Jones as a colleague for over 20 years" –

and the next sentence:

> "During that time there was no reason to doubt his professional ability or integrity."

Page 15, and this is from Major General The Reverend RM Llewellyn CB, OBE, DL, where he states:

> "I have known Anthony Jones for almost twenty years"

and in the last paragraph:

> "He has always been very highly regarded and much respected in the community as a man of integrity with high moral standards. Someone who I would trust implicitly."

Then just one line from the reference on page 16 which is from the Brecon Medical Group Practice, and this is in the penultimate paragraph:

> " – he is held in high regard in the Brecon community in general."

This is from a practitioner who I think it is valid to say has been working there since 1978.

On page 17 there is a reference from Alys Thomas, and the first sentence states that:

> "It is with pleasure that I write this reference for Mr Anthony Jones having known him and his family since I came to Brecon 54 years ago."

And on the next page, second paragraph:

> "I had hoped a few years ago, to persuade him to become a Magistrate, since in my opinion he would have been an ideal candidate – being absolutely honest and held in great respect generally in this community."

And in the last paragraph:

> "I trust that I have been able to convey not only my honest and high opinion of this young man, but that of so many grateful patients also."

One line from the reference on page 19, Arbuthnot Opticians; he states that:

> "- I have never heard or had cause to say anything other than good about him".

Page 21, a reference from Angela and Peter Bishop, that they have known Anthony Jones for about 30 years, and in paragraph 3:

> "We have always considered Anthony to be a straightforward and upright character and have never had any reason to doubt his honesty or his professional integrity."

Then from a Senior Lecturer at Cardiff University, obviously he has known Mr Jones and he says in the last paragraph:

> "I have never had any reason to doubt his honesty or his professional integrity. [Signed] J.M. Woodhouse, Senior Lecturer."

At page 29, this is a reference from The Reverend Gerwyn Jones, and he states:

> "Until I retired some eighteen months ago I was the minister of the Plough United Reformed Church in Brecon. Mr Anthony Jones was brought up in the Plough where his grandfather was a deacon of some significant repute and service."

Then further down he says:

> "He is a person of high standing in the community, well respected and considered to be a person of the highest integrity."

Then he states in the last paragraph:

> "You will see from this that I have no hesitation in providing Mr Anthony Jones with a testimonial for his personal character, his standing in the community" –

and that is it.

Mr Swinstead: What I would propose to do is advise the Committee with regard to the first part of the direction which goes to credibility. It seems to me that it is not particularly appropriate to deal with propensity because this is not a matter of misconduct, there are no allegations for example of dishonesty, and therefore this is really to inform. It seems to me that that part of the advice that goes to a propensity would not be appropriate. Sorry to intervene at this stage, but Mrs Kapila, are you content with that?

Mrs Kapila: Yes, certainly not at this stage.

Mr Swinstead: Well, I do not think at any stage, because propensity is to deal with a propensity, if you like, to commit offences and here the issue is performance which is rather different. If the allegation for example had been dishonesty then you might have invited me to say that 'Bearing in mind his character, does it make it less likely he was being dishonest'. In this case I do not think the Committee will be helped by the fact that, being a man of character, does it make it less likely that he did or did not do what is alleged –

Mrs Kapila: Yes, in terms of being deficient.

Mr Swinstead: - because that seems to me not appropriate.

Mr Foster: I would agree with that entirely, sir.

Mr North: Thank you, Legal Adviser. Anything further Mrs Kapila?

Mrs Kapila: No; sorry, I thought it was –

Mr Swinstead: Sorry, I just simply was dealing with that at that stage while you were dealing with these testimonials.

Mrs Kapila: I see; so the directions will begin at a later stage?

Mr Swinstead: To make it absolutely clear, I was proposing to give the first half of the character direction advice which goes to the issue of credibility. It seems to me that the second element which you would sometimes give which deals with propensity, does it make it less likely bearing in mind Mr Jones' good character that he would commit the misconduct (which is normally what one would go to) which is alleged, would not be relevant in this case because it is merely a matter of deficient performance. I give you the example that if it had been alleged that Mr Jones had been dishonest then it might well have been relevant to give propensity advice to the Panel as well, but I consider it would not. Are you content with that?

Mrs Kapila: Yes. I was just wondering –

Mr Swinstead: I will give it in due course.

Mrs Kapila: Okay, that was the only point.

Mr Swinstead: I am dealing with it because you have just raised the issue and I thought I would make it clear.

Mrs Kapila: Yes, thank you.

Mr Swinstead: Sorry sir, I don't know if there is anything else that Mrs Kapila will want to say in closing her case?

Mr North: Are you now closing your case, Mrs Kapila?

Mrs Kapila: Yes, I have.

Mr North: I think therefore we can invite submissions from both parties.

Mr Foster: I am grateful, sir. I am minded of the time and minded of the number of stages the Committee has left to go through. It is entirely a matter for the Committee and I am extremely happy to make my closing submissions on facts to you now. What I would ask is if there are going to be closing submissions on facts they are either both this evening before an adjournment or both tomorrow should you wish to adjourn.

Mr North: How long do you anticipate speaking?

Mr Foster: I would not imagine speaking for any longer than 20 minutes myself, sir. I am not sure how long my learned colleague –

Mr North: And Mrs Kapila?

Mrs Kapila: I do not imagine myself speaking for much longer.

Mr North: Well, we have to leave the building at five o'clock, so given those estimates I think we can be like Waterloo and be a 'damned near-run thing', but I think we can do it, and we will deliver our decision on the facts tomorrow morning. So, would you like to begin Mr Foster?

Mr Foster: Yes, indeed sir.

Closing submissions by Mr Foster

My closing remarks will not take very much time. The reason for that is for most of the things that you need to consider on the facts you will be assisted by the evidence. It is very clear looking at the allegation that you need to determine whether Mr Jones ought to have carried out indirect ophthalmoscopy through a dilated pupil. You are very much assisted by the fact that he accepts he did not, but it will be a matter for you, the Committee, to determine whether he ought to have - in the same way that you must consider whether he ought to have carried out dynamic assessment of the anterior vitreous. Again he accepts that he did not, but you must determine whether he ought to have done.

He did not perform a visual field test, and again he says that he did not but you need to work out whether he ought to have done. He says he did enquire about the full history of recent ocular symptoms including details of flashes and floaters and it will be a matter for you, the Committee, to determine whether or not you accept that and whether or not you find that he did in fact make that full enquiry.

He did not refer Patient A and he accepts that, and you need to determine whether he ought to have done. He suggests that he did sufficiently note the details of day-to-day symptoms and history on the record card and it will be a matter for you to determine whether he is right about that, and again whether he is right about the fact that he noted the full details of ophthalmoscopy on the record card.

That is what you are called upon to decide at this factual stage, and I would suggest there are a number of stages at which your decision-making process can effectively stop. The very first stage is whether or not you accept the evidence of Patient A, because if you do accept Patient A's evidence that she went to Mr Jones' practice on 6 January and told him that she was suffering from 'shading', if you accept that, all of the other people you have heard from today accept, that he ought to have done all the things charged, and he failed to do all the things he is charged with failing to have done.

It is not just Dr Sheen who tells you that if Patient A turned up with shading he ought to have carried out the various tests, it is also Dr Barnard and it is also Mr Jones himself. He accepts that if she said that he ought to have done everything, so you will need to determine whether you accept Patient A's evidence – and in doing that you will no doubt consider and may be assisted by the fact that for Patient A this was a one-off occasion, this was something special.

She told you the reason she had made the appointment was because she was suffering from shading, and the reason that she remembers what happened very clearly was because something odd was happening to her vision and she never quite felt right about the resolution of it. She accepted initially the advice that there was nothing particularly unexpected about that, but as time went by she decided that she was not happy with that, she was still experiencing the shading, and returned to the practice and had a retinal detachment diagnosed.

So there are, I would submit to you, reasons why you might suggest that Patient A is in a better position to remember what was said than Mr Jones, and the reason Mr Jones is not in such a terribly good position to remember what was said is two-fold: he accepts that he sees 60 patients a week, so his ability to recollect the exact questions and answers given to him by patients will be less than that of the patients themselves experiencing a slightly out-of-the-ordinary event, but the other problem was that Mr Jones did not write down the questions he asked or the answers he was

given, so although now he can tell you what he thinks would have happened, it is very difficult for him to tell you exactly what did happen. However as I say that is a matter for you, the Committee.

If you do not accept Patient A's testimony that she told Mr Jones about shading the Council would say that is not the end of the matter in any event, because again we have agreement between the two experts and Mr Jones, that if you are going out to look for retinal detachment the only safe way to do that is to carry out indirect ophthalmoscopy, to carry out a dynamic assessment of the anterior vitreous, to assure yourself that there are not the signs of retinal detachment, that Shafer's Sign is not in existence, that the retina does not show a tear or any other symptom or sign.

These are the ways to make yourself sure that retinal detachment has not taken place, and you are assisted by knowing from Mr Jones in his response that he had at least considered the possibility of a retinal detachment because he was aware from the history that this patient had vitreous degeneration and that he ought to make sure either that there were no signs as he wrote in his response himself of retinal detachment, or that retinal detachment was not an issue.

It is a matter for you, the Committee, to determine which one of the things Mr Jones said was true, because it is very clear from the response he gave to the Council that he said 'I was looking carefully for the signs of retinal detachment' – and we are told that means one particular thing, and if you are looking very carefully for that particular thing there is only one way to do it, and that is the way that is charged.

Today Mr Jones tells you 'That is not exactly what I meant, what I was looking for was symptoms'. Dr Barnard tells you that you cannot look for symptoms, in fact you elicit symptoms by asking patients questions, so when Mr Jones says he was looking for symptoms by holding up his direct ophthalmoscope to the eye of Patient A he was not exactly right, but you might prefer – and you would be entitled to prefer – what he said in his response in the first place, that 'I was looking carefully for the signs of retinal detachment'.

If you find that that evidence which he gave was compelling, and he believed that he was in fact looking for signs of retinal detachment, it does not matter what the patient said to him. The only way to ensure that there is no retinal detachment is the one described. Dr Sheen suggests a particular number of tests: indirect ophthalmoscopy, dynamic assessment of the anterior vitreous; Dr Barnard agrees that is the only way to do it, and Mr Jones himself agrees that is the only way to do it.

So if you believe that was what he was doing, again you can find these facts proven on that basis. If you believe that he was looking for some sort of symptom in respect of a retinal detachment, I would encourage you that you are also entitled if you find to find that because he was looking for something to do with a retinal detachment, albeit it might not have actually been a sign, he also should have carried out these tests. There was an obligation on him to carry out these tests in order to be safe, and that is what he is charged with: 'You did not carry out indirect ophthalmoscopy, you did not carry out a dynamic assessment of the anterior vitreous you did not perform a visual field test examination on Patient A'. If you feel from the evidence, if you find from the evidence, that he was under an obligation to do these things, you can find that these things are made out.

You have also heard from both experts that there is no record of the symptoms and history on the record card. There was nothing written down on the record card specifically about floaters, specifically about flashes, there is nothing written about

the questions that were put to Patient A about floaters and flashes, there is nothing written down about the answers. You have heard from both experts that if that history was recorded they might both be in a position to know what happened on that day, but it is a matter for you as a Committee to determine whether there was an obligation to note down what he was asking and to note down what answers were given.

You have been told in the abstract in general that people's records are not very good, but I would submit to you that you can put that consideration from your mind because of course what you are considering are the specific facts of Patient A's case, and in the specific facts of the case where an optometrist has any concerns in regard to retinopathy, whether they are looking for signs or symptoms of retinopathy, you may feel that they have a duty to record what questions were asked, what answers were given, and what they observed. When they pick up their ophthalmoscope and look at the retina, if there are no problems but they are making that enquiry they are under an obligation to note down that fact, for the many reasons that you have heard given.

Again, in terms of ophthalmoscopy on the record card, you may find that in order to have noted sufficient detail some description of what was seen ought to be there, for the reasons described.

When you come to consider the fact that Patient A was not referred there are two things you can consider in relation to this. You could consider that if for any reason Mr Jones had not determined sufficiently that there was no problem to do with retinopathy he could have referred, the belt-and-braces approach, to be safe. He could have sent Patient A to a hospital - she would have lost nothing - they could have looked and made absolutely sure. Alternatively if you accept Patient A's evidence or any of the other things that would lead you to believe that referral was necessary for clinical reasons, again you may feel that he was under an obligation to refer – but we know that that referral did not take place.

As I say, on the facts I think this is a fairly straightforward matter because you have been assisted by Mr Jones. When Mr Jones answered my questions he told you, 'If this patient turned up today I would not do it like this, I would do it the way that has been described by the experts, the way that has been described in the charge'. That may not have shown sufficient insight you may feel at a later stage to be completely safe about his practice, because of course he has come here and he has told you that he did nothing wrong, but what he has told you is that he would not do it that way again, and you are entitled in my submission to take that into consideration when you come to consider 'Was there a duty on him to do the things he is charged with? Did he fail to discharge that duty?'

As we have said before, you have to make that determination to a very high standard, but I would suggest to you that someone can be sure when enough people are telling you that is the situation, and I would invite you to consider the combination of the agreement of the experts and Mr Jones when deciding whether or not you are sure he ought to have done these things for Patient A and did not do them.

Sir, unless you have any questions those are my submissions on the facts.

Mr North: That has been very helpful Mr Foster, thank you very much. Mrs Kapila?

Mrs Kapila: Chairman, I am of course presuming – and I am raising this now because of the way these allegations are worded – that we are looking at the facts as failures but not looking at the issue of deficient professional performance.

I raise this issue because as I have said the allegations are framed purely as fact, at least for the first three, and the fifth one as well, so I will address you on the basis that they are put there as failures rather than just statements of fact. I just wish to make that distinction, and wish to just confirm that we are not looking at the issue of deficient professional performance at this stage.

Mr Foster: I think I made that very clear in my opening, but I would agree with that. I hope there is no lack of clarity that you have to determine not only that this did not happen but it ought to have happened, but of course at some later stage you will then have to go on to determine whether that failure amounts to a deficient professional performance.

Mr Swinstead: Mr Foster, as I understand the position, and I think there may be a misunderstanding here, the duty or responsibility at this stage is to look at both the issue of fact and whether by reason of those facts Mr Jones is guilty of deficient professional performance. That is the first stage. The second stage is a separate stage which goes to the specific issue of impairment, and the third stage if reached is one of sanction, which would mean as I understand from looking at the notes that the Chairman has, that at this stage the Committee would also be considering whether or not these facts if found proved would amount to deficient professional performance. I don't know whether you want to address the Committee on that, because that appears to be what the Committee will be deciding at this stage, facts effectively as Mrs Kapila says these are failures, not simply 'Did to', i.e. they are blameworthy, and whether if they find them proved, some or all of them, whether those amount to deficient professional performance.

Mr Foster: Can I say this in regard to that: I would accept that fully. What I would say is it is a matter for this Committee to determine exactly when they make these various judgments; however the judgment on fact must be made to what is the criminal standard, that you are certain. The judgment on deficient professional performance is a matter for your professional judgment. If you wish to go through those two stages, as it were, in the same decision-making process then I think that is entirely right, as long as you separate out the two standards that apply.

Mr Swinstead: Of course, that is what I would advise the Committee. Mrs Kapila, are you happy with that?

Mrs Kapila: Yes, as long as we are clear.

Closing submissions by Mrs Kapila

Chairman, we have been presented with a number of allegations relating to Mr Jones and his alleged deficient professional performance, and I think it is important to go through each of the allegations in turn; and it is important to keep in mind that all of these allegations must be proved, and when I say 'allegations' I am talking about the facts set out in A(i)-(vii). They all have to proved to the requisite standard, which is the criminal standard, which is beyond reasonable doubt so that you are sure, and that the burden of proving those facts lies on the Council.

With regard to the first allegation that Mr Jones did not carry out indirect ophthalmoscopy, the second allegation that he did not carry out dynamic assessment, the third allegation that he did not perform a visual field test, and the fifth allegation that he did not refer Patient A, these have been admitted but only as matters of fact. Because of the way that these allegations are worded you are, in my

submission, going to have to indulge in a bit of mental gymnastics and see them also as allegations of failure, because in themselves if they are not failures then they should not be on this sheet at all.

When you look at these allegations that are admitted to you, you have to see them as being proved so that you are sure to be failures on the part of Mr Jones. I will start with the ones that have been admitted because they are slightly different from the others which are more a matter of record, though eventually they do link.

We have heard evidence unusually from two expert witnesses, who seem in total agreement on what would be required if the patient were presenting with a particular set of symptoms. We have heard from Dr Sheen and Dr Barnard that if Patient A was indeed complaining on that day when she came in on 6 January 2005 of shading, then Mr Jones should have carried out indirect ophthalmoscopy through a dilated pupil. He should have carried out dynamic assessment of the anterior vitreous. He should it is suggested have performed a visual field test as a matter of best practice, and that he should have referred Patient A.

The crucial point in respect of these matters is that they only become failures if the patient presented with those symptoms, and I briefly want to take you to the expert report of Dr Sheen. I will read very briefly from page 2 of this report where, after having gone through what must be done to detect a peripheral retinal detachment, Dr Sheen states:

> "This indicates that on the basis of Patient A's symptoms, Mr Jones' examination of Patient A on the 6th January 2005 was not of the extent or quality expected of a reasonably competent practitioner."

This is <u>on the basis of Patient A's symptoms</u>. He states further in his report:

> "There is some discrepancy over Patient's symptoms on 6th January [2005]" – I think that is what he means, and not "2006" as written. "Mr Jones had recorded in his records that Patient A was complaining of deterioration in the right eye with no other symptoms."

I now come to the important point where he states:

> "This alone would not necessarily make an optometrist of similar competency to Mr Jones think of a retinal detachment as a cause of the reduction in vision."

So deterioration in the right eye with no other symptoms, even bearing in mind her myopia and the vitreous degeneration, this alone would not necessarily make an optometrist of his competency think of a retinal detachment as a cause of the reduction in vision. Then further on making the same point:

> "If the vitreous degeneration was stable without any other further symptoms or suspicious history, other than a slight deterioration in one eye, then it is reasonable to suggest that a dilated BIO fundal examination would not be performed provided the pupil size was large enough to give an adequate view."

So it is based on what symptoms the patient had on the day. In this respect you have been invited to consider that Patient A would have a better recollection of what she was experiencing on that particular day, purely because Mr Jones sees a lot of

patients and she would remember as far back as that very clearly because she was the patient. In my submission it is not as simple as that; patient memories are no more reliable than the memories of optometrists, because patients too have other things going on in their lives and are not necessarily going to be absolutely sure of what they reported.

We heard when Patient A gave evidence a lot of 'I do not recall', 'I am not sure', 'Flashes were not reported' she states, and we also have a very interesting record which is in the bundle and has been referred to already in evidence, where it has been stated that the symptoms she was experiencing, the retinal detachment – and this is page 10 of your bundle and it is Mr Cheema, consultant ophthalmologist, who says:

> "[Patient A] was admitted as an emergency after referral from the Royal Gwent Hospital with an acute onset retinal detachment in the right eye."

I ask you to place that in the context of the evidence that she gave you that she had these symptoms when she saw Mr Jones.

You are being asked to find this failure to carry out these examinations proved on the basis of her evidence but in my submission her evidence is unreliable, and the only extraneous evidence that you have about what she told or might have told Mr Jones is this type of record which tells you that this was acute onset. Where is the conclusive evidence that she had these symptoms when she saw Mr Jones?

The only other extraneous bit of evidence is Mr Jones' record itself. It has been criticised as being incomplete, insufficient, but there is no doubt that these words appear on the record: "No other symptoms", under Notes/Advice to patient, "Minimal change not altered", and "Lot of vitreous degeneration (as before)". These words are on the record. No other symptoms are on the record, so I do not see, and I submit that it cannot be proved on the basis that we do not have specific symptoms not stated on that record, that that proves they were stated. I do not see how that follows. It rather suggests that they were not stated, because otherwise you would rather expect to see them noted rather than "no other symptoms".

There is a doubt, in my submission large enough there, as to the symptoms that were reported not being as stated by Patient A for you to find that there was no failure on Mr Jones' part in not carrying out the examinations and not referring the patient. In agreement with Dr Sheen we have the evidence of Dr Barnard, who is a community optometrist as well as having his academic qualifications. He tells us that on the basis of the symptoms being as recorded by Mr Jones and as reported by Mr Jones, his conduct in not carrying out the indirect ophthalmoscopy, the dynamic assessment, the visual fields and the referral was correct and within the remit of a reasonably competent optometrist; so you do not have the requisite proof that these were the symptoms that were given to Mr Jones, and therefore you do not have the requisite proof that not doing the examinations that were admitted not to have been done and not referring amounts to any sort of failure, and therefore certainly cannot amount to deficient professional performance.

I turn now to the issue of the remaining allegations. The fourth allegation against Mr Jones, and again I remind you that this has to be proven to the requisite standard, is that he did not enquire as to the full history of any recent ocular symptoms, including details about any flashes and floaters. Well, he tells you that he did ask that question. He tells you that he did enquire as to the history of any recent ocular symptoms. It is not recorded specifically, what you have there is "no other

symptoms". I do not see how that becomes 'did not enquire as to the full history of any recent ocular symptoms, including details about any flashes and floaters'. It is at the worst equivocal. We simply do not know, but it is certainly not proved so that you can be sure that he did not enquire as to the full history or ask about flashes and floaters. He tells us he did, and this is a matter you might wish to keep in mind when you look at the references in terms of Mr Jones' credibility. From what you have heard in evidence how likely is it that he now comes before this Committee and lies about what he asked of this patient?

It has been suggested that he could not possibly remember, he must have done this because that is what he usually asks, but he told you that he specifically knew this patient, he saw her regularly because she works across the road from him, so this is a slightly different situation from just suggesting that she was one of many patients that this optometrist saw.

The next allegation against him is that he did not sufficiently note details of Patient A's symptoms and history on the record card. Dr Barnard has stated that his record card should have been fuller, and Dr Sheen has stated the same; however where the two experts differ is in their assessment of whether or not it amounts to falling so far below the standard of a reasonably competent optometrist as to amount to deficient professional performance. In my submission it does not. Dr Barnard has stated that it is still within the realms of the record of a reasonably competent optometrist, albeit he is not suggesting that it is a perfect record, and that therefore nobody is suggesting that more should not have been on this record. Whether the fact that Mr Jones did not put enough detail down is a matter of best practice is quite different from whether or not it is a matter that a reasonably competent optometrist would not perhaps have done on the odd record.

There is also the allegation that he did not note details of ophthalmoscopy on the record card. Well, in my submission he did. Dr Barnard has taken us to the details that are recorded. He has suggested that perhaps more detail should have been on it, but he has told us that it is still a record card even without those details of a reasonably competent optometrist.

It has been used against Mr Jones the fact that he has stated that he would now act differently. It is being used against Mr Jones in that he stated that he would now write all these things on his record. I would have thought that was a positive. I would have thought that Mr Jones, having thought at that time that perhaps he was writing down what he saw and heard, "no other symptoms", "vitreous degeneration (as before)" and not altered, he is now stating that he would do it differently because he too wishes to raise his standards. He does not come before you and say that he wants to maintain the same standards even though he knows it is best practice to do something else, but there is a distinction between what is best practice and what is the practice of reasonably competent optometrists.

This is the not the forum in my submission to raise the barriers so that he has to comply with a higher standard than that of the reasonably competent optometrist, and I do not think it can be suggested that no reasonably competent optometrist will not occasionally omit something from his records. We are all capable of imperfection.

When you look at these allegations you must look at them firstly as having been made out so that you are absolutely sure that they are made out as failures, and secondly since we are also addressing the issue of deficient professional performance, you will need to look at whether or not they can amount to deficient

professional performance. The two in this particular case are linked because it is only if you consider that they are failures, certainly in respect of the admitted allegations, that you can find him guilty of deficient professional performance. As I have stated you can only find them as failures and therefore find him guilty of deficient professional performance if you are absolutely sure that the symptoms were those related by Patient A. That is the only basis on which you can find those failures proved and Mr Jones guilty of deficient professional performance on those grounds.

With respect to the enquiries about the full history, again the only way that you could find that proved is if you were absolutely sure that Mr Jones had not enquired about the recent ocular history or about flashes or floaters. In my submission it is clear that Mr Jones is not the type of person who would come before this Committee and lie. I would ask you also to bear in mind that he is an optometrist of 30 years' standing. I would ask you to bear that in mind also when you look at the matter of his not dealing adequately with these alleged symptoms. How likely is it that an optometrist of that much experience ignores a symptom such as shading?

Then we turn to the final two allegations, the first of which is that he did not sufficiently note details of Patient A's symptoms and history on the record card. As I have stated the note of the symptoms and history may not be as complete as it should be, but we must remember that he had the patient's record cards before him from a previous visit, he knew this patient, and we have also heard from Dr Barnard that you can get the odd record which is not as complete as it should be, and it does not therefore necessarily follow that it is not within the actions of a reasonably competent optometrist.

In the same way if we look at the details of ophthalmoscopy in the record card, we see that the ophthalmoscopy findings are detailed but maybe not to the requisite degree. Again Dr Barnard has told us, and he has a lot of community practice, that these would still not take it down to below the record of a reasonably competent optometrist although it may not be of the best standard.

When it comes to the question of visual fields, which is a slightly different matter, we have heard Dr Barnard's evidence of a recent meeting from which it is clear that visual fields are not done routinely on patients over 40 by the vast majority of optometrists.

Finally, I would like to come to one issue that has been exercised and talked about almost as if you must find the deficient professional performance and failure on this basis, and that is the word "sign" – "No sign of any detachments!", "no evidence" in the letter written to the Council by Mr Jones, and he has been questioned on why does he say there is no evidence, why does he say that he was "careful to look for signs", and why does he say "no sign of any detachments!".

Mr Jones has, as a man of integrity and honesty, explained that he made a mistake and used the wrong word. Dr Barnard has stated that it is not unheard of for 'symptoms' and 'signs' to get mixed up. It is in my submission a bit of a red herring, for want of a better word, to use this as some sort of indication that Mr Jones had set out on the basis of a suspicion of a retinal detachment to do an examination which he only carried out with a direct ophthalmoscope. That is not in my submission the case at all. Mr Jones has told us that he had no reason to suspect a retinal detachment. He has explained those words, and we have heard from him and Dr Barnard that it is part of a routine eye examination to do direct ophthalmoscopy. That is the matter, simply stated. There is no question in my submission of any sinister reading into

those words. They may not have been the best use of words or put in the best place on that record, but they nevertheless are words which he has explained and in which he is backed up by expert evidence.

So it is not proven to you so that you are sure that these allegations amount to failures and it is not proven to you that these allegations are failures and therefore that Mr Jones is guilty of deficient professional performance. In my submission he has put before you matters which raise serious doubts as to those allegations being proved, and therefore the particulars and the allegation that he is guilty of deficient professional performance are not made out to the requisite standard so that you can be sure.

Mr North: Thank you very much Mrs Kapila, most helpful. Now, I think that it would be helpful if we could hear the legal advice, and then I would propose that we take the Committee *in camera* at 0930 tomorrow and ask for the open session to recommence at 1030 tomorrow morning. Legal Adviser?

Mr Swinstead: Sir, my duty is tender advice to you as to the law rather than to direct you as to the law. The position is that you are the judges of both the law and the facts. The Committee has now reached the stage of firstly, determining whether the facts alleged have been proved by the evidence that you have heard under the provisions of Rule 50. The burden of proof with regard to any disputed fact rests throughout upon the Council. There is no burden upon Mr Jones at any stage in these proceedings to prove anything.

As to the standard of proof, the Council must satisfy you so that you are sure before you find any fact proved against Mr Jones. You must consider each particular of the allegations separately. Your approach must be with regard to each individual factual allegation, 'Have the Council proved the fact to my satisfaction so that I am sure it is proved?' Anything less and Mr Jones is entitled to a finding of 'Not proved'.

Sir, the allegations in each case allege that Mr Jones "Did not", and it is alleged that these are effectively failures and I would advise you, certainly metaphorically, to replace the words "Did not" with "Failed to" in each case, in each of the seven particulars of the allegation, and approach the allegation in that way, because as you have heard the admissions in (i), (ii), (iii) and (v) are simply bald admissions of "Did not" do what is alleged, whereas Mr Foster makes quite clear that all seven allegations are allegations that Mr Jones effectively failed to do what is alleged.

Where a failure is alleged in that Mr Jones is effectively alleged to have failed to do something, that is an allegation that he did not do and should have done whatever is alleged, and that he was under a duty to act in the particular way described and did not do so. Where such a failure is alleged it must be culpable. What makes it culpable? You must be satisfied before you make a finding of effectively a culpable failure that at the material time Mr Jones was under an obligation to take a particular course of action according to the standards of good practice which were in existence at the time, and that he did not take that course of action.

You have heard expert evidence in this case from two witnesses. An expert witness is permitted to give his opinion on the issues before you, but you are not bound by an expert's opinion. It is not the proper approach to expert evidence that you should simply accept an expert's evidence in the absence of reasons for rejecting it. If you find the evidence and opinion of assistance you are entitled to rely upon it in coming to your conclusions. If you do not find it of assistance then you are entitled to reject it

and to place no reliance upon it. What you make of expert evidence is entirely a matter for you.

As to your approach to individual pieces of evidence, you are entitled to draw inferences but you must not speculate. If you feel that it is proper you can draw an inference provided there is an evidential basis for it. On the other hand it would be wrong to speculate.

On occasions, and this is such a case, there are merely two witnesses to an event, conversation for instance, and it is relevant in this case. The question arises 'How can the Committee make a finding with regard to what happened when there is no independent witness or document which supports either one side or the other?'. The answer is that it is possible to make such a finding that you prefer one version of the event to the other, but if the finding is against the registrant, Mr Jones, then you must be satisfied so that you are sure before you make a finding that you prefer the other party's evidence to that of Mr Jones - in other words you must be satisfied so that you are sure that the other person's evidence can be relied upon on the issue in question.

Sir, with regard to Mr Jones' character evidence that was put before you, I would invite you to deal with it in this way: it comes into play as follows. Mr Jones can rely upon that evidence of good character on the issue of credibility, and argue that you should take his good character into consideration when deciding upon issues of whom you believe on matters in dispute, and consider whether it is more likely that he is telling the truth by reason of his good character and that his evidence can be relied upon in the matter in issue.

Finally, because you have received the testimonial evidence at this stage, I will give you what I would describe as a modified *Campbell* direction (following the case of *Campbell*), and that is what you must do is bear in mind the distinction between matters which go to the issue of whether in this case Mr Jones is guilty of deficient professional performance, and those which more properly would go to the issue of mitigation and penalty, which would come into play only if you were to have found him guilty of deficient professional performance. In particular the number and strength of practitioners' testimonials will almost invariably be irrelevant to the issue of culpability, but will most certainly be relevant to the question of the most appropriate penalty. It is not to say that material put before you by the practitioner may not go to both those issues, but you must be alive to the possibility of considering matters which go strictly to mitigation and not to culpability on the issue of culpability.

What I am emphasising is that in the testimonials which you have seen which refer to Mr Jones' good character, you should simply at this stage look at them on the narrow issue that I have advised you upon, and that is how they can be used on the issue of Mr Jones' credibility.

Sir, finally I would advise you that the second part of your task under Rule 50 at this stage is to consider whether, on the basis of matters found proven, you find that Mr Jones is guilty of deficient professional performance. It is a matter of judgment for you to consider whether he is guilty of deficient professional performance based upon the matters that you have found proved.

Sir that is my advice. Would either party wish me to say anything further or would you wish me to correct anything that I have said in my advice to the Committee?

Mr Foster: No, I am grateful, sir.

Mrs Kapila: I would only make the point that the references that have been put in at this stage have been put in purely on the basis of credibility.

Mr Swinstead: I am afraid it is belt-and-braces that I am giving *Campbell* advice, but I think we have made absolutely clear to all parties that the Committee know the basis on which they are put there.

Mrs Kapila: Yes, lest it be confused with mitigation, for which it is not being put in.

Mr Swinstead: No, I am being overly cautious perhaps in giving that advice, an excess of caution, but I hope the Committee are clear on the basis upon which they have this before them. Sir, that is my advice.

Mr North: Thank you; therefore then we will close the proceedings for today, and the Committee will reconvene *in camera* at 0930 tomorrow morning and I would ask the remainder of you to be available from 1030 tomorrow morning in this chamber. Thank you. I should like to thank everyone concerned for their helpful assistance during today.

[*Hearing adjourned at 4.51 p.m.*]

Wednesday, 21 March 2007

[*The hearing was reconvened at 11.34 a.m.*]

Mr North: Good morning ladies and gentlemen. Before reading the determination I just wish to make clear that whilst *in camera* the Committee received no further advice from the Legal Adviser other than a reiteration of his summing-up as it were yesterday afternoon before we rose.

The determination is as follows:

Findings in relation to the particulars of the allegation:

The Committee found particulars (i), (ii), (iii) and (v) of the allegation admitted and proven as matters of fact.

The Committee fond particular (vi) of the allegation proven.

The Committee found particulars (iv) and (vii) of the allegation not proven.

We announce our decision as follows:

"The Committee took account of the submissions made on behalf of the Council by Mr Foster and on behalf of the registrant, Mr Jones, by Mrs Kapila, and accepted the advice of the Legal Adviser. In reaching our decisions as to the particulars of the allegation, we bore in mind that the burden of proof remained upon the Council throughout and the standard of proof was that we must be sure before finding any particular of the allegation proven. We further bore in mind that with regard to the allegation of deficient professional performance, it would be a matter for our judgment as to whether Mr Jones was guilty or not.

Mr Jones is an optometrist of 30 years' experience in practice and an accredited member of the Primary Eye Acute Referral Service of Wales. On 6 January 2005 Patient A visited Mr Jones for a routine eye examination, and claimed that during the consultation she had reported "shading" in her right eye. In his evidence Mr Jones said that the patient did not mention this to him. Mr Jones examined Patient A and recorded the consultation. The examination was to a basic standard and did not include indirect ophthalmoscopy, dynamic assessment of the anterior vitreous, and visual field examinations. On 24 January Patient A returned to Mr Jones' practice and was examined by another optometrist who found retinal tearing of the right eye and arranged an immediate referral to the Royal Gwent Hospital. The following day Patient A underwent successful remedial surgery at the University Hospital of Wales, Cardiff.

We considered the evidence of Patient A and could not be satisfied so that we were sure that at the consultation on 6 January 2005 she mentioned "shading" in her right eye to Mr Jones. Medical records from the Royal Gwent Hospital indicate that Patient A stated that she had experienced "flashes" in her right eye for a period of six weeks, that is, some time before the appointment with Mr Jones on 6 January. In her evidence to the Committee Patient A's recollection was that the flashes had begun between the appointment with Mr Jones and the subsequent appointment on 24 January 2005. Consequently we considered that no blame could be attached to Mr Jones with regard to his conduct as alleged in particulars (i), (ii), (iii) and (v).

With regard to particular (iv) we could not be satisfied so that we were sure that Mr Jones had not taken a full history of any recent ocular symptoms, but neither did he record such history as he claims he took.

With regard to particular (vii) we concluded that he had noted a minimum of detail of the ophthalmoscopy that he had carried out.

With regard to particular (vi) we considered Mr Jones' note keeping fell well below the standard expected of a reasonably competent optometrist, and because of this we have found Mr Jones to be guilty of deficient professional performance."

We will now move to stage 2 of the proceedings, and I would invite the presenting officer to present any further relevant evidence with regard to impairment of fitness to practise.

Mr Foster: Sir, might I clarify one point before I do make the submission? Is it your finding therefore that only particular (vi) represents a deficient professional performance and that no other particular does, sir?

Mr North: Yes, that is correct.

Mr Swinstead: That is right.

Mr Foster: I am grateful. Sir, as you rightly said it now falls to you to consider whether or not Mr Jones' fitness to practise is impaired, and in doing so, as you have been advised before and your learned Legal Adviser will no doubt advise you again, this is of course another matter for your professional judgment.

In coming to that judgment you are entitled to consider a number of factors that have come out during the course of this hearing. You are entitled to consider that you have found Mr Jones guilty of deficient professional performance in relation to his record keeping. You are entitled to consider that record keeping under the new Rules is a matter that is taken very seriously by the Council, and the recent case law that has come out under the new Rules emphasises the fact that although in the past record keeping may have been viewed as less serious, the Council now takes record keeping extremely seriously.

The reasons for that I believe are fairly self-evident. For the Council to do its job, to perform its role as a regulator, they will almost always be reliant upon the records produced by members of the profession who appear before you, and indeed that was the case in this case. Both experts agreed that had the record taking been up to standard their jobs would have been much easier, and they would have been able to give you much more compelling opinions as to what had happened to Patient A on that day.

It was suggested to you during the course of evidence that people take record keeping very seriously when they are new to the practice; however during the course of their practice they may slip into some bad habits. Of course while that is something we can all sympathise with, as people who are in various professions and who find short-cuts to doing our work, it may be you may feel not a message that we ought to send out to the profession that thereby we do not take record keeping very seriously. You may feel that record keeping in and of itself is a clear impairment of Mr Jones' fitness to practise.

In addition to that, you are entitled to consider other things that came out during the evidence, for example the fact that Mr Jones has told you that although he is an optometrist of 30 years' standing, and although he is accredited, he has difficulty with the difference between 'signs' and 'symptoms'. It may be that you feel something that –

Mrs Kapila: Chairman, I feel I must interrupt at this stage, because if we look at the finding that you have made it states, "Did not sufficiently note details of Patient A's symptoms and history on the record card". That is the finding against Mr Jones, and that is the issue on which any address on his fitness to practise being impaired should be restricted and addressed. I feel that bringing in matters which basically just add to a general prejudicial view would not be fair to Mr Jones. I do not see how what Mr Foster is telling you now ties in with "Did not sufficiently note details of Patient A's symptoms and history on the record card".

Mr Foster: I am grateful to my friend. I would be grateful if I could address you very briefly on that matter before you come to a judgment on it, sir. I would only say that the Council is extremely keen not to prejudice Mr Jones in any way. The reason I mention it and the reason, I would submit to you, you are entitled to consider it is of course one of the problems with the record card was that it had written on it "No signs of retinal detachments!" This was something that was explained to you by Mr Jones as being caused by a difficulty he had in his own mind about the difference between 'signs' and 'symptoms', so it very much does come under the one thing you have found proven in this case – that his record keeping is not up to scratch, and one part of that record was the failure to know the difference between 'signs' and 'symptoms'.

Because you know that, and because as a Committee you are of course here to protect the public, anything that comes into your ambit through one of these charges that you may feel puts the public at any danger, and certainly an inability to tell the difference between 'signs' and 'symptoms' you may feel may do that, I would suggest you are entitled to consider – but you may wish to tell me about that before I continue with my submissions.

Mrs Kapila: Chairman, I would like to state the following: that if I am correct, and perhaps I ought to be very clear on this, the only finding that you have made in respect of Mr Jones is that he "Did not sufficiently note details of Patient A's symptoms and history on the record card". That is the finding. That is the allegation. There is no allegation here about this failure to understand the difference between 'signs' and 'symptoms', and I think that now it has been stated as his evidence we make it absolutely clear – and there is a transcript that we can turn to – that Mr Jones did not confess to a general inability to tell the difference between a sign and a symptom, he merely told you that he had put on this record card the word 'sign' when he actually meant 'symptom'.

But in my submission all of that is irrelevant to what you are hearing today. This is about a specific allegation that you have found proven, and it is not in my submission fair to Mr Jones that anything at all be thrown in as a sort of general damnation of him in the name of public protection. It has to be specific. You have made a specific finding, and the submission has to be specifically addressed to that finding so that you can properly decide the issue of his fitness to practise.

Mr North: My feeling would be that a record card is closely associated with the identification of both signs and symptoms, so therefore I feel that some mention of signs and symptoms is appropriate at this point, and that is my ruling.

Mr Foster: I am grateful for that, sir.

Mrs Kapila: Sorry sir, do you intend taking legal advice on that?

Mr Swinstead: Sir, I am afraid that the advice I would have to give you is this: that the allegation is set out and the Council alleges that the fitness to practise of Anthony Vaughan Jones is impaired in that, which you have found with regard to particular (vi), that he "Did not sufficiently note details of Patient A's symptoms and history on the record card". That with respect is the allegation that he faces, and the issue for your judgment will be whether or not by reason of that he is impaired.

I, with respect, think that Mr Foster is seeking to expand that allegation to incorporate this distinction between 'signs' and 'symptoms', and I am not sure that the allegation in particular (vi) as it stands would allow for that interpretation; and so, sir, unless the words "Did not sufficiently note details of Patient A's symptoms and history on the record card" could be incorporated into the distinction between 'signs' and 'symptoms', then I would have to advise you, sir, that what Mr Foster is submitting are not matters that you should take into account.

With respect you are tied, effectively, to what the allegation is and you must deal with it on that basis, because that is how it was cited.

Mr North: Do my colleagues have any views? [*Confers*] Yes, okay; I am afraid, Mr Foster you will have to confine your comments to that particular.

Mr Foster: Indeed sir, I have nothing further to say on that. In fact the last thing I have to say at all to you is that of course you are also entitled to note that you found particular (vi) proven. Particular (vi) was not admitted, and so I imagine that both my learned friend and the Legal Adviser would advise you that insight at this stage would be relevant to your considerations. This is not one of the things that Mr Jones said 'Yes, I have a problem with this, I put my hands up to it, and therefore I would encourage you to see that this is no longer a problem for me'. This is one of the facts that Mr Jones said 'I have no problem with this, and indeed I have done nothing wrong'. You have found that was not the case, and you may decide that lack of insight into that problem remains an impairment of his fitness to practise – but that is a matter for you, sir.

I have no further comments to make.

Mr North: Thank you Mr Foster, that was helpful. Mrs Kapila?

Mrs Kapila: Chairman, I will start with the last comment first whilst that argument is still fresh in your mind. It is true that Mr Jones did not admit allegation (vi) that you have found proven, but you must remember that he did not admit that there was not sufficient detail of Patient A's symptoms and history on the record card in the context also of being guilty of deficient professional performance, and also in the context of the various allegations against him. Further, I would also ask you to bear in mind that there was expert evidence backing that position on behalf of Mr Jones.

However I will not labour that point because that is a point I think which is in effect addressed by the fact that in his evidence Mr Jones did provide you with insight into his understanding that now that record would be insufficient. He told you very clearly in evidence that he would write a record very differently now, and would put down the

necessary negatives – and we can turn to the transcript should you wish to see that part of his evidence.

That in my submission is not a person who does not show insight into his failing, it is a person who says 'Yes, now I do indeed do things differently', and if you recall Mr Foster's submission on the deficient professional performance issue, at that stage that fact, that Mr Jones was saying that he would now do things differently, was being used as a negative, and I reiterate now what I said then, it is a positive. It shows you a person who has learned that this is not sufficient and therefore should be done differently regardless of what you found in respect of this particular instance. He has changed his practice, he has told you so. That in fact is a clear sign of insight, so I ask you please to bear that in mind when you use your judgment to consider whether or not Mr Jones' fitness to practise is impaired.

Fitness to practise, and I remind you that you have found the one allegation proven, is a current issue, the point being is Mr Jones in a position where his current fitness to practise is impaired – and those are the words, "is impaired". In this context I would ask you to look at the fact that he appears accredited optometrist, he has been practising without blemish and complaint for 30 years, and I would now like to take you to the references that are in your bundle and which are put before you to assist you in using your judgment in deciding whether in the context of this one allegation that you have found proven, in the context of the insight –

Mr Foster: Sir, I hasten and I am very reluctant to intervene at any point in my friend's submissions, I simply ask you to consider and I am aware that the AOP's position is that the references should go in as early as possible in any case, whether or not these references are actually appropriate, before you come to the point of deciding on whether there ought to be a sanction. The usual point when references become appropriate is having decided whether or not there is a fitness to practise issue, you have to decide whether there is a sanction that goes with it.

Whether you feel that the references can aid you in any way in determining whether this single particular that you have found proven amounts to an impairment of fitness to practise is of course a question for you, but it would be my submission on behalf of the Council that following *Campbell* it would be unlikely that at this stage in the process they will assist your consideration at all. Had you found all of them proven there might have been an argument that a number of people saying his practice is very good in all other areas apart from this may have impacted, but you are of course considering one single issue here: whether his record keeping amounts to an impairment of his fitness to practise. I would submit to you that the bundle of references that my friend wishes to put before you at this point is unlikely to help you at all with that consideration, and therefore it would be irrelevant at this stage.

Mrs Kapila: Chairman, there are two points I would make here. Firstly, you are in my submission entitled to look at his general practice. You are looking here at one instance of record keeping. The Council has not presented to you a number of instances of record keeping, and we know that if you see this instance of less-than-satisfactory record keeping on its own, not every error in a medical man is, using the old term, serious professional misconduct. That is established on the case of *R* on the application of *McNicholas*, which my friend is well aware of.

I think we have to look at this one failure – this one failure that you are being presented with – in the context of the rest of his practice. Now, it is being suggested to you that following *Campbell* we cannot take into account these references at any stage other than the mitigation stage when it comes to sanction, but *Campbell* was a

case about serious professional misconduct. That in my submission is a rather different matter from the issue of fitness to practise, and in fact much more akin is serious professional misconduct to deficient professional performance than it is to the issue of fitness to practise.

I quote here from the *Shipman* report:

> "This problem of taking irrelevant mitigation into account should not arise under the new procedures, where the question for the FTP [Fitness to Practise Panel] would not be whether the conduct found proved was serious enough to amount to serious professional misconduct, but whether in all the circumstances the doctor's fitness to practise is impaired, and if it is, whether the impairment is sufficient to justify action and registration.
>
> Thus the Panel must take a view in the round of the doctor's fitness to practise and all mitigation is relevant."

So this is a slightly different matter that you are now being asked to look at, - and do not forget in that context that serious professional misconduct is a matter in the past, present, whatever, but fitness to practise being impaired is a current matter. Is his fitness to practise impaired currently, and how can you reach a decision on that without knowing what his practice is generally like? How can you possibly reach a decision on his fitness to practise on the basis of one examination? It would be impossible for you in my submission to do so.

Therefore I submit, and this is not just a matter of the AOP wanting to put these references in as soon as possible, where we decided to sift out those that were only relevant to credibility we did, but at this stage these are crucial. If you are to use your judgment on whether or not Mr Jones' fitness to practise is impaired then you must see these references, and there is a distinction between *Campbell* on a serious professional misconduct issue and the issue of fitness to practise.

Mr Foster: Sir, reluctant as I am to come to my feet again before you, you have been quoted certain cases that my friend wishes to rely on. *R-v-McNicholas* of course was also a GMC case. It was also considering the issue of serious professional misconduct. What I understand from my friend's representations is that coming to a judgment about fitness to practise she would encourage you to look widely at Mr Jones' practice. I wonder how this sits with her previous submission that you ought not to consider that Mr Jones has told you he doesn't know the difference between a sign and a symptom. I would submit to you that if you are being asked to put some of the practice that you are aware of out of your mind when coming to the judgment on fitness to practise, putting a lot of other generalised evidence about fitness to practise at the forefront of your mind might not actually end up with an entirely balanced and fair proceeding – but certainly you will take advice from your learned Legal Adviser on this before –

Mrs Kapila: Before you do that Chairman, it is very important – and this is crucial, because once more you are being taken rather through the back door to the evidence about signs and symptoms which are not related to the allegation that you have found proven. They are not related. You have been advised, you have been given legal advice on that, but they are being introduced again. They are being introduced again on the basis that somehow Mr Jones has admitted to you that he doesn't know the difference between a sign and a symptom. He has not admitted that. It will not be found in the transcript. What he said was that instead of putting down 'symptom' he had noted down 'sign', and I do not wish to keep labouring this point because I

believe the decision has been made on it, and any attempt now being made by the Council to re-introduce what has in effect been ruled on can only be an attempt to add more prejudicial matter to the case against Mr Jones.

Mr North: I think we can turn to the Legal Adviser on this point.

Mr Swinstead: Mrs Kapila, I hear what you say but the issue for the Panel is surely this: based upon what they have found the question is whether Mr Jones' fitness to practise is impaired. It is based upon their finding that his note keeping on this occasion was effectively deficient, and they have found that to be deficient professional performance. Now, that is what they have to rely on. It is phrased in the present, is impaired, but it is by reason of their findings of this incident on 6 January 2005. That is the first point.

The second point is this: that as far as testimonials are concerned at this stage, what the Committee are having to ask themselves is 'Is there impairment?', and in answering that question with respect they are unlikely to be assisted by testimonials which simply say 'I think as a patient that Mr Jones is a good optometrist'.

Where a Committee may be assisted is in the expression of the views of other professionals, because they clearly have a view as to standards and what is expected, and my advice to the Committee would be that if there are testimonials which come from fellow professionals who are able to judge Mr Jones' fitness to practise, and I use that in the broadest term, by who are able to say 'In my opinion as a fellow professional he is a good practitioner', then the Committee would be entitled to take account of those, because clearly those professionals are judging Mr Jones by a standard. However I would advise the Committee that they would not be assisted by testimonials of patients, because patients are merely approaching it in a subjective way without, if you like, the application of any sort of objective standard. That would be my advice to the Committee, that testimonials that are from fellow professionals the Committee can look at and gain from them such assistance as they feel they can; but I would advise that they are not going to be assisted by testimonials simply from patients who are clearly expressing subjective views – which may be relevant in reaching the sanction stage, but I would advise that otherwise they are not relevant.

So, sir, that is my advice. Would either party wish me to say anything else or would you wish to correct anything?

Mr Foster: I would be grateful to clarify one concern, which is simply this: would you agree that it is the testimonial of a professional who has in some way been exposed to Mr Jones' practice themselves that might be relevant, rather than a professional saying 'I have heard his practice is good'?

Mr Swinstead: Yes, I think they need to be looked at. I am sorry sir, this is a technical thing, but they need to be looked at and judged. I can't say, I have not looked at them closely, but if it is simply a fellow professional who works in another town and knows Mr Jones and everything he has heard about him is that he is good, I don't think that is helpful. However somebody who may have had a patient referred on or who has had the opportunity of observing Mr Jones or in some way working with him, either because they shared patients or whatever it is, and could therefore give as it were an objective view that would assist the Committee, then certainly those should go before the Committee.

Mrs Kapila: Would you like me then to sift through these references?

Mr Swinstead: I am sorry to ask you to do it again, but this is important.

Mrs Kapila: I am happy to do so. I can certainly do so if I could be allowed five minutes or so?

Mr North: Yes, let's rise for 10 minutes, and then I and I think my colleagues would wish to see the references that fall within the criteria that the Legal Adviser has advised us are relevant to this stage of the proceedings.

Mr Foster: Sir, before we adjourn, is it your intention that these ought to be agreed with the Council or the Legal Adviser?

Mr Swinstead: It would be helpful if the parties are able to agree –

Mrs Kapila: Yes, I would certainly attempt to do that.

Mr Swinstead: - and if it requires my arbitration then I would be happy to do so. What I would suggest is that you try and agree between yourselves, and if you wish me to arbitrate on any of them before they go before the Committee then I shall do so.

Mr North: That sounds a very sensible course of action, and my colleagues agree? [*Yes*] So that is settled, thank you.

[*Hearing adjourned at 12.06 p.m.*]
[*Hearing reconvened at 12.26 p.m.*]

Mr North: Thank you, I hope that short adjournment helped you to sort through the references?

Mrs Kapila: Yes, it has.

Mr North: It may be worth bearing in mind for the future that a similar division of this material would assist the Committee, if it were in future carried out before the proceedings began. I just want to make that point.

Mrs Kapila: Mr Chairman, now that we know how the procedure has developed we would be mindful of that.

Mr North: Thank you.

Mrs Kapila: Chairman, we have managed to use the time allowed us profitably and have in fact reached total agreement on the references that we can put before you. I therefore will introduce them at this stage before I say any more.

The first one is on page 13 of your bundle. This is a reference from a consultant ophthalmologist, a Mr J. Deutsch:

> "This is a reference with regard to Mr Anthony V. Jones …
>
> I am a Consultant Ophthalmologist, Victoria Eye Unit, Hereford County Hospital, Clinical Director and Ambulatory Care Group Director. I have practiced here in Hereford for the last 13 years. In that time I have come into contact with Mr Jones on a professional basis on many occasions, having

referred patients to me and myself having referred patients back to him with regard to the business of ophthalmology.

I have always found Mr Jones extremely conscientious and helpful, his referrals being thorough and reliable."

And of course referrals are based on detail and what is on record cards and so forth.

"I have also found him very helpful in terms of reviewing patients that I have had difficulty with, particularly post-surgical, and in the course of investigating the refractive nature of particular problems.

We have also in the course of our respective practices met at local optical meetings at which I have given presentations. These times we have had useful clinical discussions.

As part of our day case cataract service in Powys, I refer patients back for optometric review and I regularly get very helpful post-operative review comments and results from Mr Jones for purposes of auditing my practice and monitoring the outcomes of cataract surgery.

I find Mr Jones' practice and ability in terms of what I experience in relation to my practice, of a very high professional level."

I then turn to page 14. Mr O'Connor Davies is an optometrist. He qualified in 1972 and has owned his own practice since 1978:

"I have known Anthony Jones as a colleague for over 20 years and have in the past employed him as a locum optician. During that time there was no reason to doubt his professional ability or integrity. Though not employing him in recent years I have met Anthony at many seminars and revision courses. His enthusiasm for his work remains undiminished."

Then on page 16, this is from a general practitioner and gynaecologist. This is Dr Johnson, who I believe is the GP head of this practice:

"I am writing regarding the professional standing and competence of Mr Anthony Jones, who has worked as an optometrist in Brecon since 1978. I have been a general practitioner in Brecon since 1979, in a partnership of 7 which has grown to 9 and I am also a practising gynaecologist.

Mr Jones is a very competent optometrist, and the whole Practice hold him in the highest respect and regard. He is a very safe pair of hands and has helped develop what is a seamless service between general practitioners, optometrists and consultant ophthalmologists in Hereford and Abergavenny. He is a skilful diagnostician and often sends us patients, commenting not just that they have cataracts, floaters or glaucoma but also more subtle retinal abnormalities, etc."

Again this is a point that does go back to record keeping.

"Equally well, we have used him as a good second opinion locally and he has been very willing to check intraocular pressures for us and for other ocular pathologies. This has been very valuable.

We know him to be a good communicator with patients and very empathetic, and he is held in high regard in the Brecon community in general.

We know him to be very competent, very professional, and very stead and easy to deal with."

I then turn to page 19, Mr Ted Arbuthnot who is an optometrist. He has been an optometrist for 40 years, has practised exclusively in the South Wales community, and:

"I have been involved in many of the developments and advancements in our profession in that time. I have been particularly closely involved in the development of the Primary Eyecare Acute Referral Scheme, (PEARS) wherein optometrists deal with patients presenting with **acute** eye problems, such as Red Eye, Flashes and Floaters or Sudden Loss of Vision. Any optometrist in Wales who is accredited on this scheme had to have extra training on these acute problems, involving detailed practical and theory examinations. It was while I was supervising in that accreditation training and examination process that I last met Anthony when he presented for accreditation.

I had first met him in the 1970s when he was training at one of the best practices in Cardiff where I knew his supervisor. I have come into contact with him since and in our relatively small community have spoken about, and been spoken to, about Anthony and can honestly say that I have never heard or had cause to say anything other than good about him, either personally or about his professional skills.

Certainly when seeing him through his PEARS accreditation process I found him to be well versed in the skills required to safely deal with the type of acute eye problem mentioned above."

Then page 22, this is from Dr Woodhouse who is a Senior Lecturer at Cardiff University:

"I have been asked by Mr Jones to provide you with a reference with regard to 'a current pending matter'. Let me begin by giving my assurance that I have no knowledge of, or involvement with, the 'matter' and am therefore providing an independent reference as to Tony's character and work performance.

Tony was a final year student when I first took up my lecturing post at Cardiff University … in 1974. In those days, we had fewer than 30 students in each year and the members of staff, including myself, therefore got to know each student reasonably well. As optometric colleagues, Tony and I have met occasionally at meetings and courses, since his graduation and qualification. In addition, I have spoken to Tony by telephone on a number of occasions in regard of patients that I was asking Tony to see in his practice, or patients that Tony was referring to my clinic."

So again he has had referrals.

"We have spent time together rather more frequently over the last three years, since the inauguration of the Welsh Low Vision Scheme, of which we are both accredited practitioners, as we have attended the same training days

> and networking sessions. I have known Tony, and had contact with him professionally therefore, for 32 years.
>
> Tony is a conscientious and rather serious person, measured in his speech and actions. He expresses a very caring attitude towards his patients, and on the occasions that we have had shared experience of the same patient, his examination techniques and actions have been entirely appropriate. His dealings with myself have been conducted in an entirely professional manner, and his patients have spoken highly of him. At courses, Tony takes professional development seriously and participates fully in all aspects of the learning experience."

He then talks about his professional integrity. Turning then to page 24, this is from another Consultant Ophthalmic Surgeon, Mr Adrian While:

> "I am very happy to give a reference for Anthony Jones. I work as a consultant ophthalmologist in Hereford and in Brecon and I have held my present post since 1984. I have had an excellent working relationship with Anthony Jones for all of those years and he has referred very many patients to me over that time. I have never had any reason to regard him as anything other than perfectly competent, indeed excellent, optometrist. No patient has ever complained to me about his professional competence or his professional manner."

There you have the directly pertinent professional references, which I believe are very important for you to have in mind when you consider Mr Jones' fitness to practise.

Just to recap, and I will not be very much longer now, you have found that Mr Jones did not sufficiently note details of Patient A's symptoms and history on the record card, and you have found that for that reason in this instance he was guilty of deficient professional performance. What you are now being asked to look at is whether or not his fitness to practise, which is a current issue, is impaired.

I remind the Committee again that this is one instance in a career of 30 years, and one record card, and one allegation which you have found proven. Against that I take you to his unblemished record, I take you to the references that I have just read out which clearly involve people getting details of examinations, because we are talking about referrals, so we have absolutely a picture of Mr Jones as someone who is in fact someone who provides details. If in this particular instance he did not, by no means can it be said that he does anything other than provide details on other occasions. As I say, this is one instance, one record card.

Fitness to practise is something that has to be decided on a current basis. In my submission there is no public protection issue here. You have seen the level of competence of Mr Jones and the type of referrals and details he provides to consultant ophthalmologists, who are people who should know, and you have also seen in him a willingness to change so that he puts even more detail on his record cards and he has said that he already does so, so here you have a practitioner who has already told you that he is doing what the experts would like him to do.

This is someone who has shown insight into his record keeping, and in whom we can in fact find evidence of good, detailed referrals in the references that I have just read out to you. In that instance there is in my submission no public protection issue. It is clear that Mr Jones generally upholds very high standards and in my submission,

although on this one occasion he has been found to be guilty of deficient professional performance, it is not a matter that affects his general fitness to practise, and he is indeed an exemplary practitioner. Therefore the allegation against him that his fitness to practise is impaired should be dismissed.

Mr North: Thank you Mrs Kapila; Mr Foster, anything in reply?

Mr Foster: Only one very brief thing, sir, which is that you have had some evidence presented to you during the course of submissions and of course it is agreed evidence. However you have also been invited to find that doctors and other professionals who have had matters referred to them can in some way put your minds at rest about record cards. I would only ask you to bear in mind of course that a letter of referral and a record card are very different documents. You have not found him guilty of a failure to refer and you cannot of course from letters of referral infer properly that they were based upon a properly-created record card. They could just as easily have been based on Mr Jones' own recollection of events, which is something that during the course of his evidence he tells you is his general practice. That is the only point that I would make in relation to that.

Mrs Kapila: And the only point I would make, and I don't know how long this will go on as I thought this was a final submission on the matter, but as the point is now being raised by the prosecution effectively I will say that it is common knowledge in my submission, and obviously you have a Panel to guide you, that record cards would be of use in terms of referrals. If referrals are detailed that detail has to come from somewhere and you have only in front of you one instance of inadequate record keeping, just this one instance.

Mr North: If any of my colleagues have questions? [*No questions*] Legal Adviser, are there any points that you would like to make at this point?

Mr Swinstead: Sir, I would just remind you that your task at this stage is to consider whether the allegation that Mr Jones' fitness to practise is impaired is made out by reason of your finding that he is guilty of deficient professional performance. This decision involves an exercise of your judgment. It is a matter for you based upon what you have found and the matters that you have heard made in the submissions you heard just now, to decide whether in your judgment Mr Jones' fitness to practise is impaired. Sir that is my advice. Would either party wish me to say anything else, or to correct anything?

Mr Foster: No, thank you sir.

Mrs Kapila: No.

Mr Swinstead: Thank you; sir, that is my advice.

Mr North: I propose now that the Committee will deliberate *in camera* on this issue. I am mindful of the time; could the parties be available again from 1.30? Thank you.

[*Hearing adjourned at 12.40 p.m.*]
[*Hearing reconvened at 2.36 p.m.*]

Mr North: Mr Jones, would you please stand? The Committee will now announce its findings in relation to impairment of fitness to practise.

The Committee found that the fitness to practise of Mr Jones as an optometrist is not impaired, and announced its decision as follows:

"We took account of the submissions put before us on behalf of the Council and on behalf of Mr Jones, and accepted the advice given by the Legal Adviser. We also took account of the professional references provided by the registrant. We reminded ourselves that in reaching a decision on impairment we should exercise our own judgment.

In considering the matter we took account of the need to protect the public and maintain public confidence in the profession, the reputation of the profession and the individual interest of the registrant. We noted that the matter found proven leading to the finding of deficient professional performance was a single instance of a falling short of the standards required of a reasonably competent optometrist and the relevant professional guidance. We also noted that Mr Jones in his evidence demonstrated insight into this deficiency in that he admitted that the standard of record keeping in the case of Patient A was poor, and that he has now taken the appropriate remedial action in his practice. In balancing these matters and in the proper exercise of our judgment, we concluded that, in this case, impairment was not found but that there may well be cases where poor record keeping could lead to a finding of deficient professional performance and consequently impairment.

We would wish to make clear that whilst we considered the professional references put before us, we found this evidence to be of limited assistance because whilst it addressed the issue of Mr Jones' practice in general terms, none of the evidence dealt directly with the issue of record keeping.

Mr Jones, notwithstanding this decision, under Rule 13F(5), it is within our power to issue a warning. You should be in no doubt that the Council considers maintenance of full, comprehensive and contemporaneous records to be a most serious matter, and you must ensure that your record keeping is at an appropriate level and standard throughout your future practice."

That ends the determination. Thank you.

May I thank the Legal Adviser and the representatives for their help and assistance to the Committee and Mr Henley for his assistance as administrative support to the Committee.

One point I would like to make which in discussion in Committee we felt was appropriate, and this is the issue of references and testimonial evidence. It would be most helpful for Committees to have relevant evidence introduced at the relevant point in the process, i.e. evidence which bears directly on the issues and matters for decision at that point of the proceedings.

Thank you, that is all, good afternoon ladies and gentlemen.

[*Hearing concluded at 2.40 p.m.*]