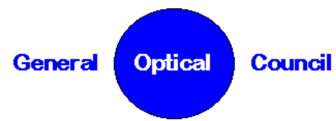

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**BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL**

GENERAL OPTICAL COUNCIL

AND

MALCOLM COATES (01-22307)

APPLICATION FOR INTERIM ORDER: 10 August 2007

APPLICATION FOR INTERIM ORDER:
MALCOLM COATES (01-22307)

Friday, 10 August 2007

Fitness to Practise Committee:	Mrs F Jones (Lay Member) (Chair) Mrs G Huka (Lay Member) Mr S Reily (Optometrist)
Legal Adviser:	Mr A Coleman
Hearings Manager:	Mr D Henley BEM
For the GOC:	Mr C Alder
For the Registrant:	Mr S Chawatama

[*Proceedings commenced at 10.33 am*]

Ms Jones: Good morning. I am Fran Jones and I have been elected to chair today's hearing of the Council's interim order application.

The Committee today is made up of one optometrist and two lay members. I will ask the members to introduce themselves and the capacity in which they sit. [*Introductions made*] To my right is Mr Coleman, 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 Rules of 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 the Committee's deliberations upon 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, Mr Nisbet, 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 support 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.

Mr Alder, can I invite you to present the Council's application.

Mr Alder: Madam, I am grateful to you for that. I understand, however, that an application would more appropriately be the first port of call for this morning's hearing and an application is to be made on behalf of the Association of Optometrists.

Mr Chawatama: Madam, my application is for the exclusion of the joint report of Mr Breakspear and Mr Gohil, because it does not comply with Rule 11 of the Fitness to Practice Rules. May I start by taking you to the Fitness to Practice Rules? [*Yes*]

Mr Alder: If it would assist you, I am conscious that I have a book similar to yours, the *Opticians' Handbook,* and the rules are from page 91. I am conscious that my learned friend is working from this and not the book, if I can put it that way.

Mr Chawatama: I am grateful.

Ms Jones: It is page 93.

Mr Chawatama: These are the rules, as you already all know, made under the Act of 1989. It is Rule 9, Assessment Notification, where the Committee, or the Fitness to Practise Committee, have appointed an assessor under Rule 7 or 8 and it is fully accepted that that is a power that the Investigation Committee has. "The Registrar shall" - and it is again accepted that the Registrant was served a proper notice, a date of the meeting with the Assessor was properly served, and the date was fixed under Rule 10 accordingly.

I then come to Rule 11 and the assessment itself took place at the practice of the Registrant on Wednesday, 9 May 2007. Following that, a report was produced by the two assessors, Mr Hugh Breakspear and Mr K Gohil. The report itself is not dated but the covering letter is dated 25 May 2007.

Going back to the rules, at page 93, and the assessment report, each assessor appointed under Rule 7 or 8 – and, again, it is accepted that the assessors were properly appointed under those rules –

> "shall, once he has completed his assessment, send a report of the assessment to (a) the Registrar and (b) the Registrant."

It is the interpretation of that rule that I would invite the Committee to consider. This is a rule which we say, on its plain reading, permits only one report from each assessor: each assessor completes *his* assessment and he sends a report of the assessment. We submit that that excludes a joint report by both assessors. The creature known as a 'joint report' has become fairly common in the civil practice area and, if the drafters of the rule intended for a joint report,

they would have said so. In our submission, this rule cannot be read so as to encompass a joint report.

It might be said that, provided the joint report is signed by each assessor, that satisfies Rule 11. The covering letter is signed by both assessors but we say that that does not cure the failure to comply with the rule. It is a straightforward rule written, if I may say so, in plain English. It may be felt that this is a minor point but the importance is that the Registrant is being assessed. He or she is being investigated and he or she could face penalties ranging ultimately from a fine, to a warning, conditional registration, suspension and erasure. We say that it is important that the rules are applied fairly and consistently and are applied strictly so as to ensure that fairness and consistency to all registrants.

It may be that two assessors come to broadly identical views, having witnessed the same examinations, testings and so on, and that is perfectly possible. It is also possible that two assessors, having objectively observed the very same assessment, examinations and so on, come to either slightly different views, or very different views. Those are matters that ought to be put before this Committee, in a form which is the fairest to the Registrant. If there is a divergence of views, where there is more than one assessor, once again it is accepted that more than one assessor can be sent and we have no quarrel with that. It is the form of the expression of those assessors' conclusions, and the form of the report that is being objected to. For those reasons, it is not possible – if you were with me, and this report is defective – it is impossible to cure it, because there are no two reports before you.

Ms Jones: Before I seek our Legal Adviser's input, Mr Alder, can I ask if you have anything to say.

Mr Coleman: Chairman, before I hear from Mr Alder, may I just ask one or two questions of Mr Chawatama? Then Mr Alder can make his submissions

Are you submitting, Mr Chawatama, that if one of the assessors disagreed, or had even a minor disagreement with his co-assessor, that he would not have referred to that in the report?

Mr Chawatama: I simply do not know. The report is fairly brief and, as I understand it, each assessor, during the assessment, made manuscript contemporaneous notes of what they observed and their views. Those written notes are not attached to these reports.

Mr Coleman: The thrust of your submission seems to be that it may well be the case that one of the assessors was not fully in agreement with the document that he has signed as being his report. Is that correct?

Mr Chawatama: In a sense, that is perhaps giving the reason or the purpose of single reports. The thrust of what I am saying is that we may discover that there are differences, and that those differences are not adequately expressed in the joint report. The thrust of my submission is that the rule itself intends for there to be a single report from each assessor.

Mr Coleman: Yes, and so my next question is this. If one spoke to Mr Gohil and asked him the question, 'Have you prepared and completed an assessment?', to which he replies yes, and then the next question is, 'Have you completed and sent a report of your assessment to the Registrar and Registrant?', how do you think he would answer that question?

Mr Chawatama: He might say yes, or he might say, 'I have sent a report of my and Mr Breakspear's assessments.' The report is to be read as each of the assessors agreeing entirely with everything that is said there.

Mr Coleman: Yes.

Mr Chawatama: So it is a joint report.

Mr Coleman: Yes. Thank you, Madam.

Ms Jones: Mr Alder?

Mr Alder: I suppose I can follow on very briefly from those questions that have been put to my learned friend. The report was sent, signed by both assessors to the Registrar and that can – although this is not my strongest point, Madam – in one interpretation, if we are asked to take literal meanings, one can interpret that as amounting to an independent report sent by both assessors to the Registrar.

Madam, my learned friend puts his application on a number of grounds, one of which is that of risk to the Registrant. In this particular case, there is no information or evidence whatsoever to allow you to be able to conclude that there is any prejudice to the Registrant, and no risk to him of there being adverse or disagreement in the findings between both of the assessors in this case.

As you will have been directed to in Part III of the Rules, the Investigation Committee at Rule 7.1 is entirely able to appoint one or more assessors. It could therefore follow that the Council could be presenting just one report but it has not done that – it has presented the reports of two assessors to ensure that there is a consistency in the view of two assessors, in effect to have two witnesses to the assessment which has been undertaken by them. To my mind, that is a protection in place for the Registrant. It very much goes firstly to his benefit but it is also not a reason, and one could say an overly technical literal argument, as to the application of the rules, which I suggest is being attempted in this case.

The assessors are instructed by the Council following consideration by the Investigation Committee of an initial allegation. There have been reports completed in this manner in the past and presented to registrants who have appointed the Association of Optometrists. It is not a very big point to make, Madam, but no objection has ever been taken by the Association of Optometrists in the past that this is an inappropriate way to proceed, or that it

puts their clients, their members, at any form of risk. The issue for you to consider in due course, and for potentially a Fitness to Practise Committee sitting in full hearing, would be to consider the conclusions that have been drawn by the assessors. Those conclusions are very clearly set out and further steps can be taken in due course to get more detail from the assessors, to ensure that that is available to allow for a complete interpretation. The risks which are set out, the concerns of the assessors in this report are such that the Investigation Committee has felt it necessary to bring the concerns to your attention and seek an interim order.

That is the purpose of today's hearing. I would suggest that you should not, to an extent, be directed to another course when in fact the information available to you is not relevant to the extent that Rule 11 applies or otherwise. The issue for you to consider is your duty to uphold the standards of the profession, to seek to safeguard patient safety. That is the purpose of this report and that is your duty and obligation today. That, itself, enables you to consider this report.

Could I ask you to turn to Part IV of the Rules, and Rule 13? I would ask you to refer to this briefly for reasons of consistency of your approach and interpretation of Rule 11. Rule 13 states:

> "The Investigation Committee shall, taking into account any report of an assessment carried out under Part III"

so that is the performance assessment, Madam,

> "- shall decide whether or not an allegation ought to be referred to the Fitness to Practice Committee."

That is the process with which we are involved today, Madam, and that is the power to the Investigation Committee, to ask you to consider this application on behalf of the Council. They are entitled to take into account any report of an assessment. This, Madam, quite clearly – and it is commonsense if nothing more – constitutes 'any report' available to them, whether that is the report of one assessor on their own, or two assessors independently, or one report which is drafted jointly. With any report which raises concerns of a clinical nature, I suggest that the Investigation Committee are duty bound to ask you to consider and to use this evidence as part of your duty in considering issues of public safety.

Mr Coleman: Mr Alder, may I just draw your attention to the fact that Rule 13 refers to an assessment carried out under Part III, so that one must surely infer from that that it is an assessment carried out in conformity with the requirements of Part III. We come back to the issue of the interpretation of Rule 11.

Mr Alder: Sir, I wholeheartedly agree, the point of course being that it is the duty for the Investigation Committee, whether information or evidence of this nature comes to its attention. Rule 11 does not, I suggest, preclude this Committee from considering this evidence and this report. I will suggest that not only the application must be dismissed but also that you go on to consider this evidence

as part of a wider hearing into the Registrant's conduct and professional performance.

If you are not with me and the Council, in asking you to reject the application, I will make an application, Madam, that this evidence is relevant and fair for you to consider pursuant to Rule 38 of your rules. That Rule, Madam, is available for you at page 99 of the handbook. Although this is an interim orders hearing, the rules of admissibility of evidence are as per a substantive hearing and Rule 38 (1) states:

> "Subject to paragraph (2) and (3), the Fitness to Practise Committee may admit any evidence they consider fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law."

Rule 38(2) says that:

> "Where evidence would not be admissible in criminal proceedings, the Committee shall not admit such evidence unless, on the advice of the Legal Assessor, they are satisfied that their duty of making due inquiry into the case before them makes its admission desirable."

Madam, in this case, the information and evidence contained within this report, prepared, I suggest, by two assessors coming to similar and consistent conclusions, is evidence which is fair and relevant to the consideration you have to make, and are requested to make by the Council during today's hearing. There is no prejudice suffered by the Registrant in you considering this evidence and it would be evidence, Madam, which could be admissible in a court of law. So, even if you reject my submissions as to the application made by my learned friend, this is evidence which, I suggest, is appropriately available to be considered by you. Rule 11 or 13 does not preclude you from considering this as evidence and indeed I would suggest that your over-riding duty as a committee of inquiry to consider your duties to the public and ensure patient safety would demand that you consider this evidence at this stage.

Ms Jones: Thank you. Can I ask my panel colleagues whether they have any questions they wish to ask? [*No questions*]

Mr Chawatama: Madam, could I reply to just one point?

Ms Jones: Briefly.

Mr Chawatama: My friend made reference to reports having been put before the Committee in this form in the past, and the AOP not objecting. The AOP is not the party, however, but it is the Registrant who is the party and these submissions are being made on behalf of the Registrant.

Secondly, as well as these reports having been put before the Committee in this form, I am reliably informed that on at least one occasion, and perhaps more, two reports have been prepared by two assessors performing an

assessment. Ultimately, the issue remains one of statutory interpretation of Rule 11, which is a stand-alone rule and is not subject to a sweep-up clause, such as Rule 38 or to be read in conjunction with Rule 13 in interpreting its meaning.

Ms Jones: Can I invite the Legal Adviser to ask any final questions or advise us, and then we will clear the room.

Mr Coleman: Chairman, if I may ask one final question of Mr Chawatama, in the event that these two assessors had taken their report and had run off a photocopy and assessor A had signed the first copy and assessor B had signed the second, would you say that that would fall foul of Rule 11?

Mr Chawatama: It might, in this sense because, applying commonsense, it is highly unlikely that any two assessors will use, word for word, comma for comma, full stop for full stop, an identical approach.

Mr Coleman: Each will still have prepared a report and sent a report, in compliance with the rule.

Mr Chawatama: Legitimate questions could be asked whether each was actually the author of that report – there must have been some collusion.

Mr Coleman: What if there had been collusion and they have reached conclusions on which they happen to agree in every regard? What is so very inherently flawed with that?

Mr Chawatama: It may be that, if there is collusion, it would undermine the weight of those reports. In a very strict literal sense it might comply but it would be highly unlikely that such an outcome could ever be possible. Perhaps I may use the old analogy with which you may be familiar, Sir, of the police notebooks in the magistrates' courts where, word for word, dot for dot, comma for comma, it was alleged that some police officers had made independent observations and come to independent views, and yet their notes were identical. That whole system was undermined.

Mr Coleman: But, on the face of it, it was to be inferred that they agreed with their recollection and there was no disagreement between them – it was the same recollection. If it was flawed, it could be challenged by calling the police officers and cross-examining them.

Mr Chawatama: Yes. On the other hand, as I have said, there are occasions when assessors go away and prepare the opposite. It is not an onerous task in asking that the rules be applied as they are meant to be and the consequences - whether risk, prejudice or what if they simply photocopy it – the central issue is that if that is what is required under the rule, it is not asking the assessors to perform anything that is unduly onerous, or which would make their task difficult. It is simply saying, do the performance assessment and yes, do it together, but go away and write your reports. That is a simple and straightforward enough activity which would not compromise either the

effectiveness of this Committee, or the ability of the Council to present its case and the standards of the profession to be upheld.

Mr Coleman: Thank you. Mr Alder, do you have anything to add arising out of my question?

Mr Alder: No, Sir, not on the technical point. I would just suggest that it seems an unattractive approach, if I can put it that way, to suggest on the one hand that we should apply common sense in respect of the joinder of reports and, on the other, to suggest an overly literal technical legal argument. It would be of assistance to have a consistent approach in the application.

Mr Coleman: You have the final word, Mr Chawatama.

Mr Chawatama: But common sense in terms that it is questionable whether two independent assessors would arrive at identikit reports. That is what I meant.

Mr Coleman: Chairman, this is an application in relation to Rule 11 which reads as follows, in relation to the heading 'Assessment Report' (*singular*):

> "Each assessor appointed under Rule 7 or 8 shall, once he has completed his assessment, send a report of the assessment to (a) the Registrar and (b) the Registrant."

I remind you that it is my role to advise you. My advice is in no way binding on you and you have to reach your own decision on the matters raised by this application.

You always have, as a fall-back provision, the contents of Rule 38, to which you have been taken by Mr Alder, that the primary task you have to undertake is to examine the words of Rule 11 and reach a decision whether, in the circumstances, it can be said that each of the two assessors has sent a report of his assessment to the Registrar and to the Registrant. In my advice to you, had this report been photocopied and one copy signed by assessor A and the other signed by assessor B, then there would be no conflict between that state of affairs and the requirements of Rule 11. Each assessor will have completed his assessment and will have sent a report to the various parties. The rule does not require that there should be separate reports.

You may consider that you have to have regard as to the effect of two people signing the same document. What would have been their intention by so doing? My advice to you is that, by signing, albeit that they were not the only signatory, each assessor was confirming the truth of the opinions and conclusions reached in that document, and documented by that particular assessor. Therefore, there is no great vice, or any vice, in the fact that there will be recourse to a joint report as opposed to two separate reports which may reach identical or very similar conclusions. The rule does not outlaw or proscribe the provision of a joint report. Ultimately, you have to look at the words of Rule 11 and conclude whether the requirements of that rule have been complied with in this particular case.

Unless there is anything else that can be urged on me by counsel in the case that concludes my advice to you.

Ms Jones: Thank you. Mr Henley could I ask you to clear the room for 10 minutes? Thank you.

[*Hearing adjourned at 11.04 am*]

[*Hearing resumed at 11.34 am*]

Ms Jones: The Registrant has applied to exclude the report of the assessment on the grounds that Rule 11 of the Fitness to Practise Rules has not been complied with. The Committee has carefully considered this application and, in particular, it has examined the assessment report and the covering letter, signed by both assessors. The Committee is satisfied that each of the assessors has completed an assessment and has sent a report of the assessment to the parties as required by Rule 11. The Committee is further satisfied that, by signing to the joint report, each assessor was confirming that the content of that document fully reflected his own conclusions and opinions. Had this not been the case, the Committee has no doubt that the assessors would have said so, whether by way of a rider to the joint report, or by way of a separate report.

May I therefore invite the presenting officer, Mr Alder, to present the Council's application?

Mr Alder: Thank you, Madam. I understand that the Committee have available to them two bundles, one prepared and presented by the Council and one by the Association of Optometrists. Is that the case?

Ms Jones: That is the case.

Mr Alder: Can I take it that the Committee have all read those papers through? [*Yes*] Thank you, Madam.

The Council's application, referred through by the Investigation Committee, as you will very clearly be aware now, is to seek consideration by you as to whether to impose an interim order upon the registration of Mr Coates. That power to you derives from the Opticians' Act itself at Section 13D(9). If I could take you to page 26 of the Handbook, it sets out very clearly at Section 13D the power available. That particular section reads:

> "If the Investigation Committee are of the opinion that the Fitness to Practise Committee should consider making an order for interim suspension or interim conditional registration under Section 13 L below in relation to the Registrant who or which is subject to an allegation, they should give a direction to that effect and then serve notification "

and so on. That is the power under the Act.

Section 13 L of the Act which is at page 34 sets out the powers available to you and also the test for you to apply when considering this particular case. Section 13 L (1) states that where you:

> "-the Fitness to Practise Committee, are satisfied that it is necessary for the protection of members of the public, or is otherwise in the public interest or is in the interests of a Registrant for his registration to be suspended or to be made subject to conditions, or an entry relating to a specialty or proficiency to be removed temporarily or made subject to conditions, the Committee may make an order specified in subsection (2)."

Madam, that sets out very clearly first the test for you to apply. It is for you to consider whether such an interim order is necessary, either for the protection of members of the public, or is in the public interest. The Council do not put this case on the basis that it is in the interests of the Registrant for such an interim order.

The powers available to you are set out at Section 13 L (2). Those two orders available to you are that it is for the Registrant's registration to be suspended, or that an entry relating to a specialty – which does not apply in this case –

> "for such a period not exceeding 18 months as may be specified, that to be termed an interim suspension order, or such registration shall be during such period not exceeding 18 months, with such requirements so specified that you think to impose an order for interim conditional registration."

The Council's application in due course – but so that it is absolutely clear from the outset – is that you should consider the imposition of an interim suspension order in this case. That is put on the ground that there is not, certainly to my mind or instructions, a condition which could be appropriate to raise the standards of this Registrant sufficiently to ensure protection to the public, which would allow there to be a condition which would be applicable and allow the Registrant to practise. Therefore, any such condition would, in effect, have the affect of suspending. It seems fair to the Registrant for the Council to put its case very clearly on that basis.

Having considered the papers, you will have read the statement of facts which has been prepared which states to be in support of an interim order. Madam, as you will appreciate, this is not the totality of evidence which could be available at a final substantive hearing but it sets out the broad nature of the allegation and sets out the evidence available to you at this interim, this emergency stage at which the Investigation Committee requested you to consider the imposition of an interim order.

Initially, allegations were made by a patient to the Council. Those allegations were considered by the Investigation Committee and a statement was prepared

by the patient. The Investigation Committee, having considered that allegation, sought a performance assessment and that was undertaken, as you will now be very acutely aware, by Mr Gohil and Mr Breakspear. Their conclusions are clearly and consistently set out in the report to which you have already been referred today.

The Investigation Committee considered that report and was so concerned about the findings of those assessors as a result of this performance assessment that they felt it necessary, in the public interest, to refer it through to you, to consider whether an interim order should be imposed. Madam, you have two senior, expert optometrists assessing the practice of the Registrant. They witnessed Mr Coates examining three patients, to provide certainty as to the background of his practising ability and his performance. They raised their concerns very clearly and these are set out in the report.

That assessment itself, Madam, as I imagine you will be aware, was undertaken by the assessors in terms of comparison against criteria set out in GOC Core Competencies. Madam, could I ask you to turn with me to the report of Mr Breakspear and Mr Gohil, a copy of which is at page 13 onwards of your bundle. You will see very clearly the competencies as are set out by both assessors – for example, competency 1.2, competency 1.3. There is a statement in the report which sets out the particular core competency which the assessors have concerns about.

At the very back of the bundle, Madam, there is a list of all of the GOC stage 2 core competencies against which Mr Coates was assessed, and those are at page 17 onwards in your bundle. I suggest, and the Council's position is clear, that the core competencies identified by both assessors show there to be a lack of basic competence in a number of very key core competencies. By not undertaking sufficiently competent ocular examinations, patient care was not sufficiently competently provided by not providing safe and competent care against what are minimum standards. The core competencies referred to in this particular report reflect quite closely those requirements or guidelines set out by the College of Optometrist guidelines: they are not a high standard by any stretch of the imagination but they are the minimum standards for these particular competencies.

Also, Madam, there was a very real concern, broadly, from the assessors, that future patients were not be examined with sufficient care and competence, which may have led to ocular pathology being left undetected. As you will appreciate having read the report that was the basis of the nature of the allegation brought to the Council's attention by the patient in the first instance, which led to these performance assessments.

In identifying these concerns there are clear worries, if I may put it in that way, that patients are at risk and that the Registrant is not performing to the standard that one should expect of a reasonably competent optometrist, but also of a safe practitioner.

If I can touch very briefly on the report presented by both assessors, it refers to the date of the performance assessment being 9 May 2007, and this is at page 14 of the bundle. It refers to:

Competency 1.2 - the ability to elicit significant symptoms. There is reference made that:

> "Most of the questions were of a closed form and where the patient mentioned a problem there was little or no exploration of the symptoms or possible causes. The history and symptoms taken were very brief on all three patients.

Competency 1.3 - the ability to elicit relevant family history:

> The patients weren't asked about any family history of eye disease. However patient 2 did volunteer some information about his family.

Competency 1.5 - the ability to impart to patients and explanation of their physiological or pathological eye condition:

> Explanations of the outcome of the eye examination were confused. For example patient 2 was told he had a cataract in the left eye, however, when he queried this because he could see better out of the left eye than the right, no further explanation was given. The record card in fact indicated that the patient had a central cataract in the left eye and therefore a reduction of vision in this eye would be expected."

Madam, I apologise for reading these through but I am conscious that this is a public hearing. Whilst you and your colleagues have read the report, it is important for issues of transparency for the public and profession to understand the background to the competencies.

"Competency 2.2 – the ability to create and keep clear accurate contemporaneous records:

> The practitioner's records were barely legible as his handwriting is extremely difficult to interpret. The record cards were limited especially with regard to ophthalmoscopic findings and intraocular pressures and consistently items such as near acuity, time of measurement of intraocular pressures and recall times were omitted.

Competency 3.1 – the ability to refract a range of patients with common optometric problems by appropriate objective and subjective means:

> Unaided vision was not assessed with any of the patients observed. A limited number of letters were used to check visual acuities; none of the patients were asked to read a complete Snellen line."

That refers to the Snellen chart, Madam.

"Patients were corrected if they got the letters wrong. Subjective refraction was poor and inappropriate cross cylinder technique used. Consequently patients became easily confused.

Competency 5.7 – the ability to examine fundi using direct and indirect techniques:

Ophthalmoscopy was brief and no attempt to view the peripheral fundus was made by asking the patient to look in a different direction of gaze. The macular area was not assessed by asking the patient to look at the light. Mr Coates's technique was considered unsafe as pathology could easily be missed.

Competency 5.10 – the ability to use a contact tonometer to measure intraocular pressure and analyse and interpret the results:

When examining patient 2 and on subsequent questioning, the registrant did not exhibit a sound understanding of referral criteria for glaucoma, when to repeat intraocular pressure measurements or the significance of intraocular pressure variations with the diurnal cycle. The relevance of visual field loss was also misunderstood.

Competency 6.9 – the ability to manage a patient presenting with cataracts:

Patients 1 and 2 presented with cataracts. On questioning, the registrant was unable to identify the different types and was also unable to assess when referral for further investigation or surgery was appropriate."

Madam, I suggest that these are minimum basic standards of care which can and should be expected by patients. In not undertaking those basic standards, patients are, I suggest, at risk. The clear conclusion by both the assessors was:

"We are of the opinion that Mr Coates failed to achieve an acceptable standard of clinical practice with regard to the competencies listed above. In view of this, we are particularly concerned that future patients may well have pathology remain undetected."

Madam, those concerns are very clear and, I suggest, clearly put by both assessors.

Following service of the report, Mr Coates instructed a Mr Taylor, and a report is available for you, which sets out an assessment undertaken by Mr Lyndon Taylor in July 2007. I will touch on that report in due course because I have a number of concerns about the admissibility of a number of paragraphs in that report. There are a number of observations that I would make regarding that report and ask you to take into account when deliberating on whether you are satisfied that it is necessary for the protection of the public for an interim order to be imposed.

At the point at which Mr Taylor was instructed by Mr Coates, he had had available to him the report prepared by both of the assessors. He had therefore had time to digest its content, to consider whether further steps or practice should be undertaken by him, and ask any further questions via the General Optical Council as to clarification by either assessor.

Whilst having a copy of that report, Mr Taylor in fact still identifies a number of issues and a number of concerns about the conduct and professional performance of Mr Coates. He refers to Mr Coates being clinically isolated and he refers to that in the overview part of his report. He refers to his practice being still dated, and this is despite ongoing training and the CET requirements that he is complying with. Mr Taylor refers to Mr Coates not applying theoretical knowledge and, while that is of course clearly speculation, there is a concern if an optometrist is not applying the knowledge available to him and within his understanding to the patients presenting before him.

He agrees with both assessors that there was no assessment undertaken of visual acuity measurement and particularly the unaided visual acuity measurement. He refers, in paragraph 3.1, to not using standard cylinder practice. He refers, in the same paragraph, to developing 'his own ways', and having his own idiosyncrasies, as he refers to it.

Madam, I would suggest that that raises a number of concerns and I would ask you to consider that carefully that, despite the clear indicators laid down by the assessors instructed by the Council, he is unable still, some two and a half months later, to be able to apply the knowledge that had been drawn to his attention to an assessment being undertaken by an assessor appointed by himself. I suggest that that would raise concerns about the ability to develop one's practice to provide safe care.

Mr Taylor comments in his report about having a more friendly assessment and Mr Breakspear is available to provide evidence about the nature of the assessment – nothing more than the nature and atmosphere prevailing at the performance assessment. However, despite being witnessed and assessed by, in effect, his own assessor, knowing that he was possibly facing an interim order hearing, and possibly knowing that his practice would be questioned, and having the benefit of the knowledge of two assessors who had assessed his practice in May, there are still concerns about his practice.

I suggest that Mr Taylor's report is a gift in the art of understatement in the way that certain phrases are put but that, Madam, is clearly a matter for you in your consideration of the report. I suggest Madam that, despite this evidence and this report coming to light post-the listing of this particular hearing before you, the Investigation Committee's conclusions and concerns are valid and, if not valid, even more assured, given the concerns which still prevail as to safe practice being provided by Mr Coates.

That would ordinarily conclude my brief summary of the evidence available and brief opening. However, the report of Mr Taylor in a number of respects

goes beyond areas which he is able to provide opinion about – and it is opinion, Madam. He is able to provide, to an extent, witness evidence of what he saw and what he assessed Mr Coates performing. However, he goes on to comment in some detail upon the nature of the assessment undertaken by Mr Breakspear and Mr Gohil. I have suggested and raised my concerns with the Association of Optometrists, who have disagreed with me about the admissibility of much of that evidence.

For that reason, Madam, and given that I am conscious that, by the time of this morning's hearing, you have read this particular report, I would suggest that it is appropriate to ask Mr Breakspear to provide brief evidence for you as to the nature of the assessment and as to those issues which are, I suggest, inadmissible in Mr Taylor's report. This would allow you to be able to make full inquiry and full consideration just of those areas where there is dispute.

For the purposes of your learned Legal Adviser, Madam, there are a number of paragraphs in which I would say that clear hearsay evidence is given and clearly inadmissible speculation is provided by the documentary evidence of Mr Taylor and there are irrelevant paragraphs within it. I am conscious that the Committee have read the report and therefore it would be somewhat of a waste of time to ask for these matters to be redacted or pulled from their memory. I would therefore suggest that it would be appropriate to call Mr Breakspear to give evidence about the nature and the atmosphere that was prevailing during the period of their assessment.

I would be absolutely clear that the Council's position in calling Mr Breakspear is not to ask him to go into detail into the clinical matters, because that is not evidence available to the Council, but also, and fairly, to the Association of Optometrists or Mr Coates to be able to confront effectively on foot during the hearing today. That is why I would ask that his evidence would merely be to ring-fence, in effect, those issues as to the atmosphere prevailing and the nature of the performance assessment itself. I had asked for these matters to be redacted before you but it seems a better use of time, given today's hearing, to be able to call Mr Breakspear to give that evidence before you.

Mr Coleman: Mr Alder, the difficulty about that is what is the basis of jurisdiction that would permit an Interim Orders Committee to hear evidence?

Mr Alder: The basis of that would be, in effect, the same as before – this is, in effect, a substantive hearing. There is Rule 38 which could apply and I could seek, for the admissibility of evidence. I accept that it is incredibly unusual for evidence to be given live during a hearing of this nature but the Council finds itself in a very difficult position, given the nature of certain paragraphs in Mr Taylor's report. The only way to address those fairly, in fairness to the Council, would be to ask for live evidence to be given. There is no written evidence at this stage which could be presented to the Committee.

Mr Coleman: Which passage in particular would you say is inadmissible in Mr Taylor's report, which would merit the calling of Mr Breakspear to give evidence?

Mr Alder: Sir, could I refer you please to the Association of Optometrists' bundle at section 5.7 of Mr Taylor's report.

Ms Jones: Mr Alder, before you do that, can I just clarify – we have had two bundles, or part of the bundle was replaced today from the Registrant. Can you clarify what was the difference between the two, in case we operate from different sets of papers?

Mr Chawatama: The second bundle should contain the complete patient notes. There were one or two pages missing from the initial bundle submitted.

Ms Jones: So the substantive report from Mr Taylor is the same? [*Yes*] Thank you for clarifying that. Mr Alder?

Mr Alder: Thank you. Sir, at page 4 of your bundle, in the third paragraph on section 5.10, there is reference made there to distress by the Registrant, and that would not be, I understand, the basis of an assessment undertaken by Mr Breakspear. It is certain to go beyond the opinion and evidence that Mr Taylor could give. Similarly –

Mr Coleman: I am sorry – the final paragraph of 5.10?

Mr Alder: Indeed.

Mr Coleman: So that is an expression of opinion by Mr Taylor, on which you seek to call evidence that goes to the question of whether or not Mr Coates appeared distressed by the whole experience and so on?

Mr Alder: Indeed, Sir. The only evidence that can be provided in that regard is from Mr Coates, or indeed from Mr Breakspear, who was available and was making his assessment at that time.

Mr Coleman: Yes, so that your aim would be to call Mr Breakspear to say what - to say that he did not appear to be distressed by the whole experience?

Mr Alder: Indeed, Sir. Just to give evidence as to the atmosphere and the –

Mr Coleman: If that evidence is indeed led, let us assume that it is challenged in cross-examination of Mr Breakspear. Let us assume for these purposes that Mr Coates then goes into the witness stand and says, 'I was really distressed by the whole experience.' What is the Committee to do, having heard that evidence, if it has no power to make any findings of fact, which is clear from the rules.

Mr Alder: Sir, the purpose of recalling Mr Breakspear is to provide some balance to the evidence which is given in an inadmissible form, I would suggest, by Mr Taylor. There may be issues in Mr Coates saying 'I was distressed' – I do not know what his evidence was. However, if he were to say 'I am distressed' before this Committee, on one level there would still need to be a finding of

fact as to whether they accept the evidence of Mr Coates in giving that evidence in due course.

Mr Coleman: Yes, but Rule 50 precludes this Committee from making any such finding. If one looks at the powers of the Interim Order Committee –

Ms Jones: On which page?

Mr Coleman: If one turns to page 95,

> "Rule 19(1), Rules 8 to 12, 20 to 24, 35 to 43, 45 to 49 and 54 (2) to 58 shall apply to an application for an interim order."

Excluded from that list of rules is Rule 50 on page 101, which says:

> "The Fitness to Practise Committee shall then determine their findings as to fact and as to whether or not the allegation is proven."

From which it follows, on my reading of the rules, that this Committee cannot make any findings of fact, mainly because there is never evidence called that raises issues of conflict that need to be resolved by this Committee.

Mr Alder: Sir, I accept your point. Rule 50, to my understanding, relates to a hearing before the Fitness to Practise Committee of the substantive allegation.

Mr Coleman: Yes.

Mr Alder: So reference to the proof of the allegation being –

Mr Coleman: But it is not only the allegation because it is findings as to fact.

Mr Alder: Indeed, Sir, but this particular rule, as I understand it, relates to the procedure and the findings to be made, and when, at the – I cannot use the phrase 'substantive hearing', because this takes on the mantle of a substantive hearing - but at a final Fitness to Practise Committee hearing into the allegation considering all evidence before it. I would suggest that the absence of this rule, given the availability of Rule 38, on which the Committee can consider evidence before it which would be admissible in a court of law, does allow it and should allow it to consider evidence which is available for it to hear.

This remains a committee of inquiry, albeit that I accept that an Interim Orders Hearing Committee has difficulty in having to tread that line between the evidence available before it, and evidence not. If Mr Coates is to give evidence, it will still have to consider issues as to fact and it will still need to apply its mind to the weight to apply to that evidence. Given that it will be making those determinations, there is merit, I suggest, in Mr Breakspear having the opportunity to be able to give evidence as to the nature of the matters which are inadmissible in Mr Taylor's report.

Mr Coleman: When you say that these matters are inadmissible, are you saying that they are legally inadmissible, or simply that it goes to the weight as to the extent to which Mr Taylor could have reached any conclusions about those matters?

Mr Alder: Sir, I suggest that these are not conclusions or opinion which Mr Taylor could be competent to give but they are the result of conversations with practice staff and they are the result of opinion, him being appointed by Mr Coates, which go way beyond what you could and should expect from an assessor or an expert who is witnessing his performance assessment.

He is entitled to give opinion as to the nature of the practice he is witnessing but he is not, I suggest, entitled to give any level of opinion or seek to give evidence, which is what he is seeking to do via this report, as to the nature of the performance assessment undertaken by Mr Breakspear. That would seem to me to go way beyond his remit and way beyond what level of admissible evidence he could provide.

Mr Coleman: But by way of submissions, you are able to point to those matters which you can criticise in that way and those submissions will be listened to and heeded by the Committee. That is the other way of dealing with what you regard as the flawed content of Mr Taylor's report.

Mr Alder: Sir, I accept that wholeheartedly. I could make submissions all afternoon about the admissibility or otherwise of these particular matters.

Mr Coleman: Or the weight to be attached to them.

Mr Alder: Or the weight, indeed. Sir, my suggestion would be that the Committee would be more greatly assisted in considering what weight to apply, if it is being asked to do that which it would, even by way of my submission. If it is being asked to apply weight to the information that is being given inappropriately by Mr Taylor, it can be assisted in a degree of certainty by Mr Breakspear giving live evidence to them. That would seem to be the highest form of evidence that they could consider and it would be a matter still for the weight for the Committee to apply. I appreciate throughout that I cannot give evidence – I was not available at this performance assessment any more than Mr Taylor was. However, Mr Breakspear was, and he is available to this Committee of inquiry, if the Committee feels it is appropriate to ask questions of him.

Mr Alder: Mr Chawatama, what do you say?

Mr Chawatama: I say that it cannot be right legally that these paragraphs are inadmissible, by virtue of section 38. It is a matter for the Committee. Admissibility of evidence, subject to subparagraphs (2) and (3) – I am sorry, I do not have the page reference.

Ms Jones: It is 99.

Mr Chawatama: Thank you. This rule applies to this Committee –

> "The Fitness to Practise Committee may admit any evidence they consider fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law."

So references to things such as hearsay or, as I think it was insinuated, that he cannot give opinion evidence as an expert because he was told by Mr Coates – those are matters for this Committee to weigh in the balance as to whether you consider that that evidence is fair and relevant to your deliberations. The hearsay rule does not apply. Whether or not an expert is instructed in the traditional sense – again, you are not bound by that because it says specifically

> "whether or not such evidence would be admissible in a court of law."

There is therefore no legal bar stopping you from considering whether to hear or read, rather, those parts of Mr Taylor's report to which my friend objects. I disagree that there is any legal basis but obviously you will have your own legal advice.

So far as Mr Breakspear's evidence is concerned, my understanding is that, in any event, if Mr Breakspear were to be called, the starting point would be that he would be called to give evidence on his report. In his report, however, he does not talk about matters such as the atmosphere of the assessment.

Mr Coleman: As I understand it from Mr Alder, he is going to be asked questions about the latter issue – namely, about the atmosphere, rather than about the content of the report.

Mr Chawatama: Yes, but I am saying that he is being asked questions about another expert's report – Mr Taylor. To me, that cannot be right, because this is not the forum in which to resolve issues such as that. It would be impossible to arrive at a finding as to whether or not what Mr Coates – and Mr Coates is here and he can and will give evidence – whether or not such an atmosphere existed. The proper place for that is in final submissions. He is not being called to talk about or give evidence on his report and therefore that is not in itself a proper basis on which to call him, to comment on another expert's report.

Mr Coleman: There are two issues: either to comment on the report or to express or give evidence about the factual situation at the time of his assessment and whether there was an atmosphere.

Mr Chawatama: Those issues, if I may say, are not covered in his report.

Mr Coleman: No, and that is why Mr Alder seeks to call Mr Breakspear just to touch on those points, as I understand it.

Mr Alder: That is exactly right, Sir.

Mr Chawatama: That is my second objection to that. The last one is that it is not an issue of whether – these are matters of perception rather than objective findings which can be reduced to a finding of fact, i.e., 'This Committee finds that there was no intimidatory effect', or that there was. You have an actor and another person, and perceptions differ. It would be inappropriate to go down that route when one is looking at a series of substantive allegations made against Mr Coates. Mr Coates himself can talk about how he felt – he is here and he can do that. That is a matter on which he can be questioned.

Mr Coleman: Is it your proposal to call him to give evidence?

Mr Chawatama: Yes.

Mr Coleman: Do you have anything else to add, Mr Alder?

Mr Alder: If I may be honest, Sir, I am a little confused. I understood that there was some question mark as to whether Mr Breakspear was entitled or able to provide evidence. I understand from my learned friend that he, too, relies upon Rule 38, which I had sought to do as well, which – I would seek – allows Mr Breakspear to give evidence to the Committee. I reiterate that point. The Council are in difficulty, given the nature in which the chronology of these reports happened and are provided. At no point prior to the service of Mr Taylor's report were there any issues as to the atmosphere prevailing during the assessment.

In order for this Committee to be able to make due inquiry – it being a committee of inquiry – the only reasonable and fair course for the Council and the Registrant is for full evidence to be provided. I have indicated those areas about which I think Mr Breakspear can fairly provide evidence, and clearly there are criticisms of him if this evidence is to be accepted and weight to be provided for it by the Committee. For that reason, there is fairness also to Mr Breakspear to be able to counter those issues and to provide his perception and view as to the nature of the assessment and how it began. The clinical issues themselves are not to be touched upon any further because that would be unfair.

Ms Jones: Can we hear from the Legal Adviser?

Mr Coleman: Chairman, the position appears to be that there is a wish on the part of Mr Alder to call oral evidence before you, in response to today's application. My understanding is that it would be rare if not totally unknown for oral evidence to be given on an application before the Interim Orders Committee. Indeed, I must remind you that it is only under Rule 50, which refers to the stage in substantive proceedings when the Fitness to Practise Committee may determine their findings as to fact, and Rule 50 is expressly excluded, or not included rather, in those provisions that apply to hearings before the Interim Orders Committee. However, by Rule 38, that does not preclude you, if you regard it as necessary and appropriate, from allowing oral evidence to be

called, always bearing in mind the fact that you have control over the areas that would be the subject of that oral evidence.

It would be possible for these matters that have been raised to be dealt with by way of submissions but this is entirely a matter for you as to whether you are content that Mr Alder should be permitted to call Mr Breakspear to give evidence along the lines and subject to the limits that he has outlined to you. It is possible, according to the rules and it is possible for you to determine whether you would be assisted and whether you would regard it as fair and reasonable for such evidence to be called and given by Mr Breakspear. That concludes my advice on this issue.

Ms Jones: Thank you. Mr Henley, could you clear the room, please.

[*Hearing adjourned at 12.14 pm*]

[*Hearing resumed at 12.20 pm*]

Ms Jones: We have considered the matter raised by the Council and the Registrant's representatives and we are minded not to take evidence from Mr Breakspear at this point, but we note your comments.

Mr Alder: Madam, you have indicated that you would not take evidence from him at this point. Is there an anticipation that you would take it from him at some point? Otherwise, I would ask that Mr Breakspear be released.

Ms Jones: Yes, we do not intend to take Mr Breakspear's evidence today.

[*Mr Breakspear is released*]

Mr Alder: Thank you, Madam. It may be that you have drawn sufficient conclusions as to what my submissions in respect of Mr Taylor's report are. There are a number of paragraphs – for example, the final paragraph in section 5.10 on page 4 of the defence bundle, and the first two paragraphs on the next page. Those matters are well outside the remit, knowledge and evidence and opinion that Mr Taylor can give. I would suggest to you that that would not be a fair representation of the assessment and it is not evidence. That is merely a submission for you.

The third paragraph of the section under the title 'Issues about initial assessment', Madam, is completely irrelevant to the issues for you to consider, and indeed completely irrelevant to the consideration of any allegation which would face Mr Coates in the future.

The second paragraph under the section 'Conclusion' is also itself largely inadmissible, given that it touches on those matters to which I have referred earlier. The final sentence of the third paragraph of the conclusions section is itself also highly inadmissible: that is not evidence which Mr Taylor can give,

him having no understanding of previous cases before this Fitness to Practise Committee or indeed other disciplinary committees in the past. He has not, to my knowledge, sat as an expert before any committee and unless information of a detailed – and very highly detailed – nature has been provided to him by the Association of Optometrists, which I do not suggest has been the case, then without that detailed knowledge he would be unable to conclude in the way that he has. For that reason, that is well outside of his remit and evidence. For those reasons, I would ask you in due course to apply no weight, or indeed very little weight, to those matters and it is not evidence that you can hear from.

I do not wish to repeat myself but I repeat that there are concerns raised throughout the report of Mr Taylor and I know that you will consider it in due course very carefully. His final conclusion, however, is that,

> "The main lack is, in my opinion, a peer view model for him to "benchmark" himself against and I would suggest that any action that flows from this rather sad set of events should aim to address that lack."

I suggest that this presents evidence to you, from an expert appointed by Mr Coates, to suggest very clearly that there is a lack of ability on behalf of Mr Coates, and there is a lack of competency available to him which needs addressing. In Mr Taylor's own words, that lack of adequate and competent performance, again to use Mr Taylor's words, to reflect the idiosyncrasies, the clinical isolation, the lack of peer review – all of those do not go to satisfy the concerns clearly identified and concluded by Mr Gohil and Mr Breakspear.

Madam, I will close very briefly by reiterating the point I made at the very beginning. These are fundamental areas of optometric practice and they have been fundamentally failed. Mr Coates is not, I suggest, able to provide safe care for patients, as to patients before him, but also for detecting future potential pathology. The examinations he has been undertaking, as clearly assessed by Mr Breakspear and Mr Gohil, are not those which provide safe and competent care for patients, and they place patients at risk in not providing such care. For that reason I suggest that you are able to conclude that it is necessary for the protection of members of the public to impose an interim order today.

That concludes the Council's opening and the issues as to its application. Thank you, Madam.

Ms Jones: Thank you. Mr Chawatama, would you like to respond?

Mr Chawatama: Until my friend, in his closing, made reference to the potential basis of the Council's application today, I have to confess that I was not clear on what basis the Council was recommending or basing its application for an interim suspension order.

In his opening, according to my note, he referred you to Section 13 L, and the three limbs under that, but there was no express reference there as to which

limb the Council relies upon. There was then the reference to the interim suspension order but on the basis that were not any conditions that could be attached to the Registrant's practice or to the Registrant that would sufficiently raise his standards. That sounded to me like a suspension order by default.

There has been no reference at all to the burden and standard of proof that you are required to apply before imposing what would be, in any circumstance, a draconian order of a suspension, which is the only order just short of erasure from the Register. I know that the Committee will be legally advised and will be aware that the burden is on the Council, and the standard is a heavy one – and that is a criminal one. You must be satisfied, so that you are sure, that it is necessary to suspend this Registrant. It is not a civil standard on the probability. I say this because it was not made clear by my friend that this is in fact the case when one is looking at issues of protection of the public, or any other public interest, or the interest of the Registrant. You have to be satisfied, so that you are sure, that the weight of the evidence before you permits you to impose one of those two orders – either an interim suspension order or a condition or conditions on the Registrant. That is an important point.

You have before you the notice of application for an interim order, which in fact largely reproduces the competencies and report by Mr Breakspear and Mr Gohil. You have been referred to several paragraphs in which they address specific competencies and express views as to their findings. The notice of application is almost entirely based upon the report of Mr Breakspear and Mr Gohil. These are the allegations, or form part of the allegations it is said, that will ultimately be considered by the substantive, final hearing.

Madam, it is my proposal to call Mr Coates to give evidence and, indeed, you would have the power to do so anyway, and to question him before this Committee. Before I do so, however, just by way of opening, Mr Coates – and he will confirm this – is in a sole practice. He has been registered as an optometrist for several decades now. He employs one registered dispensing optometrist and his practice is one where, apart from being relieved by a locum, he essentially runs it on his own as a sole practitioner. That, in itself, is not, we would submit, something that has the bearing which my friend seeks to put on it.

Apart from his practice, he is on the local PCT diabetic shared care screening programme and he refers widely to local hospitals and local specialist centres. He keeps up to date and that is borne out by his CET points, that he studiously attends the relevant lectures by local practitioners, including ophthalmologists. In my final submissions I will refer you to the references that have been obtained on his behalf and I know now that you have read those references, Madam. He clearly has professional contacts beyond his sole practice. In fairness to him, it is perhaps a peculiarity - if I may put it that way - that sole practitioners across the board may find themselves in. It is a legitimate sole practice and such an establishment, in the ordinary event, in terms of requirements to be a registered optometrist, is a permissible practice to set up.

Madam, what the panel has to consider are questions of whether he, as a practitioner, is so unsafe, and that the public is so at risk at the criminal standard, that it is necessary to impose what would be a draconian order of an interim suspension order. This would essentially be shutting down his practice, denying him his livelihood. I would suggest that the evidence would have to be cogent indeed and very weighty, to permit such a course in respect of a Registrant who otherwise has an unblemished career.

So far as how this matter has come before you today, the original complaint, in my understanding, is that it now is part of the mere background. It is the reason why the assessors were sent in but, for the purposes of today, no allegations are made against Mr Coates arising out of the person who is referred to as patient A in the joint report. Although the joint report comments upon patient A, and we find that on the very last page under the heading, 'The Complaint', in my submission that should form no part of today's inquiry because no allegation, when one looks at the Council's notice of application for an interim order, at paragraph 11 of that notice of application - I will read that:

> "The nature of the evidence and background facts in support of this application relate to the conclusions drawn by both Assessors following their assessment of the Registrant's examination of three patients:"

and those were patient B, patient C and patient D. In short, I would ask you to put patient A out of your mind for the purposes of today's inquiry.

So far as the allegations themselves are concerned, and the competencies, those are listed in the Notice of Application. In Mr Taylor's report, and his assessment was some two months or so after that of Mr Breakspear and Mr Gohil, it is correct that he has identified some issues arising out of his assessment. However, we would respectfully say that this is not about whether or not there are issues or concerns over the Registrant's practice – it would be surprising, if one took a straw poll of the entire profession, and there were no issues or concerns. This is why I said in my opening that the criminal standard, being satisfied so that you are sure that a sanction of the severity of a suspension is necessary, is the key part. The mere fact that issues are properly identified by Mr Taylor, it does not follow that a sanction must be applied. Therefore, if a crucial step has been omitted – and I make no apology for referring to it time and time again - by my friend, that merely having concerns and issues does not satisfy the standard of proof, it is whether those issues or concerns are of such weight that they satisfy the criminal standard, that the protection of the public, as it is now put, requires a suspension order.

We would disagree that an interim suspension order is the appropriate order in any event, but I will return to that in my final submissions.

Madam, there are issues which Mr Coates will address in his evidence and perhaps it is appropriate at this point to call him, to deal with the issues that have been raised in the Notice of Application and in the report of Mr Breakspear and Mr Gohil, with you permission.

Ms Jones: I am minded as to the time, Mr Chawatama. I would like to suggest that we take a break now and reconvene at 1.10pm.

[*Hearing adjourned at 12.42 pm*]

[*Hearing resumed at 1.16 pm*]

Ms Jones: Good afternoon. Before we begin, Mr Alder and Mr Chawatama, could I ask you both to speak up slightly? A couple of my colleagues have asked me to make that request of you. Would you like to proceed?

Mr Chawatama: I call Mr Coates.

Mr Coates, called and sworn

Examined by Mr Chawatama

Q. Could you state your full name and address?
A. Malcolm Coates, 8 Totnes Walk, London N2 0AD.

Q. And you are in practice as an optometrist – is that correct?
A. I am.

Q. When did you qualify?
A. I qualified in 1979. I graduated in 1978 and qualified in 1979.

Q. Just briefly, what has been your career since 1979?
A. I did my pre-reg year with Dolland & Aitchison. I stayed with Dolland & Aitchison for a couple of years after that and then I worked for two or three different organisations. I worked for about a year doing locums and I have been in private practice, in my practice in Swiss Cottage, since 1988.

Q. You are in private practice and do you employ a dispensing optometrist?
A. I do. I employ a dispensing optician there full time.

Q. Apart from your private practice, are you engaged in other work as an optometrist?
A. Yes, I am. I am involved in the shared care diabetics scheme in Camden and Islington and I have been for the last 11 years.

Q. What is your caseload of patients? Could you just give a brief overview?
A. I see a good number of families. My patient profile tends to be older. Many of my patients have been with me for many, many years – some of them for the last 19 years. I get most of my new patients by recommendation from existing

patients or by recommendation from local GP surgeries and sometimes from ophthalmologists. I have a very good relationship with the local GPs and with ophthalmologists in the hospitals in North London. My patients are tending to get older – I guess that I am taking on more older patients than younger patients and my existing patients are inevitably growing older.

Q. Mr Coates, you are aware of the issues that have been put before this Committee arising out of the performance assessment conducted by Mr Breakspear and Mr Gohil. You have a copy of that report in front of you.
A. Yes.

Q. That was a performance assessment conducted pursuant to the Investigating Committee of the GOC and it was done on 9 May.
A. Yes, that is right.

Q. Both Mr Breakspear and Mr Gohil attended your practice?
A. Yes, they did.

Q. And the performance assessment concerned three patients, did it?
A. Yes.

Q. And these are to be referred to as patients B, C and D, according to the sheet in front of the notes. However, I think the report itself attributes numbers, so that there is the reference to patients 1 and 2, for instance. However, it is probably safe to assume that patient 1 is patient B – but please correct me if I am wrong. There is a slight inconsistency in the reference to the patients, but are you happy that these are the three patients who are referred to in this report?
A. Yes.

Q. And just to confirm, do you have the original records of those patients?
A. I do. I have them with me today.

Q. Some of the photocopying did not come out particularly well, Madam, and so it may be of assistance to look at the originals. You co-operated in that assessment did you, Mr Coates?
A. Yes, I did.

Q. Before we go to the individual comments on the competencies, what was your experience of that assessment?
A. I found the whole experience much more intimidating than I had expected.

Q. I am sorry – could you speak slowly, raise your voice and address the Committee?
A. I found the whole experience much more intimidating than I had expected it to be. I found it a very difficult experience. It felt like an artificial situation to me, with the patients I was seeing. I tried to carry out my normal practice but the fact that there was someone in the room at the time – I must say that I found that difficult. However, I feel that I carried out a good safe examination of the patients, in spite of that.

Q. Are you able to be more specific as to what you mean by finding it intimidating?
A. I felt that I was under the microscope. I felt that everything I was doing – well, I could hear scribbling while I was writing and I found that intimidating.

Q. Presumably, you exchanged words – and I do not mean that in a derogatory sense, but you spoke to both Mr Breakspear and Mr Gohil during this assessment, did you? They asked you questions, and you answered them?
A. There was very little said during the time of the assessments but they did question me about the patients after the assessments. They spent a considerable length of time questioning me about the patients at the end of the three assessments.

Q. What was your experience of that session – the question and answer session?
A. I actually found that more intimidating, much more intimidating, than with Mr Breakspear and Mr Gohil actually being in the test room during the examinations. I felt that they were being very critical of me. With a number of the questions that they were asking me, I felt that if I was not giving the answers that they wanted, immediately and clearly, they seemed to be taking a very critical view of that. With some of the questions, I know that I did not perform to the best of my ability.

Q. May I just take you to the joint report of Mr Breakspear and Mr Gohil. You see there, on the first page, the background is set out. I need not trouble you with that. And then there is the assessment and then you come to the competencies. Competency 1.2 – can you just read that to yourself? It has been read into the record.
A. OK.

Q. Have you read that?
A. I have.

Q. It is alleged there that most of your questions were of a closed form. What do you say about that?
A. I do not believe that is true. With all three patients, the first thing I greeted them with when they sat down in the consulting room –

Mr Alder: This is a difficult area for us to be in, given the nature of this hearing. I have to object to Mr Coates being taken to every single examination of the patients. As has been indicated throughout this hearing, you are not here to make findings of fact. That point was made very directly to me in my application. To ask Mr Coates to go through, in detail, the content of every single examination, and what was said and what was not said, is to go way beyond the nature of this particular hearing, given that you will not be asked to make any findings of fact. To use a colloquialism, the Council is quite hamstrung by this evidence, given that it has no evidence available to itself which can allow it to ask questions of Mr Coates.

The detail of a cross-examination of a registrant in this type of scenario, in this type of hearing, is incredibly difficult to judge, given that there is not sufficient evidence or information available to be able to rebut any points that are to be made by the Registrant, to cross-examine to the degree necessary to allow you, in an ordinary hearing, in a full substantive hearing, to make a finding of fact. We are not at that stage in this particular hearing and I have significant reservations about Mr Coates going into significant detail of the examinations. This is for the very reason that Mr Breakspear was denied the opportunity to give evidence and it is the very reason why we had concerns about the Registrant being asked to give evidence before you. It is the very reason why the concerns were raised by the learned Legal Adviser as to the nature of the oral evidence being presented to you. The Council just has to object to this particular line of examination and oral evidence of the Registrant.

Mr Chawatama: The Council are relying on all the competencies. They were all read out into the record and Mr Coates must respond to them.

Mr Coleman: How will the Committee be helped by detailed responses to the detailed allegations, when their only role is to consider this application for an interim order, which has involved the assessment of material before them and an assessment as to whether there is a risk to patients and to the public, and to the size and seriousness of that risk? How will a detailed and fact-by-fact series of question and answers assist them in that role?

Mr Chawatama: It will throw light on the cogency and the weight of the evidence of Mr Breakspear and Mr Gohil.

Mr Coleman: But how, when the Committee will not have heard or seen Mr Breakspear or Mr Gohil?

Mr Chawatama: They will have read the report and it is the weight to be attached to their conclusions, in light of what Mr Coates has to say, as well as Mr Taylor's report. These are specific and detailed allegations, some to do with whether or not a degree of examination and record-keeping was performed. Those are factual matters, in a sense, and on which the Council does rely. You will be invited, for instance, at competency 2.2, if I can use that as an example – the second sentence reads:

> "The record cards were limited especially with regard to ophthalmoscopic findings and intraocular pressures and consistently items such as near acuity, time of measurement of intraocular pressures and recall times were omitted."

These are detailed factual –

Mr Coleman: What the Committee wants to know, perhaps, is whether those are accepted or not accepted, but there the matter ends. Beyond that, you are going into matters of detail which involves all the elements and components of the substantive hearing.

Mr Chawatama: Perhaps I can approach it this way. Some competencies may require to be dealt with in a little more detail than others. I will try to deal with them in summary form, so that the Committee at least registers the fact that the criticisms, as set out there – and Mr Coates's views –

Mr Coleman: Mr Alder, do you have any further comment before the Committee considers the position?

Mr Alder: Sir, I have made my point. I do not want to repeat myself.

Ms Jones: We will take the information in summary format – and I mean summary, otherwise, we will have to curtail things.

Mr Chawatama: Mr Coates, just to continue, when dealing with each of the competencies, can you just highlight, in brief summary form, what your observations are, from your recollection, of how the performance went on that day? What is your reaction to the conclusions drawn by Mr Breakspear and Mr Gohil, in summary form? Could you go through each one, starting with competency 1.2?

A. I know that I was asking open questions of the patients and I believe that I was exploring symptoms perfectly adequately. As I said, I actually opened my examination in each of the three cases, as is my normal practice, by saying, 'How can I help you?' If that does not elicit a response, I ask whether they are having any problems with their eyes or their glasses. I actually do ask open questions.

Competency 1.3: I certainly do not remember not asking about family history of eye disease. It is my normal practice to do so. If I did not, I can only explain that – not asking it, or not writing it down – by the intimidation of the situation.

Q. Moving on to competency 1.5, over the page –

A. Competency 1.5 – this just does not sound like the same day to me. There was not really any time when the outcome of the eye examinations were confused. All three patients, at the end of the examination, were perfectly happy and unconfused. The reason why this point was raised was because the patient, patient C, after I had completed the examination with him, he stood up – and the examination seemed to have been finished perfectly satisfactorily and he said, 'But why do I see better with my left – ' - I had told him he had a cataract in his left eye and he said, 'Why do I see better with my left eye than my right eye?' So, while we were standing up, I had said that it was because his prescription was greater with his right eye than with his left eye, and so the corrected vision would be better with his right eye than with his left eye, but the uncorrected vision would be better with the left eye than the right eye, in spite of the cataract operation.

It was irregular for me to do this – there have been plenty of other occasions where, at the end of the examination, the patient has stood up and then asked a supplementary question and I would always asked the patient to sit down at this stage and say, 'Well, let's just have a look into this.' However, because of

the situation and because of me feeling concerned about looking inadequate, I had finished the examination and then to continue again – I actually did this with the patient standing up. I then opened the door for the patient to walk out, and the patient then said to me, 'Well, thank you for a thorough examination – I feel thoroughly reassured.' That must have been within the hearing of Mr Breakspear and Mr Gohil, but that moment was the only moment, with the three consultations, where there was any doubt at all about my explanations of situations to the patients.

Q. Moving on to competency 2.2, again, just in a brief summary form, Mr Coates, can you help the Committee as to your observations on that issue?

A. On the first point, my handwriting leaves something to be desired. When I am with a patient, I am actually addressing them face-to-face and then just looking down quickly. So yes, I admit that my handwriting leaves something to be desired.

> "The record cards were limited especially with regard to ophthalmoscopic findings"

- with patient 3, I think the ophthalmoscopic findings –

Mr Coleman: Mr Chawatama, with respect, this must be dealt with summarily. The Committee cannot be assisted by reference to details.

Mr Chawatama: Yes. Mr Coates, you have probably dealt with competency 2.2. You were going to refer to the notes, but could we move on to competency 3.1. Again, in summary form, can you first read that to yourself, just to be sure that you are aware of the issues, and then perhaps we could have your observations?

A. As far as the visual acuity is concerned, I always measure the visual acuity very accurately. I do not always get a patient to read the complete line. As Mr Reily will know full well, if someone can see most of the letters on the chart, the letter L will be more or less taken. I often get them to read the next line down, so I may record VA as 6.6 -1 - perhaps a difficult letter like a C, plus 3 if they are getting three letters from the next line down. It is my way of doing it and I find it gives me a very accurate representation from one year to the next.

As far as the subjective refraction is concerned, I tend to ask patients to look at a letter rather than a ring or a circle when doing cross-cyl. As Mr Taylor's report said, it is a method that is understood, and it is a method that I use. I get very good results – in fact my patients often compliment me on the accuracy of my prescriptions.

Q. We must move on. Competency 5.7 – could you be brief please, and tell us in summary form about your ability to examine fundi using direct and indirect techniques?

A. Previously, I had always asked patients to look over my shoulder when doing direct ophthalmoscopy. I would usually ask them to look over my shoulder at a fixation target in the mirror. When I am looking to the periphery of the eye, I would tend to move my head and myself, to look upwards, down and round, to

all different areas of the eye. I find this is an excellent way because it gives me a good, smooth flow from the centre of the eye and out towards the mid-periphery.

As far as looking at the macular is concerned, I would usually get the patient to look at the fixation target and then work from the optic disk and then work across to the macular, which I find to be a good, accurate method. Mr Gohil and Mr Breakspear thought that actually asking the patient to look directly into the ophthalmoscope was the only way they thought was the right way – but I was actually taught at Aston University to sweep across. I often ask people to look straight at the light as well. As far as looking at the periphery –

Q. Mr Coates, I am sorry to interrupt you, but we have said that we will deal with this in summary form.

A. One very important point –

Ms Jones: Please continue.

Mr Chawatama: Could we try to keep the responses in summary form. The thrust of what you are saying so far, Mr Coates – do you accept these criticisms by Mr Breakspear and Mr Gohil?

A. No, I do not. No.

Q. Can you go on then to competency 5.10, the ability to use a contact tonometer and measure IOPs? Again, please try to be brief if you can?

A. The reason why this was brought up is because, after I had seen my patients, Mr Breakspear and Mr Gohil asked me about my referral criteria for patients with primary open-angle glaucoma. I started by saying that this can be confusing – it can be difficult to diagnose this. Mr Breakspear seemed to be impatient that I was not actually coming up with direct facts and figures. I got very flustered and I did not represent myself very well on the referral criteria, which I actually do know and feel comfortable with.

Q. Finally, competency 6.9, the ability to manage a patient presenting with cataracts –

A. This was a similar situation in the discussion after I had seen my patients. Mr Breakspear and Mr Gohil asked me about cataracts and when I would refer for cataracts. I said that I would refer when they actually impinge on the patient's lifestyle, when the patient was having difficulty. They felt that I should be examining where the cataract is in the eye and, because – I am just trying to recall. Because I was answering that question, which I thought they had asked, they felt that I did not have a sound understanding of which part of the lens different cataracts are in. I do have a sound understanding of that but I felt, and I do feel, that it is much more relevant referring patients when the cataract is actually giving them trouble, which I believe is the recommendation in the College guidelines.

Q. That deals with all the competencies. Mr Coates, can you wait there, there may be some questions from Mr Alder?

Mr Coates cross-examined by Mr Alder

Q. Mr Coates, very briefly, you were aware of the assessment of Mr Gohil and Mr Breakspear in the time before the actual assessment in May - is that right?
A. Yes.

Q. So you were aware that assessors appointed by the General Optical Council were coming to assess your practice?
A. Yes.

Q. Would it be right to assume that, at that assessment, you would therefore pretty much try to do your best – with best practice, as you know it, to show off a bit I suppose, to two assessors. Would that be fair?
A. That would be my aim, yes.

Q. And yet your aim resulted in a report by both assessors showing significant concerns into your practice. Do you accept that?
A. Well, certainly, the report reads that way, yes.

Q. You were then sent a copy of the report by the Registrar, is that right?
A. Yes.

Q. You read a copy of the report and you read the concerns of both of these assessors. You then presumably instructed the Association of Optometrists to represent you, who instructed Mr Taylor. Is that right? So you were aware of the concerns which both assessors had about your practice and you were then assessed subsequently by Mr Taylor. Is that the correct chronology?
A. That is correct.

Q. And yet Mr Taylor, in his report, still raised a number of concerns about your practice in those areas touched on by the assessors. Do you agree with that?
A. Yes.

Q. He raises concerns about a degree of clinical isolation for you.
A. Yes, he did.

Q. And he points out that some of your practice appeared to him to be dated.
A. Yes, he did.

Q. And that is despite ongoing CET from you, ongoing continuous training?
A. Yes, that is true.

Q. And he was concerned that you may appear to have the knowledge, because you were attending training, and yet you were not applying that knowledge when testing these patients that he assessed.
A. If you read his reports, he finds much less reason to be concerned about my practice than Mr Gohil and Mr Breakspear.

Q. But he did show concerns, did he not?
A. Some concerns.

Q. And he was an assessor appointed by you?
A. Yes.

Q. In an atmosphere which was in no way, or could have been, intimidating – do you agree with that?
A. I must say that I felt a little intimidated by it, because of the nature of the assessment and because it is still a performance. After the initial assessment, that made me feel much less nervous but certainly a little bit nervous.

Q. At the point when you were assessed by Mr Taylor, were you aware of this interim order hearing?
A. Yes, I was.

Q. And you would have been aware that Mr Taylor's report would have provided information from you, which this Committee would consider.
A. Yes.

Q. And so your practice, when assessed even by Mr Taylor, should have been at its absolute peak. You were aware that this was going to be reflective of your practice.
A. Yes, I was.

Q. I will suggest to you, Mr Coates, in respect of the assessment in May – because we have not heard from Mr Breakspear – that in fact significant steps were taken by both assessors to ensure a relaxed environment for that assessment. I put that to you as a question, even though it may not have sounded that way. Do you accept that?
A. Actually, I do not, no.

Q. I am going to suggest to you that there was not an intimidating atmosphere in that assessment.
A. That is certainly not the way that I felt, or in fact my staff.

Q. I am grateful, Mr Coates. Thank you, Madam.

Mr Chawatama: I have no re-examination.

Ms Jones: Can I ask the Legal Adviser whether he has any points to raise?

Mr Coleman: No. Do you have any questions?

Questions from the Committee

Mrs Huka: Mr Coates, I note that there is an impressive range of CET over the years.
A. Yes.

Q. How do you apply the training which you have received into practice? What do you do to make sure that you actually change your practice as a result of the training?

A. If we look at something like age-related macular degeneration, I have been to a number of lectures and I have also completed a good number of exercises on this. For instance, now, with my patients with cataracts, where there is any suspicion of macular degeneration, I will dilate their eyes and look at their eyes with indirect ophthalmoscope as well as direct ophthalmoscope, to get a better view of that. This is one of the areas where my practice has changed. Also, the fact that I have attended a lot of lectures on macular degeneration and read a good deal about it means that I am more aware of the way that this has changed. Perhaps four or five years ago the only treatment for macular degeneration was a simple laser, which had very limited success and was only available for some cases of wet macular degeneration. Over the past few years, the treatments for age-related macular degeneration have changed and improved significantly and so this has made me more aware of the necessity to refer patients very quickly, if they have some wet age-related macular degeneration which may be amenable to treatment.

Q. Thank you. Do you target the training that you attend on the basis of deficits which you have identified –

A. Yes. Like with macular degeneration, if I can bring this up again, this is a subject where I felt that there was a deficit in my knowledge. About four years ago, I considered this, and so I have certainly attended more lectures and done more training on this than on anything else. I have also spoken to Clare Davey, ophthalmologist at the Royal Free Hospital, and expressed my concerns about this area, and she invited me to one of her clinics, which was very helpful.

Q. Thank you.

Mr Reily: I have no questions.

Ms Jones: Thank you very much, Mr Coates. [*Mr Coates stands down*] Would you like to conclude your submissions, Mr Chawatama?

Mr Chawatama: Thank you, Madam. This is a case where it is alleged that Mr Coates essentially is a danger to the public as a practitioner – that he is an unsafe practitioner – and that serious measures, or a serious measure, needs to be taken to protect the public from his dangerousness, that measure being proposed being an interim suspension. We say that that would be a wholly disproportionate and inappropriate measure to take today.

Mr Coates has been in practice, and has been qualified, for approaching 30 years. He is a senior and respected member of his profession. He is highly regarded by each of the authors of the references to which I will take you. He has built up a stable and successful practice in Swiss Cottage, as you heard from him. He has a range of patients whom he says, at times, refer other people to his practice. The fact that we are sitting here today should not be taken as any indication of a Registrant who has a history or a pattern of

behaviour – and that has not been suggested – that calls into question his fitness to practice.

It can be said that this all arose out of one incident. The Investigation Committee, as it is entitled to, looked into that and asked for a performance assessment and that took place and the report is before you. You have heard Mr Coates and he does not accept the conclusions of Mr Breakspear and Mr Gohil. You do not need to make, and cannot make in our submission, a finding of fact as to whether or not those allegations are made out. That is not the purpose of today's hearing. Nevertheless, it is a relevant matter as to the weight that you attach to the conclusions of Mr Breakspear and Mr Gohil. The weight is important because that will guide you as to whether, if the standard of proof is met, a sanction as serious as suspension is warranted.

In the summary form in which the allegations have had to be dealt with today, for good reason, Mr Coates has been able to give you cogent and reasonable answers to those allegations. There was not much of any challenge in cross-examination as to his position on each competency on which he is criticised.

Mr Coleman: Mr Chawatama, how could there have been any challenge, in view of the fact that no evidence has been led by the assessors, other than just reliance on the report?

Mr Chawatama: The learned Legal Adviser is correct on that, and I –

Mr Coleman: I am sorry for interrupting you, but this is a point that needs to be addressed by you before you go any further in your submissions.

Mr Chawatama: Yes, I withdraw that part of the submissions. It remains the fact, however, that Mr Coates gave you an indication, in the brief summary way that he was able to, that he would be contesting these allegations. That is the important point. Should this matter proceed in the current form to a substantive final hearing, he will be defending himself against the detail and not just the general thrust of what Mr Breakspear and Mr Gohil conclude. That is an indication that there will be issues of fact, that there will be issues that go to opinion evidence as to what is standard practice. You have Mr Breakspear's report on that. There will be issues as to where the correct facts lie and where the accepted either single opinion or range of opinion – you have seen that in Mr Breakspear's report, he refers to the different practices. Those will all be issues if this matter proceeds to a final hearing. This goes to the weight and cogency of the report by Mr Breakspear and Mr Gohil. These are matters that are live, or will be live.

When you come to consider whether you are satisfied, so that you are sure, that the Council has discharged its burden, we would ask the Committee to have in mind that some of these allegations, as a result of the challenge, may or may not be made out. There is nothing conclusive.

On the basis of three patients on one day – and this is no criticism of the concept of the performance assessment itself – from three patients on one

day, Mr Breakspear and Mr Gohil have arrived at certain conclusions but those conclusions are not accepted.

It is also of some relevance, although we do not rest our submissions on this factor alone, that there are issues surrounding the manner in which the performance assessment was conducted. I put it no higher than that. You have heard the evidence of Mr Coates and you will have read Mr Breakspear's report. Those are issues that have an impact, or might have an impact, for instance, on the second part of the assessment, which is the question and answer session. Again, in our submission, some weight ought to be given to the potential that, at a future date, if this goes to a final hearing, these matters will be fully aired, because Mr Breakspear and Mr Gohil may give oral evidence as to how they conducted the assessment.

For the purposes of today, however, it is sufficient that there are questions and concerns raised by Mr Coates and expressed through the report of Mr Taylor. These are not such strong and such weighty conclusions that they would alone justify a serious sanction such as an interim suspension order.

Can I take you to Mr Taylor's report which is at page 1 of the small bundle? At the back of his report, I hope you will have Mr Taylor's CV. You will see that he qualified with a degree in ophthalmic optics from the University of Manchester Institute of Science and Technology in 1987.

Ms Jones: Could you just hold on a moment. The page 1 that we have on the bundle is the actual report.

Mr Chawatama: It is page 23. You will see from his CV that he is an extremely experienced and eminent member of his profession.

Ms Jones: Mr Chawatama, we are not here to doubt the veracity of experts on either side. We accept that they are experts. There has not been any question about that today and this is not the place to question their qualifications. Can we move through this please?

Mr Chawatama: Can I just point out that it is not a matter of qualification but a matter of experience. Mr Taylor has provided reports for both registrants and, if you look at the last page, page 24, he has also conducted performance assessments for the Council. He has been an independent assessor as well. In other words, he has experience of work wearing both hats, for the AOP and also for the GOC. That is a further fillip, we would say, in his credentials as an objective and impartial expert.

On 18 July 2007 he carried out a performance assessment on Mr Coates and he has prepared his report. His assessment relates to three patients who are anonymised as patient 1, (on page 1 of his report), patient 2 and patient 3, using a similar format to that followed by Mr Breakspear and Mr Gohil.

At page 1, I will just read out highlights of what Mr Taylor observed on that day, from the last sentence about patient 1:

> “Mr Coates correctly noted that the result was slightly better than his previous field test from 1999 and the pressures similar to previous results.”

That may assist you, Madam, when you come to consider issues surrounding record keeping, which is one of the issues raised by Mr Breakspear and Mr Gohil.

Patient 2 is a 77-year old lady. The third sentence reads:

> “This was a relatively complex refraction as she also requires prisms to achieve comfortable binocular vision.”

He then goes on, at the end where he notes that Mr Coates handled the consultation very well:

> “He did not measure pressures on this patient and simply recorded the patient’s report of her last IOP test. … Personally I would still have measured the pressure for my own records but there is no patient risk attached to not doing so as the pressure is being monitored regularly by the HES.”

So he is emphasising once again that it is not simply a matter of recording concerns, as my friend did, but you and your Committee are concerned today about risk and patient safety. The question is, does Mr Coates present a danger to the public?

Patient 3 is an 81-year old lady. The third sentence says:

> “Mr Coates managed well with the refraction and in the end decided that the patient would best be served by a further test on a different day when she was a bit less tired.”

Again, as Mr Taylor notes in his report – and I know that this is one of the objections of my learned friend – it could be said quite fairly that Mr Breakspear and Mr Gohil perhaps highlight or accentuate the negative and do not include any of the positives. Clearly, there are three examples there, from three different patients, of positive aspects of Mr Coates’s practice.

On the same page, Mr Taylor deals with the competencies. At the bottom of page 2, in competency 1.2 – again, just highlighting bits from each competency –

> “Mr Coates’s taking of history and symptoms was entirely adequate during the 3 tests which I observed.”

> “1.3 The ability to elicit relevant family history

Again this was correctly handled and recorded in all cases and in one case where some irrelevant family history was mentioned [by the patient], he handled the discussion well.

1.5 –

The explanations of the results of the sight test were entirely adequate and any patients' questions were answered to their satisfaction."

In competency 2.2, it is accepted that Mr Coates's handwriting leaves much to be desired, but he goes on to say:

"It is fair to say that the records do not meet a gold standard but they are, in my experience, above average in content."

It is important to bear in mind there that, as well as writing independent expert reports, Mr Taylor has done performance assessment tests on behalf of the Council and so he is talking from considerable experience.

Further down, under competency 2.2:

"I would also take issue with the authors of the original report where they say that assuming a default visual acuity of N5 was unacceptable."

And then, at the bottom of that same paragraph:

"This is not a failure of process or safety, merely a choice of record keeping modality. Whilst some optometrists may prefer to explicitly record N5, others like Mr Coates choose a different approach."

Again, this is reflecting a variety of acceptable and safe practice amongst the profession itself.

Competency 3.1 concerns the ability to refract a range of patients. He starts off by saying:

"I noted a lack of initial unaided visual assessment. This is a little odd but not a major failing. It does not represent a risk to patients. The main effect of this omission is to make Mr Coates's job a little more difficult!"

Again, this is addressing the central issue of risk to the patient and the safety of the public, rather than just a list of concerns and issues, and then making the quantum leap from those to a sanction such as an interim suspension, as it is suggested.

If I stay with 3.1, if you can bear with me for a minute:

"The cross cyl technique that Mr Coates uses is to direct the patient to look at a single letter on his main Snellen chart as the target rather than

the circle target. This may not be common practice but I know several practitioners who do the cross cyl test in this manner."

He then refers to guidance and advice given on a website.

Over the page, on page 4, staying with competency 3.1, you have heard Mr Coates's evidence about not using a complete line of letters. Mr Taylor has this to say about that:

> "The comment about not using a complete line of letters applied to measuring intermediate acuities during the subjective examination which is not inappropriate. However, for the patients that were examined when I was present, the recorded visual acuities were measured with the final prescription using a complete line and often one from the secondary drum chart to avoid issues where the patient may have begun to memorise the main chart."

It may be suggested during my friend's submission that, despite the report of Mr Breakspear and Mr Gohil, and despite Mr Coates knowing about this, that he nevertheless did not perform to his absolute level best. Well, there is an example here where Mr Taylor found that in fact the patients were reading the lines to the end and, in addition he was using the lower drum.

Competency 5.7 relates to the examination of the fundus.

> "All the patients who were examined in my presence were correctly directed to look in different directions during direct ophthalmoscopy."

Then about halfway down that paragraph:

> "I know that many of my contemporaries from different university optometry departments were taught to examine the fundus in this manner. Further discussion with Mr Coates revealed that since the original complaint, he now dilates a lot more of his patients on a routine basis to get a better view of the fundus. This is entirely in keeping with current mainstream optometric practice."

Again, that is a clear example there of Mr Coates developing his practice and applying knowledge gained to his practice.

Competency 5.10 deals with the ability to use a contact tonometer.

> "Pressures were done correctly on Patients (1) and (3) and fields on Patient (1). Neither of these tests were done on Patient (2) because she was already under treatment for glaucoma by an ophthalmologist. Whilst I can understand the logic in this, I personally would have preferred to do the IOPs myself just for my own records.
>
> I discussed the issue of glaucoma referral with Mr Coates and he certainly seemed to have a reasonable understanding of current practice

in this field. …. The latter in particular is a fairly recent addition to mainstream optometric consciousness and suggests that he has kept up to date with current thinking on glaucoma detection.

I am firmly of the opinion that by the time the original assessors got round to asking Mr Coates questions on this subject towards the end of the assessment, he was so distressed by the whole experience that his answers were not truly representative of his knowledge."

As I said earlier, in the normal course of practice, Mr Coates is not being observed and he is not being supervised, and he is not being assessed. It is a relevant observation that there is, in Mr Taylor's view, some impact from the conduct or the manner of the original assessment, which may have impeded Mr Coates's performance on that day. It is not necessarily the case – and we say that it certainly is not the case – that the conditions that prevailed on the day that Mr Breakspear and Mr Gohil did their assessment are conditions that prevail in the ordinary course of events, when Mr Coates is working as a sole practitioner. He is clearly, when Mr Taylor does his assessment, in a much more relaxed mood: he answers the questions and he performs the tests and makes the appropriate notes.

Some doubt is therefore raised there as to whether what took place during the original assessment is an accurate and fair reflection of the ordinary course of Mr Coates's practice. We say that, if you are sufficiently concerned about whether or not this assessment is capable, or will ultimately be accepted – this is Mr Breakspear's assessment – will be accepted as a true reflection, then that would tend to count against any suspension order.

The conditions under Mr Taylor, we would say, are much more akin to the conditions under which Mr Coates works on a normal day-to-day basis. The proof of that is that concern has been expressed about missing diagnosis and missing pathologies but Mr Coates has been there for 30 years, nearly 20 of those as a sole practitioner. I will take you to the references. He refers patients on a regular basis. There has never been, in such a long, unblemished career, any question raised about subsequent pathologies being found which ought to have been picked up by Mr Coates.

Lastly, competency 6.9, dealing with the ability to manage a patient presenting with cataracts:

"I asked Mr Coates to describe his rationale when determining whether or not to refer a patient with cataracts and his replies were entirely sensible and in keeping with current practice. Once again, I feel that the main problem here was Mr Coates's state of mind when questions were asked."

That deals with the competencies. There is a clear difference between Mr Taylor and Mr Breakspear and Mr Gohil. Yes, it is accepted, for instance, that in the note-keeping the handwriting leaves much to be desired. Yes, on one or two occasions, Mr Taylor says that he would have done things differently – but

he was always careful to qualify that with reference to whether or not that posed a risk to patients. On no occasions did Mr Taylor find that Mr Coates, in his practice, posed a risk to the public.

In his conclusions on page 5 he says:

> "Mr Coates is a caring, conscientious optometrist who is held in high regard by loyal patients who are well satisfied with the service he provides. However, he is a sole practitioner and, by his own admission, has relatively little communication with other optometrists. His standard of practice is perhaps a little dated and, whilst he has completed plenty of CET and has absorbed the theoretical knowledge from this, the lack of peer comparison has meant that he is perhaps not making the best use of this knowledge in his day-to-day practice.
>
> The initial assessment report paints a particularly bleak picture of Mr Coates's ability without noting any of his positive qualities. In my opinion, this is largely due to Mr Coates's nervousness during that assessment, which then gave a false view of his capabilities."

Moving down to the next paragraph:

> "Whilst I cannot suggest that Mr Coates' current practice is anywhere near to a gold standard, it is in my opinion unfair to suggest that his performance is so badly impaired that he represents a danger to the public. In my experience, his practice and record keeping are very considerably better than those of most of the registrants who come before the fitness to practise panels!"

Mr Taylor can say that, because he has first-hand experience of working with the Fitness to Practise panel, either on behalf of registrants or on behalf of Council.

> "Having said all of the above, it still remains that Mr Coates's practice could and should be rather more up to date than it currently is. The main lack is, in my opinion, a peer view model for him to "benchmark" himself against and I would suggest that any action that flows from this rather sad set of events should aim to address that lack. I am sure from my conversation with him that Mr Coates is now fully aware of this problem and is committed to resolving it."

That is the expert report of Mr Taylor.

May I then take you to the references which start at page 25 of the little bundle, divider 2.

Ms Jones: We have had time with these papers and the panel has read the papers. If you wish to address specific comments then please do, but please just do not read them all out.

Mr Chawatama: I am grateful for that indication. Do you have the recent –

Ms Jones: Our papers commence with an email from Clare Davey.

Mr Chawatama: Yes. We now have a signed reference from Ms Davey.

Ms Jones: Is it the same as the papers that we have received so far?

Mr Chawatama: It has an additional paragraph but it is essentially the same.

Ms Jones: If it is relevant, please read the paragraph.

Mr Chawatama: Yes, it is paragraph 3:

> "Malcolm Coates passed our locally organised training scheme (with an examination that he passed) and assessment for the screening of patients with diabetes."

This is in relation to Mr Coates's membership, or rather appointment, by the PCT, as a diabetic screener.

> "He has provided a very useful and accurate service to the diabetic retinopathy screening since 1995. The accuracy of his referrals has been audited since then and we have had no concerns."

I would just draw the Committee's attention to the fact that regular audits are done by the PCT on those optometrists who sit on the diabetic screening programme, and so it is not a once and for all appointment which is renewable automatically every year. To date, no concerns have arisen as a result of each of those annual audits.

Ms Jones: Can we please receive a copy of that?

Mr Chawatama: Yes. [*A copy is handed to the Committee*]

Ms Jones: Thank you. I am informed that we may wish to call this document 'R1'. Thank you for that.

Mr Chawatama: Madam, you have indicated that you have read these but I will just point out the second reference, which is from a Dr Edmondson, a general practitioner for nearly 20 years, again with a long association.

Over the page, there is a consultant ophthalmic surgeon, Mr Leonard. Mr Jonathan Jagger is another consultant ophthalmic surgeon, all of whom speak highly of Mr Coates.

Finally, there is Dr Lucas, who is both a GP and a patient of Mr Coates, and the letter speaks for itself.

Those are the references. Could I just say this in closing? It is our firm submission that it is not appropriate to impose an interim suspension order, for the reason that Mr Coates has not been shown to be a danger to his patients. It has not been shown that he poses a risk to the public and that the public need protection. The only evidence in support of that from the Council is the report of Mr Breakspear and Mr Gohil and I have addressed you on that.

In our submission, although there are some issues, those are relatively minor that have been identified by Mr Taylor. They do not call for a draconian sanction that would drive him out of work, such as a suspension order. If you are considering making an order under Section 13, then the appropriate order might be a condition on the registration. You have seen the reference there by Mr Taylor to the insight that Mr Coates demonstrates as to those areas where his performance could be improved. He has shown a willingness, already in this short space of time since the original complaint, to adapt, change and improve his practice. He is willing to continue to do so and, in our submission, that would be a more appropriate form of order to make on the evidence that has been adduced before you today.

It was suggested that it would be impossible to find a workable or practical order but we do not accept that. There are institutions, universities and outside agencies who are willing, or could be willing, to assist. We do not have a concrete proposal to put before you today but if you need more information during your deliberations we will be happy to look further into practical arrangements. That certainly is an option, even in his capacity as a sole practitioner, that a workable condition could be attached to his registration.

Unless I can assist you and your Committee on any other point, those are my submissions.

Ms Jones: Are there any questions? [*No questions from Committee members*] Mr Alder?

Mr Alder: I just have some brief submissions to close. My learned friend must have the last word and I propose to say very little. In my opening, I raised the broad application and the concerns raised by the Investigation Committee. The principal evidence upon which the Council rely is clearly the evidence of the two expert assessors who assessed Mr Coates's practice in May 2007.

The Council also rely upon the evidence of Mr Taylor, to the extent that it in fact raises similar and consistent concerns about the practice of Mr Coates. Of course, you will have heard the evidence of Mr Coates accepting, as he did, that he was aware of the assessments and that that was, in effect, his best practice. That I would suggest, Madam, creates, or could or in fact should create, concerns in your mind that Mr Taylor's report represents the highest practice for Mr Coates. He was prepared for the assessments and yet there are still significant concerns about the level of care and the safety of the care which he is providing to his patients.

He identified an idiosyncratic practice, with clinical isolation and no peer review, and the need for there to be some form of action to take as a result, as he referred to it, of these sad events.

I propose not to go into any further detail. The evidence is available in two bundles and you have reviewed it all I am sure, at length and in detail.

The Council's position is very clear. There are significant concerns about the safety and competence of Mr Coates in providing optometric care to patients. I need in fact to say no more than Mr Breakspear and Mr Gohil at the end of their report, when they conclude:

> "We are of the opinion that Mr Coates failed to achieve an acceptable standard of clinical practice with regard to the competencies -"

those basic competencies,

> "- listed above. In view of this, we are particularly concerned that future patients may well have pathology remain undetected."

Madam, the issue as to whether it is necessary that the interests of public protection are achieved by way of an interim suspension order is a matter entirely for you. I have put the Council's position clearly that an interim suspension order would be an appropriate sanction in this particular scenario because, if anything, it is not a matter for Mr Coates to prove but, in any case, the report of Mr Taylor does not give you sufficient confidence that he is able to provide safe, competent care for his patients.

Madam, they are brief submissions. I refer you to all of my submissions that I made in opening and of course all of the documentation that you have. Unless I can assist you further, those are my submissions.

Ms Jones: Are there any questions? [*No questions from Committee members*] Can I invite the Legal Adviser –

Mr Coleman: Madam Chairman, I think Mr Chawatama should have the last word.

Mr Chawatama: On the issue of confidence in Mr Taylor's report on safety issues, I drew your attention specifically to several passages where he specifically addresses the issue of safety. It is accepted, it must be accepted, that his report points to some areas where concerns are expressed by him but he is very careful as an independent expert to then go on to address the crucial question that is before this Committee, which is the safety of the public. His conclusion, as an independent expert, is that the public are not at risk and so you have an alternative view to that of Mr Breakspear and Mr Gohil. That is an important point, that the evidence is not all one way. That is the only point on which I wanted to address you.

Mr Coleman: Madam Chairman, section 13 L (1) of the Opticians Act 1989 provides that you may make an interim order where you are satisfied that it is necessary

for the protection of members of the public, that it is otherwise in the public interest, or that it is in the interests of the Registrant for that person's registration to be suspended or to be made subject to conditions, or alternatively for an entry relating to a specialty or proficiency to be removed temporarily, or made subject to conditions, in whichever case for a period not exceeding 18 months.

You must understand that, when considering an application for an interim order, your Committee has no power to make findings of fact or to resolve disputes of fact between the Council and the Registrant. You consider this application by reference to the material that has been placed before you and that comprises the assessment report prepared by Mr Gohil and Mr Breakspear; it includes the evidence that you have heard from Mr Coates himself; the report prepared by Mr Taylor, and finally the references to which you have been referred by Mr Chawatama.

As to Mr Taylor's report, an issue has arisen during the course of the hearing about certain opinions that have been expressed by him in his report. In particular and by way of illustration, I turn to page 5 of his report where, in his conclusions, he refers to the fact that:

> "The initial assessment report paints a particularly bleak picture of Mr Coates's abilities without noting any of his positive qualities."

He went on as follows.

> "In my opinion, this is largely due to Mr Coates's nervousness during that assessment which then gave a false view of his capabilities."

Mr Taylor was not present at the time of that assessment and so it is very much a matter of opinion and Mr Taylor is no more and no less than an optometrist: he is not a psychiatrist and nor is he a psychologist and nor is he a long-standing friend and colleague of Mr Coates. Therefore, my advice to you on this point is that you should be extremely careful before you attach weight to such opinions as are contained in Mr Taylor's report. You may feel, and it is entirely a matter for you, that, on the question of how Mr Coates may have presented at the time of that assessment, you have in fact derived more assistance from having seen and heard him give his evidence to you today, but that is entirely a matter for you, as I say.

Before you make any interim order you must be satisfied on the basis of all that material placed before you, as I have summarised, firstly that there may be such an impairment of Mr Coates's fitness to practice as poses a real risk to members of the public or may adversely affect the public interest or indeed the interests of Mr Coates himself. Secondly, you must be satisfied that the making of an interim order is necessary to guard against such risk.

You have been referred on numerous occasions to the burden and the standard of proof. These are not strictly applicable to the circumstances of this case, if only because there is no allegation. There are no allegations of fact

that need to be assessed by you and which need to be found either proved or not proved as the case may be, as in a substantive hearing. However, there is some relevance and applicability insofar as the standard of proof and indeed the burden of proof is concerned. The burden of establishing the need for an interim order certainly rests with the Council.

As to the standard, my advice is that, when you consider the second part of the question that you have to consider, namely whether the making of an interim order is necessary to guard against the risk, then having regard to the consequences for the practitioner. You also have to have a regard to the fact that this is an interim hearing at the end of which no final findings of fact will have been made or established against the practitioner, you need to be certain or sure that indeed the making of an interim order needs to be made to guard against the risk identified.

You must have regard to the principle of proportionality, the protection of the public and the protection of patients in particular, and the maintenance of confidence in your profession must be balanced against the consequences for Mr Coates, of the making of an order which may well interfere with his ability to practice his profession and indeed to earn a living.

You should firstly decide whether any interim order is called for. If it is, then you should start by considering whether or not to impose conditions on Mr Coates's registration. It is only if you are satisfied that conditions will not provide sufficient protection for the public and for patients that you should go on to consider making an order for interim suspension of his registration.

Unless there are any matters arising, that concludes my advice to you.

Ms Jones: Are there any, Mr Alder?

Mr Alder: No, indeed.

Ms Jones: Mr Chawatama?

Mr Chawatama: No.

Ms Jones: Mr Henley, could I ask you to clear the room, please?

[*Hearing adjourned at 2.43 pm*]

[*Hearing reconvened at 3.32 pm*]

Determination

Ms Jones: The Fitness to Practise Committee considered an application for an Interim Order made by the Council and decided as follows:

"When making its decision, the Committee had before it the following material:

1. The assessment report by Mr Gohil and Mr Breakspear;
2. The report by Mr Lyndon Taylor;
3. The references relating to Mr Coates;
4. Mr Coates's oral evidence to the Committee;
5. Mr Coates's CET record.

Having carefully considered that evidence, the Committee is satisfied that there may be deficiencies in Mr Coates's fitness to practise, but whether or not his performance has been deficient is for the Committee to determine at the substantive hearing. On the basis of the evidence before it today, however, the Council has not established to the Committee's satisfaction that Mr Coates poses such a risk to the public and/or to patients as to justify an interim order against him."

Thank you.

[*Hearing adjourned at 3.33 pm*]

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