BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(25)15

AND

KAAJAL VORA (01-26254)

DETERMINATION OF A SUBSTANTIVE HEARING
23-25 MARCH AND 21-23 APRIL 2026

Committee Members:	Sarah Hamilton (Chair) Joy Tweed (Lay) Vivienne Geary (Lay) Caroline Clark (OO) Kalpana Theophilus (OO)
Legal adviser:	Dr Francis Graydon
GOC Presenting Officer:	Holly Huxtable
Registrant present/represented:	Yes and represented
Registrant representative:	Eleanor Curzon (23ES) Scott Shadbolt (AOP)
Hearings Officer:	Terence Yates
Facts found proved:	1a & 1b proved
Facts not found proved:	None
Misconduct:	Found
Impairment:	No impairment (no warning)

Preliminary issue

1. At the start of the hearing, the Chair raised that Ms Theophilus, one of the Optometrist members on the Committee had indicated that she recognised someone named within the papers. Ms Theophilus clarified that she worked with Mr A in a professional clinic environment for a few days in about 2003. She added that she had not had any contact with him since then.

2. Both parties confirmed that there was no objection to Ms Theophilus continuing to hear this case. The Committee was satisfied that there was no basis for Ms Theophilus to recuse herself from the case.

Registrant's application to admit evidence (Rule 40)

3. Counsel for the Registrant Ms Curzon made an application under Rule 40(1) of the General Optical Council (Fitness to Practise) Rules Order of Council 2013 ("the Rules") to include the Council's submissions that were made as part of a Rule 16 application to the Case Examiners. The Council's application had focused on the second stage of the "realistic prospect" test, i.e. whether the allegations, if found proved, would amount to misconduct and impair the Registrant's fitness to practise.

4. She submitted that the document should be admitted into evidence at the first stage of this hearing.

5. Ms Curzon highlighted that the relevant test in the Application was one of fairness and relevance. Her primary submission was that the Rule 16 submissions from the Council were relevant to the Committee's determination of facts on the allegation, which included the Registrant's failure to detect glaucoma and refer the patient. She submitted that it was not simply a factual matter that was being alleged but a failure by the Registrant. The experts were being invited to opine on these failures.

6. Ms Curzon further submitted that such opinions on whether or not the Registrant's conduct constitutes a failure or not and whether it would fall below or far below the standard of a reasonably competent optometrist was problematic because this encroached on the issue of misconduct.

7. Ms Curzon emphasised that the factual stage and the misconduct stage were distinct and very separate stages in Fitness to Practise proceedings. She submitted that the way the Allegation had been drafted meant that there was a "sort of blending" of both the factual stage and a consideration of misconduct in this case. She further submitted that if the Committee was going to be asked to address the issue of failure as part of stage one then the previous submissions from the Council should be admitted into evidence.

8. Ms Curzon went on to submit that there was now an inconsistent position being put forward compared to that in the Rule 16 application. She added that it was relevant and fair for the Committee to be aware of what the Council had previously said. She said that the Council had previously submitted that the Registrant's conduct was not deplorable and it did not amount to a failing because there was

not a realistic prospect of misconduct. It was relevant and fair for the Committee to be aware of what the Council had previously said.

9. In respect of misconduct, Ms Curzon submitted that the submissions made by the Council in the Rule 16 application would directly assist it in that analysis and in terms of the relevant law.

10. Ms Curzon highlighted that the Registrant objected to the introduction of the Case Examiner's determination which she understood the Council wished to rely upon in the event that the Registrant's application was granted. She submitted that allowing the Case Examiner's determination to be included as evidence would not be relevant or fair.

Submissions on behalf of the Council

11. Ms Huxtable, on behalf of the Council, opposed the Application. She submitted that the previous submissions made by the Council under the Rule 16 process were not evidence and they did not, in any way, go to prove the facts of this case. She further submitted that it appeared to the Council that the Registrant was seeking to have a "second crack of the whip" in relation to the Rule 16 decision.

12. Ms Huxtable emphasised that misconduct and current impairment were matters of judgement for the Committee alone. In addition, the Committee was not bound by previous decisions, nor any previous submissions made on behalf of the Council. She submitted that the Committee has the benefit of all the evidence currently before it.

13. Ms Huxtable further submitted that if the Committee was against the Council, in opposing this application, the Council's position was that the Committee should have sight of the Case Examiner's decision to provide a full background and context. She added that if the Committee was to consider one document, it should consider the other and the submissions should not be considered in isolation. Ms Huxtable stated that the Case Examiners had considered the case twice and decided that it was a matter of the judgement for the Fitness to Practise Committee as regards misconduct.

Legal Advice

14. The Legal Adviser referred the Committee to Rule 40 and set out the test of relevance and fairness. The Committee had the benefit of detailed submissions from the advocates on relevance and fairness, as well as on fact finding and misconduct which were not matters that they had to decide at this stage. The Committee needs to decide the application and consider the test of relevance and fairness.

15. There was no comment from the parties on the legal advice that was given.

Determination of the Committee on the application.

16. The Committee accepted the advice of the Legal Adviser. The Committee very carefully considered the submissions of the parties and the relevant test to be applied.

17. The Committee noted that the Case Examiners had decided that the matter should proceed to a substantive hearing. The Committee also reminded itself that the fact finding, misconduct, and impairment stages were all separate stages of the substantive hearing.

18. The Committee considered that the failures alleged against the Registrant were matters that the Committee would have to determine at the fact-finding stage or first stage of the substantive hearing. As part of the fact-finding stage the Committee would have to first find whether there was a duty on the Registrant and secondly whether the Registrant breached that duty. The Committee also considered that whether any such breach amounted to misconduct, would be for its consideration at a later stage.

19. The Committee concluded that the document that the Registrant wished to rely upon in the proceedings was not relevant to the decisions that the Committee had to make at the fact-finding stage of the substantive hearing. Accordingly, the Registrant's application was refused. The Rule 16 application related to submissions regarding realistic prospect of misconduct and impairment, and not findings of fact. This was not evidence which was relevant to the fact finding stage.

20. Although the Committee had carefully considered the parties' submissions and the document setting out the Council's Rule 16 application submissions, it would, as a professional body, put the content of the document from its mind during the course of the remainder of the hearing.

21. For these reasons, the Registrant's application was refused.

ALLEGATION

The Council alleges that in relation to you, Kaajal Vora (01-26254), a registered Optometrist:

1. *On or around 21 August 2018, you carried out a sight test on Patient A and:*
   a. *You failed to detect signs of glaucoma; and/or*
   b. *You failed to refer Patient A to the Hospital Eye Service.*

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

Background to the allegation

22. The Registrant is an optometrist who, at the material time, was employed at Specsavers, [redacted] ("the Practice").

23. Patient A was referred to the Hospital Eye Service for cataract treatment in September 2021 by an optometrist ("Registrant C") and was latterly diagnosed with glaucoma.

24. On 8 March 2023, the Council opened an investigation against another registrant ("Registrant B") in relation to the care they had provided to Patient A in September 2021. During that investigation, further concerns were identified concerning the Registrant in the current proceedings. The Registrant had examined Patient A on 21 August 2018 and allegedly failed to detect signs of glaucoma or refer her for investigation.

25. The Council obtained an expert report from Dr Anna Kwartz, a registered optometrist. In her report dated 23 March 2025, Dr Kwartz concluded that, at the examination on 21 August 2018, "there were signs of repeatable glaucomatous visual field loss in Patient A's left eye" and that "a referral should have been made to the hospital eye service".

The Hearing

26. Ms Curzon, on behalf of the Registrant informed the Committee that the Allegation was denied in its entirety.

27. The Committee had before it a bundle of documents produced by the Council, which included the witness statement of Patient A, the expert reports of Dr. Kwartz on behalf of the Council and Professor Evans on behalf of the Registrant, a Joint Expert Report, and clinical records for Patient A.

28. The Committee heard evidence from the experts Dr. Kwartz and Professor Evans. Patient A was not called to give evidence as her witness statement was agreed.

<u>Dr Anna Kwartz</u>

29. Dr Kwartz told the Committee that the content of her expert report dated 23 March 2025, contained in the hearing bundle, was true to the best of her knowledge and belief.

30. In response to questions from Ms Huxtable on behalf of the Council, Dr Kwartz described glaucoma as a group of conditions where there was a loss of the nerve fibres at the back of the eye. There were various risk factors which included high pressure inside the eye, age, and a positive family history, that is, having a close relative with the condition. Dr Kwartz added that the change in people's vision with glaucoma is very subtle and described it as a "creeping" disease. She further

told the Committee that patients with glaucoma get visual field damage that cannot be reversed.

31. In response to questions from Ms Curzon on behalf of the Registrant, Dr Kwartz clarified that in her opinion the visual field plots for Patient A from the hospital on 31 March 2015 appeared to show some sort of generalised reduction in sensitivity around the edge of the plot and no evidence of a glaucomatous visual field defect. She stated that Patient A's left eye was a little less sensitive than the right, but it was a small amount, and overall neither of the plots showed particular signs of glaucoma.

32. In response to questions from Ms Curzon around visual field testing, Dr Kwartz stated that visual field testing was highly dependent on the patient's responses and improved with practice. She added that in her opinion, a suspect visual field test result should be repeated to see if a field defect is repeatable and, if the results correlate this clinically, that becomes a very reliable and useful piece of evidence for the optometrist.

33. Dr Kwartz was asked questions about the variability in Patient A's responses when the Registrant carried out the visual field tests in August 2018. She stated that the results from these two tests appeared variable and she had highlighted in her report the consistent defect across both tests. She added that this was not surprising and was a widely documented phenomenon in visual field testing especially where there were defects and especially where there were developing defects.

34. Ms Curzon asked Dr Kwartz about the significance of the differences in the visual field test results for Patient A in 2017 and in August 2018 when the Registrant performed the tests. Dr Kwartz stated that while she was not asked to give an opinion on the 2017 tests, she opined that the optometrist in 2017 had clearly failed to detect glaucoma at that time. Dr Kwartz accepted that Patient A missed less points in 2018 when tested by the Registrant. However, she stated that in her opinion, this did not mean that there was not a clinically significant defect in 2018. She stated that just because no action was taken in 2017, this did not mean that it was acceptable to also take no action in 2018. She opined that "two wrongs did not make a right".

35. In response to a question from the Committee about points missed during the test, Dr Kwartz confirmed that this referred to the number and position of lights that the patient did not spot and respond to. Dr Kwartz added that in her opinion, the lights presented to Patient A needed to be even brighter to be seen because there was a worsening sensitivity of the visual field defect because of glaucoma.

36. Dr Kwartz agreed with Ms Curzon that a reasonable body of competent optometrists would consider that the left visual field plot in 2018 was not significantly worse than that obtained at the previous appointment in 2017 with a different registrant. However, she added that it was not known by how much

sensitivity the points were reduced because only a screening test was conducted. It was not possible to say how damaged the visual field was.

37. Dr Kwartz did not accept Ms Curzon's suggestion that based on the variability and poor repeatability in the visual field tests from the 2018 appointment with the Registrant, a body of reasonably competent optometrists would require a larger change in results before they considered anything to be clinically significant. Dr Kwartz stated that a repeatable visual field loss was present. Patient A was in their 70's at the time of the 2018 appointment and had a positive family history of glaucoma. In addition, Dr Kwartz added that there were also the intraocular pressures to consider. She accepted that the pressures were different to those from 2015 and were better than those from the appointment in 2017. She stated that intraocular pressure varies during the day, and so the data would not necessarily be comparable and could also be explained by the use of different equipment.

38. In response to the suggestion from Ms Curzon that there was no significant worsening in the visual field tests, the intraocular pressures and the description of the optic disc cupping between 2017 and at the appointment with the Registrant in 2018, Dr Kwartz stated that a very large proportion of patients with glaucoma have pressures within the normal range. She also stated that optic disc assessment was a hugely subjective skill that was dependent on the practitioner's evaluation.

39. Dr Kwartz was asked about the nasal step in Patient A's test results included in her report. She explained that the nasal step was a pattern and a hallmark of glaucoma. She opined that there was the start of a nasal step in Patient A's left eye tests carried out by the Registrant in August 2018. She disagreed with Ms Curzon that a lot of reasonably competent optometrists would not have considered this visual field defect to be significant. She opined that because a reasonably competent primary care optometrist would recognise this as a nasal step which was a feature of glaucoma.

40. Dr Kwartz further opined that based on the visual field test results of Patient A's left eye carried out on 21 August 2018 by the Registrant at 11.33 am and 12.03 pm, there was a difference in sensitivity above and below the horizontal midline which was a nasal step. She concluded that Patient A had a nasal step which was a feature of glaucoma.

41. When asked further questions by Ms Curzon about variability in visual field tests, Dr Kwartz stated that this was why a repeated test was required. In her opinion, a repeated visual field test was clinically very valuable and provided very strong clinical data.

42. In response to questions from Ms Curzon about patient referrals, Dr Kwartz was aware that GOC standards and the Council standards of practice required optometrists to make appropriate referrals. She agreed that there was a risk of over-referring. She stated that whether an optometrist should re-refer was based

on a number of factors including; the nature of the anomaly, confirmation from the hospital that they have seen whatever that anomaly was before, they knew it was there, it was being treated, and the patient confirmed to the optometrist that the anomaly was being treated.

43. Dr Kwartz disagreed with Ms Curzon's suggestion that referring Patient A was not required. While Dr Kwartz accepted that the visual field test in 2018 was not significantly worse than 2017, she repeated that "two wrongs don't make a right". She added that in her opinion just because a referral was not made in 2017, it certainly did not mean that a referral was not necessary in 2018. She added that the Registrant had gone to the effort of doing a repeated test, which meant she then had very strong clinical evidence that there was a significant glaucomatous defect.

44. Dr Kwartz disagreed with Ms Curzon's suggestion that the Registrant's conduct did not amount to a failure in respect of not detecting glaucoma. She stated that it did fall far below the standard expected of an optometrist. In her opinion the Registrant's conduct did amount to a failure in respect of not referring Patient A. She stated that the reason for this was because Patient A had a positive family history, which is a risk factor. In addition, she was in her 70s, which was also a risk factor, and the patient had a new visual field defect, which had not been investigated by the hospital at the previous referral in 2015. Dr Kwartz added that the patient was not being treated for glaucoma, and therefore a referral was required for treatment to stop Patient A suffering further damage.

45. In re-examination, D Kwartz clarified that the pattern in Patient A's results from 2018 showed the defective locations and this was typical of glaucoma. This was the nasal step. She also clarified that she expected a reasonably competent optometrist to know that if a patient had a first degree relative with glaucoma, that this increased the patient's risk.

46. In response to questions from the Committee, Dr Kwartz clarified that disc damage was not always easy to detect. She added that because of this a triumvirate of tests were considered. Dr Kwartz also stated that disc cup ratios were not a very effective tool and in her opinion the subjective disc assessment was not an exact science.

47. In response to the question as to whether she would have expected Patient A to have shown a sign of intraocular pressure to indicate glaucoma, Dr Kwartz stated that there was no "red flag" in terms of the pressures. When considering the figures given by the College of Optometrists, in her opinion, Patient A had normal and symmetrical intraocular pressures. She considered that there was no "red flag" in terms of the pressures but there was a "red flag" for the visual field defect.

Professor Bruce Evans

48. Professor Evans told the Committee that the content of his expert report dated 25 September 2025 contained in the hearing bundle was true to the best of his knowledge and belief, subject to minor non-material amendments which he addressed.

49. In response to supplementary questions from Ms Curzon about Patient A's visual field plots from 2015, Professor Evans' opinion was that these plots were very similar to what the Registrant found in 2018 when she tested Patient A. He added that he was not a glaucoma expert but these results from 2015 were important because the glaucoma specialist was not concerned by what was shown in these visual field plots. Professor Evans highlighted that Patient A was referred back to her optometrist and did not require treatment at the hospital.

50. In his opinion, the NICE guidance defined glaucoma as a disease of the optic nerve with characteristic changes in the optic nerve head and the optic disc with changes in the visual field. He stated that it needed to be treated to prevent progression. However, he considered that the Registrant had the visual field plots from 2017, and he agreed with Dr Kwartz that the visual field plots in 2018 were not significantly worse than 2017. In his opinion, it was key that there was no evidence of progression in 2018 and therefore Patient A was less likely to have glaucoma.

51. In response to questions about what community optometrists should do in this scenario, Professor Evans considered that they should address (a) whether there was a clinically significant deterioration in Patient A's visual fields since the referral to the hospital in 2014 and (b) whether there were any other signs indicating glaucoma. In his view, if there was no deterioration in the visual field, then it was less likely to be glaucoma, because glaucoma would progress. He added that if the visual field was the same as it had been previously, it would be a waste of the patient's time and the hospital's time to refer the patient for a visual field that was not changing.

52. Professor Evans was asked about the importance of looking at the three tests used in detecting glaucoma, namely visual fields, measuring intraocular pressures, and assessing the optic discs. In his opinion it was important to consider all three tests rather than just the visual field tests in isolation. He further stated that in his view none of the changes seen in Patient A in these tests were indicative of glaucoma. Professor Evans referred to the variability in visual field tests and in his view and that of Dr Kwartz it was important for there to be a repeatable visual field defect. He considered there was large variability in Patient A when the Registrant tested her in 2018 and in his opinion, there needed to be a stronger sign for the Registrant to be confident that a progressive visual field defect had emerged.

53. Ms Curzon asked Professor Evans about whether a nasal step could be determined in 2018. In his opinion, when he compared the visual field plots for

2017 with 2018, he did not see any evidence of deterioration or evidence to conclude there was any deterioration in the nasal step.

54. Professor Evans was of the opinion that Patient A did not have low tension glaucoma, as was suggested by Dr Kwartz. He referred to the letter sent to the GP sent in 2015 stating "there does not appear to be any signs of glaucoma at the moment" and then the formal diagnosis in 2021 when no reference was made to this but instead to "glaucoma suspect" and that the intraocular pressures were abnormal. Professor Evans accepted that the Registrant would not have seen that letter. In his view, in 2021 Patient A showed glaucoma. Professor Evans accepted that reference was made to advanced glaucoma in a letter from Patient A's consultant dated 1 June 2022 and stated that he could not say with confidence when and how it advanced.

55. In response to questions from Ms Huxtable on behalf of the Council, Professor Evans stated that it was possible for the normal tension variant form of glaucoma to develop into what he described as classic glaucoma. However, he did not think this is what happened with Patient A. He considered that there was a threshold for patient referrals with some that needed to be referred and some that did not. He considered the decision came down to the judgment of the optometrist.

56. Professor Evans agreed with Ms Huxtable that family history increased the risk of a person developing glaucoma but considered that it did not mean that the patient would develop it. He also agreed with her that patients with glaucoma could have the normal tension variant where intraocular pressures are not elevated. He accepted that a reasonably competent optometrist should be familiar with this possibility. He also stated that an apparently normal optic disc appearance did not rule out glaucoma. In his opinion, intraocular pressures and optic appearance were relevant in the decision as to whether a patient had glaucoma.

57. In response to questions about Patient A's visual fields in 2017 compared to 2018, Professor Evans stated that the results for 2018 were not significantly different to 2017. He did not agree that the visual field loss in the left eye presented as a new anomaly. He stated that the plots from the hospital from 2015 and 2018 were very similar. He considered that when the Registrant saw Patient A in 2018, the visual field defect was, in his opinion, not progressing and therefore a referral was not required in 2018.

58. Professor Evans disagreed with Ms Huxtable that there was a repeatable visual field loss in Patient A's left eye at the appointment in 2018. He stated that in his opinion it was safer to say that there was an "abnormal visual field".

59. Professor Evans agreed with the suggestion that a nasal step was a hallmark of glaucomatous visual field loss. However, in his opinion the pattern he had seen in Patient A's results led him to conclude that one could only hypothesise there was a nasal step for Patient A rather than a definite nasal step. He stated that some optometrists would consider this hypothesis while others would simply

acknowledge the pattern. He did not agree that an optometrist would be expected to refer the patient for further assessment if the visual field defect was not progressing and had been stable over a year from 2017 to 2018.

60. In re-examination from Ms Curzon, Professor Evans believed the pattern seen in Patient A's results might have been caused by a long-standing developmental abnormality and not a nasal step. In his opinion, the nasal step did not have to be due to glaucoma. When asked about why it was not a failure by the Registrant not to have referred Patient A, he stated that optometrists are looking for some pathology that is progressing and needs to be treated.

61. In response to a question from the Committee about the progression of glaucoma in Patient A, Professor Evans agreed that Patient A did develop glaucoma but three years later. When asked if he had carried out the tests in 2017 and 2018 whether he would have referred Patient A to the hospital, he replied that he would have referred in 2017 due to the anomaly, but not in 2018.

62. In response to further questions from the Committee about when he would expect a reasonably competent optometrist to refer a patient with a significant visual field defect, Professor Evans explained that there are different types of visual field tests. The frequency doubling technique (FDT) used in 2012 and 2013 was fundamentally different to the technique used at the hospital and later at Specsavers by the Registrant. He told the Committee that in 2013 the hospital also used a test called the full threshold fields (FTT).

63. Professor Evans explained the difference in visual field testing programmes used in the two practice screening tests recorded, with the Frequency Doubling Technique in earlier tests and latterly the Oculus Easy field Supra threshold program. When compared to the full threshold programme testing used at the hospital, he outlined the issues in comparing them. Professor Evans did not consider that one could compare FDT test results with field plots from the Oculus Easy Field.

64. Professor Evans agreed with Dr Kwartz's opinion that the Patient A's visual field defect was not attributable to astigmatism. He also agreed that August 2017 was the first point in time where a left eye visual field defect was noted within the Specsavers environment for Patient A. He added that he would have expected the optometrist to refer in 2017, because, to the best of their knowledge, this would have been a new finding. Professor Evans stated the field defect found in the left eye in 2018 was not clinically significant compared to the 2017 field defect and therefore this indicated there was no progression and no referral was subsequently necessary.

65. He added that he would expect that a body of reasonably competent optometrists would have chosen to monitor at that time, especially considering the lack of any other signs like changes in the optic nerve head appearance or the pressures. He considered that in 2018 the Registrant had a duty to refer a finding that had not, to her knowledge, previously been brought to the attention of the hospital.

This had to be a finding that required management by the hospital or a finding which required an opinion by the hospital.

66. Professor Evans agreed that there was an indication to refer Patient A in August 2017. However, he stated that as far as he was aware, the practitioner in 2017 did not know that it was longstanding. In addition, he stated that on the basis the optometrist in 2017 did not know that it was longstanding, then they had a duty at that time in 2017 to refer.

Submissions on behalf of the Council

67. Ms Huxtable on behalf of the Council submitted that glaucoma was a progressive condition that could present as a normal tension variant, that is without raised, intraocular pressures and normal optic disc appearance. She highlighted that Professor Evans accepted that a reasonably competent optometrist should be familiar with the fact that glaucoma can present as a normal tension variant and that a family history increases the risk of a patient developing glaucoma.

68. Ms Huxtable further submitted the following: there should have been a referral in 2017 to the hospital eye service; the Registrant here today would have been aware that a referral had not been made then; there were repeatable visual defects at the examination the Registrant carried out in 2018; and that the missed points were evidence they were within the inferno nasal quadrant. Ms Huxtable highlighted that the evidence of Dr Kwartz was that the pattern identified in 2018 was a hallmark of glaucoma. In addition, Professor Evans conceded that there was a suspicion of a nasal step.

69. Ms Huxtable further submitted that the evidence of Dr Kwartz was that the results in 2018 presented a new anomaly, not previously investigated. Due to its configuration and especially the nasal step, and the patient's risk factors of positive family history, the Registrant should have considered that the visual field defect to be likely glaucomatous in origin. However, she failed to detect a sign of glaucoma. Ms Huxtable emphasised that Dr Kwartz was keen to convey that the visual defect was repeatable and the pattern of the defect, rather than how many missed points were noted within the visual fields test. She submitted that it was these factors that should have prompted the Registrant to detect signs of glaucoma.

70. Ms Huxtable submitted that Professor Evans had accepted that in 2017 there was a new anomaly in Patient A's left eye and the visual defect should have been referred at that point in time. Ms Huxtable highlighted that the previous referral that had been made in 2014 and investigated at the hospital in 2015 was in respect of the right eye, whereas the issue in 2018 was in respect of the left eye and therefore was a new anomaly which the Registrant needed to make a referral for.

71. Ms Huxtable submitted that Professor Evans' opinion on referrals was confusing and did not make sense. This was because of his opinion that he would have referred Patient A in 2017 but not in 2018 when the Registrant examined the patient and a year had passed.

72. Ms Huxtable further highlighted that Dr Kwartz was adamant that there were signs of glaucoma during the appointments both in 2017 and 2018 and simply because there was no referral in 2017 did not mean that there did not need to be a referral a year later in 2018. In addition, Ms Huxtable also referred to Dr Kwartz's expert evidence that a reasonably competent optometrist would have identified the possibility of glaucoma in 2018 given the evidence that was presented. She submitted in these circumstances there should have been a referral to the hospital service for an assessment of Patient A.

73. In concluding, Ms Huxtable referred to the fact that the Registrant had not given live evidence to the Committee. She submitted that the Registrant was the one person that could explain why there was no referral and how she interpreted the test. The Committee was left to draw its own conclusions based on the two opinions of the experts.

Submissions on behalf of the Registrant

74. Ms Curzon on behalf of the Registrant indicated that she had prepared written submissions which the Committee acknowledged it had received. She highlighted that she would refer to relevant parts or her written submissions in her oral submissions. These are summarised below.

75. Ms Curzon submitted that the burden of proof was on the Council and the standard of proof was the balance of probabilities. She referred the Committee to the Hearings and Indicative Sanctions Guidance section 13.

76. Ms Curzon submitted that the alleged facts could not be proved on the evidence that had been adduced by the Council. She referred to the expert opinion from Professor Evans and the way that the allegations have been drafted in respect of a failure. She submitted that Dr Kwartz's expert evidence was undermined by that of Professor Evans. The Committee could not be satisfied on a balance of probabilities, that the Registrant failed to detect signs of glaucoma, or that she failed to refer Patient A to the hospital eye service.

77. Ms Curzon submitted that the Registrant was described by Dr Kwartz and Professor Evans as conducting the appointment with Patient A correctly and referred to the repeated visual tests which Professor Evans described as commendable. The Registrant carried out the correct tests. In addition, the only records that the Registrant had before her was a point of comparison in the 2017 records. She highlighted that the opinion of Professor Evans was that there was a body of reasonably competent optometrists who would have considered the visual fields in 2018 not to be significantly worse than those at the previous appointment in 2017.

78. Ms Curzon referred to the variability in Patient A's visual field tests and retest results and to Professor Evan's expert report and his oral evidence on this issue. He was of the opinion that many reasonable optometrists would require a larger change in visual field results before they would consider this to be clinically significant. This, she submitted, was important because it went to the issue of the nasal step.

79. Ms Curzon submitted that following the discharge of Patient A in 2015 the community optometrist had to consider two questions: whether (i) there was clinically significant deterioration in the visual fields since 2014 and (ii) any other signs indicating glaucoma. Ms Curzon referred to the expert report of Professor Evans and submitted that there was no clinically significant deterioration in the visual field defects based on it. In relation to other signs Ms Curzon referred to the fact that both experts agreed that the three elements of visual fields, intraocular pressures, and optic disc cupping needed to be considered. She submitted that it was clear that there was not a progressive condition based on the results of these tests at the 2018 appointment.

80. Ms Curzon further submitted that in the absence of any of the three elements progressing since 2017, there was a body of reasonably competent optometrists who would have concluded that there were no clinically significant signs of glaucoma on 21 August 2018.

81. Ms Curzon referred the Committee to Professor Evan's evidence that he would have behaved exactly as the Registrant did with respect to Patient A in August 2018. She submitted, there was no stronger evidence than this to demonstrate to the Committee that there was no failure on the part of the Registrant.

82. Ms Curzon cautioned the Committee against assuming that glaucoma was present in 2018 because it was formally diagnosed in 2021. In addition, she submitted that Dr Kwartz had hypothesised a nasal step was indicative of glaucoma. However, it should not be assumed that this was the case.

83. Ms Curzon also referred to the other assumptions the Committee should avoid as set out in her written submissions including the variability in Patient A's results. When the Registrant was diagnosed with glaucoma she presented with very high intraocular pressures. The Committee was also referred to contradictions in Dr Kwartz's evidence. Dr Kwartz indicated that there was a triumvirate of tests used to determine glaucoma in patients. However, the basis of her opinion was on one part of that test (visual fields) and a part which, on her own account, was variable and had poor repeatability. She also confirmed in her report that glaucoma was a progressive condition but confirmed that the results in 2018 were not significantly worse than in 2017. Ms Curzon submitted that the Committee may think that this undermines Dr Kwartz's evidence and indicated there was no failure on the part of the Registrant.

84. Ms Curzon again referred the Committee to the issue of failure and submitted that what constitutes a failure was a matter of opinion. She further submitted that failure was something which would ultimately not form part of the factual stage

one but at stage two in respect of misconduct. In these circumstances, she suggested that the Committee may think that it was unable to make any determination on a fact which included the word “failure” because it would have to go beyond consideration of a simple fact.

85. Ms Curzon further submitted that irrespective of the expert evidence, the Committee could not find the allegations proved because of the way that they were drafted. She submitted that this necessitated a determination on an opinion rather than a fact.

86. If the Committee was not with the Registrant on this issue, Ms Curzon still submitted that the evidence as it stands did not amount to a failure by the Registrant to detect or refer.

87. In concluding Ms Curzon asked the Committee not to draw anything from the Registrant not giving evidence. She highlighted that there was no request for any adverse inferences to be drawn. Ms Curzon also highlighted that the Registrant was of good character and did not have any adverse fitness to practise history.

Legal Advice

88. The Legal Adviser said the Committee was considering an allegation involving two alleged failures by the Registrant.

89. The burden of proving the disputed facts was on the Council. The Registrant did not need to prove or disprove anything in the Allegation. The standard of proof required was the civil standard, that is on the balance of probabilities.

90. The allegation of failure against the Registrant required a two-stage approach. Firstly, the Committee needed to consider if a duty or obligation existed upon the Registrant to act in a particular manner, was established. Secondly, if a duty or obligation was established, it had to go on to consider if a failure was established in respect of it. The Committee should have regard to Standards of Practice for Optometrists and Dispensing Opticians (2016).

91. The Legal Adviser reminded the Committee it had to consider all the evidence carefully. It had to decide the case only on the evidence heard or is properly before it. All the evidence should be considered alongside each other to enable it to consider and assess it in its totality.

92. The evidence was made up of the Council's bundle of 445 pages, which included the witness statement of Patient A. There were also the optical records for the patient. There were expert reports from two different expert witnesses. Patient A did not give live evidence and therefore the evidence was hearsay evidence. However, there was no challenge to it by the Registrant, and Patient A was not required to attend for questioning.

93. The Legal Adviser outlined the approach the Committee should take with respect to good character and the two limbs to consider. Good character was not of itself a defence to the allegation. However, good character may support a Registrant’s

credibility and whether the Committee believed their evidence (credibility) or evidence that they were less likely to have failed to do what was alleged against them (propensity). Although the Committee had not heard live evidence from the Registrant the Committee could take good character into account. The weight attached to it at the fact-finding stage was a matter for the Committee. However, it had to be considered alongside all the other evidence that was placed before it that had a bearing on each fact in dispute.

94. The Legal Adviser advised that on the issue of the expert evidence the Committee was required to give clear and compelling reasons in rejecting the evidence of an expert. The Committee should state which expert evidence, if any, it accepted and which it rejected giving reasons (*Cullen v. General Medical Council* [2005] EWHC 353 (Admin)). Where there were conflicting opinions between the experts, the Committee should give reasons why it rejected one expert's opinion on the issue and accepted the evidence of the other expert on that issue (*Rimmer v. General Dental Council* [2011] EWHC 3438). It was for the Committee to decide whose evidence, and whose opinions it accepted and the weight to be attached to such evidence. In this regard, expert witnesses were no different from non-expert witnesses.

95. The Legal Adviser referred the Committee to the case of *Kuzmin v General Medical Council* [2019] All ER (D) 37 which established that committees in professional regulatory proceedings may draw negative inferences from a Registrant's failure to give evidence. However, this was subject to specific conditions being met to ensure fairness including the Registrant being given appropriate notice and warning that an inference might be drawn if they did not give evidence. The Council was not inviting the Committee to draw negative inferences.

96. There was no comment on the legal advice after it had been given in open session. The Committee accepted it.

Findings in relation to disputed facts

97. The Committee acknowledged that there was no evidence that the Registrant had previous regulatory findings against her and considered her to be of good character. It also acknowledged that the Council was not asking the Committee to make any adverse inferences based on the Registrant not giving any live evidence to the Committee.

Allegation 1(a) Failure to detect signs of glaucoma

98. The Committee rejected Ms Curzon's submission that a failure was an opinion and not a fact. The Committee did not accept that it could not consider alleged failures at the fact-finding stage or take into account the Standards of Practice for Optometrists and Dispensing Opticians (2016) ("the Standards).

99. The Committee noted that the Registrant accepted that she did not detect glaucoma and did not refer Patient A. However, she did not accept that this constituted any failures on her part.

100. The Committee first considered whether a duty arose when the Registrant tested Patient A in 2018. It noted that the purpose of a sight test in the Opticians Act 1989 (Part IV s 26 1(a) Duties to be performed on sight testing) is to detect signs of injury, disease, or abnormality. The Committee determined that the Registrant had a duty as an optometrist to detect signs of glaucoma when she tested Patient A in August 2018.

101. The Committee then considered whether the Registrant failed in this duty. The Committee carefully considered all the evidence of the experts as part of making its determination on this part of the allegation, noting where the expert opinions differed and which it found supported by the evidence. The Committee accepted the expert evidence of Dr Kwartz that there was a repeatable visual field defect indicating a nasal step in the records for Patient A and this clinical finding was a hallmark for glaucoma. This was supported by the visual field test results within the Council's bundle. The Committee considered that it was significant that in Dr Kwartz's opinion, the detection and evaluation of the previously unreferred visual field defects in Patient A was required by the Registrant. Furthermore, in her evidence to the Committee, Dr Kwartz highlighted that the visual field results were a "red flag" at the time. This was because in her opinion, a reasonably competent optometrist would recognise a left eye repeatable visual field defect (page 296 paragraph 9.1.3). The Committee accepted Dr Kwartz's evidence that the visual field defects were clinically significant in Patient A (page 296 paragraph 9.1.4), taking into account the nasal step and the previous anomaly from 2017.

102. The Committee also considered the risk factors identified by Dr Kwartz (page 291 paragraph 7.2 and page 297 paragraph 9.7.7). It noted her expert opinion that she would expect a reasonably competent optometrist to take into account Patient A's age and family history of glaucoma (her mother) and be cognisant of the fact that this increased her risk of developing glaucoma. The Committee also considered the guidance from the College of Optometrists quoted in the expert's report which states:

> *"Even in the absence of the signs or symptoms in the paragraph above [optic disc features suggestive of glaucoma, loss of peripheral vision, high IOP], patients at greater than average risk of primary open angle glaucoma include those… with first degree relatives with glaucoma".*

103. In carefully considering Professor Evans' expert report, the Committee concluded that he only dealt with the issue of the performance of visual field examinations in practice. The Committee determined that there was a significant omission of visual field defects which could indicate glaucoma from his expert evidence.

104. In addition, the Committee also concluded that Professor Evans only used the progression of a visual field defect as the indicator in making a referral. The Committee reminded itself that the duty was on the Registrant to detect an

abnormality and work within the limits of her scope of practice, not simply to evaluate a progression in visual fields.

105. In considering the records for Patient A regarding the tests performed by the Registrant in August 2018, the Committee considered that the Registrant had reliably detected an abnormality in the left eye visual field. The Committee carefully noted the expert evidence of Dr Kwartz, where she writes *"that a reasonably competent optometrist would interpret the visual field defect as likely being glaucomatous in origin (inferior nasal step) and also to consider Patient A was at an increased risk of developing the condition, given her family history".*

106. The Committee considered the information that the Registrant would have had before her within the clinical records at the time. This would have included a historic referral for a right eye visual field defect in 2014, an oral representation from Patient A that the hospital had found no signs of glaucoma in March 2015, the presence of two subsequent normal visual field tests in October 2015 and the first time a left eye visual field defect found in August 2017, which was attributed by another optometrist as being due to astigmatism. The Committee noted that Patient A had significant astigmatism in both eyes and that both experts had stated during their oral evidence that the nature of the visual field defect could not be attributed to the astigmatism in Patient A. Therefore, the Registrant should have recognised this was a clinically significant finding.

107. Accordingly, on the balance of probabilities the Committee determined that the Registrant was under a duty to detect signs of glaucoma and failed to do so.

Allegation 1(b) Failure to refer

108. The Committee rejected Ms Curzon's submission that a failure was an opinion and not a fact. The Committee did not accept that it could not consider alleged failures at the fact-finding stage or take into account the Standards of Practice for Optometrists and Dispensing Opticians (2016) ("the Standards).

109. The Committee considered whether there was a duty on the Registrant to refer Patient A. The Committee noted that under the General Optical Services contract a duty to refer Patient A existed because the 2018 sight test was recorded as conducted under the NHS contract.

110. The Committee had regard to the Standards which it considered relevant to its determination of this issue. The Committee considered it significant that:

Under Standard 6.2 the Registrant was required to:

"Be able to identify when you need to refer a patient in the interests of the patient's health and safety, and make appropriate referrals".

Under Standard 7 the Registrant was required to:

"Conduct appropriate assessment examinations, treatments, and referrals"

In particular under Standard 7.2 the Registrant was required to:

"Provide or arrange any further examinations, advice, investigations or treatment if required for your patient. This should be done for a timescale that does not compromise patient safety and care"

Under Standard 7.5 the Registrant was required to:

"Provide effective patient care and treatments based on current good practice".

Under Standard 7.7 the Committee also noted the following:

"When in doubt, consult with professional colleagues appropriately for advice on assessment, examination, treatment and other aspects of patient care, bearing in mind the need for patient confidentiality".

111. The Committee also had regard to the General Optical Council Stage 2 Core Competencies (2011) referred to by Dr Kwartz in her report which related to ocular disease. These included "The ability to identify and manage ocular abnormalities" and "The ability to manage patients presenting with eye disease including sight threatening eye disease", paragraphs 6.1.1 and 6.1.51.

112. The Committee considered that the performance criteria in the competencies were clear in expecting the Registrant to understand the risk factors for common ocular conditions such as glaucoma (competency 6.1.1). The Registrant was also expected to recognise common ocular abnormalities such as glaucoma or glaucoma suspects and refer and manage appropriately (competency 6.1.8).

113. The Committee determined that there was a duty on the Registrant to refer any clinically significant abnormality that was detected. The Committee considered that the Registrant would have been aware that the Patient was aged 75 years old at the time of the appointment and had presented with a family history of glaucoma. Dr Kwartz in her report stated that glaucoma typically presents in the fifth decade of life. She further stated in oral evidence that a reasonably competent optometrist would consider the repeatable nature of the visual field defect in conjunction with the family history and recognise the significance of a nasal step. The Committee also considered that the Registrant would also likely have been aware that Patient A had been seen by a colleague in 2017, but no referral had been made at that earlier time since the visual field defect had been recorded as attributable to Patient A's astigmatism.

114. The Committee concluded that having detected the abnormality, the Registrant had a duty to, but did not, refer Patient A appropriately on to the hospital service.

115. The Committee considered it significant that both experts agreed that the optometrist that tested patient A in August 2017 should have referred Patient A to the hospital. The Committee accepted the evidence of Dr Kwartz that Patient A should have been referred to the hospital in 2018 when she was tested by the Registrant. The Committee did not accept Professor Evans' expert evidence that because there was no significant difference between the visual field test results

for Patient A from August 2017 and from August 2018 that Patient A did not need to be referred. The Registrant knew there was an anomaly in 2017 which had not been referred. Both experts accepted it should have been referred in 2017. The Committee did not accept Professor Evans' position that just because the anomaly had not appeared to worsen by 2018, it no longer needed to be referred. The Committee acknowledged that this referral would be required in the interest of the patient's health and safety in accordance with Standards 6.2 and 7.2 as set out at paragraph 110 above.

116. In determining whether the Registrant failed to refer Patient A, the Committee also accepted the expert evidence of Dr Kwartz and her opinion,

> *"I do not consider that Registrant's action plan to "cont monitoring LE inf defect [sic]" was appropriate. Whilst there are many aspects and features of glaucoma with which I would not expect a reasonably competent primary care optometrist to be familiar, I would expect them to be cognisant with the fact that glaucoma causes irreversible damage to the retinal nerve fibre layer and that monitoring a defect, without making a referral, can cause significant risk to a patient's vision."*

117. Accordingly, on the balance of probabilities the Committee determined that the Registrant was under a duty to refer Patient A and failed to do so.

Misconduct

Registrant's application to admit evidence (Rule 40)

118. At the start of the misconduct stage, Counsel for the Registrant Ms Curzon made an application under Rule 40(1) of the General Optical Council (Fitness to Practise) Rules Order of Council 2013 ("the Rules") to include the Council's submissions that were made as part of a Rule 16 application to the Case Examiners.

119. Ms Curzon highlighted that Rule 40(1) set out what evidence the Committee may hear. She submitted that Council's previous submissions under the Rule 16 application which were at pages 2 to 9 of the amended defence bundle, were both relevant and fair to admit at the Misconduct stage.

120. Ms Curzon submitted that there were several reasons why the submissions were relevant. The Council's current position in respect of misconduct, was one of neutrality. However, she maintained that this was a change of position from that put forward as part of the Rule 16 application when they put forward positive submissions that the Registrant's conduct did not amount to misconduct. Ms Curzon acknowledged that the Council was not bound by any previous submissions it had made. However, she submitted that it was fair and relevant for the Committee to have sight of and consideration of such submissions in a context where these submissions were directly relevant to the issue of misconduct.

121. Ms Curzon further submitted that for the Committee to find that the Council's Rule 16 submissions were not relevant would arguably be inconsistent with its previous decision on the Rule 40(1) application decision set out at paragraphs 18 and 19 above.

122. Ms Curzon also referred the Committee to page 8 of the Registrant's amended bundle and in particular paragraph 30 of the Council's submissions regarding an application under Rule 16 which were dated 13 June 2025. She quoted paragraph 30 as follows:

> *"The Council submits that this case involves failings that were not deplorable, isolated to one patient and limited to a narrow time frame. The failings do not have an underlying common theme or cause. Taken together, along with the remediation and passage of time, they have not resulted in repetition to other patients. It is difficult to see how these failings can be properly presented as an impairment in the Registrant's fitness to practise".*

123. Ms Curzon highlighted that this was a position put forward when the Council was in possession of Dr. Kwartz's report but not that of Professor Evans. Therefore, Ms Curzon submitted that it was relevant for the Council's submissions to go before the Committee because it demonstrated that on the majority of the evidence before it, the Regulator's position, was that this did not amount to misconduct and impairment.

124. Ms Curzon added that should the Council submit that the Committee should also have sight of the Case Examiner's decision on the Rule 16 application, this was not relevant and had nothing to do with the present Rule 40(1) application. The Registrant's Rule 40(1) application had to do with the change of the Council's position.

125. Ms Curzon turned to the issue of fairness and submitted that it was fair for the submissions to be included. This, she submitted, was because it would allow the Committee to carefully consider the issue of misconduct with all the relevant positions that the regulator has put forward on misconduct, both historic and current.

126. Ms Curzon acknowledged that the Case Examiners were an entirely independent body, and whatever their decision was in the case, it was not relevant to the Committee's determination on misconduct. However, she submitted that it was relevant and fair for the Committee to adduce and to have a full understanding of the Council's position over the course of the proceedings.

127. Ms Curzon went on to submit that should the Committee decide that the Case Examiner's decision was relevant and wanted sight of it, then very limited weight should be attached to it, if any, for the following reasons.

128. Ms Curzon submitted that the Council's procedures and guidance specifically drew attention to the distinction between the legal tests that must be applied by Case Examiners and those applied by a fitness to practice committee.

129. She further submitted that the Case Examiners do not determine facts or reach conclusions about impairment. They simply judge whether a case was worthy of being further considered by a fitness to practise committee and are an administrative filter to determine which cases proceed to a full hearing. Furthermore, she submitted that any decision they make should not be treated as probative evidence of the events in question, or of any decision which should influence the committee in respect of misconduct.

130. Ms Curzon highlighted that the Case Examiners were not in receipt of the expert report of Professor Evans at the time of their decision. She submitted that it would be somewhat concerning if the Case Examiner's decision was being upheld as something that the Committee should rely upon to inform their own decision, especially because it applied a completely different legal test.

131. In conclusion, Ms Curzon submitted that there were strong and cogent reasons for admitting the submissions made by the Council as part of their Rule 16 application at this stage of the current proceedings on the grounds of fairness and relevance. Furthermore, there was no need for the Committee to have sight of the Case Examiner's decision because what was being looked at was the position of the Council in respect of misconduct only which, she submitted, had changed over time. If the Committee was against the Registrant and admitted the Case Examiner's decision, Ms Curzon submitted that there were also strong cogent reasons for only limited weight to be attached to that documentation.

132. In response to questions from the Committee about why the Registrant contended that the submissions were evidence, Ms Curzon accepted that they were past submissions but were a document contained within the proceedings. She submitted that the submissions formed part of the historical written documentation in the case.

133. In response to a further question from the Committee about the Case Examiner's decision being non-probative evidence of the events in question and which was therefore irrelevant, Ms Curzon focused on the Councils' position and submitted that historically it put forward a position with positive submissions that there was no prospect of impairment and within that misconduct. However, she further submitted that now the Council's position was neutral on misconduct. The Council had changed its position and this was why the present application was focused on the Council's previous position in the submissions in the Rule 16 application.

Submissions on behalf of the Council

134. Ms Huxtable on behalf of the Council opposed the application. She highlighted that the Council had been given no warning before this morning that the application would be made.

135. Ms Huxtable submitted that the Registrant through her Counsel was now trying to have a "second crack of the whip" in relation to the Rule 16 application

submissions and it also seemed they were attempting to have a “third crack of the whip”.

136. Ms Huxtable further submitted that the Rule 16 application was a wholly separate function made to the case examiners and did not form any part of the fitness to practise proceedings. She maintained that the case examiners fully considered the submissions made on behalf of the Council and rejected those submissions, and suggested that misconduct and impairment were very much matters for this Committee to determine. She submitted that the previous submissions made by the Council were not relevant today.

137. Ms Huxtable went on to submit that misconduct was a matter solely for the judgment of the Committee. Any previous submissions made as part of the Rule 16 application formed a wholly different function within the Council and were separate to fitness to practise proceedings.

138. Ms Huxtable further submitted that the Committee was not bound by those previous submissions and they were wholly irrelevant to its determination today. The Committee’s determination would be based on whether the facts found proven amounted to misconduct and was the Committee’s judgement.

139. Ms Huxtable stated the Council took a neutral position on misconduct as set out in the Council's skeleton argument. Whether the facts found proven amounted to misconduct was very much a determination that was “squarely at the door of the Committee to make”.

140. Ms Huxtable made further submissions on the difference between evidence and submissions. She maintained that evidence comes from either a witness of fact, or a document that goes to the facts. She highlighted that the experts had provided evidence but that the submissions made on behalf of the Council were not evidence and therefore it did not fall under Rule 40 of the rules.

141. In conclusion, Ms Huxtable submitted that should the Committee allow the submissions in as evidence, then it should not consider them in isolation, and the Case Examiner’s decision should also be considered. The Registrant through her representatives could not pick and choose. Ms Huxtable submitted that the Council's position was that neither the submissions nor the Case Examiner’s decision should be considered and the parties should move on to make submissions in respect of misconduct.

Legal Advice

142. The Legal Adviser reminded the Committee that the application was being made at the Misconduct Stage of proceedings. He briefly highlighted that misconduct was ultimately a matter of the Committee’s own independent judgment. There was no burden or standard of proof that should be applied.

143. He referred the Committee to Rule 40 and set out the test of relevance and fairness about evidence. The Committee had the benefit of detailed submissions from the advocates on relevance and fairness.

144. The Legal Adviser advised the Committee it had to first determine whether the submissions document that the Registrant wished to rely upon was evidence. If the Committee determined that the submissions document was evidence it should go on to apply the tests of relevance and fairness to the evidence.

145. The legal advice was unchallenged except for a minor correction by Ms Curzon for the Registrant who highlighted that the Council's previous position on misconduct at the Rule 16 application stage was that of no misconduct.

Determination of the Committee on the application

146. The Committee accepted the advice of the Legal Adviser. The Committee very carefully considered the detailed submissions of the parties and the relevant tests to be applied.

147. The Committee noted that the Case Examiners had decided that the matter should proceed to a substantive hearing. The Committee also reminded itself that the fact finding, misconduct, and impairment stages were all separate stages of the substantive hearing.

148. The Committee first considered whether the submissions document was evidence that could be considered under Rule 40(1).

149. The Committee concluded that there was a difference between evidence and submissions. The Committee had heard detailed expert evidence at the Fact Stage as well as detailed submissions from the parties on the evidence. The Committee considered that the Council's Rule 16 submissions document, which the Registrant now wished to rely upon at the Misconduct stage and which the Committee had previously determined was not relevant to its decisions at the fact-finding stage, was not evidence but rather submissions. The two were not the same. This was consistent with the Committee's previous decision at paragraph 19 above, that these were submissions and not evidence.

150. In these circumstances, the Committee having determined that the submissions document was not evidence, concluded that it did not have to go onto apply the tests of relevance and fairness.

151. For these reasons, the Registrant's application was refused.

<u>Professor Bruce Evans</u>

152. Professor Evans gave further expert evidence to the Committee at the Misconduct Stage.

153. In response to questions from Ms Curzon about how he assessed what an acceptable standard of practice for an optometrist was, he referred to his report and to the criteria set out at section 2.5 "Opinion on below v. far below the standard required" at paragraphs 54 and 55 on page 416 of the Council's hearing bundle.

154. He told the Committee that based on the facts found proved, he would strongly argue that the Registrant's actions fell below the standard but not far below. He further told the Committee that in his opinion, only one of the three glaucoma tests was abnormal, and there was a stable condition with no deterioration over the period from 2017 to 2018. In his opinion the risk of glaucoma progressing further had to be low with a low risk of harm to the patient, if any risk at all.

155. Professor Evans was also of the opinion that there was no breach of a fundamental tenet of optometry as regards the duty to refer. He added that it was debatable whether there was any duty on the Registrant to refer on this occasion.

156. In response to the question as to whether in his opinion what the Registrant did constituted a serious departure from professional standards, or whether it might be considered deplorable by colleagues, Professor Evans opined that there was a body of optometrists who would have referred. He added that there was also a body of optometrists that would not have referred. In his opinion, he did not think that this was a clear-cut case. It was not a case where any reasonably competent optometrist would have referred, and equally, that any reasonably competent optometrist would find someone who did not refer to have acted deplorably.

157. In response to a question from the Committee about the effect that firstly patient A was aged in her mid-70s and secondly had an immediate relative with glaucoma, had on the risk of harm, Professor Evans told the Committee that it would increase the overall risk of that patient developing glaucoma. He added that the risk of glaucoma was certainly higher in somebody with a parent who had glaucoma than it would be in a patient with no family history of glaucoma.

158. He further opined that there was a low risk of harm to this patient, because if it had been glaucoma, then he would have expected to see progression. He referred to the second set of visual field results in 2018 when he considered that the defect was milder than in 2017. He also considered that there was no progression, and tests were variable. This was the reason why he thought that there was a body of optometrists who would have considered that it was not likely to be glaucoma because matters were so stable over the previous year.

159. Professor Evans clarified that in his opinion the age of a patient as well as the family history would increase the risk of harm but taken together would still contribute to a low risk of harm to the patient.

Submissions on behalf of the Council

160. Ms Huxtable on behalf of the Council referred the Committee to the expert evidence of the experts. She highlighted the definition at paragraph 6 of Dr. Kwartz's expert report on page 290 of the Council's hearing bundle. She submitted that Dr Kwartz's opinion was that the Registrant had fallen far below the standards expected. She referred to the potential risk to Patient A highlighted by Dr Kwartz. This expert evidence could be considered against the evidence of Professor Evans.

161. Ms Huxtable further submitted that misconduct was not defined by statute and was a matter of judgement for the Committee and the Committee alone. She referred to the Council's skeleton argument at paragraphs 20 and 21 and highlighted the cases of Roylance v General Medical Council and GMC v Calhaem, R (Remedy UK Ltd) v General Medical Council, and Nandi v. General Medical Council on the approach the Committee should take in its decision making.

162. Ms Huxtable emphasised that the Committee may wish to consider whether the Registrant had departed from Standard 7 which was to conduct appropriate assessments, examinations, treatments, and referrals as well as Standard 17 which was not to damage the reputation of the profession.

Submissions on behalf of the Registrant

163. Ms Curzon on behalf of the Registrant indicated that she had prepared written submissions on misconduct which were made available to the Committee, Ms Huxtable, and the Legal Adviser. Ms Curzon referred to the written submissions in her oral submissions. These are summarised briefly below. She referred the Committee to the same case law set out in her written submissions at paragraph 161 above.

164. Ms Curzon submitted that on the facts found proved, misconduct was not established. She highlighted the following reasons why the Registrant's conduct did not amount to misconduct. These were summarised as follows:

(i) The Council was neutral on the matter of misconduct and did not make any positive submissions on misconduct which was a powerful indicator that the threshold was not met; The omission of the Registrant was in relation to a single patient appointment with Patient A on a single date;

(ii) There was no action taken against Registrant B and C. Therefore, the gravity of the Registrant's omission was logically less than a later failure by Registrant B and C when the glaucoma was more likely to be apparent;

(iii) The Registrant's conduct was not negligence of a high degree;

(iv) There was a significant lapse of time since the allegation arose and the concerns related to an appointment which took place on a single date in August 2018, with the current hearing taking place in March-April 2026 almost 8 years since the initial appointment;

(v) There had been no recurrence or complaint about this Registrant's conduct in the intervening period;

(vi) Conduct which fell below/far below the standards was not identified and reliance was placed on the expert opinion of Professor Evans that there was nothing in the Registrant's conduct which could be described as

deplorable or as falling far below the standard and thus amounted to serious professional misconduct;

(vii) There was no underlying common theme or cause in an otherwise unblemished career;

(viii) The Registrant's conduct has not been repeated in the almost 8 years since the appointment with Patient A;

(ix) Patient A raised no concerns about the appointment;

(x) There was no fitness to practise history or subsequent fitness to practise concerns.

165. In conclusion Ms Curzon submitted that in applying the case law and viewing the conduct in its full context, it did not cross the threshold to amount to serious professional misconduct. She highlighted that it comprised an isolated event, without repetition or evidence of any attitudinal concern, where later non-referrals of Registrant B and C would have been more serious due to the progressive nature of glaucoma (where no action was taken) and where there was expert opinion stating that the Registrant's conduct was in keeping with a body of reasonably competent optometrists and, indeed, what the expert would have done himself.

166. Ms Curzon added that the Council was neutral on the matter of misconduct and made no assertion that there was any misconduct, such that it is submitted that the Committee should be slow to attribute misconduct to the facts of this case.

Legal Advice

167. The Committee received and accepted the legal advice from the Legal Adviser.

168. The Committee was advised that misconduct was not statutorily defined (Roylance v General Medical Council [2000] 1 AC 311 (PC), at 330F–332E) and was a matter of its own independent judgment (Council for the Regulation of Health Care Professionals v. General Medical Council and Biswas [2006] EWHC 464 (Admin). There was no burden or standard of proof applied. The Legal Adviser further advised that not every case of misconduct resulted in a finding of impairment (Cohen v GMC 2008 EWHC 581).

169. For guidance on the approach to assessing misconduct, the Legal Adviser referred the Committee to several authorities and the approach it should take to determining it.

170. In Roylance v. General Medical Council (No 2) [2000] 1 AC 311, the court specifically described the essential elements of misconduct:

"misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to

be followed by a practitioner in the particular circumstances. The misconduct is qualified in two respects. First it is qualified by the word 'professional' which links the misconduct to the profession …secondly the misconduct is qualified by the word 'serious.' It is not any professional misconduct which will qualify. The professional misconduct must be serious".

171. In Meadow v. General Medical Council [2007] 1 All ER 1, the Court of Appeal made clear that "misconduct" should not be viewed as anything less than "serious professional misconduct".

172. In GMC v Calhaem [2007] EWHC 2606 (Admin) the court considered that

"(1) Mere negligence does not constitute "misconduct" within the meaning of section 35C(2)(a) of the Medical Act 1983. Nevertheless, and depending upon the circumstances, negligent acts or omissions which are particularly serious may amount to "misconduct"

(2) A single negligent act or omission is less likely to cross the threshold of "misconduct" than multiple acts or omissions. Nevertheless, and depending upon the circumstances, a single act or omission, if particularly grave, could be characterised as "misconduct".

173. The Legal Adviser further advised the Committee that it needed to have regard to The Standards of Practice for Optometrists and Dispensing Opticians that were in effect at the relevant time of the proven allegations.

174. In summary, the Committee needed to consider each of the proven allegations and determine using its own judgment whether the conduct or omission for each was sufficiently serious to amount to misconduct having regard to the standards ordinarily required to be followed by the Registrant.

175. There was no comment from Ms Huxtable on behalf of the Council or from Ms Curzon on behalf of the Registrant on the Legal Advice.

Finding on misconduct

176. In making its findings on misconduct, the Committee took very careful account of all the evidence adduced, the submissions made by the parties, and the guidance in the Hearings and Indicative Sanctions Guidance. The Committee also accepted the unchallenged legal advice of the Legal Adviser.

177. The Committee considered the Standards of Practice for Optometrists and Dispensing Opticians ("the Standards) effective from April 2016. It was mindful that not every falling below the standards expected was sufficient to amount to misconduct and went on to consider whether the conduct fell far below the standards expected, or in other words was sufficiently serious, so as to amount to misconduct. The Committee considered the issue of misconduct in relation to the conduct proved in the Allegations and considered each Allegation in turn. The Committee reminded itself that the threshold for misconduct was high.

178. The Committee attached little weight to the Council's neutral stance in relation to misconduct, as this is a matter for the Committee's judgment alone. Likewise, the fact that no regulatory action was taken against Registrants B or C was not relevant to the specific facts of this case involving a sight test in 2018 by this Registrant.

Allegation 1(a) Failure to detect signs of glaucoma

179. The Committee carefully reminded itself of its findings with respect to the Registrant's failure to detect signs of glaucoma. The Committee concluded that the Registrant breached Standards 5 and 7 in failing to detect signs of glaucoma. NEW PARA Standard 5 required the Registrant to *"Keep your knowledge and skills up to date" 5.1 Be competent in all aspects of your work, including clinical practice, supervision, teaching, research and management roles, and do not perform any roles in which you are not competent.*

180. Standard 7 required the Registrant to

"Conduct appropriate assessment examinations, treatments, and referrals"

The Committee concluded that the Registrant had also breached Standard 7.5 which required the Registrant to:

"Provide effective patient care and treatments based on current good practice" and Standard 7.7 which required the following*:*

"When in doubt, consult with professional colleagues appropriately for advice on assessment, examination, treatment and other aspects of patient care, bearing in mind the need for patient confidentiality".

181. The Committee next considered the seriousness of the Registrant's breaches. In this regard, the Committee considered its findings and determinations at the fact-finding stage and determined that the threshold for seriousness had been met. It reminded itself that at the facts stage it had accepted Dr Kwartz's evidence that *"a reasonably competent optometrist would interpret the visual field defect as likely being glaucomatous in origin (inferior nasal step) and also to consider Patient A was at an increased risk of developing the condition, given her family history".* The Committee took into account that this was an isolated incident, with no other fitness to practise concerns. However, the Committee considered that there was a moderate to high risk of harm to this patient, taking into account the test results, the patient's age and the family history of glaucoma. The Committee considered that the ability to detect glaucoma was a core competency as referenced by Dr Kwartz in her expert report. The Committee concluded that the failure to detect in this case was an elementary and serious failure and breached multiple professional standards. Thus, the Registrant's failure to detect fell far below the standard required.

182. Based on the above, the Committee concluded that the facts found proved at allegation 1(a) were sufficiently serious to amount to misconduct.

Allegation 1(b) Failure to refer

183. The Committee also concluded that the Registrant breached Standard 7, 7.2, 7.5 and 7.7 as well as Standard 6.2 based on her failure to refer Patient A.

Standard 6.2 required the Registrant to:

"Be able to identify when you need to refer a patient in the interests of the patient's health and safety, and make appropriate referrals".

Under Standard 7 the Registrant was required to:

"Conduct appropriate assessment examinations, treatments, and referrals"

Under Standard 7.2 the Registrant was required to:

"Provide or arrange any further examinations, advice, investigations or treatment if required for your patient. This should be done for a timescale that does not compromise patient safety and care"

Under Standard 7.5 the Registrant was required to:

"Provide effective patient care and treatments based on current good practice".

184. The Committee next considered the seriousness of the Registrant's breaches. In this regard, the Committee considered its findings and determinations at the fact-finding stage and determined that the threshold for seriousness had been met. It reminded itself that at the facts stage it had accepted Dr Kwartz's evidence that

> *"I do not consider that Registant's action plan to "cont monitoring LE inf defect [sic]" was appropriate. Whilst there are many aspects and features of glaucoma with which I would not expect a reasonably competent primary care optometrist to be familiar, I would expect them to be cognisant with the fact that glaucoma causes irreversible damage to the retinal nerve fibre layer and that monitoring a defect, without making a referral, can cause significant risk to a patient's vision".*

185. The Committee took into account that this was an isolated incident, with no other fitness to practise concerns. However, the Committee considered that there was a moderate to high risk of harm to this patient, taking into account the test results, the patient's age and the family history of glaucoma. The Committee considered that recognising the need to refer a patient exhibiting signs of glaucoma was a core competency as referenced by Dr Kwartz in her expert report. The Committee concluded that the failure to refer in this case was an elementary and serious

failure and breached multiple professional standards. Thus, the Registrant's failure to refer fell far below the standard required.

186. The Committee concluded that the facts found proved in allegation 1(b) were sufficiently serious to amount to misconduct.

Impairment

Evidence of the Registrant

187. The Registrant gave oral evidence under affirmation. She had provided a witness statement dated the 22 April 2026. Ms Curzon asked the Registrant a number supplementary questions.

188. In response to being asked how she thought her conduct with Patient A could have impacted upon their safety, the Registrant told the Committee that she had reflected extensively on this and reviewed her records in a lot of detail. She said she recognised that there was a visual field defect at the time but decided to monitor rather than to refer. She also stated that she did not think she gave the visual field defect *"enough significance*" and there was an error in her clinical judgement. The patient would have had earlier intervention if she had referred earlier.

189. In response to being asked how she thought her conduct could have impacted on public confidence in the profession of optometry, she told the Committee that she recognised that her clinical decision making fell below the expected professional standards. She stated that her clinical error should not cause the public to lose confidence in optometrists and others as a profession. She had reflected extensively and taken a lot of steps to make sure that this did not happen again. Since the incident in 2018 she had made meaningful changes to her practice and would continue to do so. She told the Committee she was more cautious now and had a lower threshold for referrals especially for visual field loss. She also told the Committee she had completed targeted CPD to strengthen her clinical decision making and make sure that she took a more cautious and structured approach, when managing patients.

190. In response to being asked how completing an MSc in clinical optometry in 2022 with distinction enhanced her understanding of glaucoma, she told the Committee she undertook a professional certificate in glaucoma which gave her *"enhanced clinical knowledge".* She stated that she completed CPD on glaucoma detection and management as well as visual field interpretation. She added that she now puts more emphasis on abnormal test findings and has a lower threshold for referrals.

191. In response to being asked what lessons she had learned from the regulatory process she told the Committee it was a very challenging experience. However, she said that it made her more cautious when it came to her patients. She added that there was a higher importance on prioritising her patients' safety and all

aspects of care. She was fully committed to making sure that her patients always received the highest possible standards and professional care.

Submissions on behalf of the Council

192. Ms Huxtable on behalf of the Council, submitted that the purpose of the proceedings was not to punish the Registrant for past wrongdoings but to protect the public from acts of those who were not fit to practise. The Committee had to look forward and not back to form a view of the Registrant's fitness to practise today. She referred the Committee to the case of *Meadow v GMC* and the relevant sections of Paragraphs 16.1 to 17.8 of the of the Hearings and Indicative Sanctions Guidance. She also referred to the Council's skeleton argument.

193. Ms Huxtable submitted that the appropriate approach to consider impairment was set out in the case *CHRE v NMC* and *Grant* included at paragraph 29 of the Council's skeleton argument. She submitted that limbs a. to c. of the test set out there were engaged.

194. Ms Huxtable referred to the Registrant's bundle and the evidence of the targeted CPD and the references as well as the Registrant's oral evidence. The Council acknowledged that the Registrant had continued to practise unrestricted for a significant period and over seven years without any further clinical concerns being raised to the Council.

195. Ms Huxtable submitted that the development of insight was also important for the Committee to consider in determining whether the Registrant was currently impaired and referred to the case of *Kimmance v General Medical Council*. She highlighted that the Registrant had provided evidence of insight to the Committee which it could assess.

196. Ms Huxtable submitted that the Committee should also go on to consider the public interest when deciding the issue of impairment and should not only consider whether the Registrant continued to present a risk of harm to members of the public.

197. In conclusion, Ms Huxtable submitted that current impairment was a matter of judgement for the Committee. Should the Committee come to the conclusion that she was not currently impaired, the Committee still had the option to issue a warning to the Registrant. Statutory provision for a warning was set out at section 13 F5 of the Opticians Act 1989.

Submissions on behalf of the Registrant

198. Ms Curzon on behalf of the Registrant prepared written submissions which she read out and which are briefly summarised below. She reminded the Committee to look forward and not backwards in considering current impairment. She also referred the Committee to the case law set out in the Council's skeleton argument to assist it in its decision on impairment.

(i) The Registrant was not currently impaired because her misconduct was remediable, had been remedied and there was a low risk of repetition;

(ii) The case involved a clinical issue which was more capable of being remedied;

(iii) The Registrant took responsibility for the shortcomings in her conduct and had detailed extensively in her reflective statement the practical steps she would take to ensure that there is no repetition;

(iv) The Registrant completed consistent and targeted CPD in respect of glaucoma, visual field testing, intraocular pressures and referrals. There was evidence of this in the Registrant's bundle.

(v) There were universally positive references that spoke to her being an "individual of exceptional character and professionalism";

(vi) The Registrant was evidently an individual who had made clear positive contributions to the profession of optometry and was held in a high level of regard by all her professional colleagues;

(vii) The references spoke to the Registrant's ability to practise safely and effectively and in a context where there have been no concerns raised at all regarding her professional conduct or practice.

(viii) This further supported that there had been full remediation on the Registrant's part;

(ix) The Registrant had completed and Independent Prescribers qualification and obtained a distinction in her Master of Science in Clinical Optometry from [redacted] in 2022. This further training would have helped remediate any issues and supports the submission that she is not currently impaired;

(x) The absence of any repetition in such a lengthy period of time since 2018 was the strongest objective evidence to demonstrate that there was no likelihood of repetition or ongoing risk of repetition;

(xi) The Registrant was of good character, had no previous or subsequent Fitness to Practise history and had fully engaged with these proceedings;

(xii) There was no doubt that public confidence could be upheld, given the abundance of professional confidence that existed in the Registrant, such that the public should have no concerns about a finding of no current impairment;

(xiii) The public interest could be served by allowing an individual, who had an otherwise exemplary track record, who was a skilled optometrist and genuinely committed to the profession, to return to that profession to help

and serve the public, having undergone a detailed and lengthy regulatory and remediation process.

(xiv) A finding of misconduct alone would sufficiently mark the seriousness of the conduct and maintain public confidence and, therefore, no current impairment finding is required either for public protection or in the wider public interest.

Legal Advice

199. The Legal Adviser advised that impairment was not statutorily defined, there was no burden or standard of proof, and that the question was a matter of the Committee's independent judgement taking into account all of the evidence it had considered so far. He advised that not every case of misconduct results in a finding of impairment: *Cohen v GMC* 2008 EWHC 581.

200. The Legal Adviser referred to the case of *Meadow v General Medical Council* [2007] 462 and the court's approach on the purpose and approach to take:

> *"In short, the purpose of FTP proceedings is not to punish the practitioner for past misdoings but to protect the public against the acts and omissions of those who are not fit to practise. The FTP thus looks forward not back".*

201. The Legal Adviser also set out the approach and factors for the Committee to determine if the Registrant was currently impaired as set out in the case of *Cohen v GMC* [2008] EWHC 581 (Admin). This included considering if the misconduct is easily remediable, whether it has been remedied and, the risk of repetition.

202. The Legal Adviser referred the Committee to the test for considering impairment as set out by Dame Janet Smith in the fifth report of the Shipman Inquiry (para 25.67) and cited with approval in the case of *CHRE v NMC & Paula Grant* [2011] EWHC 927 (Admin), para 76, by Mrs Justice Cox:

> *"Do our findings of fact in respect of the doctors misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:*
>
> *(a) Has in the past acted and/or is liable in the future to so act so as to put a patient or patients at unwarranted risk of harm and/or;*
>
> *(b) Has in the past brought and/or is liable in future to bring the medical profession into disrepute and/or;*
>
> *(c) Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession and/or*
>
> *(d) Has in the past acted dishonestly and/or is liable to act dishonestly in the future."*

203. The Legal Adviser further advised that the Committee should also consider the public interest and the need to maintain public confidence in the profession and maintain appropriate standards of behaviour may mean that a clinician's fitness to practise is impaired by reason of misconduct. He advised that even in the absence of ongoing risk, a finding of impairment may be necessary to reaffirm to the public and optometrists the standard of conduct expected: *Yeong v GMC* [2009] EWHC 1923.

204. The Legal Adviser also referred the Committee to several cases regarding the importance of insight in the assessment of impairment. In *Sawati v General Medical Counci*l [2022] EWHC 283 (Admin) the court emphasised that insight was a necessary precondition for remediation and maintaining public confidence in the profession. In the *General Medical Council and another v Bramhall* [2021] EWHC 2109 (Admin) the court defined insight as the development of a fair and objective understanding of the nature and gravity of the misconduct that "required empathetic identification with the perspectives of others". In *Hyder v General Medical Council* [2024] EWHC 2945 (Admin), the court highlighted that insight must be specific to the misconduct in question and involve an understanding of the motivations and triggers behind the behaviour.

205. The Legal Adviser advised that whether the Registrant had shown insight into his misconduct and how much insight he had *were "classically matters of fact and judgment for the professional disciplinary committee in the light of the evidence before it*": *Professional Standards Authority v Health & Care Professionals Council and Doree* [2017] EWCA Civ 319.

206. There was no comment from either party regarding the legal advice.

Findings on impairment

207. The Committee accepted the unchallenged advice of the Legal Adviser. In making its findings on current impairment, the Committee had regard to all the evidence it had received to date, including the Registrant's oral evidence, CPD records and testimonials, the submissions of Ms Huxtable on behalf of the Council, and the submissions of Ms Curzon on behalf of the Registrant. The Committee also carefully considered the Hearings and Indicative Sanctions Guidance (from 2021), the Council's Standards of Practice for Optometrists and Dispensing Opticians (from April 2016), and its earlier findings.

208. The Committee firstly considered whether the Registrant's conduct was remediable, whether it had been remedied and whether the conduct was likely to be repeated in future. The Committee had regard to the Guidance which at paragraph 16.1 states that *'Certain types of misconduct (for example, cases involving clinical issues) may be more capable of being remedied than others'*.

209. The Committee reminded itself that the Registrant's misconduct was centred around a single patient (Patient A) and arose from a single consultation with the patient on the 21 August 2018. The Committee determined that the Registrant's

misconduct was remediable as it was based around clinical issues that were serious. The Committee considered that the matters for which misconduct was found did not demonstrate that the Registrant had poor or deep-seated attitudinal issues.

210. The Committee went on to assess whether the Registrant had remediated her misconduct. The Committee carefully considered the evidence of the corrective steps that the Registrant had taken to improve her practice. The Committee noted from the Registrant's evidence that she appeared as a well qualified optometrist who was conscientious and was well regarded by other professionals.

211. The Committee noted that in her written statement, the Registrant had reflected on *her "clinical decision-making following my consultation with Patient A 21 August 2018, specifically my decision not to refer her to the Hospital Eye Service".* The Committee considered that the Registrant had taken concrete steps to strengthen her *"awareness of the importance of cautious, evidence-based decision-making and clear verification of clinical information".* This was confirmed by the Registrant in her oral evidence before the Committee. It further noted that the Registrant's evidence of remediation included targeted CPD around glaucoma. She also had positive references of support that had been provided by other senior professionals in optometry, who attested to her professionalism and excellent clinical skills.

212. Based on a careful consideration of the steps the Registrant had taken in the near 8-year period since the consultation with Patient A on the 21 August 2018, the Committee determined that the Registrant had developed sufficient insight, had undertaken sufficient remediation, and had demonstrated genuine remorse such as to remediate her misconduct. The Committee also concluded that there was a very low future risk that the Registrant would repeat her misconduct, noting that although the Registrant is currently on a career break, she had worked for six years after this incident without any further concerns. Therefore, the Committee was satisfied that a finding of impairment was not necessary on the grounds of public protection.

213. The Committee also considered that although limbs a-c referred to in the *Grant* case were engaged at the time of the misconduct, in light of the Registrant's remediation, level of insight and very low risk of repetition, these were no longer engaged.

214. The Committee went on to consider whether a finding of impairment was necessary in order to uphold proper professional standards and public confidence in the profession. The Committee determined that it was not necessary to make a finding of impairment on the grounds of the public interest.

215. The Committee determined that the public interest was satisfied through the focused steps that the Registrant had undertaken and completed to improve her practice around glaucoma, her engagement throughout with the process, references from colleagues and self-reflection. The Committee considered that an informed and fair-minded member of the public, if they were apprised of all the

facts, would not reasonably consider that a finding of impairment was necessary to maintain public confidence in the profession or to uphold proper professional standards.

216. For these reasons, the Committee found that Registrant's fitness to practise was not currently impaired.

Warning

217. Having found no impairment, the Committee went on to consider whether it was appropriate to give the Registrant a warning. In her submissions, Ms Huxtable on behalf of the Council highlighted that should the Committee make a finding of no impairment, it was still open to the Committee to sanction the Registrant with a warning.

218. The Committee had regard to the Hearings and Indicative Sanctions Guidance (from 2021) and considered paragraph 20 of the Guidance:

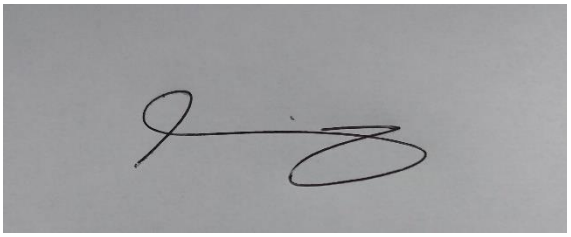
20.2 Warnings play an important role in upholding standards and maintaining public confidence in the profession. The FtPC should have regard to the public interest when considering whether a warning is necessary. A warning does not directly affect a registrant's ability to practise or undertake training but is published on the Council's website and disclosed if anyone enquires about the registrant's fitness to practise history.

20.7 If the Committee are satisfied that the registrant's fitness to practise is not impaired, they can take account of a range of aggravating or mitigating factors to determine whether a warning is appropriate, having regard to the public interest as part of their considerations. These might include:

a. Genuine expression of regret/apology;
b. Acting under duress;
c. Previous good history;
d. Appropriate rehabilitative/corrective steps have been taken; and
e. Relevant and appropriate references and testimonials.

219. Following a careful consideration of the public interest and the relevant factors at paragraphs 20.7 a, c, d and e, the Committee determined that the public interest was satisfied through the focused steps that the Registrant had completed to improve her practice around glaucoma, her engagement with the regulatory process, as well as the references from other professions and her self-reflection. In addition, the Registrant has expressed remorse and had a previous good fitness to practise history. Accordingly, the Committee determined that a warning was not necessary in this case.

Chair of the Committee: Sarah Hamilton

Signature  **Date: 23 April 2026**

Registrant: Kaajal Vora

Signature present and received via email **Date: 23 April 2026**

FURTHER INFORMATION
Transcript
A full transcript of the hearing will be made available for purchase in due course.
Appeal
Any appeal against an order of the Committee must be lodged with the relevant court within 28 days of the service of this notification. If no appeal is lodged, the order will take effect at the end of that period. The relevant court is shown at section 23G(4)(a)-(c) of the Opticians Act 1989 (as amended).
Professional Standards Authority
This decision will be reported to the Professional Standards Authority (PSA) under the provisions of section 29 of the NHS Reform and Healthcare Professions Act 2002. PSA may refer this case to the High Court of Justice in England and Wales, the Court of Session in Scotland or the High Court of Justice in Northern Ireland as appropriate if they decide that a decision has been insufficient to protect the public and/or should not have been made, and if they consider that referral is desirable for the protection of the public. Where a registrant can appeal against a decision, the Authority has 40 days beginning with the day which is the last day in which you can appeal. Where a registrant cannot appeal against the outcome of a hearing, the Authority's appeal period is 56 days beginning with the day in which notification of the decision was served on you. PSA will notify you promptly of a decision to refer. A letter will be sent by recorded delivery to your registered address (unless PSA has been notified by the GOC of a change of address). Further information about the PSA can be obtained from its website at www.professionalstandards.org.uk or by telephone on 020 7389 8030.
Contact
If you require any further information, please contact the Council's Hearings Manager at Level 29, One Canada Square, London, E14 5AA or by telephone, on 020 7580 3898.