

**F(07)04**

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

**THE GENERAL OPTICAL COUNCIL**

**AND**

**ARTHUR ROWLEY TAYLOR  
(01-7569)**

**SUBSTANTIVE HEARING: Thursday, 20 September 2007**

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**Thursday, 20 & Friday 21 September 2007**

Fitness to Practise Committee: Ms Francesca Jones (Chair) (Lay)  
Ms Margaret Hallendorff (Lay)  
Mr Rodney Varley (Lay)  
Mr Stephen Reily (Optometrist)  
Mrs Helen Tilley (Optometrist)

Legal Adviser: Mr David Etherington QC

Hearings Manager: Mr David Henley BEM

For the GOC: Mr Chris Alder

For the Registrant: Mr James Hodivala  
Ms Ella Power

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*[The hearing commenced at 12.18 p.m.]*

**Ms Jones:** Good afternoon; I have been elected by the Committee to Chair today's hearing. The Committee today is made up of two optometrists and three lay members and I will ask the members of the Committee to introduce themselves and the capacity in which they sit. *[Introductions made]* To my right is Mr Etherington QC, 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 Nesbit, who will be keeping an official record of all that is said today during the sessions of the hearing at which the parties are present. Next to the transcriber is Mr Henley, the Hearings Manager, who will provide administrative assistance to the Committee. The remaining persons sitting in the hearing room rather than in the public and Press areas are members of the respective legal teams.

All parties are reminded that where details of patients are to be discussed those patients should be identified by their initials only; and before I commence may I invite Mr Alder and Mr Hodivala to speak up a little? It would help the Panel members greatly. Thank you very much.

Mr Alder, can I invite you to present the application?

**Mr Alder:** Madam, there is no application to be presented on behalf of the Council as such. It may be that now would be an appropriate time for the allegations against Mr Taylor to be read into the record?

**Mr Henley:**

“The Council alleges that between 1 July 2005 and 31 August 2005, whilst employed by Can do Visiting Eyecare to provide domiciliary optometric care to patients whose records are detailed in Schedule 1 annexed to this allegation, Mr Taylor failed:

1. To maintain adequate patient records;
2. To conduct an assessment of intraocular pressure for those patients.
3. For the reasons set out above Mr Taylor is guilty of deficient professional performance;

**AND** in light of the above Mr Taylor’s fitness to practise is impaired.”

**Ms Jones:** Thank you Mr Henley. Mr Hodivala, can I ask whether any of the particulars set out in the allegation are admitted?

**Mr Hodivala:** Madam, before I deal with admissions can I just raise one issue? I am perfectly happy to be guided by your Legal Adviser on this point as to whether now is the appropriate time to take this point or after admissions have been considered.

Mr Taylor is an individual who has now ceased his practice. He has sold the goodwill in his practice. He has sold all of the equipment in his practice, and these allegations obviously related to a period in 2005. We have made representations to the Council about the propriety of continuing the current allegation in light of Mr Taylor having ceased effectively to practise. The Council have taken the view - and I make no criticism of this, let me make that clear – that they do intend to pursue this particular hearing.

However there is, we would submit, a certain amount of common sense that may need to apply to this case. We submit that in the light of the circumstances existing at the moment, if the Committee felt it a suitable means of disposing of this case that the Committee could consider warning Mr Taylor, without there being any specific findings in relation to his fitness or unfitness to practise, and in that regard that would be a sensible resolution to the case, and avoid any further delays in respect of this particular Committee – in other words of this Committee proceeding to a final hearing.

If, Madam, you and your colleagues take the view that that may be an appropriate course, Mr Taylor is here. I would not ask you and your colleagues to accept the submissions about this current status simply from me, I would suggest that we call him to give evidence on oath as to his current state of practice so that you have formal evidence before this Committee as to

this current state of practice. If, Madam, your Legal Adviser feels that may not be an appropriate way to proceed then we can obviously proceed to the substantive hearing.

**Ms Jones:** [*Confers*] Mr Alder, prior to taking legal advice can I check whether you have any submissions on this matter?

**Mr Alder:** Indeed I do Madam. Submissions have been presented that Mr Taylor has ceased practice, sold the equipment and has indeed sold his practice. As the position currently stands Mr Taylor is entitled to practise as an optometrist. He is still registered with the General Optical Council and notwithstanding the fact that he has perhaps no practice, you have heard no evidence but on the basis that he has no practice does not prevent him from acting as an optometrist.

Furthermore Madam it may assist you as you have heard the allegation, it is very clear that the patient records before you which are allegedly inadequate and the failure to perform intraocular pressure for a number of patients are in respect of domiciliary care provided by Mr Taylor whilst he was working as a locum optometrist. He did not take his own equipment to these particular residential nursing homes. I appreciate you have not yet heard the detail of the case, but the framework for the allegation is against a backdrop of a locum providing domiciliary care using the equipment of an independent party called Cando Eyecare Limited. He is not precluded from practising.

The Council very clearly put the case that Mr Taylor's fitness to practise is impaired, and given the nature of the factual allegations would suggest that patients are at risk from Mr Taylor's practice. The ability for him to continue to practise, notwithstanding his intention with his own optometric practice, would very much be that the public are not protected in any way by such an assertion or by such a warning, Madam.

Those are very brief submissions but I hope I have dealt with them sufficiently, Madam; I have nothing further to add.

**Mr Hodivala:** Forgive me, if I may come back with a valid point that has been made in that respect, and I do not want to keep going to and fro obviously, certainly in respect of the evidence that you would hear Mr Taylor would undoubtedly – and I have to confess I have not taken final instructions on this point but dealing with the point that has been raised – I suspect he would undoubtedly offer an undertaking to this Committee if this Committee felt it relevant that he did not practise. That would then cover the concern that the Council may have about him working as a locum or undertaking domiciliary visits.

**Ms Jones:** Mr Etherington, would you advise us please?

**Mr Etherington:** Two pieces of advice, I am afraid not what Mr Hodivala wants to hear on either front. First of all, it is my advice to you that the question as to whether the Council proceeds absent an abuse of process argument succeeding, is a matter for the Council and not for the Committee. It is their

decision whether they wish to bring a charge or not, and it is your duty to hear it if they so bring it. It only may be short circuited if there was an abuse of process or if it was conceded by all parties that the charge was not now appropriate. As for the warning that is predicated on the condition that you have found that his fitness to practise is not impaired, it not a substitute as it were for not proceeding with the case; it is when you have actually made a finding he is not impaired, so my advice to you would be that I am afraid if Mr Hodivala cannot persuade the Council that the charge should not be proceeded with, then it must be so proceeded.

**Ms Jones:** Thank you very much.

**Mr Hodivala:** That is my advice, and you can accept or reject it.

**Ms Jones:** Let me just confer with my colleagues; are you happy to accept that advice? [*Confers*] Thank you, we wish to proceed.

**Mr Hodivala:** The admissions that can be made in respect of the allegation, then, are that in fact Mr Taylor did fail to maintain adequate patient records; that he did fail to conduct an assessment of intraocular pressure for patients; and it is also admitted that that amounts to deficient professional performance. The issue remaining obviously is fitness to practise and whether there is any sanction if there is a finding that his fitness to practise is impaired.

**Mr Etherington:** That, if I just may assist Madam Chairman on the time-tabling of the case that considerably shortens the issues that will have to be decided. Would it be possible for us to be given an idea of what evidence is going to be called, a timetable?

**Mr Alder:** Sir, the timetable is as I understand it affected by a further application to be made in due course. As I understand the position – and my learned friend will obviously comment if I stray from a reasonable understanding – would be that I would set out very briefly in opening and explain the background to the factual allegations that have been admitted. There is an agreed statement from a counter-fraud investigator, Margaret McMullan; I would read that into the record purely for the public hearing's sake, and that has been agreed so I can read it through, there is no need to call that witness to give evidence.

I would then have proposed to call Dr Trusit Dave who has provided expert opinion on behalf of the Council, and he talks very much to the detail of the records, what would be expected of the records if they had been prepared to the standard of a reasonably competent optometrist. He also talks and provides expert opinion about the need for intraocular pressure testing for these particular patients, and he speaks very much to the importance of that as a test. Dr Dave cannot attend this hearing until tomorrow morning. I understand that my learned friend intends to make an application, given the admissions, that Dr Dave's evidence need not be given before you and – to anticipate the application – that on some level his expert opinion is irrelevant.

The Council's position is clear; his evidence is important for you to hear and to consider and would therefore seek for him to give evidence first thing tomorrow morning. I had anticipated that given the sheer breadth and detail and bulk I suppose of the documentation, that this afternoon or a period of this afternoon could be taken with the Committee retiring to give you the opportunity to review the papers, to review the expert opinion of Dr Dave and the written statement of Mrs McMullan. That would therefore have led I suspect quite neatly into tomorrow morning.

However that would of course be affected should my learned friend's application be successful and you agree with him that his report need not be considered and Dr Dave not be called to give evidence. That would clearly affect the timetable. I am unclear whether Mr Taylor is proposing to give evidence. I would anticipate so, only through experience of these Committees and Registrants, but that also would have an impact on the timetable. If for example Dr Dave is not to be called then there is no reason why this hearing could not be concluded in one day. If he is to be called tomorrow morning by the Council - as I would urge the Committee - that would lead us into tomorrow afternoon for the end of the hearing.

**Mr Etherington:** That is very helpful to the Committee, I am sure.

**Ms Jones:** Before we proceed is it appropriate to take the application?

**Mr Etherington:** Are you asking me, Madam? It is entirely a matter for you but my advice would be for you to take it in order so that you hear what you hear first, because that way you have as much information as you can have before you have to reach a decision about whether you require any further information.

**Ms Jones:** Okay; are the Panel happy with that? [Yes] We will proceed then thank you. Mr Alder, can I ask you to take us forward?

**Mr Alder:** Indeed, thank you Madam. The allegation has been very clearly read into the record and you have heard the admissions. Ordinarily in cases before you the burden of proving the allegation and the factual elements of that allegation fall to the Council and to me as the solicitor appointed by them, and those factual allegations are to be proven to the criminal standard: you must be satisfied so that you are sure that those facts occurred.

Now clearly Madam in this case you are assisted very significantly by the admissions of Mr Taylor, but it is still a decision for you to take. Your Rules do not oblige you to accept the admission and you can still go on to require proof to that high standard.

The allegation itself is that Mr Taylor's fitness to practise is impaired, and it is broken down clearly into the factual particulars. The elements as to impairment and as to deficient professional performance are matters for your professional judgment as opposed to proof on behalf of the Council. The Council will say throughout this hearing, as they do in the charge, that the failure to maintain adequate patient records for around 122 patients over

several weeks of testing in residential care homes, and the failure to conduct assessments of intraocular pressure on any of those patients in those homes, amounts not only to deficient professional performance but also we will say, as is alleged, that that amounts to an impairment of fitness to practise.

The standard as you will be well aware for you to apply is that of the reasonably competent optometrist; does the standard exhibited by Mr Taylor reach the standard of the reasonably competent optometrist or does it, as the Council will submit and maintain, form a significant falling short of the standard which should be expected within the profession?

Madam, Mr Taylor was an optometrist working for Cando Visiting Eyecare, and he was a registered domiciliary provider who was working in Northern Ireland. The company was registered with Eastern Health & Social Services Board. Concerns were raised to the attention of the EHSSB – and Madam, it just assists me somewhat if I can use that abbreviation – about the nature of the domiciliary care provided by the company, and a number of concerns were raised whilst they were being investigated by the Eastern Health & Social Services Board about the apparently high number of claims for eyesight payments being made by Mr Taylor.

He was visiting against their investigation a large number of patients in a high number of Homes across a large geographical spread. He had been working for Cando from February 2003 through, Madam, as you will see from the charge, to August/September 2005.

As you will appreciate, the nature of domiciliary care is often provided by locum optometrists who take with them portable equipment and visit elderly patients who are resident in both nursing homes, elderly mentally and infirm nursing homes but also residential care homes. It is very much an opportunity for an optometrist to visit those who are unable to attend practices based, for example, in the centre of towns, and I understand that Mr Taylor himself owned and was working from such a practice environment (although as you will have heard he has closed them down now). He was working for Cando however in a locum role providing these domiciliary care services as you would anticipate to elderly and vulnerable patients.

As a result of the concerns as to the number of claims being made by Mr Taylor and the company the ESBB, the Social Services Board, in the guise of Margaret McMullan, their Optometric Adviser, undertook an investigation. They began by collating patient records, by recovering the claim forms for sight testing which had been submitted by the company, by visiting the individual care homes, by if necessary attending on members of staff, and where appropriate attending on individual patients.

As you will see in the charge, a sample of that period of patient records which were completed by Mr Taylor has been provided. You will see the three significant bundles which are before you, which I have not asked you yet to look at. That bundle contains the patient records recovered by Margaret McMullan, and they include not only the patient record completed by Mr Taylor for each individual patient but also the claim form submitted by the company.

The patient records were analysed by Margaret McMullan with her optometric expertise. They were examined and initial conclusions were drawn about the adequacy of the records which were completed by Mr Taylor. Mr Taylor was then invited to reply to those concerns, and he indeed did so.

Madam, hopefully in due course there will be sufficient time for you to be able to delve into the detail of the records. Given their sheer bulk I do not propose to take you through every single optometric record, but hope to suggest it would be appropriate to take you to a number of them to indicate some of the alleged deficiencies.

As indicated Madam, the evidence that I propose to read to you is that identified by Margaret McMullan. A copy of her statement is available in the bundle. It was she who identified initially the serious concerns about the patient records completed by Mr Taylor, and as to the standard of care the record forming part of the entirety of the care provided to individual patients she does in her statement conclude, having reviewed all of the patient records:

“I believe Mr Taylor has shown extremely poor standards of care and record keeping towards his patients. This is of particular concern in light of the nature of his patients – elderly, vulnerable and in a nursing or care home.”

I propose to read to you Mrs McMullan’s statement but the headlines to draw from her evidence are that she identified a number of inadequacies in the patient records. Those inadequacies include broadly a lack of clinical notes, in some cases no real detail, no real clinical notes within the patient records. There is no reference made to intraocular pressure testing, and no reference to visual field testing. Madam, as you will appreciate from the admission made by Mr Taylor he in fact undertook no intra-ocular pressures for these patients. Madam, one can conclude I suggest that in fact there should have been a notation as to why, if it is the case, intraocular pressure testing was not available or provided for these individual patients, and similarly with visual field testing, another important test to be provided for elderly or vulnerable patients in a care setting.

Margaret McMullan also concludes that the results of ophthalmoscopy were either not recorded or were not recorded adequately. She refers in her evidence to the phrase “NAD”, an abbreviation known well to optometrists I am sure, but not being under current practice sufficient to be an explanation for the results of ophthalmoscopy. The records showed a lack of consistent recording of medical or family history, and a consistent approach to recording medical or family histories would be expected as the most basic standard of optometric care during an examination. No records were made of any clinical judgments which backed a decision not to refer individual patients. As we will come on to, the evidence of Dr Dave is that around 17 per cent –

**Mr Etherington:** I am wondering whether there is objection to that evidence, whether you ought to be opening that to us?

**Mr Alder:** Well sir, it is important I think to touch on the evidence for the reason that Dr Dave – we are in a difficult situation, sir, because of the application to be made the Council’s position is clearly that his evidence is relevant. He provides a breakdown and supports the view of Margaret McMullan. Her evidence has been accepted, and he provides certainty as to the percentages of record cards which do show this lack of detail. I am happy to touch on that point later sir, but I had proposed to refer to his

opinion in detail because it does assist the Committee in its overall conclusions. I am conscious, though, that perhaps I am jumping too far ahead.

**Mr Etherington:** I would have to advise the Committee if that was the case that there is only one of two things they can do: either you do not open it and it is faced when it comes and you close on it; or the application is heard now. I think that would be the only advice I could sensibly give. You certainly cannot open it while it is objected to.

**Mr Alder:** Sir, perhaps if I complete my opening and then read the evidence of Margaret McMullan, and then perhaps that would be an opportunity to then make the application, because certainly the Council's position is that his evidence is central.

**Mr Etherington:** It may be central, but the question is whether it is admissible.

**Mr Alder:** Exactly, sir; that is the point of the application. Certainly it is clear from Margaret McMullan's evidence and opinion that there were no records of referrals being made on any of these records, and I would suggest that a number of the patients who may have justified being referred as a result of the conditions outlined in their records have not had a notation that there has been a referral. One could not expect every patient record to list absolutely everything; on not all patient records would you expect an optometrist to state 'This patient has not been referred', that would clearly be against common sense; however on those occasions where a referral of the patient would have been justified and it comes down to the clinical decision of the optometrist not to have so referred, then I suggest as Margaret McMullan leads to in her evidence there should have been a notation as to the reasons why referral was not required in that particular case.

Throughout the 122 or so examples there were no complete or consistent recordings of results as to the condition of the fundi, and Madam, there should have been. There were no consistent results of a family ocular or medical history, no consistent recording of medication which you could imagine a number of residents at residential care homes would have had prescribed or administered. There were no records of a dilation of individual patients who were known to be diabetic. Again Madam the issue is as to no notation of such dilation. There was also no record, Madam, which could relate to an instance when it was necessary for an examination to be halted, for example insufficient being provided or could be gathered about the history of the individual patient. No notation has been made on those records as to whether and when examinations were halted half-way through. Had that been the case there should have been notation.

Madam, you will have available to you all of the patient records. The case is put – and I make this concession very openly and clearly as I have done to the Association of Optometrists throughout – very clearly on the basis that it is inadequate patient record keeping. If you are asked to review further evidence later on, some assumptions made by Mrs McMullan draw the inference that examinations have not been undertaken. It is very much a question within the profession at the moment that if there is no notation of an examination then it cannot be assumed to have been carried out; but Madam, you must be I would suggest very careful when reviewing such evidence and the evidence within the patient records, because the case for you to consider is the lack of patient record keeping. The Council does not ask you to draw inference as to whether the examinations were performed or not.

**Mr Etherington:** May I ask you on behalf of the Committee what you mean by Allegation 2 in the allegation?

**Mr Alder:** Sir, that is the *caveat* I am coming on to – with the exception of intraocular pressure testing, and sir, I draw the distinction in a response provided by Mr Taylor which is contained within the bundle, where he refers to not undertaking visual field testing. That as you will appreciate from the records is also not referred to and no results given. The Council very clearly put the case that other than intraocular pressure testing the allegation is clear: you are to look at the adequacy of the patient record, not the lack of examination.

Madam, the omissions of the patient records are fundamental, and as are set out clearly in the College of Optometrists' Guidelines, patient record keeping is essential to good clinical practice and the basic levels of practice which should be afforded by optometrists, and especially in a locum setting. It cannot be assumed that Mr Taylor would be revisiting these patients; they were not his caseload working from his practice, and therefore it is fundamental that adequate patient records are provided detailing the complete scope of the individual examination and individual tests undertaken in order for there to be consistency of care, in order for there to be assurance that a subsequent optometrist is able to understand the ocular history of the individual patients.

Madam, further concerns arose from the investigation undertaken by Margaret McMullan, and most notably through the note that no records were kept of intraocular pressure for any of the patients which were subject to this sample of records which were recovered as part of the ESHBB investigation, one of which was a response provided by Mr Taylor in which he clearly stated:

“I did not perform intraocular pressure testing for these patients.”

He maintained that he did not have sufficient equipment or adequate equipment available to him to perform those tests.

Madam, that leads on to the second part of the allegation, the second particular. The Council very clearly put its case on the basis that intraocular pressure examination should have been performed for each of these patients. They all fall within the high risk category for patients who may be suffering or have signs of potentially suffering from primary open angle glaucoma. This is set out in the College of Optometrists' Guidelines that patients over the age of 40 should be routinely tested for intraocular pressure tests because it is one of the essential, fundamental tests which can assist an optometrist in providing a complete aetiology for individual patients.

You have to take into account 122 patients, elderly patients who were in residential or nursing homes. Not one of them has had an intraocular pressure test and no note has been made that they should have been referred to other optometrists to have such pressure readings taken. We are back to the records I am afraid, in that there is no record on those to explain why tonometry was not undertaken for these individual patients.

Notwithstanding that Mr Taylor maintained both in his response to the Trust but also to the Council that he was unable to do so because the equipment was not available, the Council submits as part of its case that that quite frankly is not good enough. It was the Optometrist's duty either to undertake intraocular pressure testing himself or to ensure that the test was halted so that adequate equipment could be taken to the home to complete the intraocular pressure testing, or those individual patients should have been referred to an ophthalmic medical practitioner or doctor or optometrist to have undertaken those tests. None of those steps I understand were taken, and in failing to conduct the assessments of intraocular pressures for those patients Mr

Taylor has fallen seriously short of the standards expected of a reasonably competent optometrist.

As you will be very acutely aware the duty upon an optometrist is to perform such examination as is necessary to detect injury or disease to the eye. In this case, in these 122 individual examinations, no such pressures were undertaken and that, Madam, I suggest on behalf of the Council is significantly below the standard to expect of a reasonably competent optometrist.

I propose to review with you briefly Margaret McMullan's evidence, to read that through to you, but that closes my brief background and explanation to the facts which will form the basis of this case.

Madam, if I could ask you – I have been reluctant to do so because of the bulk of the documents available to you in these bundles, you have two Lever Arch files of papers and one slightly smaller file, so perhaps I could ask you to turn to those please. I understand it has been agreed with the Association of Optometrists that you can review these records.

**Mr Etherington:** All at once?

**Mr Alder:** If you could have them all at once then I can explain the nature of the bundle and where to find the particular documentation. The principal statement of Margaret McMullan is in the third I say 'slightly smaller' file – in the smaller third bundle.

**Ms Jones:** Can we then refer to this file as Number One should we need reference to it at different points?

**Mr Alder:** Madam, I do not mean to be difficult but if I could refer to that as Bundle 3, just because of the pagination, Madam. It is the final bundle in terms of the Index.

**Mr Etherington:** The Committee will be careful; in my bundle as may be in the rest Dr Dave's statement is there and we shall be very careful not to look at that I am sure Madam Chairman, until it is agreed. Forgive me.

**Ms Jones:** Thank you.

**Mr Alder:** Madam, confusingly there are two Schedules set out at the very beginning of the first bundle. The first bundle is a Lever Arch file which is entitled Index to Hearing Bundle. This sets out Madam, the patient records and the pagination to which you can refer. You will see at the end of that Index to Hearings Bundle a further Schedule, which is Schedule 1, which is in effect the patient identification schedule set out in the allegation, and in essence replicates the same pagination as set out in the Hearings Bundle. There is limited value to that document other than just to point out what it is in your bundle, and that is the purpose of it.

Madam, if I could ask you briefly to turn to page 2 of the first Lever Arch file, the one with the Index in it Madam, you will for each patient, for each individual examination – and you will see it begins at page 2 – a copy of the patient record completed by Mr Taylor. You will generally see a blank page next because that is the back page of the patient record, and behind that the claim forms. Those Madam have been included in order to assist you if necessary with bad photocopying or with dates for example, but this represents the bundle of documentation presented by Cando and presented by the Social Services Board.

Madam, it may be of assistance, as I am aware for your optometric colleagues but for myself and for your lay members, the patient record itself for example at page 2 sets out a number of different sections. You will hear from the evidence of Margaret McMullan those particular areas which she feels are inadequate. The top left-hand section is the date of the examination, and in respect of page 2 it was undertaken on 4 July 2005. You will see the venue of the nursing home and the address, the individual patient's details and date of birth. On the left-hand side Madam there is a patient history section in which it would be anticipated the patient's history and symptoms could be recorded. On the right-hand side of that box, External Exam and beneath that Ophthalmoscopy, so reference made to records expected to be seen in that section would fall there. On this particular section Madam you then have a number of different boxes including Cover Test, Muscle Balance, and in the centre Retinoscopy and various results.

You will see on the right-hand side IOP Method, and that very much relates to the lack of intraocular pressure being undertaken, and that particular examination of tonometry, and in the bottom the final Prescription. You will see there Madam, Right and Left, and in the bottom third that is where I understand you would expect to see visual acuity records.

Madam, that is very much a lay view of these records, but hopefully they can assist you in familiarising yourself when you turn to the evidence of Margaret McMullan. I do not propose for my part to take you through the individual patient records, they are available for you. Very much the approach taken by Margaret McMullan in her evidence is to draw broad themes from what is lacking in these individual records. I will not explain what Dr Dave does but it is very much on the same footing.

Madam, if I could ask you to turn to the third bundle, the smallest bundle of the three, this particular part of the bundle hopefully is of greater assistance to you to the extent that it contains, if we get there, the expert opinion of Dr Dave, the statement of Margaret McMullan, the response prepared by Mr Taylor, and therefore has in essence the statement evidence in what is hopefully a more manageable form than the rest of the documents in the bundles.

The statement of Margaret McMullan is at page 866, and I propose very briefly to read this, Madam, into the record. It has been agreed, and you will see that the pagination at the bottom of the statement does not follow all the way through because of a number of reductions of individual paragraphs which have been agreed with my learned friend.

The statement of Margaret Mary McMullan of the Eastern Health & Social Services Board in Belfast is dated 14 March 2006, and is signed by her on each page, and at the bottom of the page you will see, Madam, is attested by a Statement of Truth.

"I make this witness statement in support of the allegation the Eastern Health & Social Services Board notified to the General Optical Council during October 2005, and to comment on the representations made by the Registrant Mr Arthur Taylor.

I am 35 years old and the Optometric Adviser to EHSSB, a position I have held for over four years. I am also Optometric Adviser to the Western Health Board and occasionally undertake locum work. Prior to my current appointments I was a self-employed locum and also undertook an ad hoc supervisory role for optometry for the University of Ulster.

The EHSSB began investigating Mr Taylor in August 2005 following the results of routine probity work which identified a high volume of claims made for domiciliary visits undertaken by him. In addition in some cases claims were made over a large geographical spread that indicated Mr Taylor had visited many sites in just one day. As a result of this the EHSSB referred the matter to the Counter Fraud Unit of the Central Services Agency, who has formally investigated the trends by checking all claims against the clinical records of the patients. The EHSSB also undertook to visit a sample of patients who had been examined by Mr Taylor, to check that their spectacles matched the prescriptions on the record cards.

Mr Taylor had been on EHSSB's Ophthalmic list since October 2002, and began submitting claims in February 2003. He worked for Cando Visiting Eyecare who was a registered domiciliary provider on EHSSB's list. For a company to be placed on this list it must have registered a base and details of their mobile equipment are submitted. All relevant checks were performed on Cando. At the time of the firm's registration on the list in 1999 there were four partners in the firm including one optometrist. Mrs Kathy Sweeney, who Mr Taylor refers to in his representations, is not optically qualified.

As a result of the preliminary findings, both Cando and Mr Taylor were asked to desist from practising in Northern Ireland from October 2005 as EHSSB have no power to formally suspend. This request has been complied with. I understand Mr Taylor practises in Ayrshire, Scotland, and the EHSSB have informed Ayrshire & Arun Primary Care Trust of our concerns. I do not know what if any action they have taken. This is the first clinical disciplinary case EHSSB have had to deal with in the four years I have worked for them. The Northern Ireland disciplinary regulations state that investigations into clinical care must be conducted within a specific 13 week timeframe from the date of an incident occurring, therefore the records supplied to the GOC for their investigation is a two month sample covering the period July to September 2005. The EHSSB are using this time period for their internal disciplinary case.

However I have in fact reviewed all patient records of Mr Taylor in connection with his examinations performed on behalf of Cando from February 2003. I can confirm that the problems identified in the sample analysis that are described below, are repeated throughout the period Mr Taylor performed services on behalf of Cando. In that sense the sample records are representative of the situation.

The EHSSB is currently undertaking a look-back exercise to review all the patients seen by Mr Taylor since 2003, approximately 900 patients. Press releases were released by the EHSSB in early December 2005, and all patients and relevant care home managers were notified that a review was necessary. This review began in late December and involves four independent hospital optometrists visiting each patient and re-examining them. A formal report of their findings is not yet available, but where I have information that assists the GOC investigation I have indicated the early results.

The initial feedback is that the tests undertaken as part of the review have been much more comprehensive, but it is too early to comment on whether or not serious conditions were missed as the EHSSB are still gathering evidence. The EHSSB hope to produce a formal report during April/May

2006. As there are serious clinical concerns about Mr Taylor's practice, the EHSSB took the view to notify the GOC before this exercise was completed.

The CFU is also conducting an investigation into Mr Taylor and Mr Cando. The matter has been notified to the GOC, but the EHSSB have not requested formal investigation until the CFU investigation is complete and the EHSSB have decided upon a route of action. EHSSB felt that it was important to notify the GOC straightaway of the clinical concerns in relation to this registrant."

A general summary of the allegation:

"Of the 131 clinical records which form the sample period of July/August 2005 that I have reviewed" –

- and Madam I could briefly stop there; 131 records were reviewed by Margaret McMullan. Mr Taylor in his response both to her and to the Council identified and maintained that nine or so records were not his. The 122 patients that I have referred to are the records which have been identified by Dr Dave. I will not say any more about his evidence, but he has in his report stood back from those individual records which Mr Taylor maintained were not his. So of the 131 clinical records:

"- that I have reviewed I believe Mr Taylor has shown extremely poor standards of care and record keeping towards his patients. This is a particular concern in light of the nature of his patients, elderly, vulnerable and in a nursing or care home.

I note from his representations that Mr Taylor disputes that nine of these records are his. In these cases although it is clear that a date has been amended it is Mr Taylor's signature that appears on the claim form, therefore I believe that he still holds responsibility for those records.

The results of my findings following a review of the records are contained in Appendix 5, "Summary analysis of sample clinical records of ophthalmic contractor 594 Mr Arthur Taylor". This is a detailed analysis of the patient records contained at Appendices 6-14. The main areas of concern include: lack of clinical notes; no IOP [intraocular pressure]; no visual fields; no ophthalmoscopic results recorded; no medical or family history taken; no referrals made where appropriate; inappropriate dispensing of spectacles."

Madam, I refer to the concession I made in opening, where Mrs McMullan refers to "no medical or family history taken" for example, the basis of the Council's case is that it may well have been taken but it is just not recorded, and it is the record and lack of record which the Council bases its case upon.

"I will now address these and other areas of concern in more detail. In assessing Mr Taylor's performance I used as a benchmark the records and standards of other contractors providing domiciliary services in addition to professional guidance and the regulations."

Paragraph 24:

"In 16% of cases there was scant clinical detail in the records. In some cases there are no notes at all on the card. It simply records the date of the test, and we found a matching claim form for sight test and spectacles that

corresponded with that date. One example of the total absence of clinical notes is for Patient PM at Home P – no IOP [intraocular pressures] or visual field testing. In 81% of cases Mr Taylor failed to carry out and record IOP and visual field tests. As there were no notes on the record cards we assume the tests were not performed, and this is confirmed in Mr Taylor's own representation as he states that "The equipment, a non-contact tonometer, was unserviceable due to water damage" and that "no alternative equipment was available". The regulations for contractors clearly state that a contractor is responsible for the equipment, see Regulation 4(1)(a) of the Terms of Service at Appendix 3.

With elderly patients I would always expect to see intraocular pressures and visual field test results. The intraocular pressure for patients over 40 should be tested regularly. If it is not possible to obtain a reading, for example if the test was attempted but abandoned as the patient cannot co-operated, I would expect to see the attempt recorded on the record card and an explanation as to why no results were obtained. Mr Taylor did not record that no equipment was available.

Mr Taylor seeks to refute his responsibility, stating that Cando were responsible for the equipment and its transportation. I believe that if the equipment was not available to Mr Taylor then he should have refused to perform the sight tests. A sight test should have been rebooked for when equipment was available.

No ophthalmoscopy: a practitioner has a duty to record everything they see during ophthalmoscopy, and most importantly to record positive as well as negative findings. In 35 cases the recording of the findings were inadequate or absent in relation to this essential test. This equates to 26% of patients with no actual results of the condition of the fundi reported.

In some cases Mr Taylor wrote "seems OK" and "NAD". In my opinion this is not correct or appropriate recording of clinical findings. I consider it extremely poor clinical practice to not record results, particularly taking into account the age of these patients and the associated ocular pathology that many of these patients are likely to have.

Mr Taylor states that it was an "administrative oversight" that he did not record any results. I believe that 26% is an extremely high figure for an "oversight".

No history/symptoms: In 59% of cases no details of family, ocular or medical history were obtained, nor were any symptoms the patient might be experiencing recorded. I have taken into account the difficulties of working with elderly and/or mentally infirm patients. However I believe that this figure is unusually high. The practitioner has a responsibility to try and obtain the information, and if Mr Taylor was having difficulties he should have consulted the nursing staff. At the very least the practitioner should get an indication of the patient's general wellbeing. If the patient was presenting with no problems then this should have been recorded. Mr Taylor states that he did ask the relevant questions, but the patients did not know. If this is the case this should have been recorded on the card.

No record of medication: In 80% of cases there is no record of the patient's medication. Mr Taylor contends that he questioned his patients but they did

not know. As with the previous category this is an unusually high figure. Again the review visits have shown that some patients are aware of their medication, and that staff are willing to assist in providing medication sheets. Mr Taylor also states that he reviewed previous patient records where available to obtain information about medication. This is insufficient as medications can often change, and as some can have ocular side effects it is particularly important to obtain current details.

In summary and as a result of the areas of concern identified above, EHSSB have serious concerns about the patient care provided by Mr Taylor, and have duly reported the matter to the GOC for further investigation.”

That concludes the evidence of Margaret McMullan. My next step would have been to have called Dr Dave to present his expert opinion to you. You will have heard very clearly that an application is to be made, and now may be the appropriate time for consideration to be given to that application.

**Mr Hodivala:** Madam, the Rules themselves provide for the admissibility of evidence in the course of these hearings, and the Registrant observes that whilst in Rule 38 sub-Rule (1) there is a general power to admit any evidence that is deemed –

**Ms Jones:** Sorry, can you give us a page number as well? Sorry to interrupt you.

**Mr Hodivala:** Page 99; that is all right. There is a general power to admit any evidence that is considered fair and relevant to the case before the Committee, whether or not such evidence would be admissible in a court of law. Nevertheless by sub-Rule (2) where the evidence would not be admissible in criminal proceedings in England and Wales the Committee shall not admit such evidence, unless on the advice of the Legal Adviser they are satisfied that their duty of making due inquiry into the case before them makes its admission desirable.

Dealing with the admissibility of evidence, where the evidence would not be admissible in the course of criminal proceedings there is a presumption that it shall not be received by this Committee unless there is legal advice to the contrary, and you are satisfied that your duty of making fair and full inquiry should lead to the admission of the evidence. The simple point that we would make in relation to Dr Dave’s evidence is this: evidence on an ultimate issue is inadmissible in criminal proceedings, quite obviously because where there is a Tribunal of fact making a decision it is the Tribunal of fact that decides on the basis of facts that it has heard what inferences to draw from those facts, likewise what weight to attach to facts and so on and so forth.

The evidence of Dr Dave we submit is sought to be used by the Council to go to the ultimate issue of fitness to practise, and particularly whether there is an impairment of fitness to practise. Using the analogy with criminal proceedings it would not be admissible we say were this a criminal matter - and I hesitate for a moment because I am conscious that you obviously have not read the report of Dr Dave and I do not intend to prejudice this Tribunal by going in detail through his evidence. However I will just touch on one or two aspects of it which I hope fairly and accurately reflect his evidence and are not tendentiously put, and if there is anything I do say that the Council disagree with they will make their observations.

**Ms Jones:** One moment; before you do that can I just check with our Legal Adviser whether admitting part of the evidence of a report we have not yet seen will create any difficulties?

**Mr Etherington:** Council can refer to it in argument at their discretion Madam Chairman and - I say this politely – at their peril. It is a matter for Council to decide what it is necessary to put before you in order for you to resolve the issue. There is a circularity to it to an extent, as you will understand, but on the other hand if you know nothing about it then it is very difficult for you to reach a sensible decision, even if I knew something about it because I am not in the same position as you on knowing about the facts. On the other hand if you know too much about it, it might then cause a difficulty to your impartiality in due course, but I think Mr Hodivala has that point well in mind in what he is going to lay before you.

**Mr Hodivala:** Yes, absolutely.

**Ms Jones:** Thank you; if you would proceed then?

**Mr Hodivala:** On the basis that it is accepted that as a matter of law evidence of an ultimate issue would be inadmissible in court proceedings and in criminal proceedings, you have heard evidence already about the College of Optometrists' Guidelines in respect, for example, of record keeping, and you have heard the case opened for instance on the basis that the College of Optometrists' Guidelines indicate that full and accurate records are fundamental.

You have also heard in relation to the second head of charge that the College of Optometrists' Guidelines are that IOPs [intraocular pressures] should be taken for all patients over 40 years old, so for the Registrant's purposes we say it is difficult to see what evidence could be given by the expert that would be in addition to the way that the Council have quite properly opened the case that would not, in effect, amount to evidence of the ultimate issue for you to consider.

I will not give specifics at this stage but there are observations made by Dr Dave that stray into other allegations that do not concern this Committee. The concern that we have is that given the Committee has already received in the course of the opening observations about the College of Optometrists' Guidelines in any event, there is a real danger than not only would Dr Dave stray into other matters in giving his evidence but also, as I say, the evidence that he gives would amount to inadmissible comment on the inferences to be drawn from the patient records.

In any event you have the evidence from Ms McMullan, which is agreed evidence, from which you can quite properly decide this ultimate question in respect of fitness to practise.

It is a short submission, it is a simple point we say, that although Dr Dave goes into some detail with regard to Mrs McMullan's evidence and the records themselves that effectively such evidence would be inadmissible as being adduced by the Council to go to the ultimate issue in this case. I think that is all I can say at this point.

**Ms Jones:** Before I ask the Legal Adviser for his opinion can I ask Mr Alder to give his response?

**Mr Etherington:** Indeed, you should.

**Mr Alder:** Yes, thank you Madam. The expert opinion of Dr Dave goes into quite significant detail about the nature of the patient records and the need for intraocular pressure testing, and is presented in his expert capacity. He can assist you I suggest with considering the degree of seriousness both of the risk to patients, the risk to these

patients for whom intraocular pressure testing was not undertaken, and I suppose the degree of failure of the patient records.

Madam, I have not specifically taken you to individual patient records, firstly and most importantly because I cannot give evidence before you, and as you will appreciate I certainly cannot give anything to the degree of expert insight into these records which Dr Dave would be able to. Analogy has been drawn with the criminal courts, but you are quite distinct to the extent that you are a Committee of Inquiry. The tests which you are being asked to apply as to deficient professional performance and thereafter fitness to practise are very much matters for your judgment; but they are matters which allow you a greater degree of latitude in respect of the evidence which you can consider.

The point has been made that Dr Dave is being called in some way to give you a steer on the ultimate issue: is Mr Taylor's fitness to practise impaired or not. I can assure you that from knowing Dr Dave's report, having experience before Committees of this nature, that that is not the purpose of his evidence. He is called to give his expert view to provide you with some assistance if you require it as to the nature of the deficiency, the nature of the inadequacies the Council say of these records. That allows you to have a context in which you can make your decision as to whether the factual allegations which have been admitted do fall short, and it is part of that context in which Dr Dave provides his evidence. At no point in his report, and at no point as you would expect would I seek to ask any questions of him in which that would be put. It is quite open for a conversation to be had with Dr Dave in the morning to point out the limitations of his report.

The charges which face Mr Taylor come after his report, and so there are some areas as I have indicated in respect of the issue as to whether tests were performed or not which do not form part of the Council's case. There is a very open dialogue which can be had with Dr Dave either before the hearing or before he begins to give his evidence in the morning; but at no point will the question be put to him or an answer sought from him as to his view as to whether Mr Taylor's fitness to practise is either deficient or impaired. He can, though, I suggest give you wider contextual information about what is expected within the profession, what he himself sees as an optometrist as being the standard of a reasonably competent optometrist. He has significant experience in private practice, but also in terms of his visiting professorship at Aston University he can provide you with a wider snapshot of what is expected within the profession.

It is ultimately a matter for you, the issue as to impairment and indeed as to proof of fact, and that is a subsequent point which you may find of assistance. Whilst you have admissions from Mr Taylor in respect of both factual allegations and as to deficient professional performance, there is nothing within your Rules which guides and binds you to accept those admissions. It could be a matter for your judgment that despite, for example, Mr Taylor's acceptance of deficient professional performance, in your minds you may come to a different view.

If it is the case that Dr Dave can assist with providing a wider context of optometric practice, of domiciliary work, of the use of intraocular pressures, to allow you to make that decision then I would submit that the safer course is for you to hear his evidence and then to attach what weight you will, or not, to whatever his opinion may be as presented. The difficulty for you I suggest in not hearing Dr Dave is that you will be then asked to make a determination in somewhat of a vacuum. You have not heard from Margaret McMullan, and as a Committee of Inquiry you have not been able to ask questions of her as to the basis of her view. In discounting Dr Dave's evidence

as to his opinion with regard to intraocular pressure and the records you would I suggest be operating within a vacuum, and as a Committee of Inquiry would potentially lose an opportunity to ask any questions of him that you may have once you have had an opportunity to review all of the records, which I am afraid at some point you will need to do.

**Ms Jones:** Thank you, Mr Alder.

**Mr Hodivala:** The only point I make in response is that had the Council wished to do so it could of course have called Mrs McMullan to answer any questions that the Committee may have had. There were no contentious items of her statement. Her statement was agreed, and the Council have elected to read the statement rather than call her, so that is the only observational response I would make.

**Ms Jones:** Before I ask the Committee whether they have any questions can I invite the Legal Adviser to advise us?

**Mr Etherington:** May I just ask a question? How is it that the statement finds itself in our bundle? When was this objection first taken, if I can put it that way?

**Mr Hodivala:** This is not the first time objection has been taken.

**Mr Etherington:** Then how is it in the bundle?

**Mr Alder:** Because it was anticipated by the Council, I think, that there would be argument as to its admissibility.

**Mr Etherington:** Another good reason for it not being.

**Mr Alder:** Sir, if it assists you, the first understanding I had that Dr Dave and his evidence was not to be called was yesterday evening on the telephone. There were these issues in respect of the tests, and conclusions or inferences drawn by Dr Dave that tests had not been performed, hence the reason for my concession very early on in my opening that the Council's case is based upon the patient records and those inadequacies rather than the extension and inference that Dr Dave has drawn.

**Mr Etherington:** The only thing I am thinking about is that whatever advice I give to the Committee there is the statement. Now, if it is going to be said at some later stage by anybody that our eyes should not have passed over certain passages in the statement at all because they are prejudicial, they had better be collected back and that had better be dealt with before we come to it, because it will be too late otherwise.

**Mr Alder:** Sir, one of the difficulties with documentation of this nature is pretty much how to present it in the Committee. It is in the form of ring binders and I have not taken the Committee to the opinion of Dr Dave, and purely for the record the Committee have not pre-read this bundle. It can in its entirety be removed if that is the Committee's decision.

**Mr Etherington:** Yes, what I am saying is if we reach a half-way house where you are relying on Dr Dave, the Committee found it was acceptable but there were passages in it that are not. That is all I am asking you to think about – but that is perhaps for a little later. If I could just give the Chairman now the advice, objection is taken to the evidence proposed to be called by the Council of Dr Dave, and as I heard the way it was put it seems to be on two fronts: one because in effect it would be evidence as

to the ultimate issue, namely the question of whether the Registrant is fit to practise or whether that is impaired; and the second objection that was taken – a little bit of a side wind but nevertheless it is there – was that his evidence might stray into other allegations, and that was the point I was dealing with in the questions I was asking.

I have no difficulty in advising you that his evidence must not be allowed to stray into other allegations, and I would give you the strongest possible advice not to permit that to happen because it could affect your impartiality in dealing with the issue that you have to consider on these allegations. That can be cured if the evidence is otherwise admissible by editing, which should be done as soon as possible so that you do not see things that you would wish you had not seen afterwards given what you have to consider.

The main issue is ‘Does his evidence go to the ultimate issue?’ Well, in a sense we do not know that until it is heard, but what the doctor must not say in my advice to you is whether his opinion is that the Registrant is fit to practise or not, or whether his fitness to practise is impaired, because that is not what he is called to say, that is your decision. However, and it is a matter for you, you may think it may be highly relevant to the ultimate determination which you make to know or have assistance from an expert on the scale, degree and effect of any deficient professional practice which is admitted, in order for you to make the ultimate decision as to whether the Registrant’s fitness to practise is impaired. So that is the advice that I would give you.

**Ms Jones:** Thank you for that; may I just check with the Committee whether you have any questions or comments? [No] Can I suggest that we clear the room for five minutes and consider this? [Confers with Legal Adviser] I have just been advised – or maybe not ‘advised’ but it has been suggested – we had proposed to take a break at 2.30 today, just to make you aware of that, so if we just take five minutes now we can then move on. Thank you.

[Hearing adjourned at 1.31 p.m.]

[Hearing reconvened at 1.44 p.m.]

**Ms Jones:** I would like to confirm to all parties that we have not received any further legal advice. We are accepting the earlier advice of the Legal Adviser and we have determined that we will admit the evidence of Dr Dave, as we believe that evidence to be potentially relevant and admissible. We would like your help with our next decision. We would like to be very clear that these bundles that we have include no prejudicial or relevant material in relation to the report by Dr Dave, and we would like you to take back the bundles and to edit them accordingly. I want to clarify with you whether we need to hand back what we have termed the smaller Bundle 3, and whether there is editing which is necessary beyond Dr Dave’s papers?

**Mr Hodivala:** The Registrant would say we would like editing made to Dr Dave’s evidence. [Confers] We would like edits made to Dr Dave’s evidence that is currently in the bundle, yes, we would like to do that.

**Mr Etherington:** If I may just interpolate, I think the Committee were interested in the point that you made about evidence or remarks about additional allegations.

**Mr Hodivala:** Yes; although the Council have very fairly conceded that they have put their case on a very limited and strict basis, nevertheless there is material –

**Mr Etherington:** Which goes further - sure.

**Mr Hodivala:** - which the Registrant says is prejudicial, if I can put it that way.

**Mr Etherington:** We do hope and expect you could do that?

**Mr Hodivala:** We will do that, yes.

**Ms Jones:** Can you clarify for us that we only need to return that one element of the bundle, Mr Alder?

**Mr Alder:** Madam, I prosecute on behalf of the Council. To my mind there is no additional editing that needs to be made, so possibly I think that question should be put more fairly to my learned friend.

**Mr Etherington:** So there is nothing in the report that tends towards any other suggestions for instance?

**Mr Alder:** Sir, in respect of the wider bundle, no.

**Mr Etherington:** In respect of the report?

**Mr Alder:** I accept in respect of the report there are edits.

**Mr Etherington:** There is some editing of the report.

**Mr Alder:** Indeed, yes. Sorry.

**Ms Jones:** And then gentlemen, in regard to the wider bundles – I am conscious that my colleagues have just received a considerable amount of paper today that we need to read and possibly to take away what we can. We want to be sure not to read any material whatsoever which may prejudice or widen the issues that we have been asked to consider, and so we are asking you about how much you need to edit, because we need those materials too.

**Mr Hodivala:** I am just going through the bundle, and it is simply Dr Dave's report.

**Ms Jones:** Can I invite the parties then to receive Bundle 3 and to remove Dr Dave's report, and to return them to us by 2.30 today - to me it is an administrative matter – and then we would like the amended Dr Dave report to be with us by no later than 9.00 a.m. tomorrow morning, and we will recommence proceedings at 9.30 tomorrow morning.

**Mr Alder:** Madam, I wonder if I might just make a suggestion, merely to assist the timing of the hearing. I have no doubt that between my learned friend and I can we agree the edits to be made. There are some where we disagree, there are the majority where we agree, and I propose that we made those edits today so that you can have the final version of the report with you to consider possibly overnight, in order to assist any questions that you may have of Dr Dave first thing in the morning. That would seem to be a more appropriate use of time, and would utilise Dr Dave's attendance finally tomorrow in the best way.

**Ms Jones:** A number of us have not even seen it; I do not know how big the report is to which we refer?

**Mr Etherington:** It is 14 pages – or thirteen-and-a-bit.

**Ms Jones:** Can I ask you, what do you think is achievable today if we are to go ahead and have that report today?

**Mr Hodivala:** You would have the opportunity I suspect of reading the report, which will not take particularly long to do, and as I understand it that would be as far as we could go today. I am confident that we can relatively swiftly resolve any editing issue.

**Mr Etherington:** I could state the obvious, which is that if you cannot resolve an editing difficulty it has to be in anyway because we would have to hear it to decide whether to exclude it, so you might as well leave it in if you cannot agree it, and we shall see whether or not it is relevant in due course.

**Ms Jones:** Then can I invite both parties to have an amended document back to us by three o'clock today? Is that possible?

**Mr Alder:** I think that is eminently realistic, yes.

**Ms Jones:** Okay, thank you. We will reconvene tomorrow at 9.30. May I ask you to give the amended documents to Mr Henley, who will distribute them to us? Thank you very much.

*[The hearing was adjourned at 1.50 p.m.]*

## **Day 2 - Friday, 21 September 2007**

*[Hearing resumed at 09.24 am]*

**Ms Jones:** Good morning. For the record, I just want to say that, at the close of yesterday's hearing, the Panel received an amended copy of Dr Dave's report which had been the amendments agreed by both parties and it was returned to the third bundle. Mr Alder, may we commence?

**Mr Alder:** Indeed, thank you, Madam. If I may begin then by calling Dr Dave?

### **DR TRUSIT DAVE sworn Examined by MR ALDER**

**Q.** Dr Dave, I shall ask you a series of questions which relate to the report that is in front of you. Can you just confirm that that is a copy of an amended redacted report, to ensure that we are all talking to the same version?

**A.** Yes, it is the report that I have written and it has amendments on it.

**Q.** I am grateful, thank you. I shall ask you a series of questions and then the Committee may also ask you some questions or my learned friend. When you answer the questions, could I ask you to refer directly to the Committee with your answers and to keep your voice up, indeed higher than mine, to ensure that a full transcript is accurately obtained? Could I ask you to confirm the contents of your report, which is dated at the end 15 January 2007, I am referring to page 858?

**A.** Yes.

**Q.** It is a copy of your report and you confirm above there in a paragraph that the facts stated are within your knowledge, you have made clear which they are and you believe them to be true, and the opinions which you express represent your true and complete professional opinion?

**A.** That is correct.

**Q.** Thank you very much. Dr Dave, if I may briefly turn to your background. At page 846, the first substantive page of your report, you graduated in Optometry and Visual Science from City University in 1990, is that correct?

**A.** Correct.

**Q.** You qualified in 1991 and returned to university to do your PhD in Video Keratoscopy?

**A.** That is also correct.

**Q.** You are currently, I understand, a visiting lecturer at Aston University, is that correct?

**A.** Correct.

**Q.** I also understand that you are in private practice. Could you explain the background to your private practice and current optometric practice?

**A.** Sure. It is an independent private practice; we started about 11 years ago. Originally, I was involved in working there full time and now I do about three days a week.

**Q.** Have you ever been involved in domiciliary care?

**A.** I have indeed. I have worked, going back a number of years, in the domiciliary eye care setting as well.

**Q.** Dr Dave, before taking you through the allegation which faces Mr Taylor being that there was a failure “to maintain adequate patient records”, and a failure “to conduct an assessment of intra-ocular pressure for those patients”, it is important purely for the record, given the discussion between my learned friend and me and the Legal Assessor yesterday, that your opinion is restricted to those particular areas.

**A.** Yes.

**Q.** Thank you. In front of you are two quite sizeable lever arch files of the documents to which you refer in your report. I would like to refer you to those in due course but, first, could I take you to table 5A in your report at page 859. Could you briefly explain for the Committee the background to this table and how you have come to draw your conclusions, the percentages and the particular areas that you record in this table?

**A.** Sure. I looked at the eye examination, be it domiciliary or in a general eye care setting, and I looked at some of the core elements. In domiciliary eye care, one does not have the luxury of having all the wonderful pieces of equipment that we have in private practice, so you utilise the core elements of an eye examination that I would regard as being essential within a domiciliary setting. I went through 121 or 122 records which I believe are in front of me

here. I removed, I believe, nine of them from these records which I felt, according to the defendant, weren't in fact his records, so I decided to eliminate those from my analysis. I subsequently went through each and every one of those records in order to gain some insight into the recording of the specific attributes of a core examination.

**Q.** Could I ask you briefly to explain the figures, though you do so briefly in your pre-amble? For example, in the column dated 4 July, you refer there in brackets to 21: can you just explain how you have arrived at that figure and what that represents?

**A.** The 21 refers to the number of patients seen on that day, or the number of records, more correctly should I say, that I analysed. If one adds up all of the figures in the brackets, it comes to the total number of records that I evaluated. As you see at the end of that particular table, on the very right-hand side, it tells you that I have evaluated 122 records in total, which are the number of records over that period of time.

**Q.** If I could take the example of the same column of 4 July, you refer in Symptoms & History to 9[43]: could you briefly explain what those figures represent?

**A.** Sure. The number 9 refers to the number of records of the 21 records that were performed on 4 July in which symptoms and history were not documented. The [43] represents the percentage thereof.

**Q.** And that logic applies to all the figures in this table?

**A.** Indeed it does.

**Q.** For example, with Pupils in the same column, 21 of the recorded examinations did not show records for pupil examination?

**A.** Correct.

**Q.** The 100 representing 100 percent?

**A.** There was an absence of pupillary testing in all of the records on that day.

**Q.** Thank you. Could I ask you to go row by row? You have referred to the absence of a record for Symptoms and History, followed by Visual Acuity. Could I ask you to explain the relevance of each of those particular headings, starting with Symptoms and History?

**A.** When one is in front of a patient, it is very important, first, to address reasons why the patient is there and requires an eye examination, and to gain an insight into what their principal symptoms are, what they are complaining of. From there to ask a sequence of questions, which would give a further insight into those symptoms and from a history perspective to gain information such as previous ocular history, general health, medication and so on. This information is very important to build a mode of examination, a protocol, for want of a better word, in order to investigate those symptoms. Visual acuity is a core element of eye care and changes in vision and annotating what a patient can see leads to a very important piece of information with regard to loss of vision, correctable vision and so on.

Pupillary function is for me again an important issue, particularly with respect to the fact that it is an objective test. In a domiciliary setting, a practitioner is often faced with patients who are not able to communicate particularly well, so we have to rely on tests which sometimes avoid patient responses. Pupillary testing is a very simple test, all it requires is a pen torch, something that needs to be carried in a mobile setting, but it does not require any responses from the patient and can lead to information about neurological changes that are occurring, and core information such as advanced pathology in a particular eye.

**Q.** Because of the technical terms you are using such as pupillary reflexes and pupillary examination, what are you seeing as an optometrist when you do the examination?

**A.** It is a gross examination in the sense that one is shining a light into the pupil, one records the response of the pupil to that light and compares both eyes as well. So there are a variety of different pupillary tests that can be performed. However, as it is such an easy test and is a core element of training within optometry, and it is one which requires very little instrumentation, it is something that is very important particularly in the domiciliary setting.

**Q.** Similarly, with the fundus, could you explain the background to a fundal examination and the background to what you would expect to see on a record card?

**A.** A fundus examination, as I am sure the Committee are already aware, is there to give information about any pathology or disease that is affecting the back of the eye, namely the retina and structures that are visible there such as the optic nerve. Conditions such as glaucoma, diabetes and many other ocular conditions can be detected using conventional fundoscopy, which requires the use of a direct ophthalmoscope. This is a very portable, battery-operated device that can be taken very easily into the domiciliary setting. That device also enables the practitioner to look for cataracts and grossly the anterior segment, by which I mean the external structures of the eye. Again, it is a crucial element to an eye examination in detection of disease, which is one of the key requirements for conducting an eye examination. Intra-ocular pressure – may I move on to that?

**Q.** Indeed, please.

**A.** Intra-ocular pressure, particularly within a sample of over 40 year olds, is a mandatory test that needs to be performed. It is responsible for measuring the level of pressure within the eye. That pressure as it rises can result in a condition known as glaucoma. I believe in my report I have written down some of the prevalence of glaucoma: 1 in 50 over the age of 40 I believe is one of the statistics that I have presented. It can also be indicative of a number of secondary conditions that can give rise to raised pressure in the eye such as uveitis, which is an inflammation of the eye as well.

**Q.** While we are on intra-ocular pressure, which is an element for the Committee to consider, could you briefly explain the background to intra-ocular pressure, you refer to it as being a mandatory test: can you explain why and how important it is?

- A.** In its crudest form, it is to detect glaucoma, because the most common form of glaucoma – primary open angle glaucoma – causes a rise in intra-ocular pressure. We know that it goes with a higher prevalence in the over-40s and I regard this as an essential test, particularly within the demographics of the population that was being examined, i.e. they were well over 40 in a care home type of environment. Therefore, it is particularly important to detect that type of condition, which may result in a significant and permanent loss of sight.
- Q.** In a domiciliary setting, how easy is it with the correct equipment to undertake this examination?
- A.** There are portable devices, ranging from battery-operated devices which would be less in weight than the weight of this bottle of water; hand-held which would allow the optometrist to perform intra-ocular pressure measurement, as well as non-contact devices, by which I mean they do not touch the eye, which are also available specifically designed for domiciliary eye care.
- Q.** In a domiciliary eye care setting even involving a locum optometrist, whose responsibility is it to use the correct piece of equipment and to maintain that equipment?
- A.** The responsibility for the equipment lies with the optometrist in terms of issues such as calibration, whether the equipment is functioning correctly or not.
- Q.** In a scenario where such equipment is not available to a locum, what would you anticipate the actions of a reasonably competent optometrist to be?

**Mr Hodivala:** I am not sure that is necessarily an issue for this tribunal. The only reason why I object to that is because the charges, as set out, relate to the failure to take IOPs. Mr Taylor has obviously accepted that he did not take IOPs. What a reasonably competent optometrist might do in other circumstances I am just not sure is relevant to the issue with regard to deficient professional performance in that regard?

**Mr Alder:** If I may briefly respond. I anticipate the response of Mr Taylor, as it is available to the Committee, to have been that the equipment was not available. While we have an expert optometrist on the stand, that would be something with which he can assist the Committee as to the reasonableness of the actions in not stopping individual tests, not ensuring the performance of intra-ocular pressure examinations going forward.

**Mr Etherington:** The only advice that I would give, Madam, is that it is of limited relevance but it may be of some relevance; I do not believe it is of any prejudicial effect. Therefore, my advice would be that you may wish to permit the question.

**Ms Jones:** We are happy to continue, thank you.

**A.** Would you like to repeat the question?

**Mr Alder:** In a scenario where a portable tonometer is unavailable or is not calibrated correctly, what would you expect the steps of a reasonably competent optometrist to have been?

**A.** Given the scenario that an optometrist attended a domiciliary setting and a tonometer was not working, there are two options: one is to discontinue and cancel the clinic as a result of the instrument not working or, secondly, to continue working in the clinic but to make arrangements whereby those patients who have not had intra-ocular pressure measurements taken will be revisited and those measurements will be taken subsequently.

**Q.** Would you expect to see a note of that in any form on a record card?

**A.** I would indeed expect to see that recorded on a record card.

**Q.** In either scenario?

**A.** In both scenarios. If you are not seeing a patient, the practitioner cannot possibly write out a record card but where there is a situation where the patient is face-to-face with a practitioner, there has to be some record of the fact that the patient has been in front of the practitioner, some dialogue has occurred and that the instrument was not functioning on that day.

**Q.** Thank you. We come to the final section which is “Referral/report required”. Could you explain what annotation you would expect to see on a patient record card and the conclusions you have drawn in this particular table?

**A.** With respect to this last row, for the Committee’s benefit I went through all those 122 records and looked at all these different tests which I regard as being important to be conducted.

**Mr Etherington:** When you say “last row”, to what are you referring?

**A.** The “Referral/report required” row that goes across. In doing so, I have highlighted cases where I felt, as an optometrist, a report or referral was required. In this scenario, even if the report was not present within the record, I would expect that some information or record of referral and date of referral would be annotated on the record card.

**Mr Alder:** Thank you. Broadly, turning to the role of record-keeping, what is the role of record-keeping within a clinician’s practice in optometry?

**A.** The key role, of course, is to present a clear picture of the clinical signs and patient symptoms as presented on the day of examination such that any other optometrist, or even the same optometrist, who would be subsequently seeing and examining that patient would have a clear indication of the patient’s complaints, the investigations performed on that day and a management strategy that would relate to those symptoms. If it was a referral, the management strategy would be to write the referral, to inform the patient of what was wrong and the level of urgency and degree of severity of the condition.

**Q.** How important is that as part of optometric practice in the care of patients?

**A.** If records are deficient in any or all of these pieces of information, it does not present an accurate clinical picture. That could lead to conditions being misdiagnosed, it could lead to the optometrist who is subsequently handling

the care of that patient not being aware of changes that have occurred over that period of time. For example, if vision had not been recorded, a subsequent optometrist would have no idea if the patient's vision had deteriorated as to whether it had deteriorated over one year, two years or six months. It makes it a very difficult challenge for the practitioner who is continuing that care to do their job adequately or to a sufficient standard.

**Q.** Thank you. Do you draw any distinctions between operating from a clinic or domiciliary care?

**A.** In theory, there should not be. A patient in a domiciliary setting should be given the same level of care. However, I understand that the patients can be a little more challenging perhaps in terms of their responses, or the level of equipment that we carry in. However, I also believe that the tests that I consider to be a core element of care - and we are not talking about the gold standard of care with practitioners wheeling in a truckload of equipment, we are talking about a relatively simple piece of equipment that can be brought in to examine a patient - are essential to perform an adequate examination.

**Q.** Thank you, Dr Dave. I would like to take you to some specific records that you have referred to in your report. If I could ask you to turn to page 853 and if you could have the first bundle available – it is the one with the index at the very beginning. The first page reference is page 24. You refer to this record at page 853 of your report at the very top. Could you just explain briefly, as your first opportunity to present these records to the Committee, the particular sections of the record card and what kind of information you would expect to see contained within it?

**A.** May I have a minute to look at it?

**Q.** Of course, please do so.

**A.** Should I go through the record systematically?

**Q.** It would be helpful, Dr Dave, if you could initially take the Committee through the record card as if it were a blank one to explain the different sections contained within it, and then to go through your specific concerns about this particular record card for the Committee's attention?

**A.** If this were a blank record card, I would expect to see information on what were the principal symptoms of the patient: for example, did they complain of reduced visual acuity, pain or any other symptom. Then I would want to see questions which would address the how, when, where, why type of scenario. Subsequent to that, I would expect to see information on general health, medication and family history within that section which says "Patient History". Again, within a domiciliary setting, I would expect to see information on vision, either with uncorrected vision or even vision with spectacles. I would expect to see information on fundoscopy, which would highlight information about the back of the eye such as the optic nerve, the blood vessels, any other details about the retina.

**Q.** Where would you expect to see those references?

**Mr Etherington:** I would like you to identify where on the form.

- A.** Where it says “Ophthalmoscopy”, which is on the right-hand side of the form. There I would expect to see information such as CD ratio, which is the cup-to-disc ratio, information about blood vessels, information about the peripheral retina – whether it was flat, whether it was healthy. I shall touch on abbreviations in a moment, if I may. External eye: I would expect to see information about how healthy the eye was, terminology relating to the cornea, the conjunctiva, the lids, the lashes. Moving immediately below that where it says “IOP Method”, that relates to the intra-ocular pressure, I would expect to see numbers there which relate to the pressure measured, the time of measurement and possibly, though not a mandatory element, the type of test that was used, be it ablation or non-ablation.

Moving further down, on the left-hand side we see retinoscopy, which is again an objective test, and I have discussed why I believe objective measures are important, because they tend to move away from patient responses, which are quite important in the domiciliary setting. This would give us an indication of the prescription that the patient may have. Below that where we see Vision, that would record the patient’s unaided vision and to the right of that, the small boxes relate to the subjective refraction, which relates to the testing of the spectacle prescription. The visual acuity, which is abbreviated to VA, would identify the best corrected vision achieved with that particular spectacle correction, the optimal spectacle correction.

Towards the end of the record, as the eye examination had been completed, I would expect to see information that would backtrack towards the patient’s symptoms, in other words that very first box where it says Patient History, to address those symptoms in terms of a management. In other words, as a result of conducting the tests further up the form, can we formulate a management strategy which relates to those symptoms and, again, an action plan to summarise actions such as referred, not referred, urgency referral and, finally, a recall date when that patient should be seen subsequently and the signature of the optometrist who was examining the patient.

- Q.** I am grateful, thank you, Dr Dave. You have pointed out some specific concerns with this particular record card in your report. Can I just ask you to address those specific concerns?
- A.** First, the history does not identify any patient complaints. In other words, why was the patient there, why did the patient need an eye examination? What we have written down is “says he does not need glasses for near”, which I believe is pretty much the gist of the record that we see here.

**Mr Etherington:** Does or does not?

- A.** *[reads from record card]* “says he does not need glasses for near”. Those are the symptoms and history in effect. We do not see any information on general health, medication, family history of glaucoma or the real reason for any problems that are there. Moving to the right of the form where we see “external examination”, I cannot make out what that says, whether it says “implant” or “complete” I am not sure. Then it says “con cat” which presumably would be something that would indicate congenital cataracts, though it is difficult to make out.

Moving further below to the section on ophthalmoscopy, here I can address abbreviations I believe: it says NAD and no abnormality detected would be the kind of terminology that optometrists would possibly interpret, but the College of Optometry Guidelines specifically address this issue, and to not recommend the use of this term. There is no annotation of the cup-to-disc ratio, which is very important in glaucoma. I believe it says “full” for the patient’s right eye, but there is no information on peripheral retina or blood vessels. The left eye is more important to me in the sense that we see here a comment which says “no view”. Okay, that is acceptable but I would then expect to see some further tests that would be carried out in order to see that some attempt was being made to have a look at the back of the eye. By this, I mean using a diagnostic drug such as Tropicamide to dilate the pupils in order to have a look at the back of the eye in more detail.

**Mr Alder:** For absolute clarity, the issue is of record-keeping that we are expecting to see annotations of. That is the Council’s case.

**A.** Yes. Let me rephrase it; I apologise. I would expect to see documentation of whether a drug was used to show to any subsequent practitioner that attempts had been made to evaluate the back of the eye but either was or was not successful.

Moving below, we see that subjective refraction was performed and visual acuity was measured only for the right eye. In the left eye, we do not see any record of subjective refraction being recorded, or any visual acuity being recorded in this particular case. So the situation for an optometrist who could potentially be looking after this patient would be that there is some element of no view, a possibility of a cataract there but we have no idea of what the vision was with that cataract. If I were looking after the care of this patient a year later, I would have no idea what the vision was the year before.

Then we see further information moving down as to the prescription which has resulted in a prescription that was measured for the right eye but a balance lens being given, which is any lens that would match a similar powered lens to the right eye. However, one would not expect the patient to see very much at all when one is prescribing a balance lens.

Moving to the end, where it relates to the management of the record, I do not see any information which relates to the management of symptoms, or detailing why the vision was reduced in the left eye. Do we see any information on recall here? I do not see any information here on this particular sheet of recall, in other words when the patient should be seen again.

**Q.** When considering those areas about which you would expect to see further information, what standard are you applying?

**A.** I am applying the standard of a reasonably competent optometrist in order to maintain an adequate level of continuity of care, so that, first, it is clear to somebody else reading the record what had been diagnosed, detected, how

the patient was managed and for the benefit of the patient, so that the patient knows what is happening to them.

**Q.** Could I ask you to turn to page 118, which is a further record to which you refer in your Report. This is referred to by you as the fourth patient down.

**A.** Patient DY.

**Q.** Again, could you just explain your views upon this particular patient record?

**A.** Principally, again there are no symptoms or history, so we do not know what the patient is complaining of. Are they complaining of poor vision, are they having any difficulties with their sight, is there any medical history? Moving to the more key aspects of this record, as far as the external examination we see some annotation on the fact that there are dense cataracts present. Below that we see that there is no view of the fundus or the interior aspects of the eye. Again, we see no record as to whether Tropicamide was used to dilate the pupils in an attempt to have a look. We see a subjective refraction vision recorded without spectacles and we also see visual acuity, which is the best corrected vision which was achievable with the defendant's subjective refraction, which is 3/24, which would be regarded as significantly reduced vision.

We see here at the bottom of the record card that a prescription was prescribed to the patient, and it says "is still waiting for word to be seen by cat hosp eye service". So there is an element of the fact that some investigation had taken place as far as questioning to the patient but we could have seen some further information with regard to re-referring the patient. We do not know when the patient was originally referred, so in other words looking back at previous records, when was that patient originally referred: had it been a year or six months, had it been three months prior to the patient being referred – we do not see that information. For example, if it had been six months, it would warrant another referral for cataract surgery.

**Q.** Thank you, and have you applied the same standard to this record as to the previous record, that of the reasonably competent optometrist, or were you expecting a higher standard?

**A.** It is a common sense approach. If someone has poor vision, you have detected a cataract. There is evidence that some questioning has taken place to investigate whether the patient has had some encounter with the hospital, but we don't know when the patient was originally referred. In the interests of the patient, if the patient has been waiting for a year, clearly it is important to re-refer the patient in order for that process to continue. I would regard that as a common sense approach rather than something of an expert practitioner.

**Q.** Thank you. May I take you to page 278 please, which is a further record to which you have referred in your Report. This is the final patient to which you refer on page 853 of your report. Again, could you give your view to the Committee about the accuracy of this particular report?

**A.** Again, no symptoms and history, so no information on why the patient was there or what problems she was suffering from or encountering. Moving to the right of the form, for external examination we see an annotation that there

was an intra-ocular implant, so the patient had previously undergone cataract surgery in both eyes. More importantly, the defendant had detected and annotated that there was a dense capsular thickening which, for the benefit of the Committee, is a secondary complication that can occur after cataract surgery which results in an impairment of vision, sometimes quite significantly. This relates to the left eye and, as a result, the defendant has written that there was no view possible of the inside of the eye, because the artificial lens that was placed after cataract surgery had become opaque, or at least the back surface of it had become opaque. So there was no view of the back of the eye and there is no annotation of whether any medication was used to attempt to look at the back of the eye in more detail.

Most importantly, we see that the visual acuity is 3/18, which is a fairly significant reduction of best corrected visual acuity. The management of this patient has been completely omitted in this instance. [checks notes] In terms of comments/advice, which is the column immediately below Ophthalmoscopy on the right-hand side of the page, adjacent to the right-hand margin, it says, I believe, "lens cap thick to watched and referral sometime". In my opinion, I would expect a referral to be made at this point. The patient should have been referred for a YAG capsulotomy, which is an outpatient treatment, where that capsular thickening would be removed. The patient's vision would improve significantly upon removal of that, but we do not see any annotation of referral. In fact, what we see is a comment which says "to be watched and referred sometime", so there is certainly no attempt to refer that patient through to the NHS in order to have that capsular thickening treated.

- Q.** Thank you. I shall ask you to do the same exercise in respect of page 335. Again, could you explain your views on this particular record card and its adequacy?
- A.** I have discussed patient symptoms and history three times now, so I shall not bore the Committee by mentioning it again but there is an omission in the patient history box. The key area relates to the ophthalmoscopy section on the right-hand side, which uses the term NAD which, as I said earlier, is a term the College has said to avoid using. The most important aspects of omission of record-keeping here relate to the lack of CD ratios, peripheral retina detail, but what has been annotated here is "poss", which I assume is possible, "AMD" which stands for age-related macular degeneration. As we move down, therefore, we see subjective refraction and we see visual acuity that has been recorded. I state again that the visual acuity here represents the best corrected vision achievable with the optimal spectacle prescription. Again, we see that this visual acuity is poor, it is well below the normal standard of vision that we would expect of a healthy individual.

As a result of the poor best corrected vision and this possible age-related macular degeneration, the reasonably competent practitioner would want to decide whether the visual loss had occurred quickly. In other words, was it an acute loss or was it a chronic loss. That would be borne out by adequate symptoms and history questioning: has your vision always been like this, has it reduced over the last week, the last month or the last six months? Then it should be related to the finding of possible AMD, because AMD can occur,

broadly speaking, in two forms: the dry and the wet form. The wet form occurs quite quickly, which requires urgent referral to a hospital. The dry form, which occurs chronically and slowly over time, does not require urgent referral. Therefore, we do not have an idea as to the severity of patient symptoms, we do not have an indication of the exact diagnosis. Clearly, the practitioner was unsure about the diagnosis here by virtue of the fact that he has written “poss AMD”. At the bottom of the record, where we would expect to see some management which would address patient symptoms and ocular findings, we do not see any information on level of urgency, whether or not a referral was made here and subsequent recall.

**Q.** Thank you, Dr Dave. I would like to take you to the other bundle now, if I may, to page 595. I have asked you to refer to this record not just to be inconvenient in terms of the logistics of handling two lever arch files, but you referred to this particular patient’s records on a number of occasions in your report overall. Looking at page 854 specifically, could you, as you have done already with the previous records, refer to this record card and draw your conclusions as to the adequacy of this record?

**A.** If I may take the same approach again?

**Q.** Please.

**A.** As far as patient history, this patient is diabetic and we see some annotation that he is a non-insulin-dependent diabetic.

**Q.** Where are you referring to, Dr Dave?

**A.** I am referring to the patient history box which says NIDDM – apologies for my assumptions. This is an acceptable abbreviation to use, I must add, which means that the patient has identified as being a non-insulin-dependent diabetic, routine visit, has little strength to talk, “VA?” visual acuity. The examination has been conducted and we see some key information here relating to the ophthalmoscopy box, which looks at the back of the eye. There is no record of the eye being dilated, I might add, which according to virtually every diabetic protocol every diabetic should be dilated unless they are under the Health Service. We have something which says “seems OK”, and I would not regard that as a clinical term, so I would not be particularly accepting of that. Then for the left eye we see written “much diabetic retinopathy”. Again, I would expect a reasonably competent optometrist to put information relating to more detail such as the type of retinopathy, where it is occurring and, if we are going to talk about severity, we would potentially grade it according to the accepted grading terms that have now been used consistently throughout every diabetic retinopathy screening system or protocol.

As we move further below, we see the visual acuity and, again, I stress that this was the best acuity that was achievable by this patient. We see 3/36 recorded followed by a question mark, which is in the box just below where it says Final Prescription and to the right, in the middle of the page. If I may explain to the Committee what 3/36 means, it means what an individual with normal sight could see at 36 metres this patient could only see at three metres – that is the best corrected vision. Likewise for the left eye, where we do not have any subjective findings here, I am not sure exactly what it says in

that box but I would assume that is because the vision is so low that an accurate subjective refraction could not have been performed. The best corrected visual acuity here is less than 3/60 and, to give you an example, has been identified as being able to detect a hand moving in front of an eye but without being able to see detail.

Thus by virtue of the fact that the vision was so significantly reduced and there was much diabetic retinopathy, with little information on patient symptoms such as how long has your vision been reduced, how quickly has it been deteriorating, I would expect to see a referral in this instance to a diabetic specialist ophthalmologist, because this patient would probably need some level of treatment in order to prevent further retinopathy from occurring. There is no sign of any information on the record card which relates to any referral being made, the urgency of that referral or any communication thereof with the patient and any recall date again.

**Q.** Thank you, Dr Dave. Finally, you referred to a patient which is the record card at page 736 of this bundle, and you make report on the same page 854. Could you again please examine your conclusions?

**A.** Again, in the patient history box we see no reason for the visit and, therefore, no identification of the optical or visual problems this patient was having. There is some annotation on the ophthalmoscopy, which identifies age-related macular degeneration, and some writing which says, "extensive changes: degeneration R & L". I presume that would relate to the age-related macular degeneration in terms of its level of severity.

Moving on to the vision where it says Final Prescription, we see no record of any visual acuity for the right eye, but vision was recorded for the right eye as being less than 3/60 or, as an indicator, hand movements. For the left eye, we see a visual acuity that has been recorded for the optimal prescription that was found as being 3/60.

It would be fairly apparent to me looking at this record that this patient has something called dry age-related macular degeneration, which is extensive and probably this patient would be eligible for registration as being blind. Therefore, again a referral should be made, although it has not been recorded on this particular record, so I cannot say whether it has been made or not, but I do not see a record of that referral being made, for blind registration as the patient could benefit from things like low visual aids, occupational health type information which benefits them again from blind registration.

**Q.** Thank you, Dr Dave. I have taken you to a sample of the 122 records that you have taken into account in your report. Are there any in the 122 that, in your mind, are adequate and reach the standard expected of a reasonably competent optometrist?

**A.** If I may refer to my table 5.1, that is probably the most objective way of answering that question. I cannot comment on individual records, because within my report I did not identify a totally accurate record of what patients were complaining of. You can see by virtue of the parameters which I used as a benchmark to evaluate a competent record. Therefore, in order to

answer your question generally, if I may, since we have 76 percent of records where we do not have a symptom and history recorded, one in three records where we do not have visual acuity recorded, no record of pupillary testing recorded, and in 52 percent we have no record of any fundus examination findings, intra-ocular pressure not being measured in any of the records, I would have to say, reluctantly, that I feel there is a systemic or systematic lack of recording within these patient records, as I have had the opportunity of looking at 122 rather than at one record in isolation. Therefore, I believe it is systemic or systematic omissions throughout the records that I see.

**Mr Etherington:** I think the question was did you find one which was satisfactory?

**A.** I would have to say I cannot remember.

**Mr Alder:** Thank you. With the results of the conclusions you have drawn, are there any implications for patient care?

**A.** Yes, there are. If I may go back to table 5.1 and the last row which is "Referral/report required", using, as I said earlier, this benchmark, which is not a particularly stringent benchmark, it requires routine equipment within the domiciliary setting that could easily be taken into that setting, I identified, purely by looking at the records alone, 19 percent of records where I would have expected to see a referral, or the annotation of a report being sent to a medical practitioner which I did not find. The implications for the patient are, potentially, whether those tests had been performed or not, or whether a report had been sent or not. I cannot answer that, it is not within the remit of my evidence to present that. However, on a sequential basis, there could be consequences for the patient if one looks at the fact of other practitioners who are then adopting the care of these patients, because with omissions such as those we have identified today, it would be pretty difficult for any practitioner to know how a patient's vision had deteriorated, for example, over that period of time. Therefore, the short answer is that there would be an impact on the care of patients.

**Q.** Briefly on intraocular pressure and the lack of assessment of them, would you have expected a reasonably competent optometrist to have performed an intra-ocular pressure examination on each of the 122 patients in this case?

**A.** I would expect a complete reversal of the figures we are seeing here. I would expect to see every single one of those 122 to have had intra-ocular pressure measurements, assuming the machine had been working. Assuming the machine had not been working, I would still expect to see 80 percent, for example, because a reasonably competent optometrist would not have continued to examine patients after the first day, or even, if we are incredibly lenient in our approach, after two days of that machine not working. However, what we see here is a period from 4 July to 4 September, which is around two months, which is an excessive amount of time to rely on that machine being repaired. One, two, three days of examining and making arrangements for revisiting those patients could be deemed as acceptable, but over a two-month period I would say that is unacceptable.

**Q.** I suppose I would ask the same question as before: are there any potential implications for individual patients in the absence of these examinations?

- A.** With respect to intra-ocular pressure certainly. As I have mentioned with regard to the incidence of glaucoma, one in 50 over the age of 40, so if we apply that statistic to a sample of 122, there is a reasonable chance that one or two of the patients within this sample had glaucoma. If intra-ocular pressure is not being measured, and in 50 percent of records we do not see an annotation of fundus findings, it would be very difficult to diagnose glaucoma being present in a patient.
- Q.** I am grateful, Dr Dave. If you could wait there, my learned friend may have some questions for you. Thank you.

**DR DAVE cross-examined by MR HODIVALA**

- Q.** I just want to make it clear, Dr Dave, that Mr Taylor accepts there are deficiencies in his notes. I want to ask you one or two questions particularly about your table 5.1 and how it has been compiled. For instance, it is accepted that there are occasions when the symptoms and history have not been recorded but, from what you remember of your perusal of the notes, and indeed from your evidence that you have given today, speaking generally first of all, it is fair to say that domiciliary visit can present their own problems in terms of obtaining information from patients?
- A.** I would agree – if I may elaborate a little on that point?
- Q.** Yes.
- A.** Domiciliary patients can be difficult to obtain information from and, as a result, they are in that type of care setting. However, there are often nurses and carers within that location who are very able to give information on their mobility, what they have been able to achieve in terms of reading or watching television, and this type of information can be quite useful, especially for things like general health and medication. So there is a source of potential information that can be gained as well, but I do accept that it may be more difficult.
- Q.** I accept your point that nurses can be asked about simple things such as television, but patient history in terms of medication is very difficult to obtain, because that is something which, in the ordinary course, one might expect the patients to relay themselves. Is that what you are saying in respect of what is not on these records?
- A.** No, I am not. Here I am talking about symptoms and history collectively, so where I have said there has been an omission, it relates to an omission of both not or. In other words, there was no investigation of the patient's problems, but there was also no investigation of any medication. Just to add to your point which relates to deriving that information, as I mentioned earlier care home nurses and managers have their list of medication, because if they cannot remember the medication themselves, it is the nurses and the care home residents who are ordering those medication on repeat prescriptions for them.
- Q.** Fine. As far as the particular situation here, the mechanism by which these examinations were conducted was that the patient record cards were supplied

separately to this individual patient, yes? So there was another patient record card in addition to this individual sight examination form?

**A.** In other words, a prior record.

**Q.** Yes. The only observation I would make about that and on which I would ask for your comment is that, while Mr Taylor accepts now that he should have recorded the essentials on this sight examination form, this particular form would then have been kept with the patient record cards as I understand it. *[takes instructions]* Your understanding of domiciliary is that this individual form – I am not talking about specific examples – would then be kept with those patient records?

**A.** Yes, because they are a history of patient records which collectively build a picture over time.

**Q.** Yes, so, in other words, although there is no record on this individual form of medication, medical history and so on, this would be kept – for example page 24 – in a bundle with other documents that relate to that patient's medical history and so on?

**A.** Correct.

**Mr Etherington:** May I just clarify this – we are talking about the patient records kept by whom?

**Mr Hodivala:** By Cando in this particular situation.

**A.** I would agree with that. However, as I said at the outset, a record is a clinical picture in a given moment in time, and the idea is to capture that picture at any given time and, therefore, it is subject to change. Relying on a prior record does not necessarily give us information on that change that has occurred, medications can change, and not writing anything on there would not indicate that the practitioner has looked at it and is a duplication. If the practitioner wanted to say that the medication is as per last year, I would expect to see a comment which would say “as per last year's medication”.

**Q.** I agree. Can I make clear that I accept there are deficiencies, but what I am trying to do is simply put it all into some context, because the temptation could be to assume that this is the only record. However, you accept, do you not, that this would form part of a bundle and it is the non-annotation on these records that may be the confusing aspect, the criticism of Mr Taylor effectively?

**A.** The non-annotation – yes.

**Mr Alder:** Presumably, there will be evidence adduced – you said would have been, it was, we have no evidence of how these bundles were kept.

**Mr Etherington:** Mr Alder, if you are raising a point, you should raise it with us please unless you are raising it *sotto voce* but I could hear what you were saying.

**Mr Alder:** Sir, I anticipate that some evidence will be adduced.

**Mr Hodivala:** Dr Dave, may I ask you this? You are obviously aware that Mr Taylor was acting as a locum in this particular instance doing domiciliaries?

**A.** Yes.

**Q.** And he was working for a company called Cando, is that a company with which you are familiar?

**A.** No.

**Q.** You are not, okay. From your own experience of doing domiciliaries, when you do them is it right that you have this eyesight test form, which is the form that you would complete as the locum conducting these domiciliaries, yes, but they would also be provided the patient records for that individual patient, yes? So as the locum conducting a domiciliary, the ordinary procedure would be that the person who is employing you as the locum conducting the domiciliary would have overall control of these patient cards?

**A.** Well, no, because there are rules which relate to that in terms of whether that company is an optometric or non-professional company. If they are non-optometric, the responsibility for the records lies with the practitioner. I am not aware of whether Cando was an optometric company or not but, if it was a non-optometric company, in other words an unregistered company, the responsibility would lie with the practitioner for the maintenance of those records.

**Q.** And storage of the records as well?

**A.** I am not sure.

**Q.** If it was a registered company, presumably the obligation is on the registered company?

**A.** There would be a practitioner who would be the owner of that company and, therefore, the records belong to that company because it is a registered optometrist at the company.

**Q.** In respect of the criticisms that you make generally of these records, certainly it would be an improvement, would it not, if there were a record of the patient history and symptoms, because that seems to be one of the fundamental criticisms that you make of the records. Patient history and symptoms are, as you say, one of the most significant snapshots that a further optometrist would use for future reference?

**A.** It is not just for future reference. Whether we have a bundle of history which goes back 10 years, your record should represent all the findings that you make on that given day and the symptoms of that patient on that given day. As a practitioner, I look back at the records to see what that patient has suffered from, how their management has been, to gain an insight into what that patient is about or their previous history. My record then begins by having the same level or a competent level of detail which would address what their current problems are. Without asking their current problems, it is not for the next practitioner how do I manage those problems, how can I construct or formulate an investigation plan? I cannot do that. If the patient complains of a sudden loss of vision, or if I have not asked the patient to investigate those symptoms, I cannot possibly decide on what tests I need to

perform in order to investigate that particular symptom. It is like a knock-on effect whereby, ultimately, you cannot formulate a management strategy. So although the symptoms and history are useful for the next practitioner, within the current examination it is crucial to have an adequate symptoms and history in order to investigate and manage the patient.

**Q.** Generally talking about these forms, you have talked about external exams of the eye being an important aspect to record?

**A.** I do regard it as an important element but I believe that in my table, it would only be a close examination in a domiciliary setting because it would not be appropriate for a practitioner to bring in more detailed equipment.

**Q.** So is it fair to say that your table at 5.1 represents the main concerns you have had with regard to the non-recording on the forms that you saw?

**A.** I believe that those were my fundamental concerns. The only mission that is there is management, but I have touched on that in the last row which relates to a report/referral being made or not.

**Q.** Okay. With regard to your table at 5.1, you talk about fundus and it seems there are two limbs of criticism. You either said it is not recorded or it is below standard. When you say it is not recorded, does that include a reference to “no view” if we look at the notes?

**A.** No, it does not.

**Q.** So what is included and not recorded?

**A.** If you go to page 744, which is one that I have just flicked to –

**Q.** That is an example of your table, the fundus not being recorded?

**A.** Yes.

**Q.** When you say below standard, is that when you refer to NAD and flat?

**A.** Yes, in essence. I would regard that as not giving any information. Again, another example is on page 708 which clearly illustrates that. You see that “NAD flat” has been written on both sides. There is no information here on the most important aspect of the inside of the eye, which is the optic nerve head, and a cup-to-disc ratio, which is very relevant in glaucoma detection, has not been documented. Glaucoma in its most common form – primary open angle glaucoma – is a disease that is often diagnosed as a change over time. So with the absence of that measurement being recorded and the absence of an intra-ocular pressure, the subsequent practitioner would have no idea as to any change that had occurred over that interim period.

**Q.** I just want to understand your understanding of NAD. It is a term that is commonly used isn't it, but perhaps a term that ought not to be used? Let us put it in the real world.

**A.** I would say, yes, it certainly was used commonly. When I am lecturing and presenting to practitioners, as do many presenters, I clearly explain to practitioners now that NAD is not “nothing abnormal detected”. We jokingly comment that it really ought to stand for “not actually done”! I accept that NAD traditionally has been used as relatively commonplace to say “no

abnormality detected”, but the devil is in the detail. In something like glaucoma, putting a CD ratio there with NAD, I would have no objection to NAD in that circumstance. However, in the current context, I do.

**Q.** As far as the reference to “flat”, I believe the reason why you consider that to be below par is because instead of “flat” it should read 0.0?

**A.** No. Flat is an acceptable term because it relates to the peripheral retina so, in other words, if there were a retinal detachment, it clearly would not be flat. You could say “peripheral retina flat” but there is no detail on the cup-to-disc ratio and there is no detail on the blood vessels that is really what I am referring to here. So flat is just another attribute that has been recorded that I would expect to see there as well.

**Q.** Cup-to-disc ratios, is that where you would expect to see a reference to a nought –

**A.** Correct.

**Q.** Okay. As far as other criticisms that you have in table 5.1, I just want to ask you about intra-ocular pressure. I am no expert and no doubt I shall be corrected but, as I understand it, there are three mechanisms by which glaucoma is detectable in tests. One is the intra-ocular pressure, the second is by examination of the optic nerve and the third is the visual fields test, is that correct?

**A.** Not correctly, although the way you phrase it implies that each individual test –

**Q.** No, let me make this clear. If I were doing a gold standard test, I would expect to do all three.

**A.** I would not call it a gold standard test. If you were a reasonably competent optometrist, you would do all three particularly in a patient over 40 with a family history of glaucoma.

**Q.** I believe it is common ground that in many of these individuals, it was not possible to do a visual fields test?

**A.** Which is why I have not included it in my –

**Q.** I understand and make no criticism of that. In respect of the IOPs, your understanding of Mr Taylor’s situation was that the portable tonometer was water-damaged so he could not use it. Just to be clear about the portable tonometers, there is a gas version and a contact version. Clearly, the contact version would be very difficult to use in domiciliaries where we are talking about many of these patients being over the age of 80, is that fair?

**A.** No, I disagree. In fact, there is a hand-held version of the hospital contact version, which is probably what you are alluding to, which has been shown to have complete agreement in those two tests. It is called a Perkins tonometer.

**Q.** I am talking about the practicalities of things though. In domiciliaries, have you ever used a contact tonometer?

**A.** Yes.

**Q.** And you have used a gas tonometer?

**A.** Yes but not in those days.

**Q.** How long ago was it that you had experience of domiciliaries?

**A.** About seven years ago.

**Q.** And it was for six months or so that you were doing domiciliaries, is that right?

**A.** Yes.

**Q.** And over that six-month period, how many domiciliaries did you do?

**A.** Probably about 150-200.

**Q.** Separate days of working?

**A.** No, I am talking about patients.

**Q.** Okay, so 150-odd patients.

**A.** I would like to stress that there is no specialist qualification required for domiciliary testing and, of course, the standard of care within domiciliary if anything does not afford the practitioner the ability to bring in more sophisticated expert technologies as I would have in my own practice. So you tend to rely on these core competencies, which every optometrist, of course, is trained to do.

**Q.** [*confers*] I am just trying to get at your experience of the difficulties of doing domiciliaries, because you often have uncooperative patients, is that fair? You often have patients who have verbal communication problems, yes?

**Mr Etherington:** Could you answer for the transcript?

**A.** My apologies – yes.

**Mr Hodivala:** Yes, to both of those questions?

**A.** Yes, to both of those questions.

**Q.** You often have patients, for instance, who do not want to be examined, have you had that in your experience?

**A.** Yes.

**Q.** We are focusing on the ophthalmoscopy aspect of your concerns at the moment and, indeed, that relates to the intra-ocular pressure – that should be the section that records the intra-ocular pressure, is that right?

**A.** No. The intra-ocular pressure is recorded immediately below where it says IOP.

**Q.** IOP, thank you. There is an opportunity, is there not, for the person conducting this test to examine the optic nerve for damage?

**A.** Yes.

**Q.** And that would be conducted during the ophthalmoscopy?

**A.** Correct.

- Q.** If there were signs of damage to the optic nerve, that would be an indication of some significance that there were early signs of glaucoma?
- A.** I disagree. If you see signs on the optic nerve that there is damage, it is probably likely that the glaucoma is more advanced. The whole point of putting in a protocol of tests such as intra-ocular pressure and optic disc assessment is that you refine your level of sensitivity in order to detect a test and also your specificity. In other words, how accurate and able you are in order to detect early glaucoma as opposed to more advanced. If you omit one test such as the intra-ocular pressure measurement, your sensitivity drops down. If you rely solely on optic nerve assessment, your detection rate would go down quite significantly. This is a publication that was done going back over 10 years by a colleague of mine, Professor David Henson, and Adrian Hill who looked at the efficacy of using all three of these tests within practice to detect glaucoma to the appropriate level of sensitivity and specificity.
- Q.** Dealing with the other criticisms that you have of the records, the reference to referral or report required that you have in your table 5.1, I believe we have already looked, haven't we, at page 118, if we could turn back to that. Just to be clear of your criticism of page 118, the fact that there had been a record on the card, the fact that the patient was awaiting the outcome of a referral, as I understand it, your criticism is that there was no record of a chasing up of that referral, is that right?
- A.** My key criticism is when was that patient referred?
- Q.** Right, would that be on the patient records?
- A.** I would expect to see it on any previous records had the patient been referred from Cando.
- Q.** Okay. Are you aware of the background to Cando in terms of the storage of patient records at all?
- A.** No.
- Q.** Okay, you can't help us with that. Just looking at things in the round, if Mr Taylor had kept details of the symptoms of patients, the medication that individuals were currently on and details of things like occupation, whether they are a smoker or not, any hobbies they might have that might be relevant to their eyesight examination, that would be an improvement in the history and symptoms aspect of the records?
- A.** It would be mandatory, yes.
- Q.** Okay, and indeed that is your criticism of this?
- A.** Yes.
- Q.** Similarly, we see that there has been in this case but I just want to ask you, if there is a record of the external examination of the eye, which is clearly essential for the purpose of records, yes?
- A.** Yes.
- Q.** A record of the internal structures of the eye is mandatory?

- A.** Yes, and an attempt, if there is no view, to show an attempt has been made to look inside the eye using pupillary dilation.
- Q.** Yes. Tropicamide –
- A.** There are a number of drugs that can be used and that is one of them.
- Q.** Again, one would expect to see reference in the notes to the fact of a drug being used?
- A.** Correct.
- Q.** Dilation, yes?
- A.** Correct.
- Q.** The angles of the eye – again one would hope that on patient records there is some reference to the angles?
- A.** In fairness, in the domiciliary setting it is often difficult and a crude way of evaluating angles. I would not be so critical to say that in the domiciliary setting I would expect to see angles on there. Certainly, from our ophthalmological colleagues we know that the risk of inducing angle closure glaucoma is very low and, in fact, there is an argument to say that, if you do it, at least you save the patient from having it without – this is the vision of an optometrist.
- Q.** Right, okay, so notes that include reference to the VH belt, for instance, although an improvement on general practice notes if it was previously missing, would not be the kind of thing that you would expect in domiciliaries?
- A.** You are talking about the Van Herrick?
- Q.** Yes.
- A.** Okay. What I am suggesting here is to try to define a standard of care which is not necessarily gold standard. Now to do a Van Herrick properly, the best way of doing it is with a slit lamp but bringing a slit lamp into a domiciliary setting is unreasonable. Using a pen torch is another option but it is not as accurate, and a Van Herrick in itself is not the gold standard technique of looking for angles. It, in itself, does not completely agree with tests such as gonioscopy which truly identify whether a patient is susceptible to angle closure glaucoma. This is why I feel I am trying to be reasonable in saying that I would not regard that as an absolute requirement within a domiciliary setting.
- Q.** Okay. Again, would one expect to see on domiciliary notes necessarily reference – and I bear in mind table 5.1 – to the arcades, the major arcade, minor arcade and middle retina, or again, not in domiciliaries?
- A.** I would say to you that when I have looked at the notes of most ophthalmologists and most practitioners within an independent practice setting, a reasonably competent optometrist simply does not write middle arcade or outer arcade. What they aim to do is to evaluate as much of the retina as possible using different techniques in order to quantify that that retina is healthy. The record must articulate how far they have seen, and the record must articulate whether those structures are healthy or not. The typical

anatomical landmarks that a practitioner may use would be view up to equator or beyond equator, but I would not say it is common place to see reference to the arcades themselves.

- Q.** Okay. Domiciliaries clearly contain a different set of skills to general practice, it is a different scenario to general practice; would you accept that?
- A.** I would say that the patient demographics are different. As far as the skill set required, I would expect every practitioner in the primary care setting to have that fundamental skill set. The tests are more rudimentary by virtue of the fact that we have to rely on hand-held instruments or more portable instruments. These are all the things that practitioners would have had the training for extensively at university and in their professional qualifying examinations.
- Q.** If I may have one moment please, Madam? [*consults instructing solicitor and registrant*] Just one final question, I beg your pardon. If you look at page 278, for instance, I think you said there that your comment in relation to these notes was –

**Ms Jones:** Could you just give us one moment to catch up with you?

**Mr Hodivala:** We have page 278, lens capsule thickening to be watched and referred some time - that is as I read it?

- A.** I agree.
- Q.** The only observation I would make about that comment is that it is a matter of clinical judgment. He has clearly documented on this note that there is a concern that needs to be monitored
- A.** I feel I have to be quite clear about this. If we put this patient's vision in perspective, I do not think that any patient would want to be able to see at three metres what I can see at 18 metres. I do not think that is in the best interests of the patient.
- Q.** Are we not straying a little? My question was that it is noted on this particular record that it has to be watched and referred sometime, yes? I was simply saying that referral is a question of judgment.
- A.** I cannot answer that as a yes or not I am afraid simply because of the correctness – if a practitioner wants to refer someone sometime, that to me does not demonstrate that the response is in the best interests of what this patient should have had performed. It is clear that with vision such as this, a referral should have been made. I am not saying it has not been made; I am saying it has not been documented on the record card.
- Q.** Thank you. There are no more questions I want to ask.

**Ms Jones:** Mr Alder, do you have any further questions?

**Mr Alder:** Very briefly, Madam, if I may.

## DR DAVE re-examined by MR ALDER

- Q.** Dr Dave, you were referred to the abbreviation NAD, being an abbreviation that is used commonly. As far as your objection to that as an abbreviation, is it your specific objection to that abbreviation or is there a more general objection within the profession?
- A.** I believe within the current university training, it is not a term that is taught. College guidelines are only guidelines but they are still representative with respect to collaboration with optometrists and state that this is a term that ought not to be used. Also in the continuing education that is provided, I would say it is widely accepted that it is a term that should not be used. However, there will be practitioners out there who are still using that term but it is not a preferred term, certainly not in the context where other attributes of annotating the internal aspects of the eye have not been recorded. Those are the fundamental aspects.
- Q.** Would it be right that that use of the abbreviation may be acceptable, providing there is sufficient detail given elsewhere?
- A.** Exactly. If I don't record anything on the internal aspects of the eye but say all fine, it really does not give sufficient detail in a record for continuity of care. Putting down information such as cup-to-disc ratio, the fundamental aspects that have been taught right the way through the education system, if those aspects had been annotated and then I see NAD, I do not have an objection to it, although, personally, I still do not feel it is an appropriate term to use. However, that is not a view that would be judgmental in any way.
- Q.** You were referred to examinations of intra-ocular pressure and you were referred to the three examinations available to identify the potential signs that glaucoma may be developing in a patient. You referred to visual field assessments, intra-ocular pressure examinations and examination of the optic disc. We know that Mr Taylor did not undertake intra-ocular pressure examinations and in his response, of which I believe you have seen a copy, he refers to not undertaking visual field assessments. Is an examination just of the optic disc itself sufficient for a reasonably competent optometrist to be able to consider issues such as glaucoma?
- A.** No.
- Q.** How many of the three would you expect to be carried out or, if an examination is not possible, further examinations to be undertaken in future?
- A.** I think it would be reasonable to have two out of three conducted in the sample of patients we have seen even where a tonometer was not available. One can still palpate the eyes to see if there is grossly high pressure and where ophthalmoscopy is not recorded there is no way of becoming more sensitive in our approach to diagnosing the condition effectively.
- Q.** You were referred to the use of contact and non-contact tonometers within the domiciliary setting. It may be that I did not take a note, or your answer was not completed, but is it possible and reasonable to use contact tonometers in the domiciliary setting with this demographic of patients?

**A.** I would say it would probably be the norm rather than not the norm. Even the very latest devices make some type of contact, be it in a different way without the use of anaesthetic drops. I would have thought that a lot of practitioners would use a contact tonometer as well, partly because of its portability.

**Q.** And the same for non-contact tonometers?

**A.** Non-contact tonometers tend to be a little heavier and bulkier but, if the practitioner is prepared to take it into the domiciliary setting and it is their preferred instrument of choice, it is still acceptable to use that type of instrumentation.

**Q.** You were asked a number of questions about the environment of the domiciliary care setting, the nature of patients and you referred to the patient demographics you would expect to see, which would be slightly different to, say, a clinic. Have you taken the domiciliary environment into account when drawing your conclusions?

**A.** Yes, very much so. I table 5.1 I have not used and written down some of the tests that we have available in private practice, I have not talked about slit lamp examination, I have not talked about indirect ophthalmoscopy, I have not talked about some of the more sophisticated tests, I have not talked about visual field testing. What I have put together as a core essential element of tests is what I have included in table 5.1: symptoms and history, simple questioning, no instruments required, visual acuity, asking the patient to read a chart. Failing that, can you see my hand, can you see how many fingers I am holding. Pupils – a test that requires only a pen torch which is shone into the eye, requiring no questions of the patient. Fundus – hand-held device which has a battery-powered socket, get closer to the patient to have a look at the back of the eye. Intra-ocular pressure, again depending on which device was used but could be a battery-operated, hand-held device. Then the last part of the report, a core element of tests which is not unreasonable in its requirements.

**Q.** Thank you, Dr Dave. Thank you, Madam.

**Ms Jones:** May I invite the Legal Adviser to –

**Mr Alder:** Madam, it is an opportunity for the Committee at this stage to ask any questions they may have of Dr Dave.

**Ms Jones:** Right, my apologies. Can I start on my left?

**Ms Hallendorff:** Just one point, Dr Dave. We talk about intra-ocular pressures at ever visit, and you are assuming that these visits are on a yearly or two-yearly interval? Presumably, if you went back after, say, two months for some other reason to see the patient, you would not necessarily check the intra-ocular pressure at that point, or would you do it at every single visit regardless of the space between them?

**A.** If there is an early recall, for example, and I decide that I want to see that patient in three months' time, I would do intra-ocular pressure measurement.

**Q.** You would do it again?

**A.** I would.

**Mr Varley:** I am a lay member, so excuse me if I get a few things mixed up. You mentioned that the incidence of glaucoma was one in 50 over the age of 40. By my reckoning, the majority of the people we are talking about here are over 70. Does the incidence increase in patients over 70 or are there no records for this?

**A.** Every year over 70, the incidence of glaucoma rises, so that statistic of prevalence I have given you is a statistic that has been evaluated as a core group of patients over the age of 40. However, we know that if you are 70, that index would rise and there would be an even higher prevalence of glaucoma in those aged 70 and above. I cannot give you the figure off the top of my head, that was one of the statistics I found from the Moorfields website.

**Q.** But in patients of this age, it is more and more important to do that?

**A.** Indeed it is.

**Q.** That leads me to the intra-ocular testing of patients. In your opinion, is there any clinically acceptable reason why a reasonably competent optometrist would not take intra-ocular pressures, particularly with reference to these domiciliary patients?

**A.** Unless they refused, in which case you would document it on your record card.

**Q.** It would be on the record card?

**A.** Yes.

**Q.** Just going onto the records, were you able to examine the complete records of the patients, or just Mr Taylor's examination on a particular day?

**A.** I was given what we have here, which are, I believe, simply Mr Taylor's records, rather than having a picture over the course of time, possibly because they felt very sorry for me having to look through 120-odd records.

**Q.** But they could contain a great deal of medical information that would be useful to the optometrist?

**A.** Yes. One would expect any reasonably competent optometrist to have those pieces of information as the norm rather than the exception. Therefore, I would expect those previous notes to have been complete.

**Q.** Finally, on the practicalities of dealing with these types of patient, particularly in the area that you have highlighted on the medical history and medication, would you have a meeting with the nurse and the manager of the nursing home first to go through the medical histories with them as the people who would know, or would you just try to rely on the patients' memory knowing that some of them would not be able to give you the information you require?

**A.** It depends on how each practitioner prefers to conduct his or her own examination. If you have a patient who is cooperative, there is no problem, but if you find that patient is unable to communicate, you would probably call in the nursing home manager or the nurse who is resident. Failing that

attempt to try to ascertain information, you would document that someone was not available to give you that information, the point being that you made an attempt to gain that information and recorded it.

**Q.** If you didn't know or could not find out the medical history or the medication, it would not be, in your opinion, an acceptable record or test?

**A.** I am not saying that. You have to show that you have made every effort to try to gain that information. If that information just has not been forthcoming, it would not be in the patient's interests for you suddenly to stop doing the examination either. If you were able to identify what a patient's symptoms were but were unable to gain their medical history in terms of medication, you continue that examination in order to diagnose another condition which probably has nothing to do with the medication. It would not stop me but I would make sure that I had made every effort to try to gain that information at the outset.

**Mrs Tilley:** *[no questions]*

**Mr Etherington:** Madam Chairman was right to ask me if I have any questions first under the order in which we do things now.

**Mr Alder:** I apologise for that, I jumped in too early.

**Mr Etherington:** In the past, it used to be the other way around.

**Ms Jones:** I have one question. Dr Dave, I wonder if you could explain for me – I am another lay member – how long would an examination using these core elements take in a standard setting? We have heard of the complexity of domiciliary settings, so how long might these things take in a domiciliary setting?

**A.** There is a reasonable amount of variance, one has to accept that, but I would not expect there to be too much of a difference in terms of consultation time. With a patient who is more able to communicate, you also need to divulge more information to them, whereas with a patient who is less well able to communicate, you can condense your eye examination in terms of the core number of tests you can do, so you save time but then you have to communicate that information to somebody else who is providing the care for that patient. Therefore, I do not see there is too much difference in consultation time. If you want a figure from me, I would say if you were fully optimistic about 20 minutes but it used to take me around 45 minutes, I have to say, so anywhere between 20 and 40 minutes.

**Mr Etherington:** I have one matter purely for clarification. I was trying to manipulate my exhibits while you were talking. I do not think that everyone else needs to look this up, it just so you understand the record you were looking at which, as it happens, was page 595 which was the type 2 diabetic patient.

**A.** Yes.

**Q.** You made a comment that I only partly wrote down and did not understand, which was I think you said that every diabetic patient should be dilated unless

they are under the Health Service, so I did not understand the last part of your remark?

**A.** If they are under a consultant ophthalmologist, they are clearly within a secondary care environment so there would not be a need to dilate them in that respect, as they are already getting expert care.

**Q.** You mean specialist care within the Health Service?

**A.** Precisely.

**Q.** I understand. Thank you, Madam Chairman.

**Ms Jones:** Thank you very much, Dr Dave. I would like to propose that we take a 15-minute break. Mr Henley may I ask you to clear the room? Thank you.

**Mr Alder:** Madam, if it is acceptable to you, I would ask that Dr Dave may be released.

**Ms Jones:** Yes, indeed, thank you.

*[Hearing adjourned at 11.14 am]*

*[Hearing resumed at 11.57 am]*

**Mr Etherington:** Mr Alder, just for the record, since I am not sure whether the recording device was still running, at the end of the previous session I asked you if you had concluded your case and the answer was, in terms of evidence, you have?

**Mr Alder:** Indeed I have, thank you, Sir.

**Ms Jones:** Mr Hodivala, are you going to make any statements or call any witnesses at this time?

**Mr Hodivala:** No, I am not calling Mr Taylor in relation to the question of unprofessional performance or indeed at all in this case. As I understand it, the procedure is that we are going to consider all three limbs, effectively, in one sitting.

**Mr Etherington:** May I say, because I know that I have raised this with you, that without setting any precedent but purely on the facts of this case, in the light of the admissions that your client has made in respect of the allegations and of deficiency, it seemed that it might be a sensible way to proceed to take all three limbs at the same time but only if that met with the agreement of both parties.

**Mr Hodivala:** Sir, I can say that, on behalf of Mr Taylor, we consent to that course, yes.

**Mr Alder:** On the part of the Council, that makes eminent sense.

**Ms Jones:** Can you therefore make your submissions on all three limbs, Mr Alder.

## SUBMISSIONS

**Mr Alder:** Thank you, madam. I will break them down into the three areas that are before you to make your determinations upon. You will expect and have probably come to understand from the nature of my closing that I propose to make quite brief comments.

You have heard the evidence of Dr Dave and you have read very recently the total patient records available to you, as well as the evidence of Margaret McMullan. There are two factual particulars which face Mr Taylor and they are to be ordinarily proven to the standard that the criminal courts would expect and you must be satisfied so that you are sure. You are entitled to – and I would anticipate that you would – take into account very significantly the admissions made by Mr Taylor as to the failure to maintain adequate patient records as well as the failure to conduct an assessment of intra-ocular pressure.

Insofar as you would have any concerns about accepting those admissions, you have the evidence presented by the Council – the evidence of Margaret McMullan as to her conclusions about the adequacy of the patient records. You have her evidence, as she adduces the patient records for you, and you have, of course, your own competence in determining the adequacy or otherwise of those patient records. You also have the clear expert opinion of Dr Trusit Dave: fewer than 20 minutes ago you heard his conclusions as to the adequacy of the records, both in terms of those set out in table 5.1 and the further explanations he gave to you this morning.

He raises significant concerns, as did Margaret McMullan, as to the areas of symptoms and history; the records for visual acuity, pupillary examination, the recording of the fundus examination; the recording also of intra-ocular pressure although we know that Mr Taylor accepts not performing that examination. We also have concerns about the lack of notation as to onward management of patients and their care in terms of – in specific instances – diabetic screening and referral for those matters such as age-related macular degeneration. I submit that the evidence before you is sufficient for you to find the facts proven.

Furthermore, the sheer nature of the inadequacy and the sheer numbers of the records, and the sheer number of occasions upon which the examination of intra-ocular pressure was not undertaken, at a time, as the profession holds, I understand, to be the reasonable standard in these scenarios, where patients should have had an examination of intra-ocular pressure or other steps taken to manage that examination. They were not taken and there are 122 examples in which intra-ocular pressure was not undertaken and backed up with significant examples of inadequate patient record-keeping.

You will have heard very recently the evidence and opinion given by Dr Dave as to the implications for patient care, the continuity of care and the

involvement of a number of healthcare practitioners or clinicians in the examination of patients, and their inability to be able to have a clear picture of a patient's ocular needs, given the lack of information provided on the records. He was also able to explain very clearly to you the implications for patient care, and these specific patients, of not having intra-ocular pressure examined. He went on, of course, to provide you with the further context in which visual field assessments were not undertaken on these patients and, therefore, any reliance to be placed on mere examination of the optic disc, as an indicator for potential glaucomatous change, is not, in his opinion, sufficient and places patients very clearly at risk.

Dr Dave's opinion was also very clearly put before you and has a high degree of credibility, given that he is experienced in domiciliary practice. He is a man who is currently in private practice, and only drew to your attention those matters of an eye examination which he felt would be appropriate in a domiciliary setting. He has not provided a gold standard and he has not listed every possible examination which could or should have been undertaken by a reasonably competent optometrist. He has drawn the very basics, the very fundamentals of eye examinations, to your attention. Madam, if I may say, that goes very much to his credit and the credibility of his opinion.

Your first determination is on the facts and the second is as to deficient professional performance. As I explained in opening, the standard for you to apply is that of the reasonably competent optometrist. You have heard my learned friend refer to it and you have heard Dr Dave refer to that as the standard being applied to these records and to the practice which has been conducted by Mr Taylor. That standard is the one against which you will determine whether deficient professional performance is, in your judgment, made out. My submission and my suggestion is that you should accept quite properly the admission of Mr Taylor, accepting as he does that failing to maintain adequate patient records and failing to conduct an assessment of intra-ocular pressure for these patients is to fall below the standard expected of a reasonably competent optometrist.

Madam, that is a question for you and your colleagues' professional judgment, as is the next question to which you will put your minds: the issue as to whether Mr Taylor's practice is impaired. I trust that Dr Dave has been able to assist in providing the context and the standard which he has applied and the concerns he has as to the adequacy of practice. However, as was pointed out during the application made by my learned friend yesterday, it is a matter for your professional judgment. There is no test in your rules as to what a definition for fitness to practise is.

It is explored before a number of regulators, one of which determines that the question for you is whether this is a registrant suitable to be registered without restriction on – in this case – the GOC's Register of Optometrists. Madam, I would submit that Mr Taylor's conduct in this case and in the case which, if you find it proven, has been made out before you, is sufficient for you to have very grave concerns about his professional practice, such that you are able to conclude that his fitness to practise is impaired.

One of the factors that you are able to take into account is that no evidence has been presented to you by Mr Taylor. Therefore, you are unable to have any form of certainty, or any form of interrogation, as to his normal practice, as to whether this is representative of how he approaches all of his patients. There is no forum for you to be able to interrogate whether he has shown any insight into those matters which have been admitted by him. We have no evidence as to whether he, in one sense, draws a distinction between the patient records that he has undertaken for these patients or those in private practice, and whether he understands the crucial nature of intra-ocular pressure assessment. Madam, in not being able to interrogate that, I would suggest that you may have concerns about a registrant who is currently able to practise in all forms of optometric practice and, I suggest, who has identified clear risks of patient safety.

Dr Dave was able to assist you with concerns about the risk at which these patients were put in only the failure to perform intra-ocular pressure. He referred you to the statistics for glaucoma and, as was the response to Mr Varley's question, there are clear increases in risk of patients over the age of 70. When one remembers the demographics of these particular patients and the environment of the care settings in which they are resident that presents a very real risk going forward for future patients, who can still be examined by Mr Taylor.

You have a response provided by Mr Taylor in your bundle 3. That is in a documentary form and you may feel that a reduced amount of weight can be applied to it, Mr Taylor not giving oral evidence before you and not being the subject of any questioning or examinations that you may want to put to him to assure you, if you find him guilty of deficient professional performance, that he is a safe practitioner, going forward.

Madam, at this stage, when considering the impairment of fitness to practise question, you will bear in mind those other additional duties which fall to you. They are the issues of maintaining public confidence in the profession; maintaining the standards of the profession and, I suggest, ensuring public protection. I submit that the evidence presented to you, and the opinion of Dr Dave, suggests very clearly that patients will be at risk if Mr Taylor is able to practise without restriction.

Madam, if you find that test proven and you find that Mr Taylor's fitness to practise is impaired, then you will go on to consider whether to impose any form of sanction or any form of disciplinary order. That, again, is a matter for your judgment. I appreciate that you will seek legal advice on that point.

The role of a sanction, if one is to be imposed by you, is not to punish to Mr Taylor. It is not to be punitive in any way but it is to assure members of the profession and the public that confidence can be held in the profession, and a profession which regulates itself, and that their safety is of paramount importance in your decision. Any sanction, if one is to be imposed, must be proportionate to those matters which you find proven. You would need to

begin at the bottom of your scale – and I know that legal advice will be given on this point –

**Mr Etherington:** I am sorry, if I could just interrupt you. At this stage, we are just dealing with the limbs leading to the issue of whether impairment is found. I am sorry if I confused you on that.

**Mr Alder:** *[After brief discussion]* I am grateful, Madam, for that brief pause. It may be appropriate, depending on any submissions to be made by my learned friend, for an opportunity to come back just very briefly on a matter of clarification. You may be pleased to hear that, other than that, I complete my submissions in closing.

**Ms Jones:** Thank you very much, Mr Alder. Mr Hodivala?

**Mr Hodivala:** Madam, in closing the case for Mr Taylor on this particular aspect of the case, you have heard that Mr Taylor accepts the factual allegations and accepts that they amount to deficient professional performance. I shall not trouble this Committee any further with submissions because that is obviously a matter for this Committee.

If I can turn, however, to the question of fitness to practise, there is a bundle of documentation that we have compiled containing references and continuing education provisions. There is also a sample of notes. Could I hand these up? *[Documents handed up]*

**Ms Jones:** Can we accept these as C1?

**Mr Hodivala:** C1, yes.

**Ms Jones:** Sorry, R1.

**Mr Hodivala:** Could I address the panel, first, on the notes? I think there should be seven copies of the notes as samples. I am afraid that, the way they have been photocopied, the reverse of them has been copied upside down. These demonstrate, in my submission, the standard of Mr Taylor's notes as of 2007. The reason why I emphasise that is because the current allegations are said to have taken place some time ago, in 2005. Certainly, one would expect to see an individual who is fit to practise, or certainly whose fitness to practise is not impaired, learning lessons from any kind of disciplinary proceedings taken against them.

If I could very briefly go through the evidence of Dr Dave in addressing these current notes, and in showing that they demonstrate the kind of increase in performance and increase in record-taking that one would expect of a reasonably competent optometrist. Looking through these notes – and I shall not go through them in detail – one can see the details of symptoms and medication, the occupation and whether the individual being examined is a driver. You should be able to see in the top right-hand corner in each of these examples whether the individual is a smoker, and hobbies – obviously being

relevant, as Dr Dave has accepted, to the kind of examination that would be performed. Clearly, in all of these notes, that is now present.

There is evidence of the external examination as well. You can see, half-way down, that there is reference to the external examination of the eye itself, PRN (pupil reaction normal). One can also see an examination of the internal structures. Although Dr Dave commented that perhaps one would not ordinarily expect it, turning over the page on the first one of these, it seems that there is an individual examination of major and minor arcades and middle retina.

Turning back to the front – and I beg your pardon for jumping around – one can see the VH belt – in other words, the angle of the eye, which was something that Dr Dave gave evidence about. We can see that, in each of these cases, the angle has been given a figure so that is something that has been assessed.

Turning over the page, to the back of the page, one can see an indirect ophthalmoscopy in terms of a Volk test has been conducted in respect of each of these patients. Again, this is all demonstrated on the basis of these records.

One can see – again, importantly, because it seems to be a criticism that Dr Dave quite properly levelled against the previous standard of notes by Mr Taylor – that Tropicamide has been used in certain circumstances. Where it has been used, it is noted, and where it has not been used, it is noted. That is about halfway down on the reverse of each of these pages.

We can see that on the reverse of each page, instead of referring to the cup-disc ratio as flat, there is a value given there of 0.0. Forgive me one moment. [Confers] These are all criticisms that Dr Dave previously had of the notes and one hopefully has a flavour now of the standard of note-taking of Mr Taylor having increased dramatically. On the front of the page, we can see that there is reference to the vision, to visual acuity and so on. Therefore, in my submission, the Committee may take it that his standard of note-taking has improved. When one is considering the heads of charge in respect of Mr Taylor, although accepting that the previous notes in 2005 fell deficient of his professional performance, nevertheless now the Committee has a flavour of the vastly improved standard of his record-keeping.

Turning to the second head of charge, one can also see from these records that there is intra-ocular pressure taken on the first page of each of these sheets. On the right-hand side, there is reference to IOP and then NCT or APP. Again, we can see that this is an instance of his having taken intra-ocular pressures and the only exception being in respect of AK, who at the date of the examination is 14 years old and, therefore, there is no obligation to take IOP in respect of him.

Unless the Committee has any specific questions about the notes, I propose to move on to the bundle of references and continuing education certificates, dealing with it in this way so that it is nice and neat.

**Ms Jones:** May I just check with my colleagues to see if there are any questions.  
*[no questions from members of the Committee]*

**Mr Hodivala:** You have in the bundle two sections, the first one relating to references on behalf of Mr Taylor. These references combine to talk of Mr Taylor's general character, and he is certainly a man of great honesty and integrity. They also talk about his professional competence. We see at page 2 of the bundle that, although Mr Taylor is now retired, he was a point of reference for diabetic eye checkups for patients, and never encountered any problems since 1978 with Mr Taylor's expertise. We see again at page 4 a professional reference, and that there have been no professional concerns about Mr Taylor in that regard, particularly relating to the second head of charge since there is a reference to intra-ocular pressures there. In my submission, Mr Taylor is a man who has demonstrated integrity and he is trustworthy when it comes to his background, and he has references in support of his clinical competence.

As far as the continuing education certificates, the most important of which we would say is at page 6, although all of these are important, demonstrates that he has completed a Certificate of Training for the GOS eye examination in Scotland. As I understand it, this is a training course that came into force in 2006 and it was widespread, so although it post-dates the allegations, it demonstrates that he has achieved high standards in respect of the GOS eye examination in Scotland. Madam, we would submit that these are all relevant to the question of his fitness to practise as of today.

While the point is taken by the Council that back in 2005 there appear to have been concerns about his record-keeping, and the failure to conduct intra-ocular pressures, there are two points that we would make about that on behalf of Mr Taylor. The first is, as has been repeated numerous times throughout these proceedings, that there is no criticism of Mr Taylor of failing to conduct certain tests, and I would urge the Committee to confine themselves to the heads of charge that are laid out in considering whether or not the fitness to practise issue is impaired. Therefore, the first point is to take care simply to refer to the deficiency in recording certain tests, rather than any wider concern the Committee may have either as a result of evidence or as a result of speculation.

The second point to make is this. Although it is said that Mr Taylor has not given evidence and, therefore, there is no evidence from him as to his current practice, you have the notes. Of course, the Council rely on his statement of response as part of their case, because it is only the letter in response from Mr Taylor that details the fact and the acceptance that he did not conduct intra-ocular pressures. Indeed, there is an explanation given in that letter as to why he did not conduct intra-ocular pressures. Again, this all serves as background for the submission that I shall make in the not too distant future,

that these are specific circumstances that, undoubtedly, by his admission Mr Taylor did not deal with as professionally as he should have done. However, when one looks at today at the improvements that have been made, in my submission this Committee should not conclude that his fitness to practise is currently impaired. That deals with the bundle.

May I indicate that there has been evidence from Dr Dave about the retention of the records by Cando. He cannot assist the tribunal from his own knowledge as to whether or not Cando were responsible for maintaining the records. We would say there is evidence before this Committee from Margaret McMullan that would indicate it was Cando's responsibility to look after those records. She talks about Cando being a registered domiciliary provider on the EHSSB's list, so, in my submission, it falls into the latter of the two categories that Dr Dave had in mind when he said he could not say whether or not the obligation would have been on Mr Taylor to look after and maintain these records, or whether it would have been on Cando. We would submit, on the basis of the evidence that is before this Committee, that the obligation was on Cando to look after these records.

That comes down to the point that these 122 records have to be put into a context: not Mr Taylor's responsibility to look after those records. I have accepted, on behalf of Mr Taylor that those records have deficiencies but when those records are kept together, they form a clearer and a wider picture. It is perhaps – and I do not emphasise this point too much – putting it in some context that the previous medication would have been on those record cards. While I accept that, if there had been any changes, these were not documented, the main thrust of this submission is that there were more than simply these eyesight test documents that formed part of these patients' records.

Therefore, when one looks at the gravamen of the first head of charge in the failing adequately to document and record certain things, we would put it into a wider context that is perhaps more realistic than simply looking on the face of each of these individual records, and say there are criticisms of these individual records.

We also say that of particular relevance is the fact that Mr Taylor is offering an undertaking to the Committee that he will not practise optometry. Forgive me, Madam, for the wide nature of that undertaking. If the Committee has in mind any more specific or tightly drafted undertaking, I am sure that specific undertaking is something that Mr Taylor would be prepared to offer to the Committee. However, the thrust of the undertaking is that he no longer wishes to practise optometry. He does not accept that his fitness to practise is impaired, and you have seen from the references that he has now retired from the practice of optometry.

The reason why he is offers this undertaking is that there are, we would submit, two limbs to the fitness to practise concern, and whether or not an individual's fitness to practise is impaired. The first is that, if the public need protection and an individual's fitness to practise is impaired, the Committee

will find that the fitness to practise is impaired as a mark of protecting the public against future risk. However, we also accept that a finding of impairment of fitness to practise can reflect the public concern at the maintenance of those who are fit to practise as being those who are not publicly criticised in the course of these Committee hearings. By criticism, I mean by a finding of impairment of fitness to practise.

The undertaking that we offer we say is relevant to the question of fitness to practise for this simple reason. Certainly, it would serve to protect the public in the future and, therefore, obviate the first limb of concern that the Committee may have as far as his current fitness to practise. In other words the issue of the protection of the public. As far as the second question with regard to the maintenance of public confidence, we would submit that the undertaking is of perhaps lesser relevance. However, when one looks at the fact that his standard of record-keeping has clearly improved since 2005, and from his notes we can see that intra-ocular pressures are recorded on these charts, we would submit that the undertaking, as a whole, is of very high relevance in the determination of fitness to practise.

We would remind the Committee at this stage that, if they find that his fitness to practise is not impaired, it nevertheless has the power to issue a warning to Mr Taylor pursuant to Section 13F(5). Bearing mind all of the surrounding circumstances in this case – the improvement in his record-keeping, his taking of intra-ocular pressures as documented by the notes – we would submit that this is the kind of case where the Committee could find that his fitness to practise is not currently impaired and that, therefore, a warning may be a consideration for the Committee.

The final observations we would make on the fitness to practise point are these. It is accepted by Dr Dave, and no doubt within the competence of the Committee, that domiciliary visits form a reasonably specialised area. I say that because there is limited equipment, one does not have the same level of equipment as one has in practice. Therefore, when one looks at Mr Taylor's fitness to practise and whether or not it is impaired, we say that the specialised nature of domiciliary visits and the failings that are put before the Committee may be of some reference in determining whether his current fitness to practise is impaired. Just pausing there, you will see that some of the records that are currently before the Committee relate to domiciliary visits. For example, if you look at JNS and MS, which may be the last and penultimate pages of the bundle, you will see in the top right-hand corner the letters DOM, clearly depicting that these are domiciliary visits as well.

Although we accept that there has been deficient professional performance and, therefore, it is likely that the Committee will find as a fact that there has been deficient professional performance, we make strong representations that at the state of play today, as demonstrated by a number of factors, his fitness to practise is not impaired. If the Committee feels it appropriate, it may see fit to issue a warning about his future conduct, bearing in mind the undertaking that Mr Taylor offers the Committee today. May I be clear about

submissions at this stage if you find that his fitness to practise is impaired: we are not moving on to that stage now, is that correct?

**Mr Etherington:** What one might call the sanction stage. I am sure the Committee will give you an opportunity to address them on that in due course, if it arises.

**Mr Hodivala:** That is all we submit at this stage, Madam.

**Ms Jones:** Thank you very much. May I invite the Legal Adviser to advise us.

**Mr Etherington:** Thank you, Madam. I shall take this slowly because I am aware when giving legal advice that a lot of information is being given at once which is quite important. I wonder if we might look, first, at the allegation sheet and deal with the first issue it sets out. At the end of my advice to you, I am sure you will give counsel the opportunity to raise with me any concerns they have about the advice I have given, because we want you to be in the best position to reach the correct decision.

You will see that there are three elements to the allegation. First, the specific acts complained of, namely inadequate patient record-keeping and the absence of conducting an assessment or assessments of intra-ocular pressure in the same patients. The second allegation is that if, and only if, you find the specific acts proven, whether those acts are taken by themselves or together, do they amount to deficient professional performance by Mr Taylor. If but only if you find, first, the acts proven and, secondly, that they do amount to deficient professional performance by Mr Taylor, do you turn to this third issue of whether, in your judgment, the facts you have found impair Mr Taylor's fitness to practise. So it is a three stage approach: allegations, deficiency, impairment. My advice is that you should approach your decision in that same order: acts and allegations first of all, deficiency second, impairment third.

I advise you that the Council bears the specific legal burden of proving that the alleged acts occurred, namely that Mr Taylor kept inadequate patient records and/or, secondly, that Mr Taylor failed to carry out assessments of intra-ocular pressure in those patients. The Council must prove these allegations so that you are sure of them before taking them into account. They seek to do this in three ways: through the evidence of Margaret McMullan, through the evidence of Dr Dave and through the admission made on behalf of Mr Taylor by Mr Hodivala at the commencement of these proceedings.

I use the word "evidence". Evidence is either given to you orally by a witness, who may refer to documents which we call exhibits, or by statements read to you by agreement, together with any exhibits produced by agreement through those statements, or by admissions made on behalf of the party and accepted as such by the opposing party. Statements are read to you as opposed to evidence you hear live. Statements read to you carry precisely the same weight as if the evidence had been given to you orally. It may be that they have less dramatic impact because they are being read, but it is important

that I advise you that they have exactly the same significance as if the witness had come here and given that evidence. The weight which any piece of evidence carries is a matter for you. You may accept all, part or none of the evidence given to you by any witness.

Expert witnesses are in a different category only to this extent. Uniquely among witnesses, they may examine evidence collected by others, test it analyse it and crucially comment upon it. You will doubtless give any expert evidence careful consideration, particularly if it is uncontradicted by other evidence. However, like all evidence it is entirely a matter for you whether you accept or reject all or parts of it.

As with Dr Dave, where a witness has given evidence and you have seen a copy of his report for convenience, it is the evidence he has given, or the parts of his report he has adopted in evidence, that is the evidence, not the report itself. One part, an important part, adopted by Dr Dave is the table that he went through at page 15 of his report.

I advise you that, in respect of the evidence, you are entitled to draw inferences, and inferences are no more and no less than conclusions about which you are sure. They are not speculations which may or may not be correct. Speculation is the real enemy of fairness in any fact-finding exercise, and I advise you that you must avoid it entirely.

It is a matter for you whether that evidence satisfies you so that you are sure of either or both of the allegations. In this particular case, no evidence has been given by Mr Taylor. He is not obliged to give evidence, nor should you draw any inferences against him for not giving evidence in the light of the admissions he has made. On the other hand, he cannot benefit from the fact that he has not called evidence by the evidence he would have called, and nor has there been an opportunity to cross-examine any account he may have given.

Some notes and references have been put in during the course of submissions by Mr Hodivala. The weight you give to them is entirely a matter for you. They perhaps fall into two different categories. The references, which are no doubt agreed as references between the parties are there, and you examine them for what they say. The notes, of course, cannot be explained – nor has Mr Hodivala sought to do this – by Mr Hodivala other than what they appear to show to you on their face. It would be only Mr Taylor who could in evidence explain the full detail of the notes and be asked questions about them. However, you are entitled to look at them and draw any conclusions you feel safe to draw if you wish so to do from what the document shows on its face. I hope I summarise Mr Hodivala's submission correctly if I say that, in his submission, they show a vastly improved position in respect of note-taking, and the training, which is evidenced by some of the other documents in the bundle, also shows the seriousness with which the registrant takes the position with regard to the matters commented on by Dr Dave.

You will, of course, wish to consider carefully submissions made to you by both parties. However, as with any comments you think I may have made in the course of this advice, submissions and comment are not evidence. If you agree with any submission or comment all well and good. If you do not agree, I advise you that not only do you have the right to reject such submission or comment, but you should reject it because it would not be your view at all. If, but only if, you are sure of either or both of the allegations – that is at (1) and (2) on your allegation sheet – you must decide whether that amounts to a deficient professional performance of Mr Taylor’s professional duties to the patients concerned, giving “deficient” its normal English sense. That is not a conclusive definition or a legal definition, but in the sense of defective, insufficient or inadequate and, importantly, judging Mr Taylor’s performance against that of a reasonably competent practitioner in his field.

The Council would rely additionally on the admission made by Mr Hodivala at the beginning of the proceedings that Mr Taylor admits that his professional performance was deficient, although that decision is still yours and yours alone. If, but only if, you judge Mr Taylor’s professional performance to have been deficient, you move to the final stage, namely whether you judge that Mr Taylor’s fitness to practise was impaired by that deficient professional performance. It is perhaps fair to say that this is where the real dispute lies in this case but, again, that is a matter entirely for you.

Whereas the test of deficient professional performance looks at the registrant’s historical actions by the standards of a reasonably competent practitioner, the question of fitness to practise turns to the issue of the effect and consequences of such deficient professional performance as you have found to have occurred. Impairment is, again, an ordinary English word, implying weakening of, damage to or diminution of functioning, and I advise you to give it its normal sense in language.

Looking at this word in that way, it can be seen that impairment of fitness to practise carries a potentially wider application than simply impairment in the strict practising of a registrant’s professional duties to his patients, although you may obviously consider that. The practice of a professional man involves his professional reputation and the reputation of his profession itself, and I advise you that, additionally, you are entitled to examine whether any deficient professional performance has impaired the fitness of Mr Taylor to practise by damaging his own professional reputation, or public confidence in the profession of which he is a member. That is a different and distinct question, without in any way detracting from Mr Hodivala’s submissions, from whether were he to practise, he would pose a danger to the public in any way. They are two different questions. That, Ma’am, subject to any comments by either party, is the advice that I tender to you at this stage of the proceedings.

**Ms Jones:** Thank you. Mr Alder?

**Mr Alder:** I have not had an opportunity to make submission as to the suggested undertaking through my learned friend. I would be grateful, Sir, if you could provide legal advice to the Committee about the enforceability or lack of it of

any undertaking that could be suggested. My submission would have been that the undertaking, as offered, would be something to be taken into account at a further stage if it is reached.

**Mr Etherington:** I believe that, as I understood Mr Hodivala's submission, he was really saying that, if that undertaking was given, it evidenced that there would be limited opportunities to endanger the public in the future if it was the conclusion of the Committee that that is what this deficient performance had done, and was limited to that aspect. Of course, undertakings may be made; whether they are kept or not is ultimately a matter for the person. That in itself might constitute a further disciplinary offence if an undertaking were not kept. It could only go at this stage, and I believe that Mr Hodivala accepts that, to the limited limb of whether it bears on whether there is any future danger, which is one but not the only consideration that the Committee has at this stage, and I suppose the fact that he is retired does as well.

**Mr Alder:** Indeed, Sir, I am grateful for the clarification. It was put very clearly that the Committee would be able to take it into their consideration at the impairment stage, because they could be satisfied that the public were protected in the future going forward. My submission, and I would again be grateful for your learned legal advice, is in respect of the nature of that public protection. My submission would be that such an undertaking given through my learned friend, indeed even if Mr Taylor were to give that undertaking before you in evidence, would not in itself have a degree of legal force or enforceability such that it could protect the public from future acts. An undertaking is not provided for in the Council's Rules or by legislation in perhaps the same way as it is in the General Medical Council's Rules, so perhaps that is where the approach has been taken from. If reliance is placed on the public being protected going forward, I would submit and disagree with that. I certainly note from the record that dated 31 March of this year, the issue as to point of retirement and when Mr Taylor has ceased to practise may also become relevant. I would be grateful, therefore, for your clarification on this point.

**Mr Etherington:** Mr Hodivala, would you like to say anything more?

**Mr Hodivala:** May I listen to the legal advice in response to that and then come back.

**Mr Etherington:** I would advise the Committee that it could, in the circumstances, amount to no more than a statement of intent that the registrant does not intend to practise in the future. I think it fair to say on his behalf that were, through his Counsel, he to make such a statement of intent in proceedings such as these and then breach it, it might – might – be open to a charge of misconduct for misleading the Committee. However, the Committee, obviously Mr Hodivala, will have to take into account the fact that events may change and people may say, "I was perfectly genuine in what I said at the time but time has passed and something else has happened". What it cannot be is a complete bar to the logical possibility of his returning to practise.

**Mr Hodivala:** I accept that as a theoretical possibility. The only analogy that we would submit, not that we are talking about sanctions at this stage, is that even for an individual who is erased from the Register there is no ultimate sanction other than disciplinary proceedings for continuing to practise. We make the point very simply that this is an undertaking in no uncertain terms, the precise wording of which may be of concern to the Committee, but the general thrust of it is that Mr Taylor will not conduct optometry in the future. I adopt the advice of the Legal Adviser that that goes, we submit, to the stage of public protection. It is a facet, though not the only one, that you and your colleagues have to consider, but we say it is a highly relevant facet.

**Mr Etherington:** On the issue of public protection as opposed to public confidence.

**Mr Hodivala:** Yes, as opposed to public confidence. I have made submissions about the limited relevance of that to public confidence, because we say there are other factors in play that deal with the public confidence aspect.

**Mr Etherington:** And in giving advice to the Committee and, to be fair, to Mr Alder, his point would be, and this is a matter ultimately for the Committee to judge, that undertakings are one thing but they do not amount to a legal obligation on a person being imposed upon them. They may run whatever risks there may be of charges being brought as a result of them going back on that undertaking, and the Committee ought to bear that in mind when it considers whether it is a true answer to the issue of public protection. I express that fairly, Mr Alder.

**Mr Alder:** Indeed, thank you, Sir. I do not wish to make further submission on the point, but merely as a point of clarification with my learned friend, if a registrant is erased from the Register and then goes on to practise and test sight, that becomes a criminal matter and is a criminal offence. That underlines the seriousness of the issue, where there is a distinction between a breach of any undertaking, whatever that may be or whatever force that may have, as opposed to seeking to practise while unregistered.

**Mr Etherington:** I am sure that having heard what I have said, and having heard the submissions of both of you, the Committee now have well in mind the competing arguments on that particular point. Unless there is any other matter that anyone wishes to raise at this stage, I shall hand back to Madam Chairman.

**Ms Jones:** Thank you. May we invite Mr Henley to clear the room? I suggest that we reconvene as shortly after 1.30 pm as is possible so that we can take a lunch break. If you could be on standby from 1.30 pm, we would appreciate it.

*[Hearing adjourned at 12.51pm]*

*[Hearing resumed at 14.10pm]*

**Ms Jones:** Good afternoon, I would just like to inform the parties that no further legal advice was taken during the recess. I would like to read the decision of the Committee.

## Determination

### Findings in relation to the particulars of the allegation

The Committee found all particulars of the allegation admitted and proven including the allegations of deficient professional performance (particular 3) of which we noted that Mr Taylor had admitted that he was guilty.

### Findings regarding impairment

The maintenance of proper and adequate records is a cored requirement for the continuing care and management of patients and the public has a right to expect that this will be done. In the first instance, Mr Taylor's level of record-keeping fell well below that expected of a reasonably competent optometrist. This included a failure to conduct an assessment of intra-ocular pressures for all of those 122 patients who are deemed to be at risk of glaucoma by reason of advanced age. Mr Taylor has chosen not to give evidence before us to explain his reasons and to have that explanation tested.

The Committee is satisfied that the public perception of standards of his practices and the standards of the profession have been brought into disrepute and public confidence in the profession thereby damaged.

Proper examination and record-keeping is essential for all patients and particularly in vulnerable groups such as the elderly and infirm in residential and/or nursing care. The Committee do not accept that faulty equipment constitutes a continuing justification for the reasonably competent optometrist not to conduct an examination of intra-ocular pressures.

The Committee is satisfied that Mr Taylor's fitness to practise is impaired.

Mr Alder, would you like to present any further relevant evidence relating to sanctions?

**Mr Alder:** Madam, I have no additional evidence for you but can, by way of brief submission, assist the Committee, I hope. As I briefly touched upon in the wrong part of the procedure earlier on, the determination for you now is to consider whether, as a result of your decision concerning Mr Taylor's fitness to practise, it is appropriate to impose a disciplinary order. If that is your decision, what disciplinary order would be appropriate?

As I said briefly earlier today, the purpose of a disciplinary order is not to be punitive, it is not a punishment of Mr Taylor. It is a way of marking your decision as to impairment to seek to uphold the reputation of the profession, to seek to maintain the standards which should be expected of those who are registered with the Council. You will be advised by your learned Legal

Adviser in due course. However, you will begin with the first decision of whether to impose a disciplinary order and, if so, thereafter to consider, if I may put it in this way, a less serious punitive option and work upwards. The first is whether to impose a conditional registration order. Madam, given the clear findings you have made in respect of impairment, your reference to the essential need for all records to be maintained, and the need for there to have been intra-ocular pressure testing undertaken, it may be that, in order to protect the public and to ensure there is no risk to patients in the future, and given you have no evidence from Mr Taylor as to insight or his current practice in that regard, you may feel that a conditional registration order may not be appropriate or proportionate in that regard.

You may also consider, given the indication from my learned friend that Mr Taylor has retired, or intends not to practise again. You may consider that a conditional registration order may, on one construction, be fairly pointless, and the message to send to the profession and public as to the maintenance of the standards of the profession may, on one construction, be undermined by such an acceptance or disciplinary order.

Madam, the issue as to a disciplinary order is a matter entirely for you. I do not feel it is my role to suggest one but you may consider it appropriate and proportional to consider one of the serious disciplinary orders to be appropriate given the seriousness of the case, the breadth of time over which the patients in this case were examined, the number of them and the degree to which Mr Taylor, as you have indicated, has from a matter of public perception and the standards of the profession brought the profession into disrepute. You will, of course, also bear in mind very significantly as part of your decision those issues as to ensuring public protection and that members of the public may be satisfied that those testing sight are of the appropriate ability and show sufficient insight into those standards. Thank you, Madam.

**Mr Etherington:** [*confers with Chair*] Mr Alder, I wonder if I may raise one matter with you in fairness to Mr Hodivala before he addresses me so that he knows.

**Mr Alder:** Indeed.

**Mr Etherington:** There is also the potential for a financial penalty order, is that correct, at page 30 of the Handbook, which can be in addition to, or in substitution for, the penalties you have mentioned to the Committee. I think it right that the first date of the offence being 1 July 2005, the maximum limit comes under the new Rules and not the old Rules? There was a time when it came under the old Rules, and I have asked Mr Henley about this so that I get it right, and I believe that, curiously, the end of June marked the division between the two. Is that your understanding also?

**Mr Alder:** It is my understanding, Sir, that the new Rules are engaged in this particular case. As a consequence, the financial penalty is an option that is available to the Committee.

**Mr Etherington:** I do not say in any way that is in anybody's mind at all. It is merely because we both have the new Rules but a date from which they apply, and I just wanted to be clear before Mr Hodivala addresses me that we are all working on the same basis.

**Mr Hodivala:** Madam, by way of background to Mr Taylor, he is 63 years old and he has been practising for some 42 years, 32 of which have been in the Ayrshire area, 10 years or so being in the Glasgow area. For those 42 years, he has had no blemishes whatsoever on his record either by disciplinary proceedings or by private civil proceedings. This is, therefore, the first time he has come into contact with the disciplinary arm of the General Optical Council. He has completed a means form and there is a dichotomy that we submit the Committee faces today, considering the practical realities of the punishment in respect of Mr Taylor, bearing in mind that he is a man who has retired from practice, and bearing in mind that the undertaking he has offered remains open. In my submission, the public protection element which will concern the Committee in terms of sanction is of a significantly lesser degree than it might otherwise be were he still practising.

The approach that we commend to the Committee is not to adopt a sanction for convenience, and the Committee I know would not do so. Therefore, when one looks at the practical realities of the situation, accepting, as we do, that conditional registration would be impracticable to work in Mr Taylor's case, we would submit that there are limited sanctions available to this tribunal, if a sanction is deemed to be necessary.

I address the first question of whether a sanction is necessary in this way. Given that he is not practising, to all intents and purposes, and given the undertaking that he has offered, the registration period for him would finish on 31 March. As from 31 March, he would no longer be on the Register in any event. The practical reality is that, as far as considering whether a sanction ought to be imposed, the protection of the public element is not here. Therefore, we would suggest that the first consideration, when looking at whether or not a sanction is required, is the age of Mr Taylor, the length of time that he has been working in the profession. His record would also be of consideration and the fact that he is no longer practising. It is of professional concern to anybody that there has been a finding that one's fitness to practise is impaired and, in the circumstances, Madam, the Committee may feel that any further sanction would be inappropriate.

If, however, this Committee goes on to consider that a further sanction is required in this particular case, we would ask the Committee to bear in mind that his standard of note-taking had improved prior to his retirement. When looking at the financial situation, one needs to bear in mind that he is a man whose sole income comes from his pension. He has some savings, albeit they have to last him for the rest of his life. I can give details of his financial situation should the Committee wish me to do so but, again, the reality is that his income is less than is expenditure at the moment, primarily because his 20-year old daughter is at university in Aberdeen and he has to contribute towards her rent and upkeep while she is in continuing education.

That being the case, Mr Taylor appreciates that, if the Committee feels it appropriate to mark a finding of his fitness to practise being impaired by a sanction, and bearing in mind the reality of the situation, a financial penalty, we would submit, would be the appropriate way to deal with this matter. Again, if you and your colleagues are against us on that, we accept that, realistically, the only other sanction would be erasure from the Register. Having said that, bearing in mind the background I have explained of this being his first brush with disciplinary proceedings, we would submit that erasure would be disproportionate, and simply the fact that he no longer practises would not be grounds to suggest that erasure is merited on the facts of this case, simply as a matter of convenience, I should add. In those circumstances, Madam, we would suggest that a financial penalty is the appropriate means of dealing with Mr Taylor today.

**Mr Etherington:** That is your conclusion is it?

**Mr Hodivala:** Yes.

**Mr Etherington:** Before I advise you, Madam, I want to advise one thing. If a financial penalty were to be the order made, one of the general considerations of any financial penalty is ability to pay, and it must be a matter for you as to whether you would wish to give the Committee, in broad terms, any detail about that.

**Ms Jones:** Sorry, before you do so, I understand there is a standard form which may have been completed. If so, is that information contained on that form?

**Mr Hodivala:** It is and in fact I shall hand that up.

**Ms Jones:** It would make sense that we look at this should we deem that is an appropriate route.

**Mr Hodivala:** Madam, the only point that I want to emphasise about the finances is that, although he has some savings marked on there, as I said those savings are to last him for the rest of his life now.

**Ms Jones:** Okay, thank you. Are there any further comments?

**Mr Hodivala:** Forgive me, there is one further point that I want to make. Again of concern is the fact that, in theory, there could have been endangerment of public safety. You have heard from Miss McMullan's statement, which was read, that all of these patients were re-examined and there is no evidence before the Committee that any of those patients had serious conditions overlooked by Mr Taylor. Again, we say this is relevant to the sanction.

**Mr Etherington:** Madam Chairman, we come to advice on the sentencing matters. You have the following options open to you and I agree with what has been said that you should consider each one of them in ascending order. I also agree with the sentiment that you are not here to punish Mr Taylor in any way

but to direct such sanctions as in your opinion restore and maintain public confidence in the profession and its standards, and protect the public. The lowest sanction which achieves this aim is the appropriate one.

You are not obliged to impose or direct any sanction at all, so your first decision is whether public confidence and/or protection of the public demand any directed sanction. If you are sure that it does, you would proceed to the imposition of conditions upon registration, suspension or erasure in that order – in other words, the ascending order, as I described. I agree with what Mr Hodivala says, that it would not be appropriate to move to a more serious penalty which you did not consider appropriate, only because you could not find a less serious one which you did. For instance, to take the extreme example, if erasure were to be the order you arrived at, it must be because you consider that erasure is necessary to protect public confidence and/or protect the public.

Fines stand in a rather curious part of the order; they are not specifically in the hierarchy that I have placed to you. They would partly depend upon any order that you made but you have the power to impose a direction that, instead of directions in relation to suspension or erasure, you would impose a financial penalty. Either you may do that in addition to it, or you may do it in substitution for it. Because of the date of this case, a financial penalty may specify any sum not exceeding the maximum penalty which is now £50,000. However, it is important, if you decide to impose a financial penalty that two things occur: one, that you specify a period within which the sum that you have specified is to be paid and, two that you have taken into account the ability of the registrant to pay. It would be wrong in principle to impose a penalty that you know he does not have the means to pay. Subject to that, the matters are, as usual, in your discretion.

The factors that you may wish to take into account, they are not exclusive, are the seriousness of the deficiency or deficiencies that you have found, including any possible risk to patients or implications for patient care, the frequency of the deficiency or deficiencies and any explanation for the deficiencies which might reduce the seriousness in terms of public confidence and/or public protection, or any other matter proved in evidence which you consider relevant.

I do not advise you to ignore personal mitigation but it has very much less relevance in this sort of inquiry than, for instance, in a criminal trial, because you are not considering punishing the registrant. You are primarily protecting the public and the reputation of the profession. However, where a fact in mitigation such as the fact that the registrant is not going to practise again, or that he has no previous disciplinary findings bears on the issue of risk to the public, it would be a matter you could take into account if you so wish. That is the advice that I tender to you, Madam, in respect of sentence, unless there are any other matters.

**Mr Hodivala:** The only other factor I believe is the undertaking which remains open.

**Mr Etherington:** I don't think that is really advice; that is just a feature that you draw to their attention again on the aspect of risk.

**Ms Jones:** Thank you. Mr Alder?

**Mr Alder:** No, thank you.

**Ms Jones:** Mr Henley, would you clear the room again.

*[Hearing adjourned at 14.30pm]*

*[Hearing resumed at 15.41pm]*

**Ms Jones:** I would like to read the decision of the Committee.

### **Further order**

The Committee found the allegations in this case to be both serious and troubling, involving, as they do, the elderly and infirm in residential and/or nursing care. These patients are particularly dependent on professionals and trust them to be performing their duties competently. Any failure to do so is bound to damage public confidence in the profession, particularly with the number of instances shown by this evidence. In the light of the mitigation, the Committee considered with care and anxiety the appropriate sanction both to protect public confidence and the maintenance of proper professional standards, and has concluded that only the erasure of Mr Taylor from the Register can meet these requirements. The Committee considered all other options before reaching this decision. Whilst it gives the Committee no pleasure to direct erasure in the case of an optometrist with no previous disciplinary findings, who is 63 years of age and who tells us he has now retired, the primary responsibility of the Committee is to ensure that the public is protected and that proper professional standards and public confidence in the profession are maintained.

*[Hearing concluded at 15.42pm]*