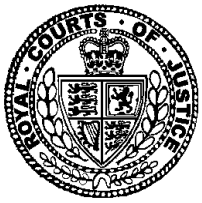

Neutral Citation Number: [2021] EWHC 2888 (Admin)

Case No: CO /185/2021

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 01/11/2021

Before :

THE HONOURABLE MRS JUSTICE COLLINS RICE

- -

Between

THE PROFESSIONAL STANDARDS AUTHORITY FOR HEALTH AND SOCIAL CARE

Appellant

- and -

(1) THE GENERAL OPTICAL COUNCIL
(2) MS HONEY ROSE

Respondents

- -
- -

Ms Fenella Morris QC (instructed by Browne Jacobson LLP) for the **Appellant**
Ms Eleanor Grey QC (instructed by DWF Law LLP) for the **First Respondent**
Mr Sandesh Singh (instructed by the Association of Optometrists) for the **Second Respondent**

Hearing date: 7th October 2021

Approved Judgment

Covid-19 Protocol: This judgment was handed down remotely by circulation to the parties' representatives by email, release to BAILII and publication on the Courts and Tribunals Judiciary website.

The date and time for hand-down is deemed to be 10.30am Monday 1st November 2021.

Mrs Justice Collins Rice:

Introduction

1. This is a statutory appeal by a regulatory authority against a decision of 12th November 2020 by a Fitness to Practise Committee (FTPC) of the General Optical Council (GOC). The decision concerned Ms Honey Rose, a registered optometrist.

2. The FTPC found professional misconduct proved against Ms Rose. It concluded that public trust and confidence, and the need to promote proper professional standards and conduct for members of the profession, required a finding that her fitness to practise (FtP) was consequently impaired. It suspended her from practice for nine months (without requiring any further review).

3. The Professional Standards Authority for Health and Social Care (the Appellant) brings this appeal under section 29 of the National Health Service Reform and Health Care Professions Act 2002. The Appellant says the FTPC's decision is not sufficient for the protection of the public, and asks for the decisions on impairment and sanction to be quashed and Ms Rose's case remitted to a differently constituted FTPC for fresh determinations.

Background

4. Ms Rose's case came to light in tragic circumstances. On 13th July 2012, an apparently fit and healthy eight-year-old boy was suddenly and unexpectedly taken ill at school, and, despite all the medical professionals could do, died in hospital within hours. The cause of his death was subsequently established as hydrocephalus, a build-up of fluid in the brain. The boy's case was unusual because his hydrocephalus had been asymptomatic. But it was a treatable condition, with surgical intervention; there was no reason why this boy could not have been successfully treated at any time before the fatal build-up of fluid on the 13th July. He had not however previously been the subject of *medical* health checks or procedures which might have picked up his condition.

5. But five months before his death he had been taken by his mother, along with his younger sister, for an eye test. Ms Rose, working as a locum optometrist at a high street optician's, tested the whole family. Photographic images taken on that occasion of the boy's retina were abnormal, clearly revealing a rare condition called papilloedema: swelling of the optic nerve. Papilloedema is caused by increased intracranial pressure, for example by a build-up of fluid in the brain. It is one of the most important signs of hydrocephalus. It must be urgently referred for medical investigation and treatment.

6. Ms Rose had not spotted the papilloedema. She did not refer the boy. This was investigated by the police, and she was prosecuted for gross negligence manslaughter, and convicted in the Crown Court on 15th July 2016. But her conviction was overturned on appeal. The Court of Appeal (*R v Rose* [2017] EWCA Crim 1168) held that the trial judge ought to have withdrawn the matter from the jury at the close of the prosecution case; and, having failed to do so, had misdirected the jury as to the proper approach to the component of the offence of gross negligence manslaughter which asks whether 'a serious and obvious risk of death was reasonably foreseeable' at the time of the alleged negligence. It had not been right to direct the jury to take into account what *would have*

been reasonably foreseeable *if* the necessary additional steps had been taken to enable the papilloedema to be spotted. Ms Rose had failed to take those steps, so someone in her position could not reasonably have foreseen a *serious and obvious* risk of the *death* of her patient. Asymptomatic papilloedema in an apparently healthy child is rare.

7. In overturning the conviction, the Court of Appeal said this:

> "We add that this decision does not, in any sense, condone the negligence that the jury must have found to have been established at a high level in relation to the way that Ms Rose examined [the boy] and failed to identify the defect which ultimately led to his death. That serious breach of duty is a matter for her regulator; in the context of this case, however, it does not constitute the crime of gross negligence manslaughter."

The FTPC Proceedings

8. Ms Rose's regulator is the GOC. It obtained the police documentation and duly brought regulatory proceedings against her, and the case came before the FTPC in 2020. She faced allegations detailing a number of particulars in which it was said she failed to conduct a proper eye test on the boy (and on his sister also); and made records of the examination which did not correspond to what she had actually done.

9. The FTPC adopted the standard four-stage procedure: (a) fact-finding, (b) deciding whether misconduct was made out on the facts, if so (c) assessing whether Ms Rose's FtP was impaired as a result of misconduct and (d) sanctioning. The first two stages of the FTPC's conclusions are not challenged in this appeal, but the last two are.

(a) Facts

10. The FTPC established as fact that Ms Rose's routine examination of the boy's eyes with an ophthalmoscope had been discontinued before completion without sufficient reason and without sufficient exploration of alternative means of getting a proper look at the interior of his eyes. In exceptional circumstances it may be appropriate for an optometrist to look at photographic images of the interior in substitution for direct observation. These were not exceptional circumstances. Ms Rose had however consulted an image which she assumed was the photograph just taken of the boy's retina. But she looked at the wrong patient's image. She had not taken the 'basic step' of checking the name of the patient that was brought up on the screen.

11. The FTPC also established that Ms Rose had not made a proper note of this unorthodox and incomplete examination – a particularly important duty of a locum, who is making records for a different future optometrist to rely on. Further, she had recorded that the periphery of the boy's eyes had been examined and was 'normal'. The periphery had not been examined, and Ms Rose had no observational basis for recording 'normal'; she had simply made an assumption. She accepted this record was inaccurate and misleading, and made knowing it was untrue. The FTPC further concluded that she had been dishonest by the standards of reasonable and honest people.

12. Ms Rose had also noted that the boy should be recalled for his next examination on a routine basis in 12 months' time, when, in all the circumstances of the incomplete test, a much earlier recall was indicated.

13. Record-keeping failings in relation to the examination of the younger girl's eyes were also found.

(b) Misconduct

14. The FTPC concluded Ms Rose had failed to carry out an adequate internal eye examination, and this was the most serious and significant of her failings. It was her professional duty to conduct an internal examination by ophthalmoscope or other appropriate means, precisely because the point of such examinations is not only to consider eye functions themselves but also to look for signs of other serious health problems. She had begun the examination by ophthalmoscope but discontinued it prematurely, without sufficient justification and without consulting the boy's mother. While the likelihood of identifying clinical pathology in a primary school child may have been low, '*this was a significant failing because it exposed [the boy] to an unwarranted risk of harm. Had the Registrant complied with her duty she would have detected the bilateral papilloedema and urgently referred [the boy] for treatment*'. The FTPC concluded that the failures to assess the optic nerve and detect papilloedema '*were inevitable consequences of the Registrant's fundamental failure to perform her basic statutory duty*'.

15. Specifically, the FTPC found that Ms Rose had breached the duties set out in her code of conduct to (i) make the care of the patient your first and continuing concern, (ii) give patients information in a way they can understand and make them aware of the options available and (iii) respect the patient's right to be involved in decisions about their care. It held that Ms Rose's failure to undertake an adequate internal eye examination 'and the inevitable consequential failures' were so serious they amounted to misconduct.

16. It also held that the failure to carry out an adequate internal eye examination was '*inextricably linked to the record keeping failures in two interrelated respects. First, the Registrant, having discontinued [the boy's] internal eye examination failed to make an appropriate record of that fact. Secondly, the inaccurate, misleading and dishonest record keeping demonstrates an attitudinal failing*'. Ms Rose had created a false impression that an internal eye examination had taken place when it had not. The FTPC considered that '*although no direct harm was caused to [the boy] as a consequence of the misleading record, there was a risk of harm because incomplete and inaccurate clinical records have the potential to adversely impact patient care*'. Ms Rose had a professional duty to maintain accurate records based on appropriate assessments and sound clinical reasoning but had failed to do so. This was a breach of the code of conduct duty to 'maintain adequate patients' records' sufficiently serious to amount to misconduct.

17. The FTPC also found that the inaccurate, misleading and dishonest record that the periphery of the boy's eyes had been examined and found to be normal was serious dishonesty. It had the potential to mislead future optometrists and undermine trust and confidence among her colleagues, the wider profession and the public, who are entitled to expect that a registered optometrist will maintain high standards of honesty and integrity at all times. This too was a sufficiently serious failing to amount to misconduct.

18. There were further record keeping failures relating to both children. The FTPC decided that they would not have amounted to misconduct on their own, but that the cumulative picture '*demonstrates a casual attitude to record keeping*'. It found in all the circumstances breaches of the code of conduct duties to (i) maintain adequate patients' records, (ii) be honest and trustworthy and (iii) ensure your conduct does not damage public confidence in you or your profession, sufficiently serious to amount to misconduct.

(c) Impairment of Fitness to Practise

19. The FTPC directed itself on FtP to criteria addressing whether a professional has in the past, and/or is liable in future to: put patients at unwarranted risk of harm; bring the profession into disrepute; breach a fundamental tenet of the profession; act dishonestly. It directed itself to have regard to the following 'interrelated aspects of the public interest': a 'personal component' (Ms Rose's current FtP based on her past acts and omission, the scope and level of her insight, the remedial action she had taken, and the risk of repetition) and a 'public component' (the need to protect patients, declare and uphold proper standards of behaviour and maintain public trust and confidence in the profession). It directed itself to look first from the perspective of Ms Rose's personal ability to practise safely and effectively as an optometrist, and second from the perspective of the wider public interest.

The 'Personal Component'

20. The FTPC had had evidence before it that, since seeing the boy and his family on 15th February 2012, Ms Rose had continued to practise for some months, carrying out some 2,000 eye tests between then and 7th September 2012 without apparent incident or complaint. But she had not worked as an optometrist since March 2013 and it was submitted on her behalf that she was as a result currently not fully FtP for that reason.

21. What the FTPC concluded under this 'personal' heading was that, save for the dishonest record entry, Ms Rose's failings were '*easily remediable*' by '*meaningful reflection and a resolve to ensure that they are not repeated*'. It noted that the consultations in question had taken place on a single day over a period of two hours. It accepted that her failings were '*momentary, in that it is highly likely that the Registrant's acts and omissions were spur of the moment decisions. Although they were serious, they were transient.*' They were '*isolated incidents within a short but unblemished career*'.

22. The FTPC accepted that Ms Rose had demonstrated, with the assistance of the Association of Optometrists (the profession's membership organisation) '*a commitment to return to practice*'. She had completed training and study, and recorded her learning. She had not been able to demonstrate this had been embedded into practice because of the long period of years since she had worked as an optometrist, and had not been able to secure a shadowing placement (in part because of the pandemic), but it concluded that '*she has done all that could reasonably be asked of her in relation to the inadequate eye examination and ambiguous record keeping*'.

23. The FTPC decision continued as follows:

> "The Committee accepted that there was merit in the submission, made on behalf of the GOC, that there were some aspects of the Registrant's evidence which demonstrated limited insight. In particular, it was not apparent from her oral evidence that she

> recognised that she had taken insufficient steps to attempt to complete the examination and despite the history of the case she did not readily accept that her ambiguous record keeping fell below the standard expected of a registered optometrist. However, the Committee concluded that the absence of complete insight, in the circumstances of this case, had a limited effect on the risk of repetition. The Committee was satisfied that the risk of repetition was low. The Registrant had demonstrated some insight, and in any event, the Committee concluded that the impact of these proceedings is likely to have had a salutary effect on her. In reaching this conclusion, the Committee was of the view that it was highly unlikely, in light of the tragic consequences for [the boy] and his family, that the Registrant would forget what happened. The Committee concluded that as a consequence it was likely that the Registrant would be more vigilant in future.
>
> "The Committee was mindful that demonstrating remediation following a finding of dishonesty can be particularly difficult. Although the Committee noted that the Registrant did not readily admit that her deliberately misleading entry in [the boy's] record was dishonest, it did not conclude that the Registrant is likely to make a dishonest entry in a patient record again for the same reasons as set out in [the preceding paragraph].
>
> "The Committee concluded that the Registrant has remedied the specific clinical failings it had identified. Therefore the Committee was unable to identify any basis upon which it could conclude, based on the Committee's misconduct findings, that the Registrant is currently unfit to practise from a personal perspective."

The 'Public Component'

24. The remainder of the FTPC's consideration of FtP is as follows (in its entirety):

> "In considering the wider public interest, the Committee had regard to the need to maintain public confidence in the profession and to declare and uphold proper standards of conduct and behaviour. The Committee took the view that well-informed members of the public would acknowledge and accept that the ambiguous record keeping failures occurred as a consequence of human error and that the finding of misconduct would be sufficient to mark that aspect of the Registrant's wrongdoing. However, the Committee concluded that well-informed members of the public would be extremely concerned to learn that a registered optometrist had discontinued an internal eye examination without adequate justification, relied on the retinal image of the wrong patient and made a deliberately misleading entry in a patient's record. The Committee concluded that this behaviour included dishonesty, brought the profession into disrepute, and breached the fundamental tenet of the profession

> that registered practitioners are required to make the care of their patients their first concern.
>
> "In all the circumstances, the Committee determined that public trust and confidence and the need to promote proper professional standards and conduct for members of the profession would be seriously undermined if a finding of impairment is not made.
>
> "Therefore the Committee determined that, on the basis of the wider public interest, the Registrant's fitness to practise is currently impaired."

(d) Sanction

25. The FTPC directed itself to apply a principle of proportionality by weighing Ms Rose's interests against the public interest and to consider each available sanction in order. It began by considering the 'non-exhaustive list of aggravating factors set out in the Indicative Sanctions Guidance (ISG)'.

26. Under this heading it noted its previous determination that '*there were some aspects of the Registrant's evidence which demonstrated limited insight*'. But she had demonstrated some insight. The FTPC

> "…was satisfied that the absence of full insight was not an aggravating factor given that she had undertaken timely remediation, that there is no ongoing risk to patient safety and that the finding of impairment was solely made in order to promote and maintain the wider public interest. The Committee was also satisfied that the full extent of the Registrant's dishonesty is reflected in the factual findings and therefore is not an additional aggravating factor. The Committee concluded that in this case there are no aggravating factors for the purpose of determining sanction."

27. The FTPC then turned to mitigating factors. It considered the following to be relevant under that heading:

- Ms Rose's failings were spontaneous and momentary;
- she had demonstrated commitment to returning to practice and had taken appropriate steps to bring her skills and knowledge up to date;
- her good character, and the fact that her failings on the day in question were an isolated event in the context of her professional career.

28. The FTPC directed itself to the ISG's indicators for suspension. The ISG says this, about suspension:

> "This sanction may be appropriate when some or all of the following factors are apparent (this list is not exhaustive):

a. A serious instance of misconduct but where a lesser sanction is not sufficient;

b. No evidence of harmful deep-seated personality or attitudinal problems;

c. No evidence of repetition of behaviour since incident;

d. The panel is satisfied the registrant has insight and does not pose a significant risk of repeating behaviour;

e. …"

29. Having satisfied itself on the first of these, the FTPC took the view that

> "…although it has concluded that the Registrant's dishonest record keeping demonstrated an attitudinal complacency, it did not consider it appropriate to characterise this as a '*harmful deep-seated personality or attitudinal problem*'. In reaching this conclusion the Committee took into account the transient nature of the Registrant's dishonesty and the fact that it stemmed from an erroneous assumption that an asymptomatic child was unlikely to have any underlying pathology. It has already found that such conduct is unlikely to be repeated. The Committee also noted that the Registrant continued to see patients for several months after her consultation with [the boy and his sister] and no other concerns were raised."

30. The FTPC also directed itself to what the ISG says about erasure from the register. It says that this will be appropriate '*where this is the only means of protecting patients and/or maintaining public confidence in the optical profession*'. The ISG draws attention to the decided legal cases which, on the one hand, emphasise that erasure should not be seen as necessary to remove '*an otherwise competent and useful registrant who presents no danger to the public in order to satisfy public demand for blame and punishment*'; but on the other hand emphasise that '*the reputation of the profession is more important than the fortunes of any individual member*' and that sanctioning committees have a role in maintaining public confidence in their profession so that erasure may be appropriate '*despite a practitioner presenting no risk*'.

31. The ISG goes on to say this about erasure:

> "This sanction is likely to be appropriate when the behaviour is fundamentally incompatible with being a registered professional and involves **any** of the following (this list is not exhaustive):
>
> a. Serious departure from the relevant professional standards as set out in the Standards of Practice for registrants and the Code of Conduct for business registrants;
>
> b. Doing serious harm to individuals (patients or otherwise), either deliberately or through incompetence, and particularly where there is a continuing risk to patients;

c. Abuse of position/trust (particularly involving vulnerable patients) or violation of the rights of patients;

d. …

e. …

f. Dishonesty (especially where persistent and covered up); or

g. Persistent lack of insight into seriousness of actions or consequences."

32. The FTPC concluded as follows:

> "The Committee has determined that the Registrant's failings fell short of the standards expected of her. However, on the basis of the findings it has already made, it does not consider the departure from the relevant professional standards to be sufficiently serious to warrant erasure. The Committee did not accept [the GOC's] submission that an inadvertent exposure to a risk of harm equates with '*Doing serious harm*' in circumstances where causing harm had not been alleged by the GOC. The Committee was mindful that dishonesty is a serious finding. However, the Committee was also aware that there can be varying degrees of seriousness and there is no presumption that erasure is the appropriate sanction in all cases of dishonesty. Having balanced the relevant features of this case against the effect a finding of dishonesty has on public trust and confidence in the profession, the Committee concluded that erasure is not inevitable, particularly as the Registrant's dishonesty was not persistent or covered up. Furthermore, although the Committee has previously determined that the Registrant has demonstrated some but not full insight, it concluded that it would not be appropriate to characterise this as a persistent lack of insight into the seriousness of her actions and the consequences. The Committee noted that none of the other factors as set out in the ISG which indicate that erasure may be the appropriate sanction applies to the circumstances of this case. The Committee also noted that erasure is a sanction of last resort and should be reserved for the category of cases where there is no other means of protecting the wider public interest. The Committee took the view that the Registrant's case does not fall into this category and therefore concluded that erasure would be disproportionate and purely punitive.
>
> "In these circumstances, the Committee concluded that a Suspension Order would be the appropriate sanction as it would send a clear signal to the Registrant, the profession and the public re-affirming the standards expected of a registered optometrist. The Committee was satisfied that a Suspension Order would adequately address the wider public interest."

Grounds of Appeal

33. The Appellant challenges the FTPC's decision on the following grounds:

> (1) the FTPC wrongly decided that Ms Rose's fitness to practise was only impaired on the grounds of the public interest in maintaining confidence in the profession and professional standards, and not on the grounds that she posed an ongoing risk to the public;
>
> (2) the FTPC took the wrong approach to the issue of what sanction to impose on Ms Rose, particularly bearing in mind the terms of the relevant guidance;
>
> (3) the FTPC wrongly decided not to require a review of Ms Rose before the conclusion of the period of suspension, and failed to give sufficient reasons for its decision.

Legal Framework

34. Where an appeal is brought under section 29(4) of the National Health Service Reform and Health Care Professions Act 2002, section 29(4A) provides that consideration of whether a decision is sufficient (whether as to a finding or a penalty or both) for the protection of the public involves consideration of whether it is sufficient:

> (a) to protect the health, safety and well-being of the public;
>
> (b) to maintain public confidence in the medical profession; and
>
> (c) to maintain proper professional standards and conduct for members of that profession.

35. As confirmed by the Court of Appeal in *Ruscillo v CRHCP & GMC* [2004] EWCA Civ 1356 at paragraphs 69 to 73, Part 52 of the Civil Procedure Rules applies to this sort of appeal. An appellate court is limited to a review of the FTPC decision (unless it considers that in the circumstances of an individual appeal it would be in the interests of justice to hold a rehearing). It will allow an appeal if it is satisfied that the FTPC decision was (a) wrong or (b) unjust because of a serious procedural or other irregularity in the proceedings of the FTPC.

36. The correct approach of an appellate court on such an appeal was summarised at Divisional Court level in *GMC v Jagjivan* [2017] EWHC 1247 (Admin), [2017] 1 WLR 4438, at paragraphs 39-40. Since the appellate court lacks the FTPC's professional expertise, it must approach a challenge that the FTPC has made 'wrong' decisions about what is necessary to protect the public, and maintain public confidence and proper standards in the profession, with a degree of 'diffidence'. But there may be matters (dishonesty or sexual misconduct are examples) where the court is likely to feel that it can assess what is needed to protect the public or maintain the reputation of the profession more easily for itself, and thus attach less weight to the expertise of the FTPC. In such cases the court will afford an appropriate measure of respect to the FTPC's decision, but not more than is warranted by the circumstances. Matters of mitigation are likely to be of considerably less significance in regulatory proceedings

than to a court imposing retributive justice, because the overarching concern of the professional regulatory is the protection of the public. A failure of the FTPC to provide adequate reasons may constitute a serious procedural irregularity rendering a decision unjust.

37. Further guidance is provided by the Court of Appeal in *Bawa-Garba v GMC* [2018] EWCA Civ 1879; [2019] 1 WLR 1929, at paragraphs 60-67. A sanction decision of the FTPC is an evaluative decision based on many factors – a 'multifactorial decision' involving a mixture of fact and law – and the same may be said of the assessment of FtP. An appellate court has limited scope for overturning such decisions. Its approach should be conditioned by the extent to which it is at a relative disadvantage. It should interfere only if it identifies an error of principle by the FTPC in carrying out the evaluation, or the evaluation was wrong because it falls outside the bounds of what the FTPC could properly and reasonably decide.

Analysis

38. The Appellant and the GOC criticise this FTPC for finding no impairment of FtP from the 'personal perspective'. The FTPC said it was unable to identify *any* basis in her misconduct on which to conclude Ms Rose was personally unfit to practise. The Appellant and the GOC say that is simply wrong – a conclusion it was not entitled to reach consistently with its own previous findings.

39. The Appellant and the GOC also criticise the FTPC's approach to sanction, bearing in mind the ISG. They say it discloses error of principle and procedural irregularity, both including and resulting in defective analysis and reasoning. They say this is in part because of the defects vitiating the decision it had made on FtP, and in part because of mistakes in applying the ISG in any event.

40. Mr Singh, Counsel for Ms Rose, underlines the proper limits of an appellate court's functions, and characterises most or all of the criticism levelled at the FTPC as simply disagreement with evaluative assessments, including clinical assessments, made and sufficiently explained by the FTPC on the basis of evidence and findings which they were entitled to take into account and weigh up as they saw best.

41. My task on this appeal is limited. It is not to agree or disagree with the FTPC, or to revisit its findings of fact or misconduct. It is to consider whether the FTPC subsequently went wrong to the extent of reaching further determinations it was not properly entitled to reach at all. That might be because the decisions on FtP and sanction are internally illogical or cannot be reconciled with the FTPC's own decisions on facts and misconduct. Or it might be because procedural or other irregularity – error of principle or failures of approach or reasoning – mean the FTPC did not do the case proper justice. So before getting to grips with the detail of the parties' arguments either way, it is important to stand back and establish the undisputed context of this appeal – the foundation of fact and misconduct on which the FTPC constructed its decisions on impairment and sanction. It was for the FTPC to assess the gravity of Ms Rose's misconduct on the facts it had found, and that assessment of gravity is crucial for the ensuing stages of its decision-making.

(i) The gravity of the established misconduct

Breach of duty to examine

42. The FTPC assessed the failure to undertake a proper internal eye examination as the most serious and significant of Ms Rose's failings, a 'fundamental failure to perform her basic statutory duty'. People are encouraged to get their eyes seen regularly not just to deal with visual problems but precisely in order to pick up signs of a range of health concerns which can be noticed from the state of the eyes (diabetes and high blood pressure are well-known examples). This is what optometrists are trained to do, a crucial part of what the tests are for.

43. No real doubt or disagreement can be seen at any stage about the nature or dimensions of Ms Rose's failure – the distance between what she ought to have done and what she did do in performing an eye test. The FTPC had access to a quantity of expert evidence, including from the experts who had given evidence in the criminal proceedings. The oral expert evidence given to it at the hearing was that Ms Rose's failure to assess the optic nerve head or conduct a full internal examination of the eye was 'extremely serious'. She had not looked at the optic nerve, or even made sure to look at the correct image of it. She had failed to complete the examination, and to explain and communicate with the boy's mother about it. She had failed to take any mitigating action, neither back-up forms of test nor shortening the time before the next appointment. She had barely performed an examination worth the name at all.

44. The duty to make an examination was a professional obligation and a duty owed in law to her patients, who were entirely reliant on her expertise. They had no other possible means of knowing whether anything might be wrong, without symptoms. They thought the children's eyes had been examined and given the all-clear. They had not been examined. The boy and his family were thoroughly let down.

45. A breach of duty as fundamental and substantial as this was described by the FTPC as conduct falling *far* below the standards expected of a professional. In other contexts, that is known as gross negligence, but whatever the label, the assessment remains the same: this was a radical, a grave failure of the duty to examine. That was what the FTPC had found.

Breach of duty to record

46. Not only had Ms Rose not done a proper, complete examination, she had failed to make the necessary notes to record what had happened. Again, the FTPC identified that as a serious professional failure in its own right, especially for a locum on whose written notes she could expect other professionals to have to rely. Accurate patient records are essential to patient care. Whatever the reasons or explanations for an incomplete examination, the *fact* that an examination has been incomplete is a vital part of the story, and recording it a part of a professional's duty to take care of a patient. So the failure to record what had happened exacerbated the failure to examine even further.

47. The FTPC generalised its finding on this point. It described Ms Rose's attitude to record keeping as 'casual' and as demonstrating an 'attitudinal failing'.

Dishonesty

48. It was not just that Ms Rose failed to set out a proper account of what had happened. She had positively set out an admittedly inaccurate and misleading – and, as the FTPC found, dishonest – account of what had happened. The FTPC found, in other words, that when she recorded that the periphery of the boy's eyes had been examined, that was a conscious lie. She had not made that examination. And when she said that the

periphery had been examined and was normal, that suggested that the conclusion 'normal' was based on the examination, when it was not and could not have been. It was based on an erroneous assumption that because the boy was asymptomatic, and there were no other clues, his peripheral retina must be normal – which is, of course, the complete reverse of the professional diagnostic process she was required to undertake.

49. This dishonesty was held to be serious in its own right. The decided authorities leave no doubt in any event about the seriousness with which dishonesty is regarded in a professional, not least in a clinical context. Ms Rose apparently offered no explanation for why she recorded that she had performed an examination she had not performed or suggested that a diagnostic conclusion was supported by observations she had not made. But recording she had performed an examination she had not performed was, at the least, consistent with giving a false account of events in which she had not breached her duty to examine.

Exposure of patients to unwarranted risk of harm

50. The FTPC's decision on misconduct says two memorable things about the consequences *for the boy* of Ms Rose's failures. It says the failure to detect his bilateral papilloedema was an *inevitable* consequence of the fundamental breach of her statutory duty to examine. It also says that although the likelihood of identifying clinical pathology in an asymptomatic primary school age child is low, the failure to perform a proper test '*exposed [him] to an unwarranted risk of harm*. *Had the Registrant complied with her duty she would have detected the bilateral papilloedema and urgently referred [him] for treatment*'.

51. At the hearing of this appeal, I invited Counsel to address me specifically on the question of the proper approach for the FTPC to take to the fact that Ms Rose's young patient died of undiagnosed hydrocephalus five months after she failed to examine, detect papilloedema – and, inevitably, refer him. The FTPC's decision-making says little about the ultimate tragedy (otherwise, indeed, than to describe the 'salutary effect' on *Ms Rose* of the whole course of events by way of mitigation of the impairment of her FtP).

52. It is important to record that there are some good reasons for this. The first is that the FTPC's job is quite distinct from that of the courts which had previously considered the question of Ms Rose's criminal responsibility for the boy's death. That question had been definitively answered by the Court of Appeal. Ms Rose had been acquitted of any such responsibility, and was entitled to put the shadow of criminal suspicion entirely and conclusively behind her. It was no part of the FTPC's task to revisit the criminal charges or to exact retributive justice.

53. Another reason, which is also about the function and purpose of FTPC proceedings, is that the charges the GOC brought against Ms Rose, and therefore the FTPC's consideration of her misconduct, properly focused on her duties, her actions and her omissions, and not on outcomes. The GOC has some internal guidance on drafting allegations for consideration by FTPCs which spells this out. It says:

> "For misconduct and deficient professional performance allegations, the consequences of a registrant's actions are not relevant and should not be included. The allegation should not require the GOC to prove that the registrant's conduct led to a

particular result. Rather, its purpose is to set out what the registrant did or did not do."

54. As it was explained to me, the key policy points here are that the GOC should not be *required* to prove ultimate *causation* of particular (adverse) outcomes, because an (adverse) outcome is no *necessary* part of establishing misconduct. Misconduct may be very serious even though no harm is in fact caused. The gravity of misconduct must be assessed on its intrinsic nature, *whether or not* harm has been caused.

55. The FTPC nevertheless identified that the intrinsic nature of the failures established in this case was that they were disempowering of, and dangerous for, the patient. The language the FTPC used in its misconduct determination – 'exposure to an unwarranted risk of harm' – is taken from the decided legal cases identifying features going to gravity of misconduct relevant for an FtP decision.

56. The concept of 'risk of harm' is variable along both axes – magnitude of risk and magnitude of harm. It was suggested to me in argument that this was a case of low risk/high harm – that is to say, the likelihood of any asymptomatic child having papilloedema is low (it is rare) but the condition itself a clear sign of a very serious health problem. That is not a complete analysis of the relevance of risk of harm in a case like this. The distribution of papilloedema in the general population of asymptomatic children is only part of the picture (however important it may have been to the Court of Appeal's analysis that, on Ms Rose's *actual* state of knowledge, a *serious and obvious risk of the boy's death* was not, objectively, reasonably foreseeable). The FTPC's assessment of the gravity of the misconduct it identified also had to deal with the risk, relevant to *that* issue, that if a proper examination of the optic nerve is not undertaken, a patient with papilloedema will not have that condition identified.

57. The FTPC did so. It identified that Ms Rose's 'fundamental failure to perform her basic statutory duty' exposed the boy to a high risk – an inevitability – that the signs of papilloedema would be missed. It found that but for the breach of duty she would have noticed the papilloedema and would have referred the boy. While the GOC did not need to prove, or even charge, a linked chain of events leading from the failure to examine to the loss of a child's life, the FTPC found the failure to examine and record was grave and serious in its own right because of the lack of assurance (or the false assurance) that provided, and the unmanaged risks to which it therefore exposed patients. It would have been so even had there been no papilloedema to detect; it would have exposed any patient to an unwarranted risk of missed diagnosis. There could, however, be no more eloquent and terrible testimony to the vital importance of doing a proper eye test, taking mitigating steps where for any reason that is impossible, and making proper records, than this particular child's tragic outcome. The FTPC must have been in no doubt whatever, in this case above any other, of the nature and gravity of the misconduct with which it was dealing.

(ii) The impairment decision

58. No issue is taken with the ultimate finding that Ms Rose's FtP was impaired by reason of her misconduct – as such. Its encapsulation of the 'extreme concern' of the public perspective (paragraph 24 above) lists in brief many of the elements it had taken into account in identifying the high gravity of the misconduct it had established. The challenge on this appeal is to the analysis carried out in the 'personal perspective' section and in the way the two perspectives were brought together.

59. Reaching the right result for the wrong reasons can in an appropriate case amount to a serious procedural irregularity making the outcome unjust. That is the core of the challenge here. Although the Appellant's ground of appeal refers to the impairment decision as 'wrongly decided', it is the reasoning and not the conclusion which is challenged. It is a challenge to the internal logic of the decision and its consistency with what the FTPC had already found in its factual and misconduct determinations. And it proposes that the impairment decision is sufficiently defective to make it inevitable that the sanctions analysis would start off on the wrong foot.

60. The FTPC relied on 'personal' and 'public' stages in its impairment analysis. These sorts of analytical tools may be useful aids to thinking, but they are only that. The important point, as the FTPC recognised, is that both aspects are 'interrelated' and both are components of the *public* interest. The criteria to which the FTPC had properly directed itself (paragraph 19 above) encourage looking at the issues in a slightly different way – not at the 'public' and the 'individual', but at the past and the future.

61. All four of the 'features which have been identified as likely to be present when impairment is found' were clearly present in this case on the FTPC's own findings so far as the past was concerned. It had found that Ms Rose had put her patient(s) at unwarranted risk of harm, brought the profession into disrepute, breached one or more of the fundamental tenets of the profession and acted dishonestly – in each respect to a serious degree. It might well have paused there to consider whether the historical conduct alone made an impairment finding inevitable; the authorities and guidance are clear that the gravity of historical misconduct may require a finding of impairment even if there is no future risk at all. Future risk is nevertheless a relevant dimension of the overall assessment, and it was not irregular for the FTPC to go on to consider it.

62. This appeal challenges the way the FTPC did so. The essence of the challenge is that, perhaps through forgetting that the 'personal dimension' is an aspect of the public interest and not a distinct perspective personal to Ms Rose, the FTPC lost sight of the gravity of the misconduct and the fundamental nature of the failings it had found when it came to consider the future. The challenge adds that the FTPC in any event made a number of specific adverse findings on matters going to future risk – or more generally to 'attitudinal issues' – which were incompatible with finding that Ms Rose had fully remedied her failings and posed no future risk to the public.

The specific adverse findings

63. The FTPC had found that in the proceedings before it, Ms Rose had 'denied' that making a record indicating that the periphery of the eye had been examined and was normal was dishonest. Her explanation, that it was not dishonest because it proceeded from a mistaken assumption that the eye was likely to be normal, did not account for the knowingly untrue and misleading note that the peripheral retina *had been examined* when it had not. It had found that the dishonest and casual approach to accurate record keeping amounted to an 'attitudinal failing' which in itself exposed patients to risk. The records of both of the children had been deficient. It took the view that the dishonesty was a failing that was not easily remediable, and it can be particularly difficult satisfactorily to demonstrate remediation where dishonesty is involved.

64. The FTPC had also accepted that there were aspects of Ms Rose's evidence which demonstrated limited insight. It noted in particular that '*it was not apparent from her oral evidence that she recognised that she had taken insufficient steps to attempt to complete the examination and despite the history of this case she did not readily accept*

that her ambiguous record keeping fell below the standard expected of a registered optometrist'.

65. The FTPC had further noted Ms Rose's own indication that she had been out of practice for a considerable period, and that she had not been able to demonstrate that the learning she had done had been embedded into practice because she had not worked as an optometrist since 2013.

The FTPC's analysis of future risk

66. The FTPC then put weight on the following factors in concluding it was unable to find *any* basis for finding Ms Rose unfit to practise 'from a personal perspective'.

67. First, it considered the misconduct an isolated incident in an otherwise short but unblemished career. It was serious but 'momentary' and 'transient'. Her misconduct proceeded from 'spur of the moment decisions'.

68. Second, aside from the dishonesty, it considered all the failings 'easily remediable' by 'meaningful reflection and a resolve to ensure that they are not repeated'.

69. Third, it found she had demonstrated that resolve, and had done all that could reasonably be asked of her to get a better understanding of the importance of completing eye tests and making proper records.

70. Fourth, even with limited insight, it thought her highly unlikely to fail in the same way or act dishonestly again, because the tragic consequences for the child and the impact of the proceedings since his death would be something she would never forget and were likely to have a salutary effect.

Consideration of the FTPC's approach

71. There are problems with the logic and reasoning of the FTPC's approach. The first is the gap between the *fundamental* nature of the failures and finding them *easily* remediable. Ms Rose was held to have failed in the basics of doing an eye examination, engaging with and informing her patients and making proper records. These failures were, on the FTPC's own analysis, multi-faceted, interconnected and radical. She had behaved overall as no professional optometrist could properly think of behaving. So the conclusion that the gap between what she should have done and what she did, however wide, could be easily bridged simply by meaningful reflection and resolve, is unexpected. It needs a clear explanation to be comprehensible.

72. The explanation would have to start with an account of Ms Rose's own understanding of the magnitude of her failings – her 'insight'. But rather than providing a clear explanation, another gap appears: between the FTPC's findings of failures of insight and the conclusion that these had a limited effect on the risk of repetition. Even after all that had happened in the intervening years, the FTPC noted that Ms Rose had *not* demonstrated that she recognised that she should have done more to complete the examination, *or* that her 'ambiguous' record-keeping fell far below the standard expected of her. That is, on the face of it, a startling and alarming finding of failure of insight (or being in denial), in a case where things had gone so very wrong for her patient. She could not have had a more vivid example of why proper examinations and proper records are so fundamentally important, and why her failures were so serious.

73. Insight – an acknowledgment and appreciation of failure, its magnitude, and its consequences for others – is an essential prerequisite to a confident conclusion that a problem has been properly understood, addressed and eliminated for the future. The FTPC's finding that eight years' worth of opportunity for 'meaningful reflection', and the death of a child, had not brought Ms Rose to a recognition of the magnitude of her failing, but that nevertheless that could be overlooked as having a limited effect on the risk of repetition, makes an even more pressing case for the clearest of explanations.

74. The FTPC's own findings on failure of insight are particularly significant when it comes to the question of dishonesty. It had found Ms Rose had *not* 'readily admitted' dishonesty in the proceedings before it. It had labelled her dishonesty serious. It had acknowledged the importance of dishonesty as a species of professional misconduct, not least where patient records are concerned. It acknowledged that dishonesty is not easily remediable. And yet it found it unlikely that Ms Rose would repeat her dishonesty, despite not even readily admitting it. It does not explain why.

75. It then went on to conclude that '*well-informed members of the public would acknowledge and accept that the ambiguous record keeping failures occurred as a consequence of human error*'. That is simply incomprehensible. The FTPC had not found the record-keeping 'ambiguous'. It had found it deficient, untrue, misleading and dishonest. It had itself also thereby eliminated human error as a possible explanation. The record Ms Rose made had, on the FTPC's own findings, falsely and knowingly set out a version of events which was consistent with her having performed her professional duties when she had entirely failed to do so.

76. These gaps between the FTPC's own findings and its optimism for the future are problems of coherence and comprehensibility. Its reasoning does not eliminate these problems. It seems, for example, that the FTPC placed considerable weight on the 'isolated' nature of the events before it, and deduced from the absence of evidence of other complaints or problems in Ms Rose's (short) career that her failings were one-off impulsive aberrations. Whether they were or not was a matter it needed to probe and assess rather than assume. That is because of the findings it had already made about the unusual matrix of facts which had brought the incident before it to light.

77. Most patients coming for eye tests will not have papilloedema. Most patients with papilloedema will not be asymptomatic. So most patients who present without concerning symptoms and whose eyes are not properly examined will never have cause to know that, never mind complain about it. The issue the FTPC needed to address is how likely it was that the sole occasion on which Ms Rose happened to make a fundamental, multi-faceted and dishonest failure in the execution of her professional duty chanced to be in the case of a child with asymptomatic papilloedema whose subsequent death identified the problem and led to the discovery of her failings. The FTPC's conclusion that that was *very likely* is on the face of it baffling, given the odds. The FTPC of course had to focus on the evidence before it. But there is a world of difference between a proper focus on the limited evidence of fault before a tribunal and an extrapolation by that tribunal that it is safe to assume that it occurred on no other occasion and can be relied on not to happen again. That is a matter for investigation, assessment and explanation, not assumption, and to the extent that the FTPC made a deduction of logic from the absence of other complaints to answer the question, the logic is defective.

78. That is especially so since the FTPC had attributed at least some of the default to underlying *attitudinal* failing. How that is reconciled with the conclusion that Ms

Rose's failings in the case before it must have been an isolated one-off aberration is not apparent.

79. The FTPC also placed weight on the steps Ms Rose had taken to develop professional learning about 'inadequate eye examination and ambiguous record keeping' and, noting the effect of the pandemic, concluded that she had done all that could reasonably be asked of her in the circumstances. There is a gap between that finding and the conclusion that she was fully fit to practise. Was 'all that could reasonably be asked of her' in constrained circumstances sufficient on an objective assessment? That last and necessary step does not appear.

80. And finally, there is a gap between the cumulative adverse findings made, and the conclusion that the tragic events and the impact of the proceedings were themselves enough to establish confidence for the future. The logic that the more fundamental the failings and the worse the outcomes and consequences, the more confidence may be had that lessons will have been learned and the risk of repetition will be low, has little intrinsic merit. On the contrary, the worse the failings and the more disastrous the ultimate outcome, the greater the need for public reassurance about the future. The FTPC's determination does not explain why the public is entitled to be reassured.

Conclusions

81. FtP is an overall evaluative decision for an expert tribunal. This FTPC's final conclusion that Ms Rose's FtP was impaired is not challenged. I am not myself concerned with Ms Rose's FtP; it is not a matter I am asked to determine, and I express no opinion about it. I am concerned solely and wholly with the FTPC's analytical structure, explanation and reasoning – with how it reached and presented its decision, not with the substance of the decision it reached. And I am concerned with that because the law concerns itself with the duties that expert tribunals have to the public – to ensure that the public can understand why certain decisions have been reached in its name; can be reassured that healthcare professionals on whom they must depend are well and fairly regulated; and can know that the overarching obligation professionals have to deserve the trust the public places in them, and to discharge their professional duties with the interests and safety of patients uppermost, has a secure foundation.

82. The gaps in this FTPC's analysis, logic and reasoning are too many and too significant for the public to be able to understand why, although it had found that Ms Rose had breached the fundamental tenets of her profession in a number of respects, brought her profession into disrepute, acted dishonestly and put her young patient at unwarranted risk of harm – inevitably failing to make an obvious diagnosis of signs of a life-threatening condition demanding urgent medical referral – there was *no basis* for fearing future risk to the public in her impaired FtP. Its own adverse findings on her unexplained dishonesty, and her lack of insight (failure to recognise she had taken insufficient steps to complete the eye examination, and failure *despite the history of the case* readily to accept that her record-keeping fell below professional standards), and its attribution of that at least in part to attitudinal failings, called for a particularly clear explanation of how these findings could be reconciled with optimism about the future. The apparent reliance on a subjective rather than objective evaluation of the remedial steps taken, the unsupported inference that the conduct before it was an isolated aberration, and the inexplicable invocation of 'human error', do not come close to providing the necessary explanation. The observation that the tragedy itself could be relied on as making it *likely* that she could be depended on in future is the opposite of reassuring.

83. This determination discloses multiple and serious irregularities and errors of principle. These may be attributable to an overly disjunctive approach to the successive determinations of fact, misconduct and impairment; or possibly to a faulty understanding or application of the 'personal/public' approach as being distinctive, rather than complementary aspects of the overall *public* interest. In any event, the determination of impairment, so far is it relates to future public risk, is insufficiently reasoned to deal with what are otherwise gaps of logic and analysis, and internal inconsistencies. It does not make enough sense, on its own terms. So it does not do justice to the case, and to the public it considered entitled to be 'extremely concerned' by the grave misconduct established.

84. In these circumstances, I conclude that the challenge to the impairment decision of insufficiency from the point of view of public protection is made out, and the remedy must be to quash the determination and remit it to a differently constituted tribunal for fresh consideration and a fully explained decision.

(iii)`Sanction

85. I also conclude in these circumstances that the FTPC's consideration of sanction inevitably started off on an insecure basis, depending as it did on some of the unsupported and unexplained impairment conclusions. It is equally inevitable that sanction will need to be reconsidered in the light of the redetermination of impairment of FtP. It is not therefore necessary to consider the existing sanctions determination in detail for the purposes of determining this appeal. However, by way of brief observations, the following may be noted.

86. Any determination of sanction must be approached by regarding the ISG as giving an 'authoritative steer'. When a FTPC decides – as in an appropriate case it may – to depart from the ISG's steer, it has to give clear and case-specific reasons for doing so.

87. On the existing findings of misconduct, the FTPC had, appropriately, directed itself to the ISG's provisions on suspension and erasure, considered together, as the surest route to a sustainable decision on the proportionality of sanction.

88. So far as suspension is concerned, this was not a case where, on the FTPC's own findings, there was *no evidence* of harmful attitudinal problems. Its own conclusions had also included reservations about whether it could be *satisfied* that Ms Rose had insight. A clear explanation was needed for why these indicators were either met or could properly be departed from (and which).

89. The ISG also indicates that a decision to suspend must *normally* be made subject to pre-expiry review and a detailed explanation of the relevant factors given if a case is considered to lie outside the normal rule.

90. So far as erasure is concerned, the ISG gives a proper reminder of the weightiness of the obligation to maintain public trust and confidence in the profession, as against the weight to be attached to personal mitigations in any individual case and even any assessment that an individual practitioner presents *no risk.* It also directs tribunals that erasure is likely to be appropriate if *any* of the non-exhaustive indicators appears.

91. In view of some of the submissions made to the FTPC, and at the hearing of this appeal, about the meaning of some of the individual indicators, the following points arise:

a. *Serious departure from the relevant professional standards* is an amplification of the 'serious instance of misconduct' test mentioned in the suspension indicators. There is ample indication in the misconduct determination that this factor appears in the present case. It had been held to be a case of fundamental professional failure in more than one dimension.

b. *Doing serious harm to individuals (patients or otherwise)* was distinguished by the FTPC from '*exposure to an unwarranted risk of harm*'. In part, that was said to be on the basis that the GOC had not pleaded 'doing serious harm'. The proper reasons for that are considered above – misconduct is pleaded on its inherent qualities rather than being made to turn on proof of outcomes. But if and insofar as the ISG is intended to make any distinction of substance between doing harm and exposing a patient to unwarranted risk of harm – a question which itself merits sober and express reflection on the purpose of this guidance and its application to the facts of the case – then a tribunal would in my view be unwise to dismiss exposure to unwarranted risk of harm as *irrelevant* to sanction without at least pausing to consider all the dimensions of that risk and the degree of culpability to be attached to its creation. This was a case in which all the risks were fully eventuated and the worst imaginable outcome came to pass; the public is entitled to a proper explanation of how that may or may not be reflected in the determination of sanction.

c. A tribunal considering whether this was a case of *abuse of position/trust (particularly involving vulnerable patients)* ought to address the young age of the child patients in this case and the importance of engaging with and informing their mother in relation to the discharge of an optometrist's duties.

f. *Dishonesty* is identified as an indicator of erasure, especially, but not exclusively, where persistent or covered up. It is right that the nature and extent of dishonesty may be variable and must be evaluated on a case by case basis. It is at least relevant that the dishonesty found in this case comprised making a false patient record so that it indicated that an examination of the peripheral retina had been made when, in fundamental breach of duty, it had not.

g. A tribunal considering whether this was a case of *persistent lack of insight into seriousness of actions or consequences* needs to take into account the evidence which led the FTPC to make adverse findings on Ms Rose's insight, bearing in mind the length of time available to her for the development of insight and the powerful incentive to do so afforded by the tragic outcome of the case.

Decision

92. The appeal is allowed. The FTPC's determinations on impairment of FtP and on sanction are quashed and remitted to a differently constituted FTPC for fresh determinations.