BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(24)41

AND

GERAINT GRIFFITHS (01-10586)

DETERMINATION OF A SUBSTANTIVE HEARING
07 – 24 JULY 2025, 5 – 19 JANUARY 2026
AND 25 - 27 FEBRUARY 2026

Committee Members:	Gaon Hart (Chair) Ben Summerskill (Lay) Ian Hanson (Lay) Gemma O'Rourke (Optometrist) Danielle Ellis (Optometrist)
Legal adviser:	Jennifer Ferrario (7 – 24 July 2025) Dr. Francis Graydon (5 – 19 January 2026) (25 – 27 February 2026)
GOC Presenting Officer:	Hannah Hinton
Registrant present/represented:	Yes and represented
Registrant representative:	Trevor Archer
Hearings Officer:	Terence Yates
Facts found proved:	2, 3, 5, 6, 10, 11, 13, 14, 15, 17, 21, 25, 31(i) and 31(ii) 24 (admitted), 26 (admitted) 28 (admitted), 30 (admitted)
Facts not found proved:	1, 4, 9, 12, 19, 20, 23, 27, 29 7, 8, 31(iii) (no case to answer)
Misconduct:	Found for 2, 3, 5, 6, 11, 14, 15, 17, 21, 24, 25, 26, 28, 30 and 31(i)

Impairment:	Not Impaired
Warning:	Warning issued for 3 years

Preliminary Matters

Potential For Bias

1. Ms O'Rourke informed the parties that she had attended training events facilitated by the expert witness instructed by the General Optical Council ('the Council'), Ms Janet McCrudden. Ms O'Rourke said that she had not spoken to Ms McCrudden. Ms Hinton for the Council, and Mr Archer acting for the Registrant said that they had no issue with Ms O'Rourke's disclosure and thanked her for bringing it to their attention. The Committee received and accepted legal advice from the Legal Adviser. The Committee in the absence of Ms O'Rourke decided that there was no potential for bias or any perception of bias, on the basis that Ms O'Rourke had not spoken to or developed a relationship with the expert and that neither party had an issue with Ms O'Rourke continuing. It was consequently appropriate for Ms O'Rourke to remain on the Committee.

Redactions

2. Mr Archer, on behalf of the Registrant, made an application for the redaction of some witness evidence. He referred the Committee to his skeleton argument. In summary, he submitted that in his referral complaint form, the witness Ms Ahad given opinion evidence about *'long term psychological damage'* when he had not been qualified to provide such an opinion and he had not been instructed by the Council as an expert witness. In relation to Mr B, a witness of fact, he submitted that any opinion evidence in his witness statement ought to be redacted because he was not being relied upon by the Council as an expert witness. Mr Archer referred to the Council's Fitness to Practise Rules ('the Rules') and to relevant case authorities in line with his skeleton argument.
3. Ms Hinton, on behalf of the Council submitted that the evidence from both witnesses should not be excluded at this stage on the basis that it is *'useful and relevant.'* She said that both witnesses can be asked questions about their evidence and the Committee can decide, once it has heard all of the evidence, what weight, if any, should be attached to it.
4. The Committee received and accepted legal advice from the Legal Adviser. The Legal Adviser said that in line with rule 40 of the Rules, the Committee should consider whether the evidence has been provided as expert evidence. She said that the case authority of *Kennedy v Cordia (Services) LLP* [2016] UKSC 6 at [44] may assist because it sets out the considerations that tribunals or courts ought to consider when deciding on the admissibility of expert or 'skilled' evidence:

    (i) Whether the evidence will assist the court in its task;

(ii) Whether the witness has the necessary knowledge and experience;

(iii) Whether the witness is impartial in their presentation and assessment of the evidence and,

(iv) Whether there is a 'reliable body of knowledge or experience to underpin the witness's evidence.'

5. The Legal Adviser highlighted that in *Cordia,* the Court had been satisfied that the witness had been called upon as an expert witness. The Committee was advised to consider whether the two witnesses in question had been invited to give their evidence as experts and if so, it should ask itself the four questions posed in the *Cordia* case.
6. The Committee was advised to have regard for the case of *National Justice Compania Naviera SA v Prudential Assurance Co Ltd (The "Ikarian Reefer")* [1993] 2 Lloyd's Rep. 68 (Comm Ct) when considering whether the evidence for either witness amounts to expert evidence. She said that *Naviera* decided that evidence may be regarded as 'expert' if it is independent, objective and unbiased and the witness should be clear that the evidence falls clearly within their field of expertise.
7. The Legal Adviser referred the Committee to rules 40 and 40(2) of the FTP Rules and advised that it should admit evidence that it considers *'fair and relevant to the case before it, whether or not such evidence would be admissible in a court of law.'* The Legal Adviser said that if the Committee decided to agree to redact any of the proposed evidence, that as an independent professional Committee, it ought to be able to put the evidence out of its mind.
8. The Committee considered the application very carefully and treated the evidence from each witness separately. It noted that Mr A was an Orthoptist and the opinion evidence that he had provided was, on balance, outside of his area of knowledge. He had not been instructed by the Council as an expert witness. His evidence was contained in a referral form that had not been tendered as a formal witness statement or exhibit. It did not contain a statement to say that he was qualified to give the opinion evidence, or that his opinion was accurate and true. The Committee went on to determine that the opinion evidence was not relevant to the issues that the Committee had to consider. For these reasons, the Committee agreed the Registrant's application to redact the opinion evidence, in line with Mr Archer's skeleton argument and would put the evidence out of its mind.
9. The Committee considered the opinion evidence from Mr B. It noted that he is an Orthoptist. The Committee considered each of the seven pieces of opinion evidence provided by this witness, in line with Mr Archer's skeleton argument. It determined that whilst Mr B had some knowledge in the areas for which he provided an opinion, he had not been called to give evidence by the Council as an expert witness. The Committee further noted that the opinion evidence from Mr B had very limited relevance to the issues that the Committee had to decide upon. It reminded itself that the Council and the Registrant had instructed independent experts to provide evidence and Mr B was not entirely independent. The Committee was satisfied that in the circumstances it would be fair to rely on the

expert evidence of Ms McCrudden and Professor Barnard. It decided to agree to the Registrant's application to redact the opinion evidence, in line with Mr Archer's skeleton argument, and would put the evidence out of its mind.

10. The Committee was provided with a redacted version of the hearing bundle before the case was opened by Ms Hinton.

ORIGINAL ALLEGATION

The Council alleges that you, Mr Geraint Griffiths (01-10586), a registered Optometrist:

1. *Misdiagnosed Patient 1 with divergence insufficiency and/or convergence excess and/or accommodation insufficiency on the following dates:*

    a. *30 June 2020; and/or*
    b. *19 January 2021; and/or*
    c. *22 March 2022; and/or*
    d. *25 November 2022*

2. *Prescribed Patient 1 spectacles with varifocal lenses and/or prisms when it was not clinically indicated to do on the following dates:*

    a. *30 June 2020; and/or*
    b. *19 January 2021; and/or*
    c. *22 March 2022; and/or*
    d. *25 November 2022*

3. *Failed to record, adequately or at all, the assessment of Patient 1's binocular vision on the following dates:*

    a. *30 June 2020; and/or*
    b. *19 January 2021; and/or*
    c. *22 March 2022; and/or*
    d. *25 November 2022*

4. *Misdiagnosed Patient 2 with divergence excess and/or convergence insufficiency on the following dates:*

    a. *29 December 2012; and/or*
    b. *27 April 2013; and/or*
    c. *15 June 2013; and/or*
    d. *17 August 2013; and/or*
    e. *18 January 2014; and/or*
    f. *7 June 2014; and/or*
    g. *31 January 2015; and/or*
    h. *1 June 2015; and/or*
    i. *6 June 2015; and/or*

j. 9 January 2016; and/or
k. 14 October 2017; and/or
l. 23 November 2018; and/or
m. 10 July 2020; and/or
n. 23 July 2022;

5. *Prescribed Patient 2 spectacles with varifocal lenses and/or prisms when it was not clinically indicated to do on the following dates:*

a. 29 December 2012; and/or
b. 27 April 2013; and/or
c. 15 June 2013; and/or
d. 17 August 2013; and/or
e. 18 January 2014; and/or
f. 7 June 2014; and/or
g. 31 January 2015; and/or
h. 1 June 2015; and/or
i. 6 June 2015; and/or
j. 9 January 2016; and/or
k. 14 October 2017; and/or
l. 23 November 2018; and/or
m. 10 July 2020.

6. *Failed to record, adequately or at all, the assessment of Patient 2's binocular vision on the following dates:*

a. 29 December 2012; and/or
b. 27 April 2013; and/or
c. 15 June 2013; and/or
d. 17 August 2013; and/or
e. 18 January 2014; and/or
f. 7 June 2014; and/or
g. 31 January 2015; and/or
h. 1 June 2015; and/or
i. 6 June 2015; and/or
j. 9 January 2016; and/or
k. 14 October 2017; and/or
l. 23 November 2018; and/or
m. 10 July 2020; and/or
n. 23 July 2022.

7. *On or around 23 July 2022 misdiagnosed Patient 2's vision as less than 1/60 in the left eye and/or the right eye.*

8. *On or around 23 July 2022 failed to refer Patient 2 on a same day basis and/or to seek advice on Patient 2's management.*

9. *Misdiagnosed Patient 3 with divergence excess and/or convergence insufficiency and/or accommodation insufficiency on 17 September 2022.*

10. *Prescribed Patient 3 spectacles with varifocal lenses and/or prisms when it was not clinically indicated to do on 17 September 2022*

11. *Failed to record, adequately or at all, the assessment of Patient 3 's binocular vision on the following dates:*

    a. *28 July 2022; and/or*
    b. *17 September 2022*

12. *Misdiagnosed Patient 4 with divergence excess and/or convergence insufficiency and/or accommodation insufficiency on the following dates:*

    a. *1 August 2018; and/or*
    b. *17 November 2018; and/or*
    c. *5 May 2019; and/or*
    d. *17 August 2019; and/or*
    e. *28 August 2019; and/or*
    f. *18 February 2020.*

13. *Prescribed Patient 4 spectacles with varifocal lenses and/or prisms when it was not clinically indicated to do on the following dates:*

    a. *1 August 2018; and/or*
    b. *17 November 2018; and/or*
    c. *5 May 2019; and/or*
    d. *17 August 2019; and/or*
    e. *28 August 2019; and/or*
    f. *18 February 2020*

14. *Failed to record, adequately or at all, the assessment of Patient 4's binocular vision on the following dates:*

    a. *1 August 2018; and/or*
    b. *17 November 2018; and/or*
    c. *5 May 2019; and/or*
    d. *17 August 2019; and/or*
    e. *28 August 2019; and/or*
    f. *18 February 2020*

15. *Prior to prescribing spectacles failed to carry out an external and/or internal examination of Patient 1's eyes on the following dates:*

    a. *30 June 2020; and/or*
    b. *19 January 2021; and/or*
    c. *22 March 2022; and/or*

d. *25 November 2022.*

16. *In the alternative to 15. above you failed to record the external and/or internal examination of Patient 1's eyes:*

    a. *30 June 2020; and/or*
    b. *19 January 2021; and/or*
    c. *22 March 2022; and/or*
    d. *25 November 2022*

17. *Prior to prescribing spectacles failed to carry out an external and/or internal examination of Patient 2's eyes on the following dates:*

    a. *27 April 2013; and/or*
    b. *18 January 2014; and/or*
    c. *7 June 2014; and/or*
    d. *31 January 2015; and/or*
    e. *9 January 2016; and/or*
    f. *10 July 2020;*

18. *In the alternative to 17. above you failed to record the external and/or internal examination of Patient 2's eyes:*

    a. *27 April 2013; and/or*
    b. *18 January 2014; and/or*
    c. *7 June 2014; and/or*
    d. *31 January 2015; and/or*
    e. *9 January 2016; and/or*
    f. *10 July 2020;*

19. *Prior to prescribing spectacles failed to carry out an external and/or internal examination of Patient 3's eyes on the following dates:*

    a. *28 July 2022; and/or*
    b. *17 September 2022*

20. *In the alternative to 19. above you failed to record the external and/or internal examination of Patient 3's eyes:*

    a. *28 July 2022; and/or*
    b. *17 September 2022*

21. *Prior to prescribing spectacles failed to carry out an external and/or internal examination of Patient 4's eyes on the following dates:*

    a. *1 August 2018; and/or*
    b. *17 November 2018; and/or*
    c. *5 May 2019; and/or*
    d. *17 August 2019; and/or*

e. 28 August 2019; and/or
f. 18 February 2020

22. *In the alternative to 21. above you failed to record the external and/or internal examination of Patient 4's eyes:*

a. 1 August 2018; and/or
b. 17 November 2018; and/or
c. 5 May 2019; and/or
d. 17 August 2019; and/or
e. 28 August 2019; and/or
f. 18 February 2020

23. *Between 4 February 2020 and 25 November 2022 did not obtain informed consent from Patient 1's parent/s in that you did not explain, adequately or at all, the evidential basis of the treatment.*

24. *In the alternative to 23. above failed to record any discussions held with Patient 1's parent/s in relation to the obtaining of informed consent.*

25. *Between 29 December 2012 and 23 July 2022 did not obtain informed consent from Patient 2's parent/s in that you did not explain, adequately or at all, the evidential basis of the treatment.*

26. *In the alternative to 25. above failed to record any discussions held with Patient 2's parent/s in relation to the obtaining of informed consent.*

27. *Between 28 July and 17 September 2022 did not obtain informed consent from Patient 3's parent/s in that you did not explain, adequately or at all, the evidential basis of the treatment.*

28. *In the alternative to 27. above failed to record any discussions held with Patient 3's parent/s in relation to the obtaining of informed consent.*

29. *Between 1 August 2018 and 18 February 2020 did not obtain informed consent from Patient 4's parent/s in that you did not explain, adequately or at all, the evidential basis of the treatment.*

30. *In the alternative to 29. above failed to record any discussions held with Patient 4's parent/s in relation to the obtaining of informed consent.*

31. *Acted outside the scope of your expertise in that:*

i. On or around 1 August 2018 you advised Patient 4's mother that Patient 4 had and/or was predisposed to dyslexia;

ii. *On or around 1 August 2018 you provided dietary advice in respect of Patient 4 to their mother in that you recommended a book named the Plant Paradox;*

iii. *On or around 1 August 2018 you provided dietary advice in respect of Patient 3 to their mother in that you recommended a book named the Plant Paradox*

As a result of the matters set out above your fitness to practise is impaired by reason of your misconduct.

Background to the allegations

11. The Registrant is an Optometrist and was entered onto the Register on the 31 October 1980.

12. Ms B is a Consultant Ophthalmologist at the University Hospital of [redacted] NHS Trust. On the 18 July 2022, concerns were brought to her attention by a colleague about a patient and a prescription that had been issued by the Registrant. The Registrant had advised Patient 1's parents that Patient 1 would benefit from the support of a white cane. Ms B saw Patient 1 and their parents in clinic between 12 September 2022 – 6 February 2023 and informed them that there were no clinical findings to support the use of a white cane.

13. Mr B is an Orthoptist, and he worked with specialised clinics at the University Hospital of [redacted] NHS Trust. He saw Patient 3 and their mother in clinic at the hospital on 23 September 2022. The patient had visited the Registrant's practice on 17 September 2022 and following a glasses test, the Registrant had prescribed glasses which had included varifocals, prisms and a tint. Patient 3 told Mr B that they had been wearing the glasses all of the time.

14. Mr B was concerned because he could see no reason for prescribing varifocal lenses and/or prisms. He explained to the patient's mother on the 23 September 2022 that the glasses should be disposed of and a new pair ought to be obtained using the prescription issued by the hospital.

15. Mr B first saw Patient 4 on 4 November 2019. The Registrant had prescribed glasses to the patient which they were wearing all of the time. The glasses contained prisms and varifocals. Mr B saw the patient again on 21 January 2020 with their mother and advised them to dispose of the glasses prescribed by the Registrant as the hospital assessment had revealed no reason for a prism or varifocal prescription. A further glasses assessment was arranged for the new year. On the 21 January 2020 when Patient 4 was assessed, they were advised to take the hospital prescription to a high street optician.

16. Patient 4 returned to the hospital clinic on 2 June 2020 at which time they told Mr B that the Registrant had decided not to issue the prescription that had been produced by the hospital. The patient's parents showed Mr B an email from the Registrant dated 19 November 2019 explaining why he had prescribed prisms. They also showed Mr B a letter from the Registrant dated 18 February 2020 explaining why he had not made the glasses to the hospital prescription. He had asked that the letter be shown to the hospital clinician. Mr B became concerned about the Registrant's explanation because he could find no evidence for the Registrant's diagnoses. The patient continued to be assessed by the hospital and have since changed their optician.

17. Ms C is an Advanced Orthoptist at the University Hospital of [redacted] NHS Trust. Ms C saw Patient 2 and their father in clinic at the hospital on the 14 October 2022 following a referral from the Registrant. The referral had been made due to 'severe visual impairment' and a diagnosis of specific eye conditions. Ms C found that her examination of the patient did not align with the referral. When Ms C informed Patient 2's father in clinic, that the patient's sight was normal, the father said that he was content for the patient to be discharged.

18. Mr A is the Head Orthoptist at the University Hospital of [redacted] NHS Trust. On the 23 December 2022, he made a referral to the General Optical Council ('the

GOC'), in which he raised concerns about the Registrant. His concerns related to the 'misdiagnosis and mismanagement' of four child patients dating back to 2020.

19. The GOC instructed Ms Janice McCrudden to prepare an expert witness report which is dated 24 August 2023. Ms McCrudden provided an addendum expert report on the 20 June 2024.
20. On the 7 December 2023 and the 23 May 2024, the mother of Patient 2, ('Ms A'), provided a witness statement to the GOC.
21. On the 13 December 2023, and the 8 May 2024, the mother of Patient 3, ('Ms D'), provided a witness statement to the GOC.
22. On the 5 February 2024 and the 29 May 2024, the mother of Patient 4, ('Ms E'), provided a witness statement to the GOC.
23. Professor Simon Barnard was instructed by the Registrant to prepare an expert report, and his report is dated the 15 June 2025.
24. Professor Barnard and Ms McCrudden provided a joint expert report, dated the 22 June 2025. The report provides their expert opinion in relation to particulars 1 – 13 of the Allegation.

The Hearing

25. On day one of the hearing, Mr Archer informed the Committee that all of the Allegation was denied.
26. Ms Hinton said that she will provide the Committee and Mr Archer with a document setting out the evidence that the Council relies on in respect of each patient and the relevant allegations, over the course of the coming days. Mr Archer told the Committee that he was content to continue without the written document and he asked the Committee to allow him additional preparation time in due course should he require it. The Committee agreed.
27. Ms Hinton opened the Council's case. She said that in view of the number of allegations, that there is a considerable amount of detail. Ms Hinton told the Committee that the allegations relate to four child patients and she referred the Committee to the individual allegations:

    Patient 1: particulars 1, 2, 3, 15/16, 23/24;

    Patient 2: particulars 4, 5, 6, 7, 8, 17/18 and 25/26;

    Patient 3: particulars 9, 10, 11, 19/20, 27/28 and 31(iii);

    Patient 4: particulars 12, 13, 14, 21/22, 29/30, 31(i) and (ii).

28. The Committee heard evidence from the following persons in addition to the Registrant:

    - Mr A
    - Mr B
    - Ms B
    - Ms A
    - Ms C

- Janice McCrudden
- Professor Simon Barnard

Mr A

29. Mr A told the Committee that the content of his witness statement dated 2 June 2023 contained in the hearing bundle was true to the best of his knowledge and belief and he asked the Committee to adopt it as his evidence. He confirmed that he submitted the referral to the Council on the 23 December 2022.
30. Mr A said that as the Head Orthoptist at the University Hospital of [redacted] NHS Trust ('the Hospital'), he specialises in 'eye movement disorders.' He said that he works collaboratively with Optometrists at the Hospital and he uses different measurements and forms to measure the eye to those used by an Optometrist.
31. During cross examination, Mr A said that he was not familiar with the terms 'fixation disparity' or 'divergence/convergence/accommodation insufficiency'. He was asked why he had included in his referral to the Council that the Registrant had not listened to the Hospital in terms of managing patients. In response, Mr A said that ordinarily, the Hospital sent a copy of a letter to parents of a patient, to the Optometrist. He was unable to say whether the Registrant had been sent a copy for the four patients. He said *'The indication was that our management of the patients was not being considered by the Optometrist.'*
32. When answering questions from the Committee, Mr A said that the Hospital operates a collaborative process however it relies on communication from the community Optometrist. He explained that if the Optometrist disagrees with a prescription issued by the Hospital, ordinarily the Optometrist advises the parents of the patient, to return to the Hospital. He said that there is no formal 'shared care' and if a patient is referred to the Hospital, they will continue to be monitored until their symptoms have settled, and then they will continue to be reviewed by the Community Optometrist.

Admissions

33. At the beginning of day two, Mr Archer, informed the Committee that the Registrant admitted the factual particulars 24, 26, 28 and 30.
34. The Committee received and accepted legal advice from the Legal Adviser. She advised the Committee that whilst rule 46(5) of the FTP Rules refers to the Chair inviting admissions, there is nothing in the rules preventing the Registrant from making admissions at this stage of the hearing. She said that rule 46(6) requires the Chair to announce that admitted facts ought to be found proved.
35. The Committee considered the admissions and accepted them. The Committee indicated that considering the complexity of the issues and the limitations of the admissions it wished to hear the evidence prior to finding the facts proved. The Committee decided to wait until it had heard the totality of the evidence.

Ms B

36. Ms B told the Committee that the content of her witness statements dated 21 June 2023 and 26 March 2025 contained in the hearing bundle are true to the best of

her knowledge and belief and she asked the Committee to adopt them as her evidence. She confirmed that she is a Consultant Ophthalmologist at the Hospital which in lay terms is a medically qualified eye specialist.

37. When she was asked about the letter of the 11 April 2022 written by the Registrant, Ms B told the Committee that the Hospital carried out eye examinations for Patient 1 and the results did not align with the diagnosis in the Registrant's letter.

38. Ms B was asked if she was familiar with the term 'divergence insufficiency.' She said *'it is when a patient tries to look in the distance and the eyes do not move outward as they should.'* She told the Committee that it is not a term that is used by Ophthalmologists but she is aware that it is commonly used by Optometrists. Ms B described 'convergence excess as *'a presentation of a patient that directs their eyes closer than they need to and it often results in double vision, headaches or blurred vision.'* She described 'accommodation insufficiency' as *'insufficient muscle movement in the eye to enable a patient to view objects up close'.*

39. During cross examination, Ms B said that when she saw Patient 1 she had been aware that the patient had been diagnosed with ADHD by their GP. She had not identified any communication issues and had found the patient to be *'engaging.'*

40. Ms B went on to say that she first saw Patient 1 at the Hospital on the 28 June 2022. She referred to the patient record in which she had stated twice that the patient had been struggling with their spectacles and had preferred their old ones that were prescribed by the Registrant. On the 12 September 2022, the patient's parents informed Ms B that Patient 1 was *'always bumping into things'* and on the 3 October 2022, she advised them that tinted lenses without prisms should be prescribed and Patient 1 should stop using the white stick. When the patient and their parents returned on the 7 November 2022, they told her that when they had removed the patient's white stick it had impacted negatively on Patient 1's confidence.

41. During re-examination, Ms B said that the prescription with prisms would have allowed the patient to become reliant on their spectacles rather than using their own vision potential. She said that ordinarily the Hospital's approach is to try and encourage a child with ADHD and a multitude of symptoms to use their own vision ability as much as possible. She said that the prisms prescription had not demonstrated any improvement in the patient's vision nor any harm. However, as a team they always try where possible to minimise the medical intervention, to allow for natural repair. Ms B told the Committee that whilst the removal of the prisms and the white stick may have impacted on the patient's confidence, there will always be a period of adjustment in which they will require support and encouragement. She said that in the majority of scenarios, including a child patient with ADHD, the adjustment may take longer than a child patient without the condition, however in her experience, the outcome is usually favourable.

42. When answering questions from the Committee, Ms B said that whilst there ought to be no direct harm in using an unnecessary prisms prescription, it will discourage the child patient from using their own eyes to focus. She said that varifocals were not considered for this patient, and in her experience, they are rarely used for children. In relation to using a white stick, Ms B told the Committee that a child can become over-reliant, and she would expect the school to assist with mobility issues. She said that ordinarily where the Hospital disagree with the Community Optometrist's prescription, *' …healthy discussions take place. This case was*

different because despite the hospital advising the Optometrist that prisms and a white stick were unnecessary, we had been unable to reach an agreement'.

43. Ms B was asked about the different eye test results from the Registrant and from the Hospital within a short period of time. She told the Committee that results can and do differ, depending on the time of day the examinations occur. She said that for this reason, a patient is usually assessed over the course of several visits, before a diagnosis is reached. She said that she saw Patient 1 on several occasions and described a *'common theme'* in her findings.

44. Mr Archer asked further questions. He asked Ms B if she was aware that when the Registrant saw Patient 1 on the 30 November 2022, he had advised the patient to use the hospital prescription pending confirmation of the referral. She said that she had seen this recorded in the patient's Vision Assessment Report.

45. Mr Archer asked Ms B to explain why she had described the circumstances relating to Patient 1 as 'different.' He asked if it related to the Registrant having advised the patient to use a white stick. She said that it was a *'complex case and he should have worked with us as a team. I was happy with the prescription but without the prisms. It became more complicated unnecessarily.'*

46. The Committee asked further questions around her evidence that there had been a lack of cohesive working between the Hospital and the Registrant. She told the Committee that it is key to have the Community Optometrist and the Hospital work closely together, in the best interests of the patient. She described a *'disconnect. I was very disappointed that we were unable to work together to help this patient with their rehabilitation journey.'*

Ms A

47. Ms A told the Committee that the content of her witness statements dated 7 December 2023 and 13 December 2023 contained in the hearing bundle are true to the best of her knowledge and belief and she asked the Committee to adopt them as her evidence. Ms A confirmed that she is the mother of Patient 2.

48. During cross examination, Ms A told the Committee that she has two daughters, both of whom have been diagnosed with a rare gene mutation disorder. They have learning disabilities and Patient 2 has repetitive and delayed speech. She described her as *'very talkative but her understanding of other people talking is low.'* Ms A said that Patient 2 had been around 5 years of age when she first saw the Registrant in his practice, in 2012. She said that she recalls the eye examinations always taking 'a while' and the Registrant would explain what he was doing. She said that her daughter would not have understood what the Registrant was saying. Ms A recalls the Registrant examining Patient 2's eye during the appointments however she cannot remember the exact tests that he carried out.

Ms C

49. Ms C told the Committee that the content of her witness statements dated 19 May 2023 and 24 October 2024 contained in the hearing bundle are true to the best of her knowledge and belief and she asked the Committee to adopt them as her evidence. Ms C confirmed that she is an Advanced Orthoptist at the Hospital and she saw Patient 2 at her clinic on the 14 October 2022.

50. Ms C told the Committee that the reason for the referral to the Hospital had been due to *'historical divergence and other conditions.'* Patient 2's father had raised concerns about the optical assessment carried out by the Registrant. She said that she made different findings to the Registrant. Ms C said that the Registrant had recorded 'neurological impairment' however she could find no evidence of this. She said that whilst neutropenia, coeliac and ADHD had been diagnosed, Patient 2 had been part of a very vibrant educational life in which she navigated her learning disabilities well. The second difference that she found related to the patient's vision. She said that the Registrant had recorded her vision measurements equal to vision that was 'severely sight impaired'. She said that her findings showed that the patient had *'better than perfect vision.'*

51. Ms C said that she had been very concerned to read the Registrant's findings. She said that not only was the term 'partially sighted' a term that is rarely used in modern times, but it caused an urgent triage of the patient *'which could have been extremely anxiety inducing for the patient and their family.'* Ms C said that she and her hospital colleagues see many child patients with *'special needs*' and she said that the majority are very engaging and communicative. She described being *'very happy with the patient's assessment'* and gave advice to see a different Community Optometrist and the patient was discharged following the first visit.

52. During cross examination, Ms C was asked if she could explain the terms '*psychogenic visual disturbance; hysterical blindness; hysterical amblyopia; visual convergence reaction; psychogenic amblyopia and amblyopic school girls' scenario*' all of which she said that she was not familiar with. When asked to describe '*neurological impairment'*, Ms C said that it was a *'vague term which encompasses a very wide range of conditions.'*

53. Ms C was asked if she would expect an urgent referral for a patient that demonstrated a sudden decline in 'visual acuity.' She said that she would expect an emergency referral and would advise a patient to attend the emergency department of an eye hospital.

Mr B

54. Mr B told the Committee that the content of his witness statement dated 1 June 2023 contained in the hearing bundle is true to the best of his knowledge and belief and he asked the Committee to adopt it as his evidence. Mr B said that he is an Orthoptist at the Hospital and he first saw Patient 3 at the Hospital clinic on the 23 September 2022.

55. Mr B told the Committee that when Patient 3 came to his Hospital clinic on the 23 September 2022, the patient's parent handed him the prescription that had been issued by the Registrant. He said that he made a note of it and saw that it was different to a prescription that had been given to the patient by the Hospital following an assessment on the 18 July 2022. Mr B assessed the patient's eyes and arrived at a different prescription to the prescription that had been issued by the Registrant. He advised the patient's parent to change to another Community Optometrist.

56. During cross examination, Mr B was asked about the eye examination that was carried out by the Hospital on the 18 July 2022. He explained that a 'cyclo refraction' is a process that involves using eye drops to temporarily paralyse the

eyes, and to prevent the patient from focusing on objects that are close by. He said that the patient is not required to speak during the process and it enables a prescription to be estimated. Mr B said that, the Hospital record indicates that the Optometrist decided to reduce the prescription. He was asked if this indicated that the hospital prescription was '*not ideal*' to which he said *'it is the ideal one because only the left eye has been slightly reduced and this will enable the patient to adapt to the change in prescription.'*

57. Mr B was asked questions about his witness statement. He described 'accommodation insufficiency' as *'an inability for the eye to fully change curvature of the lens and focus on objects close by.'* He said that when the eyes are paralysed by the use of eye drops, it is impossible to measure 'accommodation' because a patient's eye cannot change curvature. Mr B told the Committee that the Hospital *'measured near vision and the vision was very good.'* He said that this was carried out before the eyes had been paralysed and described how the patient had been assessed by the use of a card with text on, commonly known as a 'near vision test.'

58. In relation to Patient 4, Mr B told the Committee that he first became aware of this patient on the 4 November 2019. He said that he saw him at the Hospital on this day however his record is not included in the hearing bundle. He referred the Committee to Ms B's record, and she raised questions around the Registrant's prescription because it included varifocals and prisms.

59. Mr B went on to explain that when Patient 4 returned to the hospital on 21 January 2020, he tested their vision and had no orthoptic concerns. He was asked about an email that the Registrant had sent to the Hospital on 19 November 2019 and he was unable to understand the use of the prisms having regard to the eye assessments that he had carried out. He said that he advised Patient 4 and their parents to return to the Registrant, to have the Hospital prescription made up.

60. During cross examination, Mr B said that on the two occasions that he had assessed the patient's eyes he had not used a fixation disparity test. He said that he did not use this type of test and instead used a cover test. Mr B was referred to paragraph 29 of his witness statement and was asked if he agreed that misalignment that causes double vision needs addressing. He said that it would. He went onto say that if a patient presented with misalignment and did not present with double vision, the Hospital would not address it if the patient was symptom free.

Janice McCrudden

61. Ms McCrudden told the Committee that the content of her expert report dated 24 August 2023, addendum report dated 5 November 2023 and joint expert report with Professor Barnard dated 22 June 2025 all contained in the hearing bundle is true to the best of her knowledge and belief.

Patient 1

62. Ms McCrudden said that the evidence in the hearing bundle indicated that Patient 1 had been born in 2012. During the time period of the allegations relating to this patient, they were aged 8 – 11. Ms McCrudden said that Patient 1 had ASD and ADHD and communication issues. She had noted that the patient had been part

of an Educational Health and Care Plan which had indicated that they had *'special needs'*. During cross examination when it was put to Ms McCrudden that at the relevant time, Patient 1 had been attending a '*special needs'* school, Ms McCrudden said *'I don't think I had been aware of that.'*

63. Ms McCrudden told the Committee that when presented with a patient with Patient 1's needs, she would expect a practitioner carrying out an eye assessment to spend three or four times longer with the patient than they would when carrying out a standard assessment. She would expect the practitioner to use pictures rather than letters or words and to adapt the testing where appropriate. She said that sometimes they can be *'the easiest type of patient, but certainly one size does not fit all.'*

64. Patient 1 was described by Ms McCrudden as a child with concentration issues. She said that where a child patient struggles to focus, toys can often be useful and an Optometrist should ensure that they have the equipment and tools to examine young patients including those with '*special needs'*. She went on to say that sometimes appointments need to be short to allow for short periods of concentration and the patient will be asked to return on another day.

65. In relation to particular 1(a), Ms McCrudden said that Orthoptists do not always use the same terms as Optometrists. She said that Orthoptists use the term divergence insufficiency to describe a patient that cannot see objects at a distance because the eyes do not sufficiently diverge; convergence excess to describe when the eyes move too closely together to see an object that is close by; and accommodation insufficiency to describe where the eyes ability to change the curvature of the lens, the accommodation, is insufficient and the patient struggles to see objects that are close by.

66. Ms McCrudden said that she found the Registrant's notes that are relevant to particular 1(a) difficult to read. She said that there was often insufficient information to justify the findings. When she was asked about the Registrant's notes of the 30 June 2020, Ms McCrudden said that she could not see how the Registrant had arrived at his diagnosis. She said *'I cannot say if the diagnosis was wrong because there is no evidence to explain it. I read these notes along with the clinical records from the hospital and the assessment reports. I have to assume that if something is not recorded, it has not been done.'*

67. In relation to particular 1(b), Ms McCrudden was asked about the record for the 19 January 2021. When asked how she can allege a mis-diagnosis, she said that there was no evidence in the record to explain the diagnosis. She was therefore unable to say that the diagnosis had been correct or wrong.

68. In relation to particular 1(c), Ms McCrudden was asked if the record indicated that the Registrant had had a telephone call with the patient's parent on the 22 March 2022. Ms McCrudden said that she did not understand the record and if it had been a telephone call with the patient's parents, she would have expected the record to have made that clear. When she was asked if the record indicated that the Registrant made a diagnosis during that conversation, Ms McCrudden replied *'No, it does not appear that anything was done.'*

69. In relation to particular 1(d), Ms McCrudden was asked whether the record for the 25 November 2022 indicated that the Registrant had mis-diagnosed. She said *'I*

can't say whether the diagnosis was correct or not because there is no evidence to explain the diagnosis in the record.'

70. In relation to particular 2, Ms McCrudden said that the Registrant's notes were inadequate. She said *'the notes that have been written down do not relate to the prescription.'* When she was asked about particular 2(c) and the note from the 22 March 2022, Ms McCrudden said that she did not see a dispensing record in the note.

71. In relation to particular 3(a), Ms McCrudden said that a 'reasonably competent optometrist' would not necessarily record an entire discussion during an appointment. She would expect them to record a diagnosis, an explanation for the diagnosis and a prescription. Ms McCrudden said that the notes indicate that the Registrant carried out an assessment of distance *' .. and possibly a binocular assessment but it is not clear to me which one. I can see additions of prism which I don't understand. I can see that a partial binocular assessment seems to have been carried out but it is inadequate.'*

72. Ms McCrudden was asked to explain a Mallett test. She said that it is a binocular vision test to assess how well the eyes work together and a device *'that looks like an iPad'* reads the measurements for the practitioner. She said that a patient is asked to identify straight lines on the device. Ms McCrudden was asked if the measurements at the bottom might be the results of a Mallett test to which she replied *'I don't know because it doesn't say'*. It was suggested to Ms McCrudden that the notes indicated that measurements were taken that related to prisms to which she said *'I don't know, I can't interpret the record.'*

73. In relation to particular 3(b), Ms McCrudden said that she could see on the patient's record that a Mallett test was not conducted because it said 'no Mallett.' She described the record as *'confusing.'*

74. In relation to particular 3(c), when Mr Archer suggested to Ms McCrudden that the relevant record was a telephone call, Ms McCrudden said *'It's very confusing, you can't test for binocular vision over the telephone'*.

75. In relation to particular 3(d), Ms McCrudden was taken to notes dated the 25 November 2022. When she was asked if the circle on the record indicated that a type of binocular assessment had been carried out, she said *'Yes. Most people would write the name of the test that was done.'*

76. In relation to particulars 15 & 16, Ms McCrudden was asked if she was aware that some community optician practices offer enhanced optical services and she said that she was. She said that she recognised that in line with this type of service, sometimes patients would attend an appointment and there would be no need to carry out an eye examination. She said that where an eye examination is necessary, the practitioner should always carry out an internal and external eye test. Ms McCrudden said that she was not familiar with the enhanced optical service offered by Optical 3 at the relevant time. She had not been aware that for a monthly fee, a patient could attend an unlimited number of review and eye examination appointments within a specific period.

77. Ms McCrudden said that she understood that Patient 1 had attended the Registrant's practice on four occasions between 30 June 2020 – 25 November 2022. She was also aware that he had attended the hospital on the 9 June 2022; 28 June 2022; 12 September 2022; 3 October 2022 and 7 November 2022. She

told the Committee that she would not expect a full eye examination to be conducted at each appointment, whether that be at Optical 3 or at the Hospital. She said *'It would be unusual.'* Ms McCrudden went on to say that it would not be possible to conduct an internal or external eye examination over the telephone.

78. In relation to particular 23, Ms McCrudden said that the majority of patients, of any age, digest only a small amount of information during an eye appointment. She was taken to her report, and the reference to The College of Optometrists Guidance for Professional Practice. Specifically, the requirement to ask for written consent where an 'innovative treatment designed specifically for the patient's benefit is being advised.' Ms McCrudden said that she had regarded some of the words used by the Registrants in his patient records to be *'novel.'* Ms McCrudden referred to her notes and explained that the words 'This is likely to be associated with the stress caused by a muscle imbalance (divergence insufficiency) and the consequent stretching effect across the cornea' are *' .. novel words because I have not previously come across this as an explanation for an astigmatism. So for me, its innovative.'*

79. Ms McCrudden said that consent can be verbal or implied. She described that implied consent can occur when a patient rests their chin on a piece of equipment, to enable an eye examination to be carried out.

Patient 2

80. Ms McCrudden told the Committee that she was not familiar with the genetic disease that Patient 2 had. She recognised that Patient 2 had learning disabilities including a low comprehension and use of vocabulary. She said that she would expect an Optometrist to adapt their methods of testing for this patient.

81. In relation to particular 4, Ms McCrudden said that she had been unable to identify sufficient evidence in the Registrant's clinical notes to explain the prescription that he had issued. She said *'I can't see anything to justify the diagnosis at all. There should be reasons behind what you are doing. There has to be a follow through explaining why you have got somewhere.'*

82. When she was asked if she could see the words 'divergence excess or convergence insufficiency' between the relevant dates, Ms McCrudden considered the clinical notes for each appointment. She said that she could not see these words in any of the Registrant's notes however in the clinical notes of the 29 December 2012 and 18 January 2014, the Registrant had recorded 'convergence weakness.' Ms McCrudden said that the notes were mostly illegible.

83. In relation to particular 5, Ms McCrudden told the Committee that for the dates specified in the particular, the Registrant had not provided evidence to explain why he had prescribed varifocal lenses or prisms. When she was asked to consider the Registrant's clinical note of the 18 January 2014, Ms McCrudden said that it appeared from the words 'lag +1' that there may have been a reason for prescribing a varifocal *'but it had not been acted on. This prescription had a prism in it which I did not understand but no varifocal. The patient management was very confusing for me.'*

84. In relation to particular 6, Ms McCrudden said that she could not see an adequate record of a binocular vision assessment for the relevant clinical records. She

referred to the joint expert report and said that for some of the records, minimal information had been recorded, and for the majority of the notes she had been unable to follow the Registrant's decision making. Ms McCrudden told the Committee that if tests had been attempted and the patient had not engaged, she would have expected to have seen this recorded in the notes. She went on to say that whilst there were some measurements in the notes, there was often no indication to explain how these measurements had been obtained. She said that she found all of the clinical notes for the relevant days difficult to follow and *'there is not enough logic.'*

85. In relation to particular 7, Ms McCrudden said that there was no explanation in the Registrant's clinical notes to explain his findings and this was why in the joint expert report, she and Professor Barnard had determined that there had been a misdiagnosis.

86. In relation to particular 8, Ms McCrudden was asked whether an 'urgent' referral had been reasonable in all the circumstances. She said *'I would have thought that he would have sent them to casualty. The patient needed to be seen as a matter of urgency or as an emergency.'*

87. In relation to particulars 17 and 18, Ms McCrudden said that in her opinion, not all optometrist appointments with a patient, will require an external and/or an internal eye examination. She said that the Registrant's clinical notes do not explain why the eye examinations were not carried out on the relevant dates.

88. In relation to particular 25, Ms McCrudden said that Patient 2 was prescribed prisms and whilst this may not be 'novel' in itself, she considered that it may be 'novel' because she could not understand the reasons behind the prescription.

89. Prior to concluding his questions about Patient 2, Mr Archer asked Ms McCrudden about images that she had provided overnight, to the Committee. She explained that the circle with a cross in the middle was an alignment test. Ms McCrudden described the device similar to an iPad device was a Mallett device, and the video explains a cover test.

<u>Patient 3</u>

90. In relation to particular 9, Ms McCrudden was asked whether she could tell the Committee that the 'diagnosis was wrong' for the clinical note on the 17 September 2022. Ms McCrudden said *'I can't establish that.'*

91. In relation to particular 10, Ms McCrudden was asked whether she can say with any certainty that the prescription had not been 'clinically indicated.' Her response was *'I can see an indication for the reading addition. I can't see any justification for the prism.'*

92. In relation to particular 11, Ms McCrudden was taken through the Registrant's clinical notes for the relevant dates. She said that she did not recognise some of the terms used by the Registrant and the words that she could read, did not describe how binocular vision had been assessed. Ms McCrudden was asked if she was familiar with the 'Miles' test and she said that she was not. She was also asked if the measurements in the clinical notes may have been obtained using a Mallett test and she said *'it could be, but I don't know.'*

93. In relation to particulars 19 and 20, Ms McCrudden accepted that according to the clinical note, Patient 3 had been seen by the hospital ten days before the relevant appointment with the Registrant. She was asked whether in those circumstances it would have been appropriate to carry out a further eye examination by the Registrant to which she said *'You can develop complications in that time but another eye exam may not have been necessary. I do not know whether the Registrant had had access to the hospital records. If he had not had access, I would have wanted to know about the eye test results before I made a decision about whether or not to do an examination.'* Ms McCrudden acknowledged that the relevant clinical notes demonstrated that the Registrant had carried out a *'check of the eye muscles and an observation of the patient's external eye. I wouldn't term it as an external eye test.'*

94. In relation to particular 27, Ms McCrudden said that when the Registrant prescribed tinted lenses, that he would have required consent to do that. She told the Committee that in her opinion, it was not a standard prescription.

Patient 4

95. Ms McCrudden said that the relevant clinical notes prepared by the Registrant indicated that it was unclear whether Patient 4 had presented with headaches or not. She went on to acknowledge that the patient's sister had an eye that turned inwards.

96. In relation to particular 12, Ms McCrudden said that the Registrant's records had been insufficient. She said that she could not see any justification for the diagnosis of 'convergence insufficiency.'

97. In relation to particular 13, Ms McCrudden told the Committee that in her view, the information in the Registrant's record did not explain the clinical management. She said that she could not say that the prescription had been 'wrong' or 'right' because the record contained insufficient information.

98. In relation to particular 14, Ms McCrudden said that she could see from the relevant notes prepared by the Registrant that he had collected some measurements of the patient's eyes. She went on to say that for some of the measurements, she could not understand what the measurement related to. When she was taken to the various records Ms McCrudden said, '*There is some recording in these notes but they are inadequate in terms of explaining the prescriptions that followed.'*

99. In relations to particulars 21 and 22, Ms McCrudden said that in terms of the appointment on the 1 August 2018, there is a record of an external eye examination. For the appointment record of the 27 November 2018, Ms McCrudden said that the Registrant's record is *'not ideal but I'm not overtly critical.'* She went on to say that internal eye examinations were recorded by the Registrant for the appointments on the 1 August 2018 and the 17 November 2018.

100. In relation to particular 31, Ms McCrudden said that poor eye tracking can affect a person's ability to read. She also said that a person with a learning disability is *' …more prone to a vision anomaly.'* Ms McCrudden went on to say that Optometrists are not trained in diagnosing Dyslexia and *'referring the patient on would have been the right thing to do.'*

101. In relation to particular 31(ii) and (iii), Ms McCrudden said *'I don't know if Mr Griffiths has done any dietary training but giving this type of advice is not within our training as Optometrists. I think it would be very ill-advised for an Optometrist to give advice on a subject that they are not trained in.'*

102. During re-examination, Ms McCrudden said that in terms of whether the Registrant had carried out internal and external eye examinations, she would have expected to have seen in his records an explanation for why he prescribed a prism or any other non-standard prescription.

103. In terms of whether an examination of binocular vision was carried out, Ms McCrudden said that in the Registrant's notes she would have expected to have seen a recording of distance vision.

104. In relation to particular 7, Ms McCrudden said that there was no information in the Registrant's records to explain why the vision had presented in the manner suggested. She said that the vision assessment recorded such a low visual acuity that she would have expected Patient 2 to have been unable to walk unaided into the examination room. Ms McCrudden said that sometimes patients say that they cannot see something when it is possible that they can. She would have expected the Registrant, in the circumstances, to have carried out further tests upon recording such low vision, to ascertain whether it was accurate.

105. In relation to particular 8, Ms McCrudden told the Committee that if Patient 2 had been her patient, she *' …may have called eye casualty. Maybe Mr Griffiths saw the patient walk across the room so he made an urgent referral rather than sending them to A&E. Maybe there were other reasons which were not recorded. An Optometrist should be alive to seeing if the inability to read is genuine.'*

106. In relation to particular 12 and the diagnosis of 'conversion insufficiency' Ms McCrudden said that she could not see in the Registrant's notes, how he had arrived at this diagnosis. She gave the same evidence when she was asked about 'accommodation insufficiency.' She went on to say *'Only the note of the 1 August 2018 shows how the diagnosis had been reached.'*

107. In response to questions from the Committee, Ms McCrudden said that she was familiar with the Brock String test, but it was not a test that she used. She said *'I think hospitals use it for convergence insufficiency, I know it more as a treatment than a diagnostic test. I don't know how it is used as a test.'*

108. When she was asked about the Howells test, Ms McCrudden told the Committee that she knows very little about it and *'It's not commonly used as far as I am aware.'* When she was taken to various records and asked if the references indicated that a Howells test had been used, Ms McCrudden said *'I don't know. It's essential to know which test was performed from looking at the records. Some of the notes indicate that a particular test may have been done but they should be specific.'*

109. The Committee asked about particular 15 and Ms McCrudden's opinion about how many times the Registrant should have carried out internal and external eye examinations during the relevant period. She said that the statutory guidance suggests that children should have a sight test every six months however she would not criticise annual checks.

110. The Committee asked about a Mallett test and Ms McCrudden said that it could detect a smaller sight deviation than a cover test. When she was asked if a Howells test could also detect a smaller sight deviation she said *'I don't know, I have never used it.'*

111. When she was asked about a prism, Ms McCrudden said that whether a patient would find a prism a more comfortable lens, she said that this could differ from one day to the next. She told the Committee that a *'small amount of prism is unlikely to do any harm'.* Ms McCrudden said that she would not have criticised the use of the prism if the notes had provided a rationale to support the prescription.

112. Ms McCrudden was asked about Patient 2 and the consultations on the 23 November 2018 and the 23 July 2022. She said that in her opinion, the Registrant had adapted the eye examinations to be age appropriate.

113. Mr Archer, asked some further cross examination questions on behalf of the Registrant. He asked Ms McCrudden if she agreed that there is a difference in recording a test result, and providing a diagnosis. She agreed and added *'You have to understand the results of a test to form a diagnosis.'*

114. Mr Archer asked if it was possible to detect fixation disparity by carrying out only a cover test. Ms McCrudden told the Committee that as far as she is aware, fixation disparity can be detected by a cover test. She acknowledged that fixation disparity can be the cause of a headache but said that additional information would be required to understand the cause. Ms McCrudden said that tired eyes and double vision can be symptoms of fixation disparity and that some of these symptoms can occur where the patients vision is *'very slightly out.'*

115. When Mr Archer asked if Ms McCrudden agreed that only a small number of Optometrists are trained in Dynamic Retinoscopy she replied *'No. It's used a lot with children. It gives you a good result without any patient involvement. A significant and growing number of Optometrists are using it.'*

116. On day five of the hearing, the Committee decided that it was appropriate to consider amending particulars 1 – 6 and 12 - 22. This was during the witness evidence from Ms McCrudden as the Committee felt that it may assist the Registrant to prepare additional questions if the amendments were made at this stage. The Legal Adviser informed Ms Hinton, and Mr Archer of the Committee's intention to hear submissions prior to it being raised in the hearing and explained the proposed amendments. The parties were given sufficient time to prepare submissions.

117. In the hearing, the Committee informed the parties of its concerns regarding certain particulars and how the cross examination of Ms McCrudden had appeared to focus on the dates alone in the medical evidence and not the totality of all the additional evidence. The Committee expressed the view that particulars 1 - 6 and 12 - 22 contained various dates, which were so voluminous that they left the particular unclear as to whether all the specific dates had to be found proved or just the offending in the particulars. The Committee asked the parties whether they agreed that the conduct of the Registrant in terms of mis-diagnosing, or wrongfully prescribing or failing to record was key, rather than the actual dates on which the conduct allegedly occurred. The Committee indicated that the evidence related to the spanning of a particular period as opposed to the specific dates that

appeared in the current particulars. The Committee was somewhat surprised that this had not been picked up by the Council.

118. The Committee informed the parties that the proposed wording for particular 1 was;

    1. *Misdiagnosed Patient 1 with divergence insufficiency and/or convergence excess and/or accommodation insufficiency between the dates of the 30 June 2020 – 25 November 2022.*

120. The Committee indicated that it was considering amending each of the particulars at 1 - 6 and 12 - 22 in the same manner.

121. Ms Hinton, on behalf of the Council, endorsed the Committee's view in terms of amending the particulars. She said that no unfairness ought to be caused to the Registrant with the proposed amendments because it will not involve a material change, and the Registrant has long been aware of the Council's case.

122. Mr Archer objected to the proposed amendments. He said *'the goalposts are constantly changing. There is no new evidence to justify the making of any amendments.'* He submitted that the amendments would be unfair because they have arisen due to errors by the Council and *'allowing the amendments will send out the wrong message.'*

123. The Committee received and accepted legal advice from the Legal Adviser. She referred the Committee to rule 20 of the FTP Rules which provides:

> *(20) Where it appears to the Fitness to Practise Committee at any time during the hearing either upon the application of a party or of its own volition, that –*
>
> *(a) the particulars of the allegation or the grounds upon which it is based and which have been notified under rule 28, should be amended; and,*
>
> *(b) the amendment can be made without injustice,*
>
> *It may, after hearing the parties and consulting with the legal adviser, amend those particulars or those grounds in appropriate terms.*

124. The Legal Adviser said that the Committee ought to have regard to its powers, its overarching objective, and its inquisitorial role. She referred the Committee to the case of *PSA v HCPC & Doree* [2017] EWCA Civ 319 which was upheld in *Gleeson v Social Work England* [2024] EWHC 3 (Admin). She advised that *Doree* and *Gleeson* state that of paramount importance is the balance for the Committee in terms of avoiding injustice for the regulator and injustice for the registrant. In *Doree,* the allegation was amended to become more closely aligned with the regulator's evidence.

125. When considering fairness or injustice for the Registrant, the Committee was advised to have regard for whether the proposed amendment would have a material change on how the Council brings its case. This was explored in the case of *Ahmedsowida v General Medical Council* [2021] EWHC 3466 (Admin) when the tribunal amended the charges of its own volition after closing submissions on the facts. The amendment was opposed by the Registrant who said that they would have presented their case differently. The Appeal Court found that there had been no material change to the allegations following the amendment and the registrant

had known the case that they had had to meet. It was also found that the lateness of the amendments did not necessarily mean that it was unjust. The appeal court decided that the tribunal's decision that the amendments could be made without injustice had not been procedurally unfair.

126. The Committee was advised to consider the nature of the proposed amendments and whether they represented a material change to the case that the Registrant has to answer. If it decided that on balance it was a material change, it may be appropriate to consider adjourning the hearing to enable the parties to fully prepare their case. If the Committee determines that it is not a material change, it should consider whether there would be any injustice or unfairness caused to the Registrant in continuing with the hearing. The Legal Adviser reminded the Committee that the first of two expert witnesses was in the process of being cross examined by Mr Archer.

127. The Committee considered the submissions from Mr Archer and Ms Hinton. It reminded itself of the evidence in the bundle and the core alleged misconduct. The Committee considered that Mr Archer, in his questions to Ms McCrudden had focused on the specific dates rather than whether the alleged misconduct had occurred although it recognised that it was a matter for Mr Archer as to how he put the Registrant's case, but that it confined the Committee to a limited perspective on the evidence and the allegations. The Committee noted that it was not proposing to introduce new evidence or a new line of enquiry and it was satisfied that if it amended particulars 1 – 6 and 12 – 22, that the Registrant would be clearer about the case that he had to answer. It went on to acknowledge that it would provide Mr Archer with sufficient additional time to prepare his questions for Ms McCrudden, in light of the proposed amendments, should he require it.

128. The Committee determined that the proposed amendments would properly reflect the evidence. It reminded itself that the Council's evidence consisted of several different sources and the documents ought to be considered alongside each other which would enable the Committee to hear the totality of the evidence. It decided that in introducing the amendments, there ought to be no material impact on the evidence and no unfairness or injustice to either the Council or to the Registrant and any prejudice could be mitigated by offering the Registrant time to prepare for the amended particulars.

129. The Committee concluded that in the circumstances and in line with its overarching duty to protect the public, including the public interest, it was necessary and fair to amend particulars 1 – 6 and 12 – 22.

130. Particular 1 will therefore read as follows:

    1. *Misdiagnosed Patient 1 with divergence insufficiency and/or convergence excess and/or accommodation insufficiency between the dates of the 30 June 2020 – 25 November 2022 inclusive.*

131. The Committee determined that for particulars 2 - 6 and 12 - 22, the framing of the Allegation will follow exactly the same pattern.

132. Upon announcing its decision in the hearing, Mr Archer requested some time to prepare his remaining questions for Ms McCrudden, which the Committee agreed to.

Allegations (as amended)

The Council alleges that you, Mr Geraint Griffiths (01-10586), a registered Optometrist:

1. *Misdiagnosed Patient 1 with divergence insufficiency and/or convergence excess and/or accommodation insufficiency between 30 June 2020 and 25 November 2022 inclusive.*
2. *Prescribed Patient 1 spectacles with varifocal lenses and/or prisms when it was not clinically indicated to do between 30 June 2020 and 25 November 2022 inclusive.*
3. *Failed to record, adequately or at all, the assessment of Patient 1's binocular vision between 30 June 2020 and 25 November 2022 inclusive.*
4. *Misdiagnosed Patient 2 with divergence excess and/or convergence insufficiency between 29 December 2012 and 23 July 2022 inclusive.*
5. *Prescribed Patient 2 spectacles with varifocal lenses and/or prisms when it was not clinically indicated to do between 29 December 2012 and 10 July 2020 inclusive.*
6. *Failed to record, adequately or at all, the assessment of Patient 2's binocular vision 29 December 2012 and 23 July 2022 inclusive.*
7. *On or around 23 July 2022 misdiagnosed Patient 2's vision as less than 1/60 in the left eye and/or the right eye.*
8. *On or around 23 July 2022 failed to refer Patient 2 on a same day basis and/or to seek advice on Patient 2's management.*
9. *Misdiagnosed Patient 3 with divergence excess and/or convergence insufficiency and/or accommodation insufficiency on 17 September 2022.*
10. *Prescribed Patient 3 spectacles with varifocal lenses and/or prisms when it was not clinically indicated to do on 17 September 2022*
11. *Failed to record, adequately or at all, the assessment of Patient 3 's binocular vision between 28 July 2022 and 17 September 2022, inclusive.*
12. *Misdiagnosed Patient 4 with divergence excess and/or convergence insufficiency and/or accommodation insufficiency between 1 August 2018 and 18 February 2020 inclusive.*
13. *Prescribed Patient 4 spectacles with varifocal lenses and/or prisms when it was not clinically indicated to do between 1 August 2018 and 18 February 2020 inclusive.*
14. *Failed to record, adequately or at all, the assessment of Patient 4's binocular vision between 1 August 2018 and 18 February 2020 inclusive.*
15. *Prior to prescribing spectacles failed to carry out an external and/or internal examination of Patient 1's eyes between 30 June 2020 and 25 November 2022, inclusive.*
16. *In the alternative to 15. above you failed to record the external and/or internal examination of Patient 1's eyes between 30 June 2020 and 25 November 2022 inclusive.*

17. *Prior to prescribing spectacles failed to carry out an external and/or internal examination of Patient 2's eyes between 27 April 2013 and–10 July 2020, inclusive.*

18. *In the alternative to 17. above you failed to record the external and/or internal examination of Patient 2's eyes between 27 April 2013 and 10 July 2020, inclusive.*

19. *Prior to prescribing spectacles failed to carry out an external and/or internal examination of Patient 3's eyes between 28 July 2022 and 17 September 2022, inclusive.*

20. *In the alternative to 19. above you failed to record the external and/or internal examination of Patient 3's eyes between 28 July 2022 and 17 September 2022, inclusive.*

21. *Prior to prescribing spectacles failed to carry out an external and/or internal examination of Patient 4's eyes between 1 August 2018 and 18 February 2020, inclusive.*

22. *In the alternative to 21. above you failed to record the external and/or internal examination of Patient 4's eyes between 1 August 2018 and 18 February 2020, inclusive.*

23. *Between 4 February 2020 and 25 November 2022 did not obtain informed consent from Patient 1's parent/s in that you did not explain, adequately or at all, the evidential basis of the treatment.*

24. *In the alternative to 23. above failed to record any discussions held with Patient 1's parent/s in relation to the obtaining of informed consent.*

25. *Between 29 December 2012 and 23 July 2022 did not obtain informed consent from Patient 2's parent/s in that you did not explain, adequately or at all, the evidential basis of the treatment.*

26. *In the alternative to 25. above failed to record any discussions held with Patient 2's parent/s in relation to the obtaining of informed consent.*

27. *Between 28 July and 17 September 2022 did not obtain informed consent from Patient 3's parent/s in that you did not explain, adequately or at all, the evidential basis of the treatment.*

28. *In the alternative to 27. above failed to record any discussions held with Patient 3's parent/s in relation to the obtaining of informed consent.*

29. *Between 1 August 2018 and 18 February 2020 did not obtain informed consent from Patient 4's parent/s in that you did not explain, adequately or at all, the evidential basis of the treatment.*

30. *In the alternative to 29. above failed to record any discussions held with Patient 4's parent/s in relation to the obtaining of informed consent.*

31. *Acted outside the scope of your expertise in that:*

    i. *On or around 1 August 2018 you advised Patient 4's mother that Patient 4 had and/or was predisposed to dyslexia;*

ii. *On or around 1 August 2018 you provided dietary advice in respect of Patient 4 to their mother in that you recommended a book named the Plant Paradox;*

iii. *On or around 1 August 2018 you provided dietary advice in respect of Patient 3 to their mother in that you recommended a book named the Plant Paradox.*

As a result of the matters set out above your fitness to practise is impaired by reason of your misconduct.

Application of no case to answer

133. At the end of the Council's case, Mr Archer provided a written submission that there was no case for the Registrant to answer in relation to particulars 7, 8 and 31(iii). He took the Committee through the skeleton and said that the Committee is being asked to determine whether there is sufficient evidence to support the particulars.

134. Ms Hinton told the Committee that she accepted that in terms of particular 7, there was no evidence to indicate an inaccurate recording by the Registrant. She said that she will leave the remaining elements of this particular to the Committee to assess. Ms Hinton submitted that the remaining particulars were supported by evidence and taken at its highest, there was a case for the Registrant to answer.

135. The Committee received and accepted legal advice from the Legal Adviser who advised that rule 46(8)(a) of the Rules permitted the Registrant to make submissions about the sufficiency of evidence to prove the factual allegations. The Committee has an obligation now that those submissions have been made to consider the application.

136. The Legal Adviser referred the Committee to the leading case authority of *R v Galbraith* [1981] 1WLR 1039 and the questions that the Committee should ask itself. The Committee was also directed to *R (on the application of Metropolitan Police Commissioner) v Police Misconduct Panel* [2025] EWHC 1462 (Admin), which endorsed and applied the test laid down in *Galbraith.* The Committee was advised that the following approach should be followed by the Committee:

    (a) If there is no evidence to prove an essential element of the offence, a submission must succeed;

    (b) If there is some evidence which taken at face value establishes each essential element, the case should normally be left to the jury.

    (c) If however, the evidence is so weak that no reasonable jury properly directed could convict on it, a submission should be upheld.

137. The Committee considered particular 7. It noted that the Allegation was that the Registrant had 'misdiagnosed.' The Committee had regard for the documentary evidence including the relevant patient record and the Council's opening skeleton. It found that the record by the Registrant was a measurement, it was not a diagnosis. The Committee had noted that in the joint expert report, both of the experts had stated that the Registrant had had a duty to record the results of eye tests, including measurements. The Committee had not been presented with any evidence to suggest that the Registrant's recorded measurements had been inaccurate or obtained by using an inappropriate means of testing.

138. The Committee for these reasons, found that there was no evidence upon which this particular could be found proved and upheld the application that there was no case to answer in relation to particular 7.

139. The Committee went on to consider particular 8. It considered the joint expert report and noted that in their opinion a same day referral had been sufficient, in the circumstances. This had been supported by Ms McCrudden's oral evidence. The Committee had regard for the fact that the patient had been known to the Registrant for approximately ten years prior to the relevant appointment and their history would therefore be known to him.

140. The Committee determined that the evidence in support of this particular was 'inherently weak' such that no reasonable Committee would find it proven. For this reason, the Committee upheld the application that there was no case to answer for particular 8.

141. In terms of particular 31(iii), the Committee considered the evidence and found that it had no evidence to suggest that the Registrant had had any contact with Patient 3 or their mother in 2018. Ms Hinton, on behalf of the Council had submitted that the first contact with Patient A and their mother had been in 2022 and the Allegation ought to have read the 1 August 2022. The Committee determined that in the interests of fairness that amending the particulars after all the evidence had been called could be prejudicial to the Registrant. The Committee acknowledged that it could recall witnesses, but considered that at this late stage it could still lead to confusion and prejudice to the Registrant. It therefore concluded that it should consider the Allegation as it had been presented by the Council.

142. In the absence of any evidence to support the particular, the Committee upheld the application and determined that there was no case to answer in relation to particular 31(iii).

The Registrant

143. The Registrant described his career to the Committee. He said that he was the Managing Director of [redacted] Limited, and he was the Chair of a group primarily focused on the connection between sport and school vision. He was taken through the first few paragraphs of his witness statement and confirmed that he had been in registered practice for almost forty five years.

144. The Registrant went on to say that he had been the author of several research papers, predominantly in the field of sports vision, for which he had a particular interest. He also informed the Committee that he has written over forty articles for optical journals.

145. During his evidence in chief, the Registrant was taken through his witness statement. He was asked to explain how he tested binocular vision. And told the Committee that he often uses a LogMAR chart. He said that he had personally devised *'a specific battery of tests which is why some of my notes look as they do.'*

146. The Registrant said that there are various types of tests that he used for school age children. He described the fixation disparity test as *'a wonderful test.'* He explained that the test enables an Optometrist to measure '*in real time what is happening to the right and left eye in the visual cortex'*. He said that symptoms of a 'stressed' visual system are often headaches, double vision, blurry eyes and dry eyes. He said that he does not ask patients to complete a questionnaire about their symptoms before the consultation and he *'asks them on the spot to save time.'*

147. He described 'divergence insufficiency' as a condition where the eye is unable to turn sufficiently outwards. He said that he would detect it by using a Mallett test, and it may be addressed by a prism.

148. In terms of 'convergence excess' the Registrant described it as a condition where the eyes '*over converge'* and turn inwards. He said that he would address this with *'plus power lenses.'*

149. The Registrant described 'accommodation' as *'The eye's ability to bend a lens when trying to focus on a near object.'*

Patient 1

150. The Registrant said that sometimes he thought that the patient said what she thought the Registrant had wanted to hear. He would therefore often check her answers to his questions by repeating them or asking them in a different way.

151. The Registrant told the Committee that [redacted] provided a private eye care plan for patients and this patient had always been part of the plan. He said that the initials 'EP' recorded in the patient notes, indicate that the patient was part of the eye care plan.

152. Mr Archer took the Registrant through the patient records that he had created. The Registrant explained the entries to the Committee:

> 30 June 2020: *'She was seeing double without her glasses. She had had a squint without her glasses but now has an alternating squint. She then told me about her symptoms. I was then told about her personal and family history; that she was not on any medication, and that she was a new patient.'*
>
> *'I examined the patient and recorded the LogMAR readings which means that I measured her vision. ESO is the cover test, and means inwards and she has a very small squint. The 0.5 and 0.6 is the vision measurement using the LogMAR chart. My writing isn't very good. I think it says 'log' on there. MOT means 'motility full' which tells me that they could follow a target such as my pen, with no issue. This is part of an external eye check. LH means left hand and LF means left foot and I can see very strong right eye dominance. RRRR is the response to the dominance test. I can see that I asked questions about dominance and close to face means that they are holding their hands very close to their face.*
>
> *The words difficulty with L or R tells me that I have seen the patient trying to work out which is their left or right hand. The test for eye dominance is important because it allows me to understand the significance of binocular results and how a patient's disability might affect their reading. CP means that I have carried out an eye bright test and 20 SOP means that I have measured 20 dioptres from a cover test. This is a result of a binocular assessment. It is also a preliminary assessment. The record 1:15.65 is a measurement of the patient's ability to read characters instead of words. It is called a Crest test and I developed it. The reference to LSOT is the Brock String test which you could equate to the Mallett test. I use it to test for fixation disparity.*
>
> *I can see that I put a prism in front of the patient's eye to help her read the characters because it says OMB. This is objective muscular balance and it is another record of a binocular test.'*
>
> *'DFT is a dynamic fixation test which measures near and far tracking. I use a hand held chart with numbers arranged in various angles. You look through it*

at another chart of numbers. I helped to develop this test and patented it. It helps us understand how patients cope with cognitive issues. I can see that the patient understood the test very well and I have recorded six over twelve which means that I should check the prism in six months' time.

The next measurements are not very clear. I can see that I have used the patient's own prescription to measure binocular vision with a cover test. On the right is their own prescription and the circle with the lines through it means that I have discovered Orthophoria in the distance using the cover test. I did not do a near vision test according to these notes.

The HC measurements relate to the patient's reading speed and I can see that there is a 2.00 add. The recording of 48.87 is another reading test and 2 out to Comp tells me that they had a strong right eye dominance and a vertical phoria which could be remedied by a prism. The +6.50 measurement is the prescription with an addition and 6 over 9 means that their vision is a little bit worse than normal vision. LSOT is Esotropia and a squint and 25 and 15 is an estimate, using a cover test of the prism without the patient wearing their glasses. These notes show the variability of the patient's vision.

I repeated the cover test and the notes say that stayed on the same line which means there was a small improvement. At the bottom is the prescription which says it includes multifocal lenses.

There is no record in these notes of an internal eye examination. The purpose of the appointment was to discuss the problems the patient was having with their glasses. They had been discharged from hospital because there had been no 3D vision. I had a suspicion of binocular disability. I did not always undertake an eye examination at every patient consultation.'

153. Mr Archer asked the Registrant about the Vision Assessment Report for Patient 1 and the Registrant said that he prepared this type of report as and when it was needed, and the patient or their parents pay a fee. He said that this report dated 14 July 2020 recorded a prescription with a prism in the right eye. He said that the report must have been asked for by the patient's parents, following the consultation on the 30 June 2020.

154. The Registrant referred to the concluding comments in the report, and said that accommodation insufficiency had been diagnosed because the patient's focusing had been weak, and he had found this having measured the patient's accommodation facility. He said that he will have placed a binocular add in front of the patient and asked them if the add improves the image that they are looking at or not. He said that he will continue to add a reading addition until the patient says that their vision is not improved.

155. 19 January 2021: The Registrant told the Committee that the purpose of this consultation was to check the patient's binocular vision, and the prism. The Registrant explained the entries in the patient record,

'Things good, glasses have helped. Confidence seems to have improved. Still getting the odd slip, relates to balance.

The there is an assessment of distance and reading. There was a slight improvement in reading which could be due to age and/or his confidence in

trusting his eyes. I did a retinoscopy whilst the patient was wearing his glasses. It says there was no prism subjectivity which means that I tested it subjectively by asking questions. I must have removed the prism and it didn't seem to upset him.

The letters RCYCL mean that I looked with the retinoscope and saw an astigmatism. I didn't specify the amount. I can see that the left eye showed little change but there was an astigmatism. The left eye showed suppression with a near Mallett test. This is a worry because it is difficult to tell whether he needs the prism or not. It suggests that he is suppressing the vision to avoid double vision. I can see that I have carried out a binocular review.

Below that is my final prescription and a prescription for the astigmatism. I can see that he still needed the addition. The letters EP mean that he was paying for the eye plan with a 25% discount.'

156. The Registrant said that he did not carry out an internal or external eye examination during this consultation. He said *'I didn't do the examinations however when you do a retinoscopy you can detect the level of acuity. It gives you a feel for the health of the eye.'*

157. 6 June 2021: The Registrant said that this consultation note had not been prepared by him. He pointed out that the date on the note is the 2 June 2021. The Registrant told the Committee that according to the note, his colleague had included a prism into the prescription and *'put it back. This indicates that it was helpful to the patient.'* He said that the entry 'OPH media clear' suggests that an internal and external eye examination was carried out. The Registrant told the Committee that he will have had access to these notes at the relevant time. When he was asked about the Vision Assessment Report dated 14 July 2021, the Registrant said that he could not explain why he had prepared it. He said in preparation for the report, he would have taken all previous records for this patient into account.

158. The Registrant was asked about the Functional Vision Assessment, and he said that it is a special educational needs type report to assist the patient's school in understanding the patient's visual needs. He said that the patient's mum was very proactive and she will have obtained this report.

159. 23 March 2022: The Registrant told the Committee that this was a telephone call and he believed it to have been *'out of the blue.'* He said that he had been listening and writing at the same time. He told the Committee *'I probably asked what happened and when, and about any changes in school because mum has rung me to tell me that he has got a sudden onset of double vision. I remember it distinctly because I had thought that he was doing fine. I made a note of what she said to me. I have written 'swap dominance' because these were my thoughts at the time. I didn't say for certain what was happening but I asked her some questions. She said that his eye had been wandering again and I'm pretty sure she told me that there had been no head trauma. Covid was an issue because he had been away from school and the outcome was that she went to the hospital.'*

160. When the Registrant was asked about the Vision Assessment Report dated 11 April 2022, he said that he had not seen the patient since receiving the telephone call from his mum on the 23 March 2022. He told the Committee that his diagnosis which was in the report, had been based on earlier assessments and the patient's

most recent prescriptions. He told the Committee that the patient's mum had asked him to prepare the report. The Registrant said that the document, is a prism referral form dated 13 April 2022 which will have been completed by the patient's GP and sent on to the hospital.

161. 25 November 2022: The Registrant explained the entries in the patient record:

> *'Went to GP. Referred to eye specialist. CV1 is a certificate which gives people help with low vision and mum wanted to see if the school could help and the certificate gives the school financial support.*
>
> *Didn't get better. Went back to the glasses that we had supplied. Functional visual loss. Brain not connecting to eye properly. Couldn't get on without prism. Then just the tint suggests the hospital removed the prism and left the tint in. I think the patient had an ECG. I think this did happen. I have written EHCP, I forget what that is. Its to do with the school being unhappy with the cane. I am struggling to read my own note but it seems to say cannot justify with relatively good acuities. I can see that I have said that it may help to stabilise because of the binocular issue and I think I was referring to the cane. It seems to be a history.*
>
> *At page 151, this is a continuation of the same visit. OCT means that there has been a detailed look at the retina, disc and field of vision. The hospital did that check and it confirmed that there was nothing wrong with the patient's vision. The patient was advised by the hospital to go back to wearing our glasses and strongly advised a psychological assessment.*
>
> *For me, it was with the binocular vision that the patient was having some hiccups. It was a shame, I was sorry for the patient.*
>
> *The numbers six over eighteen and twenty four are the patient's prescription and the circle with the lines through shows that I did a cover test. I have recorded Anatomical L Hyper which means that one eye is physically higher than the other which can cause vision issues. The words No add indicate that when I showed him the addition, the patient didn't need it. And then I've written a prescription with prisms for both eyes. I would have used a Mallett test. It says Chart 2 and records a reading speed. CP Blue means that I did an Eyebrite test and his colour preference was blue and the test suggested that a tint was still needed, but a lighter one.'*

162. The Registrant told the Committee that the purpose of the consultation had been to *examine* the patient in preparation for report for the hospital which the patient's mum had asked for. The Registrant said that he did not carry out an internal eye examination during the consultation because *'the hospital had already conducted a very thorough examination using better equipment than mine.'*

Patient 2

163. The Registrant told the Committee that Patient 2 had been around five years old when he carried out her first eye examination. He described her as a child as *'bubbly, bright, enthusiastic and could not see very well.'*

164. 29 December 2012: The Registrant explained the entries in the patient record:

I have written that the patient was struggling to read in year one. The patient can see pictures but not the words. I then provide a background history for this patient. I can see from the figures three over six that I carried out a Sheridan Gardiner test which gives me a reasonably good result. It's a test that asks a patient to identify pictures at 3 metres. I can see that I carried out a cover test and the patient resisted me covering her right eye. I assumed this meant that their right eye was dominant. My assessments however showed that the patient's left eye was the dominant one.

CTN difficult means that when I carried out the cover test, I saw that the patient had a wandering left eye and it was moving so much that I couldn't test it. Tracking losses means that her eyes were very unstable. The words 'can see N12 letters individually' is probably my speed reading test.

At page 188, I can see that I carried out a subjective test, largely based on retinoscopy. It is another example of a binocular assessment. And then I can see a prism measurement. I felt that the patient had real trouble seeing binocularly and I wanted to try and do something. I tried a reading add and a prism to help with convergence. My choices were to do nothing and refer the patient to the hospital or to try and help which is what I did. The poor kid had some sort of congenital problem and I thought I would try and help. I was teetering on a referral but I decided not to, and to monitor instead.

I have recorded that the patient's eyes tended to wander off. I used the retinoscope here and I probably tried the ophthalmoscope but couldn't get anywhere. I have recorded that the patient's visual development is impeded by their medical history. Also, that all systems accommodation or convergence was weak. This means I had a look in the eye and didn't get anywhere. The words Try for NV mean that I didn't find a distance prescription but I could come up with a prescription that would assist the patient with reading a bit.'

165. 27 April 2013: The Registrant said that the purpose of this visit was a review. The Registrant explained the entries in the patient record:

'No progress with reading. Diagnosed with learning difficulties. I then record her current circumstances. I can see that an ophthalmoscopy was attempted but I couldn't do it because her eyes were still wandering. This meant I tried but could not complete an internal eye exam. I have noted that the patient is going strong with being gluten free, I have a real interest in nutrition. Their binocular vision is worse without her glasses and the patient's gaze is very unsteady. A retinoscopy was done and they were just seeing the odd letter with their specs on. I used a prescription with an add, and a prism for near vision.

There is no cover test recorded here. I think I would have written it down if I had done it. I was focusing on other matters. Maybe I forgot. It wasn't easy to test someone with her learning difficulties.

They couldn't do the Mallett test. The prism was reached subjectively and because I had wanted to try something, and I thought that the low prism would not do any harm. I jumped up the prism because I was encouraged by the small improvement.'

166. 15 June 2013: The Registrant told the Committee that the purpose of this consultation had been a review. The Registrant said *'I wanted to see if my intervention had had a positive effect. I was teetering on referring them. I was encouraged to see a little bit of progress at the beginning of the assessment.'*

167. The Registrant went on to explain the entries in the patient record:

'I made a note of her current circumstances. I have recorded that the patient was looking under her specs which indicated to me that the prism was too strong. She was very variable, her energy levels will have played a part in her vision. Binocularly, I saw that she was not doing very well. This could be due to my measurements or my notes which say that she was not engaging with me. The words near 'ret' mean that I used the retinoscope and I looked inside her eye And then as I read more of the note I can see that I did a near vision cover test because I have put NV CT. The notes show that I attempted an internal eye exam and I have recorded the results of a binocular assessment.

Going onto the next page, I see that the patient has been through medical assessments and things have improved visually. The medical assessments were not carried out by me. I can see that I booked a school vision assessment with the patient's older sister to understand any similarities or differences and two over twelve is a reminder to see the patient in two months' time. I have written 'not changed wear previous specs' because this means there has been no change in her prescription.'

168. The Registrant told the Committee that Patient 2 had *'never been able to engage with the Mallett test.'*

169. 17 August 2013:The Registrant went on to explain the entries in the patient record:

'It says that her new specs were definitely helping and she was not looking under them so much. It says that it helps that her sister was wearing specs, and this was because she wanted to be like her sister. I checked her vision with the Sheridan Gardner test. I have written down that there was some resistance to cover her right eye which suggests right eye dominance. The note tells me that she could not read the big print chart without her specs.

I have noted her normal retinoscope reading and made a note of the reading. The NV in brackets show a near vision reading. Below that I have noted that she recognised some letters and the left eye was dominant which explains why she resisted her eyes being covered. It tells me that there is conflict between her two eyes.

I have then carried out an internal exam and was able to see some but not all of the internal eye because the left eye kept taking over. I wrote 'fixation difficulty' in there. The difficulty was the same throughout her records. LH strong means that the patient's left hand is strong and because I couldn't measure dominance properly, it would have been a clue to a type one individual. I think her mum may have made this observation. Three over twelve means that I am reminding myself to see the patient in three months' time for a review.

I can see that the prescription included a prism because the wandering left eye and a lag of accommodation made me wonder how I could help. I thought

to myself, shall I refer or shall I try something, and that's where the prism comes in.'

170. The Registrant was asked about the prism that he had included in the prescription of the 15 June 2013 but which appeared to have been removed in the prescription of the 27 July 2013. The Registrant said *If I look back in the notes, I see that I first saw this patient on 29 December 2012. Usually, I hold back with a prism and see how a tint works first. I definitely prescribed the prism in June 2013 but from the notes, I am struggling to see why. It's not in my notes.*

171. The Registrant was asked about the prescription dated 4 January 2014, at page 250. He confirmed that it was a prescription that he wrote, however he was not certain that it related to Patient 2. Ms Hinton checked with the Council and confirmed to the Committee that this prescription related to Patient 2's sister.

172. 18 January 2014: The Registrant explained the entries in the patient record:

'My notes say that the patient was not getting on with her glasses and so I saw her again. The glasses related to the prescription of the 27 April 2013. I am looking at both of the notes now. I had convinced myself on the 27 April that she had needed a strong distance script and I had put quite a lot of prism into it. It says in the note that she was getting on fine with her other glasses and so it looks as though she had two pairs. The strong pair were for reading and another pair which I think I gave her on the 17 August 2013 for distance.

This implied to me that I made an error in reading her distance prescription. That error partly came about because I misread the retinoscopy result. She looked straight into the retinoscope and I didn't realise this at the time.

I have then made a note of the prescription that I gave her for distance vision and it confirms that she was long sighted. LT65 is the tint. This prescription was the one that she was seeing okay with.

I have then noted that I have made a frame adjustment or replacing the pads. Four over six is the binocular vision measurement and below that, I have made a note of a retinoscopy. I have noted that she was recognising most letters on chart two. I can see that her oph-bright fundus reflex R&L has been tested and I have advised her to wear the pair that she feels comfortable with. The words 'fixation difficult' mean that she cannot see anything close in her right eye.

I could have used Optical Coherence Tomography to examine the back of the eye but I didn't have the equipment in our practice because its beyond our affordability.'

173. 7 June 2014: The Registrant explained the entries in the patient record:

'The nose pad had come off. And I have made a note of her current issues. It says that mother had no concerns with her distance vision. I have written that a cover test was not possible and the word attention in brackets tells me that she could not fix her attention at a point in the distance. It is sometimes very difficult to quantify results from a cover test. I have made a note about the retinoscopy. It was difficult because the patient is very sensitive to light. I have noted that she could only see one or two of the chart letters.

I was grasping at straws. I wanted to see if adding an additional tint would help with reading performance. No-one has really clarified why, but I have written a paper about colour preference and the Eye bright test. Its quite a fine test for binocularity. I wanted to see if a much darker tint would help Patient 2 but from these notes, apparently it didn't. It would have been an indication that the root of the problem wasn't very binocular.

The note says that there was still very slow progress with reading. Six over twelve means that I am reminding myself to make another appointment to see in six months' time. I noted that she had read one book in three years and was not able to write. It says that reading and writing was a real struggle. TNO means that I have measured how the eyes work together and surprisingly, I got some results form that. I have recorded the TNO tests as she was able to see circles and shapes and I can see that I carried out a retinoscopy because I have written 'clear retina reflex R + L.' I think it then goes onto say something about light but I can't make sense of it. And it then says that ophthalmoscopy was not attempted.'

174. 31 May 2015: The Registrant explained the entries in the patient record:

'It says that things seem stable. The code 5.2 recorded on there means that it was an NHS test. I don't know why, because this patient was on the eye plan and we don't usually mix the two. Maybe her eye plan had lapsed.

The note says that her distance prescription was DV Rx and I can see that with a prism she read a line on chart 1 which was very surprising. She had never been able to do that before. The prism was added subjectively because she could not do the Mallett test. I tested the prisms during the visit and she told me they helped. I remember being astonished and pleased that she could read the small text with the prism. I was pleased. There had been no consistency with her vision. I have made a note that mum was pointing to show her where to look. I was very much encouraged by the improvement in her reading and I didn't want to put her through an internal eye examination so I've made a note that an ophthalmic test was not attempted and to review in three months' time.

The prescription includes a prism for distance. I issued a new prescription only for near vision. I wanted to try it because of the results from the reading test. It had a pink tint. Pink is halfway through the spectrum and helps to contrast light sensitivity. Patient 2 regarded it as her colour preference.'

175. 6 June 2015: The Registrant explained the entries in the patient record,

'It says that the specs seem okay, and this relate to the glasses that I prescribed six months earlier. I tested her visual acuity and she gave me a reading and I made a note of the prescription. I was able to use the Mallett test on this occasion, I can see that from my note. The 4in is the Mallett test result which records near fixation disparity. I can also see that I did an internal eye examination with an ophthalmoscope. I remind myself to review her again in three months' time.'

176. 9 January 2016: The Registrant explained the entries in the patient record:

'My note says that the patient was doing well with her specs for reading and writing. 3in is the prism that I have recorded. I tested subjectively which means that I did not use any equipment and I asked her what she can see using

prisms. I can see that I did a retinoscopy and I added a prism. I have written DV Rx better which means that her distance vision was better with the prescription. With a patient whose vision is so variable, it's good to know that she was doing well with her glasses.

I did a standard Gardiner test. I didn't do ophthalmology because I'd done it previously and I was reasonably happy about her performance so I didn't feel I needed to subject her to examining the back of her eye. I decided to try varifocals for the first time.

I have written EP at the top right which means the consultation was covered by the eye plan. I have put a prescription on there for varifocals. I found a distance and near prescription that seemed to help and was trying to combine them into one pair of glasses. I have noted accommodation insufficiency and divergence excess here. The prescription at the bottom includes a prism.'

177. 1 June 2016: The Registrant explained the entries in the patient record:

'In the top left of the record I have written 'guide' which means that under NHS policy, I should see the patient every six months. I don't know why I ticked this because she was on the eye plan, it may have just been a reflex.

The note says that she was getting on fine all of the time apart for PE. It says that her general health was well. I have made a note of her medical history. I can see a prescription that includes a prism. It was measured and I've made a note of her up to date visual acuity which was arrived at subjectively. The tests that I did continue on the second page of the note. I can see that I considered her accommodation and I recorded PERRLA which is a measure of external eye check and pupils. I have now reduced that abbreviation to PERRL which tells me that I didn't actually do an accommodation test. There is no new prescription on here because she was getting on fine with her glasses and I didn't find any significant difference when I did the refraction.'

178. 14 October 2017: The Registrant explained the entries in the patient record:

'I think it was an NHS eye test but I don't know why. I can see that her vision has reduced. Her general health is well and I recorded a brief history. Her vision without glasses I would describe as pretty shaky. The cover test that I did is showing orthophoria. During the cover test I can see that there was a loss of vision with her left eye. I have noted that she reverted to phonetic reading. I see that I did an internal eye exam and noted that fixation is happening, the left eye is wandering and making testing difficult. Then I've written the script. Its less than it was and I'm not sure why.

The note tells me that we got to a good place with varifocals. They got broken and it was a considerable amount of time before I was able to see her again. The prescription includes a prism which was measured subjectively. She definitely did better when the prism in her right eye was removed. The notes say that the left eye prism still helped, again subjectively. I didn't put a reading addition on there.

My notes say 'adjust script gen vision' which means that the prism is important. The prism was now just in the left eye. She wasn't getting the benefit from the reading addition, I don't know why. So I reduced the prism

and did not include an add. Its not a varifocal anymore, it doesn't need to be. I am assuming that the glasses are for reading and distance.'

179. 23 November 2018: The Registrant explained the entries in the patient record:

'It appears to be another NHS test and top right it looks to be an annual recall. I've put D in there for the reason to visit which tells me that it was to review the prism. It says that the specs seem fine, Dad sees no issues and her general health is good. I can see that I carried out a cover test and it told me that she was losing fixation in her left eye. I did a retinoscopy and I put my findings in there. I determined the prism by a subjective assessment. It says 'not easy which means I must have found it challenging and I will have checked her answers.

I can see the prescription that I found. I carried out an internal exam, I can see from the notes that I got a fleeting glance at the discs and saw that fixation was still a problem. I issued a prescription.'

180. 10 July 2020: The Registrant explained the entries in the patient record:

'It says that she broke her glasses before lockdown and was wearing her old glasses. I can see that I did a cover test and fixation was very difficult. It's quite a big gap since her last eye test. I don't know if this was NHS, it seems to be part of the eye plan but I'm not sure.

I assessed her near vision. The notes tell me that she didn't want the addition. It's quite confusing because I've put +4 Binocular add better but I don't know why. The results did not support that. I'd previously written on the note that +0.50 addition might help.

I started off with a distance prescription and put an addition in front of her and we got up to +4 according to these notes. She must have liked the additional power, she probably liked the increase in the size of the letter. I have recorded +1 for distance and +4 for near. I issued a distance prescription, which should also have worked for near vision, with the prism unchanged.'

181. 23 July 2022: The Registrant told the Committee that this had been a *'routine check.'* He went on to explain the entries in the patient record,

'It says that it was a routine check and her general health was good. It also says that she felt that she had been struggling with things for a long time. I checked the prescription with her glasses on and got worrying vision. I couldn't see any obvious reason for it. I saw instability in her left eye and I did a cover test. I checked her unaided vision which was no better. I used a retinoscope and could see no obvious reason for her poor vision. The squiggle under where it says 'Ret' tells me she had no power of vision at all.

I'm now grasping at straws. I've made a note that I tried to get her to read and she couldn't see the chart within one metre with either eye. I did an ophthalmoscopy test and recorded the fixation result. I have noted that I said she needed to be referred for an opinion from an Orthoptic Consultant.'

182. The Registrant told the Committee that he completed the referral form, to the hospital, and *'an information note would have gone to the doctor.'* He said that he recorded the test results in the form. He said *'I believed it was a cry for help. Covid was a big factor, especially for children with learning difficulties. Her confidence*

will have impacted on her vision. I took into account her medical history and I was concerned that it may be neurological or at the very least it could be ruled out. She did not bump into things when she walked into the room, she had found her seat as normal. We now know that she has a very rare genetic disorder. I didn't know that at the time. It wasn't an emergency in my view but she needed looking at by the hospital as soon as possible.'

183. The Registrant said that according to the evidence in the bundle, Patient 2 was seen by the hospital on the 14 October 2022. He said that he was unable to explain why she had presented with healthy vision and 'healthy eyes.' He told the Committee that when he saw the email from the patient's dad on the 27 October 2022, confirming that they no longer had confidence in his practice, he had been very disappointed. He said it was a *'total shock, I had known her for ten years.'*

184. Mr Archer asked the Registrant whether he had obtained informed consent to carry out the various eye examinations of Patient 2. The Registrant said *'I had assumed that as the patient was always there with a parent, and they were mostly on eye plan, that I had consent. They allowed me to do the tests. They will have signed an eye plan agreement to understand what they were entitled to. I always assumed that this included informed consent. I've improved my practice since this all came to light.'*

185. In response to the evidence of Ms McCrudden, the Registrant told the Committee that in his view, the eye examinations that he had carried out for Patient 2 had been standard. He said that it was appropriate to use the fixation disparity test. In relation to understanding his rationale for prescribing a tint, the Registrant said that he would always explain an Eyebrite test to the patient and their parent when he considered the test to be necessary. He would tell them that it was necessary to measure light sensitivity and the tint prescribed would be as a result of that test.

Patient 3

186. 28 July 2022: The Registrant explained the entries in the patient record:

'I have noted first of all that on the 18 July 2022, this patient had an eye examination at the hospital, it's at page 105. I saw the patient on the eye plan on the 28 July. The parents were concerned about how the patient was doing at school and asked me to help with binocular vision. They were with the hospital because of arthritis but they didn't have any further scheduled appointments. I didn't want to interfere with the arthritis tests so I carried out a binocular vision test.

My note tells me that I went through the medical history and I have written PH clear which means that their personal history was clear of any issues. I put the hospital prescription in my trial frame and found that the right eye needed correcting and the left eye too. I tested the visual acuity. There had to be a reason for the vision having no improvement, I had no reason to doubt the hospital prescription. 'GVE' means that I did a cover test and my explanation for the poor vision is on the second page of the note.

I've made a note about a school visual assessment and also about advising on dietary matters. I suffer from arthritis and I have looked int the connection between diet and the functions of the body. I have read a book called 'The

Plant paradox' written by a Cardiologist and it helped me enormously. Sometimes, I suggest that patients or their parents have a look at the book. I have always had an interest in diet and for me it should be encompassed as part of optometry because there is a connection between food and vision.'

187. 17 September 2022 : The Registrant explained the entries in the patient record:

'This was the patient's second visit. It would have been a full binocular assessment. His parents could see what I was doing. I measured the LogMAR vision and noted the result in the note. I measured his reading speed using chart one which is very small letters and it was very slow at two minutes and eight and a half seconds.

Then I measured his eye dominance by asking him to put his right hand over his left hand, and to peer through it at my nose, and I can see which eye he's using. The notes record it as LLLL and the D above the L tells me that the eye dominance wasn't stable. Having measured and recorded a head tilt, I've enabled a situation where I can look to improve the vision, for instance, by using a prism.

I have noted that dad has left eye dominance. I have recorded that I carried out a cover test for near vision. I have noted that he is left-handed and left-footed and that movement of the eye was full. I can see that there was one loss of tracking which means that the patient was unable to follow an object. This is significant. When I've written 'head to follow' it means that they move their head rather than their eyes to follow an object. I have recorded his colour preference as Fuchsia which is strong and I see that I carried out a Rice test. This is a test using the brock string. It's a measure of fixation disparity and it showed very clearly that the right eye was suppressed or had switched off. I have written that one string could be seen which means that the patient could see the first string held in front of him. Where I have written 'NV OMB' this relates to objective muscle balance, it's a vision test.'

188. Mr Archer asked the Registrant about the document of the bundle. The Registrant told the Committee that it is a dispensing form from the hospital issued on the same date as the consultation. He said that the prescription issued by the hospital *'suggested that the eyes were unable to work together.'*

189. Mr Archer asked the Registrant about the document of the bundle. The Registrant said that this was a prescription issued by him on the 17 September 2022. He said that he considered this to be the appropriate prescription *'to get the eyes to work together.'*

190. The Registrant was asked whether he had prepared the document at page 141 of the bundle. He replied *'I must have done because of the references but it's not in my usual format and it's not dated.'* Mr Archer asked the Registrant if he recognised the document at page 148. The Registrant said *'This is my note. I remember the patient's parents were confused about the hospital involvement. I'm not sure why I made these notes, maybe Patient 3's parents asked me to do them.'*

Patient 4

191. The Registrant referred the Committee to paragraphs 91 – 93 of his witness statement for some background context to this patient. He was then asked by Mr Archer to explain the entries that he had made for this patient's clinical records.

192. 1 August 2018: The Registrant said:

> *'This was the first time that I had seen this patient. It was a school vision assessment, paid for privately. The top of the page shows the short-sighted prescription that he was wearing. I was interested when he told me that he had been registered as visually impaired. My notes tell me about his history and he appeared to have a binocular issue. It seems that a convergence problem featured here which means for the patient that he will have been unable to focus on close objects.*
>
> *I recorded all of his symptoms and on the next page I carry on doing this. I can see that I carried out a LogMAR test and made a note of the results. I did a cover test, which would not give me a precise test of binocularity but it's very helpful. I tested for fixation disparity, I have noted his dominant hand and foot and I could see a binocular conflict in terms of dominance. I measured his near vision with the cover test.*
>
> *I then went on to measure his colour preference which I have noted as blue. Blue is comfortable for someone like Patient 4 with strong light sensory reactions. I have recorded 'OMB' which means that he had an objective motor balance, a binocular problem. He had issues with near and distance vision and I would have been looking at a reading addition to solve the esophoria at near.*
>
> *Then I did a Rice test. It's a 3D test and it gives a better indication about what's happening with the near vision. Although, I would never prescribe a prism without a Mallett test. Then I measured his dynamic fixation. This is a very exhaustive test. It was a preliminary part of the binocular vision assessment. This test gives me lots of information. Going onto page 209, I can see that I measured for spectacles. I did a cover test and retinoscopy, I can see the measurements. Measured fixation disparity with the Mallett test and found that it was compensated, it says there 'DV Comp'd.' The visual acuity that I found was six over twelve in both eyes which was an improvement on the vision from his own glasses.*
>
> *I tested reading speed and noted that the prism in the right eye seemed to make vision better at high contrast. I have suggested that he consider single vision sports specs and the note about fundi tells me that I used an ophthalmoscope to look at the rear of the eye. The words 'from close to start' means that accommodation insufficiency can cause short sightedness. I was keen to try a prism before changing the distance vision rather than reducing the myopic tendency.'*

193. 7 November 2018: The Registrant explained the entries in the patient record:

> *'This was a follow up to check the prescription, visual acuity and the level of myopia. The note says that things were good, his vision has improved using the glasses that I'd prescribed without having made any changes to his distance prescription.*
>
> *I've noted that he had a Dyspraxic headshake which is a term I've come to use. I carried out a Mallett test and found that a prism corrected a vertical disparity in his left eye. This was key for me in assisting with the patient's binocular vision.*

This is where optometrists and orthoptists should work together, when it comes to trying to assist with a binocular vision issue.'

194. 4 May 2019: The Registrant explained the entries in the patient record,

'This was a three-month assessment. Patient 4 had told me that sometimes he gets headaches, other than that his vision and general health I've recorded as well. I measured his sight and saw that he was orthophoric in the distance. My retinoscopy findings were that he was under corrected in his right eye. You can see from the note that his prescription had changed. His vision was better, his left eye was more stable.

My own thoughts were that I had a situation where the muscles were struggling to pull the eyes together. Distance and near vision were compared with an addition. He has two pairs of specs one with a prism and one without and the changes could have brought on the headaches.

I have made a note of the prescription that I gave to him. I was encouraged by the improvement and the excellent reading speed. In the top right hand corner I have said that I wanted to see him again in three months' time to review.'

195. 17 August 2019: The Registrant explained the entries in the patient record:

'The patient had been to hospital and retinal dystrophy had been diagnosed. I presume, that's what the hospital told him. A dystrophy means it's not quite right, it doesn't tell me anything specific.

The patient or their parent tells me that the patient had had an eye test the previous Monday. I was told about a blood test to see if his genes were impacting on his vision.

I measured his vision using his current glasses. I saw orthophoria on the cover test. I've noted the measurements, did a Mallett test and found prisms. I always find a prism by using a Mallett test. I have no idea where the figure 10.00 comes from. There had been improvements in his vision but the reading addition was still needed. I used the usual accommodation facility test. His recorded reading speed showed a small improvement. I checked the Mallett test results again after checking the reading speed and it was unchanged. I gave him an estimate of an addition and built on that. I then gave him a prescription. I re-checked the prism at near and found that it was difficult at distance, re-checked it at near and then re-checked the distance vision with the prism in it.'

196. 28 August 2019: The Registrant explained the entries in the patient record:

'This was about eleven days after the previous visit. I wanted to check the prescription. It's a review. I have recorded some measurements in the note and checked the prescription. My notes tell me that a convergence problem in the right eye is possibly producing a disparity in the left eye. The body adapts to try and correct an insufficiency and sometimes the eyes can over compensate if I'm trying to correct it with a change in prescription.

It looks as though his binocular vision has changed over those eleven days. Nothing surprises me about that. There could have been a genuine change in vision or it may have been about how he was feeling. I was aiming to remove

the prism. He was born with his right eye mis-aligned and so he was predisposed to myopia. I have recorded in the note that I have measured disparity using red and green dots. I have written 'report by email' and I don't know what that refers to, it is my handwriting. If I am asked to do a report I will send it by email. I can see that I issued a prescription.'

197. 18 December 2020: The Registrant explained the entries in the patient record:

'This visit was a check. I can see that at the last visit on the 28 August (page 203), I had put them down for a six-month check and this was the check.

I have recorded that he has to sit at the front in school. I did a retinoscopy over the prescription. It indicated more myopia. The retinoscopy finding indicated that he was becoming more short-sighted. The prescription I found wasn't much different to the one that he was wearing. According to my notes, he was most comfortable with the addition, with the prism. Something was causing the myopia, it was still unravelling and this can take time. I used a fixation disparity test and then saw that he had maintained a good speed level of reading. I will have discussed the eye plan because it enables me to see patients more regularly.'

198. Mr Archer asked the Registrant about the Vision Assessment Report dated the 18 February 2020. He said that he cannot say for certain why he produced the report. He told the Committee that he did produce it, and he can only assume that the patient's parents must have requested it because he will have charged them a fee.

199. The Registrant said that on page one of the report, he had referred to a 'predisposition to dyslexia' because *'it was my way of connecting my findings to the patient's symptoms.'*

200. He was asked about the reference to dyslexia at page 266 of the bundle, and the Registrant said that this document was a prescription that he had issued on the 1 August 2018. He went on to say that he had used the words 'predisposed to dyslexia' as an adjective to describe people who have reading difficulties. He said, *'for me, it's about binocular disability. I've come to the conclusion that I should not mention these words at all. I realise that the word dyslexia often generates a lot of emotion. If I have upset or offended anyone I apologise but at the time, I was trying to bridge a gap. I don't use these words anymore. In relation to 'The Plant Paradox' I believe that the brain is related to the visual system, its 80% related.'*

201. Ms Hinton asked questions of the Registrant by way of cross examination.

202. In response to the questions, the Registrant said that at the time of the eye examinations for all four patients, he had understood his obligations in terms of carrying out internal and external eye examinations. He said that he had also understood his obligation to record the results of these examinations.

203. In terms of particulars 15 and 16, the Registrant was asked why he disagreed with the views of his own expert witness, Professor Barnard. The Registrant said *'I don't want to disagree with him. I want to say that I acknowledge some of the deficiencies. I have spent two years trying to learn from this, I hope I've improved my records. I'm quite happy to admit that Professor Barnard is right.'*

204. The Registrant was asked about particulars 17 and 18 and page 324 of the bundle where Professor Barnard states that some of the visits fell below the standards

expected. The Registrant said *'I did consider carrying out an internal exam. I should have recorded this in the notes and the reasons why I did not.'*

205. Ms Hinton asked the Registrant why he had not carried out an internal or external examination during consultation visits and she referred him to Professor Barnard's opinion at page 326 in relation to Patient 2. The Registrant said *'I agree that an internal and external eye examination should be done at each consultation. Sometimes however I use my clinical judgment and will not do an internal eye examination on a child because it can put them off having their eyes tested. I accept that I should have written this out in full.'*

206. The Registrant went on to say that in the patient record of the 31 January 2015, he should have recorded the reason for not carrying out an ophthalmoscopy test. He accepted this also for the records of the 9 January 2016 at page 179 and the 10 July 2020 at page 193. He told the Committee *'I haven't recorded the examinations or why I didn't carry them out. I suppose if I had to excuse myself it would be a pre-occupation with trying to assist the patient with their difficulties. It's fair to say that sometimes I didn't carry out the internal or external examinations and I don't know why.'*

207. The Committee offered the Registrant the opportunity to consider overnight whether he wanted to admit any additional particulars, due to his evidence. The Committee said that the Registrant had no obligation but that it was an option for him.

208. The following day, Mr Archer informed the Committee that he had received an email from the Registrant at 2am containing further explanations for his actions. The Committee, having received and accepted legal advice from the Legal Adviser, informed the Registrant that he could choose to rely on this document if he wanted to, but as it had been submitted during his evidence, the Committee could consider at a later stage in the hearing, whether to admit it as evidence.

209. Ms Hinton continued with her cross examination. She asked the Registrant about Patient 3, particular 19 and invited him to explain why he had not recorded examinations of the internal and external eye. The Registrant said *'I understand what you are doing as prosecuting Counsel. I believe that I did not record the tests because I did not carry them out, having regarded them as unnecessary. I also have mitigating circumstances to show why I did not do the tests. In my trust in the system, I will rely on the document that I sent to my Barrister at 2am this morning.'*

210. Ms Hinton asked the Registrant if he had had access to the hospital notes for this patient, at the time of the consultations. The Registrant said that he had not. He said *'anyone who has been through the hospital system will have been examined.'*

211. Ms Hinton moved on to ask the Registrant about binocular assessments. When she asked the Registrant if he had read Professor Barnard's report, he replied *'Yes, I accept what he's written. I don't dispute it.'* Ms Hinton asked the Registrant if he agreed that his patient records relating to binocular assessments had been insufficient to ensure continuity of care. He said *'I have to challenge that.'*

212. The Registrant was referred to Professor Barnard's report and his opinion that there had been a 'habitual failure' to provide sufficient notes for continuity of care. The Registrant responded *'I disagree.'* He went on to say that he was inviting the Committee to prefer his evidence over that of Professor Barnard's. He said *'I am*

very uncomfortable about disagreeing with our own expert. I don't have anything to add to what I have already said about that.'

213. Ms Hinton asked the Registrant about particulars 3 and 11 and the joint experts' opinion for the relevant patient record. He was asked if he disagreed with their opinion that there was no binocular vision test for near vision. The Registrant said that he accepted that there had been no test for near vision and said the reason for this was that it had been a preliminary assessment.

214. Ms Hinton asked the Registrant about particular 14 and referred to Professor Barnard's opinion that the patient records had been inadequate. The Registrant said that he used only one method of testing for a prism and he was '*surprised that he is not aware of that. Maybe I should put fixation disparity or Mallett test in all of my records.'* He explained that he does not always write the methods that he used for testing because *'my colleagues will be aware from the patient record if they see a prism, that the Mallett test will have been used. Also, the practicalities and pressures of the consultations mean that I am always thinking about solving a problem.'*

215. He went on to say that he understood the importance of keeping 'proper' records. He said *'I don't write my records to enable anyone to understand them. But that doesn't stop me from making them as clear as I can. Sometimes I don't describe all of the tests because of time constraints. Hindsight is wonderful. To me its routine to use a particular test. I do them all the time. Recording is a distraction from the problem that is in front of me which I am trying to solve.'*

216. Ms Hinton asked the Registrant about his prescription of a prism for Patient 2. She asked him why he had prescribed a prism when she had been unable to engage in a Mallett test and he had told the Committee that he always used the Mallett test before prescribing a prism. The Registrant replied *'This was an example of an occasion that was not part of my standard practice. I had to use a subjective assessment with this patient. I can see from the consultation note that no-one looking at it would know that I had carried out a subjective test.'*

217. The Registrant was asked about particular 1. It was suggested to him that the joint expert report had found that the patient records, save for the record of the 30 June 2020, had provided insufficient information to justify the diagnosis of accommodation insufficiency, divergence insufficiency or convergence excess. The Registrant replied and said that the basis for the accommodation insufficiency can be found at page 157 where he had written +2.50 add. He said that he disagreed with the joint experts.

218. Ms Hinton suggested to the Registrant that during his evidence-in- chief, he had struggled to read his own clinical notes to which he replied *'Yes, but not often.'*

219. The Registrant was asked about particular 2. He was asked if he thought that he would have written in the note that he had carried out a cover test, if he had carried out this test. He replied *'At page 186, the record for the 27 April 2013 it records a binocular measurement and it says 'slow attention, being diverted.' This is me attempting to do a cover test. I didn't write cover test on there because I didn't get a result.'* The Registrant accepted that it would have been helpful for continuity of care if he had written in the note that he had carried out a cover test.

220. The Registrant said that he did not have a checklist for carrying out tests. He said *'I hate them.'* He said that Patient 2's vision had been extremely variable and on any one day could be very different.

221. Ms Hinton asked the Registrant if the consultation notes were an example of an error by the Registrant. He replied *'You could say that. The patient wasn't able to complete the retinoscopy test. I measured her near focus without knowing that. I'm not saying I made an error because it was a necessary step for me to take on my journey in trying to help her.'*

222. Ms Hinton asked the Registrant about Patient 4. She asked him to explain if the circle with the lines through it meant that he had conducted a cover test. The Registrant said that this circle is known as a 'cross hairs symbol' and he confirmed that he would insert that symbol into the patient record when he had carried out a cover test. He was referred to particular 4 and the patient consultation on the 23 November 2018 which included the symbol but no reference to a cover test. The Registrant said that this was his omission.

223. Ms Hinton referred the Registrant to paragraph 6.4.2 of Professor Barnard's report. It states that the Registrant informed Professor Barnard that the symbol represented orthophoria. The Registrant said *'If I said that to him, I didn't mean it. I met him online, I had a poor signal and the meeting was curtailed abruptly.'*

224. In relation to particular 4, the Registrant was asked to explain why he disagreed with the joint expert report in terms of insufficient evidence to justify the diagnosis. He said that he invited the Committee to recognise that he had known the patient for approximately ten years.

225. In relation to particular 9, the Registrant said that the patient record had been a school vision assessment. He said *'the record clearly shows that that I used the Rice test, I had measured muscle balance and this had given the result of convergence insufficiency. The second part of the record includes my prescription which shows a measured prism of distance indicating a divergence excess.'*

226. In relation to Patient 4 and particular 12, the Registrant said that he considers there to be sufficient information in the patient notes to explain the prescription. He said that the prescription does not provide for divergence excess and this justifies his diagnosis. He said that the note includes reference to high myopia which is convergence insufficiency.

227. The Registrant was asked about the particulars regarding the prescribing of prisms and varifocals. Specifically, particulars 2, 5, 10 and 13. He said that when he carried out subjective assessments to assess whether a prism or varifocal was necessary, it was *'all trial and error. You learn nothing by doing nothing. Often I would monitor a patient to see the effect.'*

228. He said that he had: *'wanted to be as proactive as possible, especially with Patient 2 because she was so challenged. Sometimes I would try a prism and the patient would come back and say it was too strong. That was part of the process. Sometimes patients with a prism would present with a headache. I bring them back fairly frequently if they have a prism.*

    Sometimes a patient can do well with a prism and then a symptom may return and the prism needs to be changed. Sometimes a prism is removed and then later down the line it has to be put back in. The brain constantly works to try and correct

vision. The prism triggers the brain and so there might come a point that a child may not require a prism. This is all based on my research.'

229. The Registrant was asked if he has a standard consent form at the practice and he said *'No. I usually make sure that consent is obtained freely.'*

230. Ms Hinton asked the Registrant about particular 2 and the lack of clinical indication. The Registrant said *'the Committee should be satisfied that there were clinical indications. For each of the consultations I have explained the methods used to obtain measured vision and I have recoded the results.'*

231. When he was asked about particular 10, the Registrant said that he had recorded his retinoscopy findings and the refraction that he had carried out. He said that he had recorded accommodation insufficiency and the prescription was prepared using the different tests. For particular 13, the Registrant said:

'it's plainly written in my records. Whenever I prescribe a prism, I always use a Mallett test. Patient 2 is the exception. Whenever I prescribe a reading addition based on an empirical test, I have measured accommodation empirically. Whenever I write a colour tint, I have used the Eyebright test.'

232. In relation to particulars 24, 26, 28 and 30, the Registrant accepted that he had not recorded receiving informed consent. He denied that he had not received informed consent. He said that he would always explain the process to patients and their parents when they had their first consultation.

233. Ms Hinton asked the Registrant about three additional documents that he had provided to the Committee during his evidence. The Registrant explained that these were research papers that he had written in relation to eye dominance, motility and athletic potential.

234. Ms Hinton asked the Registrant about particular 31(ii) and why he had included a book by the name 'The Plant Paradox' in a prescription for Patient 4. The Registrant said *'It's not a prescription. It's a recommendation based on my own interest in nutrition. I often ask myself, why are gluten free trials not being done to see if it has any impact on vision? I have done a lot of reading around the subject and I believe that all relevant threads should be pulled together. I don't believe that recommending the book could do any harm, it could address their problems. I feel a duty to recommend something that might help when there is an opportunity.'*

235. When he was asked about particular 31 and using the words 'pre-disposition to dyslexia' the Registrant said *'I accept that I acted outside of my area of expertise. I won't be using those words again.'*

236. Having concluded her cross examination, Ms Hinton referred to the document that the Registrant had sent to Mr Archer at 2am. She told the Committee that she had read it, and whilst she objected to its admissibility as evidence due to its lateness, she said that she was content for the Committee to have sight of it. Mr Archer invited the Committee to see it and said, *'You can receive stage two documents at any stage of the proceedings.' We can make submissions on the relevance of the document and the weight, if any to be attached to it at this stage of the hearing, in due course. The Registrant only prepared it because the Chair invited him to consider whether he wanted to admit any further allegations.'*

237. The Committee received and accepted advice from the Legal Adviser, who reminded the Committee that paramount to their considerations about evidence, should be fairness. The Legal Adviser highlighted that fairness in the proceedings applies to both parties, not just to the Registrant. The Committee was reminded that the Registrant had had the benefit of legal representation throughout the proceedings however his Counsel is suggesting that the document was provided in response to guidance received from the Committee yesterday.

238. The Legal Adviser referred the Committee to rule 40 of the Fitness to Practise Rules which says that the Committee may admit any evidence it considers fair and relevant whether or not the evidence would be admissible in a civil court. The Committee was advised that in order to decide if the Registrant's document is relevant, it will need to see it. The Legal Adviser said that the Committee does not need to make a decision about admissibility immediately, and it could wait until it has heard all of the evidence and any submissions the parties chose to make.

239. The Committee determined that it would read the document once it had heard all the evidence, and closing submissions from the parties. It will then arrive at a decision as to whether the document received from the Registrant today ought to be admitted as evidence and if so, what weight ought to be attached to it.

240. Mr Archer proceeded to ask questions in re-examination of the Registrant.

241. He asked the Registrant about his patient records and continuity of care. He asked if his colleagues at [redacted] understand his approach to record-keeping. The Registrant said that his colleagues all understood his patient records and it is rare that anyone outside of the practice has asked to see his notes.

242. He was asked about the cross hairs symbol and Professor Barnard's report. Specifically, whether he told Professor Barnard that he used that symbol to indicate orthophoria. The Registrant said, *'I use that symbol for orthophoria to show that I've done a cover test at near. I used both in the note of the 29 December 2012 because I am not consistent.'*

243. Mr Archer asked the Registrant about page 266 and his use of the word 'dyslexia.' Mr Archer pointed out to the Registrant that when he answered a question from Ms Hinton about using this phrase, he had not been taken to the document. He asked the Registrant to answer again, having considered the prescription, whether he had acted outside his area of expertise. The Registrant replied *'It's a bit ambiguous. I took on board what Ms Hinton suggested, it's best to leave it to an expert. You can't decide exactly what I meant from this document, from what I've written. At the time, I thought I was acting within my area of expertise. Now I'm torn. It's a very emotive and developing subject. I did the best I could at the time.'*

244. The Committee asked questions of the Registrant. He was asked about Patient 2 and whether if the retinoscopy result had been so variable, whether he could have done anything more to improve it. The Registrant said *'No. I wasn't entirely confident that drops in her eyes would have helped. It could have made it quite traumatic for her. Usually, I would prescribe something to potentially help and then have them back fairly promptly to review. I would certainly refer if I thought there really was a problem.'*

245. The Registrant was asked about Patient 4. Specifically, whether, in light of the vision having slightly improved over time, he could have considered any other means of testing other than visual acuity, before issuing a visually impaired

statement. The Registrant's answer was that he had reviewed the hospital records and did not identify anything of relevance.

246. The Committee asked about the prism that was prescribed for Patient 4. Specifically, the origin of the value of the prism prescribed in April 2019 and an explanation as to why it had moved from the right to the left eye. The Registrant said *'Where a patient is quite short sighted, I believe that something is going on to make this happen. I can't tell you why I put 8 dioptre in there. One mitigating observation is that with that prism in their eye the patient was able to read pretty fast. It's not good enough but I must have got their reading prescription up and tested a prism. I must have measured on the Mallett test. Right at the bottom it tells you why I prescribed it.'*

247. The Registrant was asked if there is an approval process that he is aware of, for carrying out a non-standard test. He said *'my guess it's through the College of Optometrists. It's a time constraint. A test can take years to get through which is a problem. I'm trying to open up communication with universities and I have many research projects on the go. But they need to be approved by the establishment. I have tried to get my tests approved, but I have not done it. I accept that just because I have had research papers published does not mean that it is a widely accepted policy, it depends on the journal.'*

248. The hearing was adjourned to another date.

Resumed Hearing on the 5 January 2026

Professor Simon Barnard

249. Professor Barnard told the Committee that the content of his expert report dated the 15 June 2025 and his joint expert report with Ms Janice McCrudden dated the 22 June 2025 and also the addendum report dated 17 September 2025 is true to the best of his knowledge and belief. Professor Barnard confirmed his expertise as set out in Appendix one of his report dated the 15 of June 2025.

250. Mr Archer asked Professor Barnard to clarify his responses to the questions set out in his supplementary expert report dated the 17 September 2025. Mr Archer asked the following questions in examination-in chief.

'Is there a universally accepted definition of the terms 'divergence insufficiency', 'convergence excess', and 'accommodation insufficiency' that is common to both the Ophthalmology professions and the Optometry professions?'

251. He stated that there were a number of classification systems. There were differences in how optometrists and ophthalmologists interpreted these systems. He said there were several differences between the systems that were not simple and not straightforward.

252. Mr Archer:

Is there a universally accepted definition of the terms 'divergence insufficiency', 'convergence excess', and 'accommodation insufficiency' within the Optometry professions?

253. He referred to table 1 in his report and referred to the simple classification system of Duane. There are differences in interpretation. He said there were differences between the optometrist and ophthalmologist professions.

254. Mr Archer:

'Does the Registrant's use of the terms 'divergence insufficiency', 'convergence excess', and 'accommodation insufficiency' accord with your understanding of those terms?'

255. Professor Barnard said that the Registrant does not use simple definitions. He uses a system of recording which may not record what he is seeing. There was a gap in what is recorded for some of the patients. He agreed with Mr Archer that the differences in terminology did not affect treatment.

256. He stated that all the measurements were there for all the tests. Things change with muscle control and there may be changes with treatment as well as over time. He could not say whether divergence insufficiency (DI) was appropriate without examining the patient himself. He told the Committee that sometimes data was missing. He understood how the Registrant measured the patients but there were gaps in the information recorded.

257. Professor Barnard's view was that there was a problem with the RAF rule to measure amplitude of accommodation. It was highly subjective. He understood that the Registrant used a method of assessing facility of accommodation using lenses. He said that the Registrant's use of the term facility of accommodation is different to what his understanding is.

258. What optometrists do is manage the patients' needs with lenses. They might take or add lens strength and come up with what is perfectly okay for adults. However, the Registrant was using this for children. He could not say whether this was wrong. The Registrant came up with a prescription based on what he found. Professor Barnard said he would be cautious to say it is wrong.

259. He added that *"I am critical of the detail in the clinical records ". "Workings are not all clear in an ordered way." "Records difficult to follow."* He stated that he could not say any prescriptions were wrong. He told the Committee it was difficult to say if they were helpful to patients. He said that *"I do not see any harm done ". "Difficult to know for certain".*

260. Mr Archer:

If there is any difference between the Registrant's use and your understanding of those terms, has that difference had any practical impact on the treatment that he provided to Patients 1, 2, 3, or 4?

261. Professor Barnard told the Committee that he was of the view that there was no difference between the Registrant's use and his understanding of the terms.

262. Mr Archer:

'Explain what 'fixation disparity' (associated phoria/retinal slip) is, how it is detected/measured, why it is important, and how it is treated.'

263. He said that fixation disparity and associated phoria and retinal slip are all terms that are interchangeable. He demonstrated exophoria using two props. When asked how fixation disparity was measured, he said that in the UK people use the

Mallet test. If there is any slippage you get an associated phoria and you can measure the fixation disparity on a scale. The optometrist can introduce prisms required to align the eyes. He was also asked how fixation disparity is treated. He said that this could be done with prisms if suitable, with modified prescription in glasses and surgery can be used if a large manifest strabismus is present.

264. Mr Archer:

'Did he agree with Hanish Chauhan's evidence that optometrists use the Maddox Rod to measure misalignment of the eyes whereas orthoptists use the prism cover test? Supplementary to this, does the Maddox Rod test for fixation disparity?'

265. When asked about the Maddox rod test, Professor Barnard told the Committee some optometrists use it and some use cover tests. It was a useful tool to measure small muscle imbalances. All orthoptists are expected to use the cover test. He did not agree with Mr A's evidence.

266. Mr Archer:

'In relation to [Ms B's] *evidence that the hospital does not routinely carry out amplitude of accommodation tests, nor test for lag of accommodation, was it possible, in your view, for the hospital to 15* [sic] *Simon Barnard Addendum Report 17 September 2025 determine whether the reading addition prescribed for Patient 1 by the Registrant was appropriate without carrying out those tests?'*

267. Professor Barnard told the Committee that in relation to Ms B's evidence the hospital does not carry out amplitude of accommodation tests nor test for lag of accommodation. His view is it was not possible for the Hospital to determine whether the reading addition prescribed for Patient 1 by the Registrant was appropriate without carrying out those tests himself.

268. Mr Archer:

Did he agree with Janice McCrudden's evidence that it is not always necessary to dilate the patient's pupil if you conduct ophthalmoscopy using head-worn equipment? Supplementary to this, is head-worn indirect ophthalmoscopy equipment commonplace in primary optometry practice, and so all reasonably competent optometrist have the knowledge and skill required to use such equipment properly?

269. He told the Committee that one generally needs to dilate the pupil. When asked whether he agreed with Ms McCrudden about the use of the head worn equipment, he said the device was not in common use. It was not used widely and not examined in the College of Optometrist's professional examinations.

270. Mr Archer:

In the video produced by Janice McCrudden during her evidence, does the narrator correctly identify the second test as the "cover-uncover" test? Supplementary to this, does the test shown in the video allow the optometrist to test binocular vision?

271. Professor Barnard told the Committee that the cover test enables eye position and an assessment whether strabismus is present.

272. Mr Archer:

Whether the Cover Test can be used to detect fixation disparity?

273. Professor Barnard said that with the cover-uncover test, the eye may recover quickly and jerkily, suggesting the muscle system was not controlled. In circumstances where the movements were jerky, prescribing prisms was an option.

274. Mr Archer:

Whether in his view, all reasonably competent optometrists have the knowledge and skill necessary to carry out dynamic retinoscopy?

275. Professor Barnard informed the Committee it was not used widely in practice.

276. Mr Archer:

Did the Registrant tell him that he uses the notation '⊕' to mean orthophoria as measured with the Howell test?

277. Professor Barnard stated the Registrant did use the notation to mean orthophoria as measured with the Howell test. He admitted that he (Professor Barnard) had made an error in recounting what the Registrant explained to him during their meeting after checking back in his notes of that meeting.

278. Mr Archer:

Whether he could explain what the Howell Test is used to measure, and when it might be used instead of the Mallet Test?

279. He told the Committee the Howell test is a test for dissociated heterophoria. He had not heard of it. He described it as a test from the US. It measured subjectively the disassociated heterophoria. It measured the size of the deviation. It does not compare with Mallet. It is not used to prescribe as standard.

280. Mr Archer:

Whether Ecronicon is a peer reviewed journal?

281. Professor Barnard stated that Ecronicon is a peer reviewed journal.

282. Mr Archer:

He was asked to explain how the Cerium Intuitive Colorimeter can be used to prescribe precision tints.

283. Professor Barnard explained to the Committee that it was an instrument that enabled optometrists to apply light of different wavelengths usually to text. *"You can ask the patient whether it is better with the colour or without"* and the saturation can be changed. He told the Committee that he had been using this for over 30 years and it can make a difference to some patients.

284. Professor Barnard was further asked whether he could explain the evidential base to it. The College of Optometrists has a protocol for children if a child says the print moves about on the page, this movement is caused by activity in the visual cortex. First you deal with the binocular vision problem and if the words still move you can screen with coloured sheets. He also told the Committee that a rate of reading test can be carried out. *"If you find the accurate rate improves off goes the child with the colour."* The number of words covered in a minute is measured with and without two colours.

285. Professor Barnard added that colorimetry was not the only way and there were quite a few other methods. He stated that the Registrant has come up with his

own test and method. He (Professor Barnard) did not think he has published on it. He added that he did not know his test.

286. Mr Archer:

Having heard the oral evidence received in the proceedings so far, had his opinion on particulars 1, 4, 9, or 12 (misdiagnosis) changed? If so, what is his current view?

287. Professor Barnard stated that having heard what the Registrant said he diagnosed, he did not know if it was misdiagnosis. He could not be certain. He also stated it would not change how the patient would be treated. He also stated the particulars regarding the misdiagnosis of vergence entities do not describe the issues concerned.

288. He was asked about the particulars relating to the misdiagnosis of accommodative disorders. Professor Barnard stated that he would have needed to see the patients at the time. Things can develop a year later and there may be a different result.

289. Mr Archer:

Having heard the oral evidence received in the proceedings so far, has his opinion on [particulars] *2, 5, 10, or 13 (prescribing varifocals / prisms when not clinically indicated) changed? If so, what is his current view?*

290. He told the Committee that it is unusual to change opinion. He had heard the Registrant and the other witnesses. Some people might use the Mallet unit, some the cover test and some might put prisms in front and ask if it is better and use their clinical intuition to decide what to prescribe. He referred to a paper by Otto et al. (2008). This was another method that might be used.

291. Mr Archer:

Having heard the oral evidence received in the proceedings so far, has his opinion [particulars] *3, 6, 11, or 14 (adequacy of the Registrant's record keeping for binocular vision assessments) changed? If so, what is his current view?*

292. Professor Barnard was also asked what his criticisms of the Registrant were. He told the Committee that some of the recordkeeping was *"profuse"*. When it came to recording the tests used, there were lots of numbers recorded which needed interpretation. It was not clear whether they were results of the Mallet test or Howell test. He could not determine this. He could see when the Registrant wrote down prisms. In his view, it was better to record the test result with the test type and the prescription.

293. Professor Barnard was asked again about the various classification systems that are employed by practitioners and about the alleged misdiagnoses (particulars 1,4, 9 and 12). He told the Committee that when others come along, they need to understand the record.

294. He was asked about the alleged inappropriate prescribing of spectacles (particulars 2, 5, 10, and 13). Professor Barnard was of the view that the allegations cannot be proved.

295. He was asked about the alleged failures regarding external and internal examinations (Particulars 15, 16, 17, 18, 19, 20, 21, and 22).

296. Professor Barnard said that it was his recollection that the patients had been seen at Hospital. Not every appointment was a sight test. Some appointments were reviews. If an optometrist is claiming for an NHS sight test, an internal and external examination must be done unless there was a reason not to.

297. In cross-examination, Ms Hinton asked Professor Barnard where was his reference to colour imagery in his evidence? He stated that the prevailing practice is to use colour overlay and then put the tint in the glasses. She asked him whether the Registrant in his view followed the protocol.

298. He told the Committee he did not know. He said there were not many colorimeters in the UK. There were only about 150. This was the protocol that he used.

299. Ms Hinton referred him to paragraph 6.1.13 of his original report. She asked whether this was still his evidence. He said that the amount of data in numbers recorded by the Registrant had nothing adjacent to it on the page.

300. Ms Hinton asked the witness how long he spent interpreting the notes. He told the Committee he had spent a considerable amount of time in the records. In terms of discussions with the Registrant, he had spent a limited amount of time with him. He added that he could have done with a lot more time. He would have liked to have learned more for the rate of reading test and the Howell test.

301. Ms Hinton asked him about the importance of continuity of care with patients. Professor Barnard said that it was not that the Registrant was not making notes. The results of the tests were not annotated.

302. Ms Hinton asked Professor Barnard whether there was a problem with the Registrant's measurements. He said that measurements were not allocated to a technique. He stated that it was important to have the workings. In his view, the measurements were written in a manner difficult to interpret. He described it as a *"different dialect of optometry "*

303. Professor Barnard was asked for his opinion on the particulars of misdiagnosis. He told the Committee that the essence of the Registrar's records that were provided meant it was not possible to agree or disagree a diagnosis. He added that he (Professor Barnard) and Ms McCrudden could not see clearly the size of the deviation between distance and near. Professor Barnard indicated that in simple terms 'divergence' indicates the distance view where 'excess' is too far apart and 'insufficiency' is too close together. The problem is at far distance. 'Convergence' relates to a near problem. 'Excess' is where the eyes turn too much inwards and 'insufficiency' is too little. The problem is at near. Finally, he stated that it is comparative in nature, so it is a comparison between distance and near. To correctly assess the issue there should be a different measurement between distance and near.

304. He opined the Registrant was relying on the definitions. The Registrant was using fixation disparity and had not always written down the distance and near measurements. In his opinion it was difficult to say whether this or that diagnosis. He stated that *"he could extrapolate that there were muscle deviations he came up with a diagnosis that I could say were wrong. The formal definition is there is a measurable difference between far and near. One patient improved over time it and was important to keep records over time to look for progress or regression."*

305. Ms Hinton asked whether the recordings help an optometrist. Professor Barnard said that "*the final prescription was from fixation disparity. There are other ways of prescribing the prism. There may be better quantitative improvements to be made."*

306. Ms Hinton referred Professor Barnard to paragraph 20 of his supplementary report dated 17 September 2025. She asked whether he still disagreed with Ms McCrudden. He stated that everyone has a *"muscle imbalance."*

307. Ms Hinton referred the witness to paragraph 5.2.2 of Ms McCrudden's report (page 222) He agreed that the records were *"not adequate for continuity of care".*

308. Professor Barnard was asked what he said about the importance of notetaking. He said the "*Registrant knows what he is using others may not know.*" He added that he did not think the *"colour thing"* is a good example.

309. Ms Hinton asked about the joint report with Ms McCrudden. In relation to Patient 1 she highlighted that his opinion was the Registrant fell far below the standard for a competent optometrist. He was asked what was the cumulative effect of the Registrant's breaches or lapses? He told the Committee that it came back to the poor record keeping, and he had his view because of this.

310. Professor Barnard was asked about paragraph 196 of his addendum report. He told the Committee that when considering conduct this was a minor error. *"It was different when it was far below as this was more serious with an increase to the risk of harm."*

311. Professor Barnard was taken to paragraph 6.15.3 of the joint expert report (page 324) where he said that the Registrant fell far below the standard. Professor Barnard informed the Committee that "*where the Registrant had not done the test he did not say why."*

312. Ms Hinton asked whether the statutory requirement is in place to decrease the risk of a condition being missed and for it to be treated as appropriate. Professor Barnard agreed. Professor Barnard was asked whether he would characterise that minor errors don't cause harm. He stated that "*there were clinically challenging children that the normal optometrist could not deal with. He added that children can be difficult, and clinicians need to have some learning."*

313. Ms Hinton asked Professor Barnard about the four occasions that the Registrant did not carry out an internal or external eye test. He was asked about his previous view that the reasons for not doing so should have been recorded by the Registrant. Ms Hinton asked the witness to comment on why he changed his opinion. Now he was of the view that any failure did not fall far below the standard whereas previously it did fall far below the standard. She suggested to the witness he told the Committee that ordinarily the optometrist would not see the child for another 12 months. Professor Barnard indicated that internal and external examinations for children should be carried out around every six months, but at least every 12 months to be sure. He was further asked about the requirements of the law and statute. Professor Barnard stated that "*the four dates needed to be looked at"* He said, *"the panel members will know the latitude on the requirements*."

314. Mr Archer highlighted to the Committee that the questions were put on the basis of four dates but there were other dates.

315. Professor Barnard was informed by the Chair that he would be required to attend on Wednesday the 7 January to continue with his evidence. He was warned that he was still under oath and that he should not discuss his evidence with anyone.

Professor Barnard (continuation on the 7 January 2026)

316. At the start of the second day (Wednesday 7 January) of the resumed hearing, the Chair made the parties aware that while Professor Barnard was in the hearing room with him and Ms Ellis before the start of the resumed hearing, Professor Barnard tried to raise a question with the Chair on procedure.

317. The Chair confirmed to the parties that he interrupted Professor Barnard before he could ask anything specific and indicated that he should wait for the full Committee and parties. Both parties accepted this explanation.

318. When Professor Barnard continued, he clarified some of the evidence he gave on Monday, the 5 of January 2026 to the Committee regarding methodologies for reading and colours. He informed the Committee that he was aware they were some publications on the Registrant's methods. This realisation had occurred to Professor Barnard in the middle of the night, and he wished to clarify this as part of his evidence to the Committee.

319. Ms Hinton did not have any further questions, and neither were there any re-examination questions.

320. The members of the Committee each asked Professor Barnard questions. Ms Ellis referred him to paragraph 191 of his addendum report. He was asked whether he would expect an internal and external eye examination of the patient at the hospital to be done and whether the Registrant would know if it had been done.

321. He told the Committee that if orthoptists were involved at the hospital, they would not perform the internal or external eye examinations but if ophthalmologists were involved he would expect this to be performed. He said if the patient is seen at the hospital, he could not assume that internal and external examinations have been done.

322. Ms Ellis asked Professor Barnard if there is a difference between adults and children in adding the plus lenses and whether he would expect a more plus prescription for accommodation.

323. Professor Barnard said that children might be less reliable if you add plus to a child. They may notice magnification.

324. Professor Barnard indicated that practitioners may note a different clinical outcome depending on when the patient is seen. There is a possibility that patients seen at different times in different environments and through using different tests may manifest different results.

325. Mr Summerskill asked Professor Barnard what is meant by peer reviewed.

326. The witness explained that a paper is submitted to a number of practitioners asking them to read and critique it. One outcome is that it is not publishable. One outcome is it is acceptable without revisions. He did not know the importance of the Ecronicon journal compared to The Lancet and Professor Barnard indicated that he did not know the Ecronicon journal and did not know how robust their peer

review process was. When it comes to comparing techniques, there would be a need for trials.

327. Professor Barnard was asked about the difference between NHS practice and non-NHS practice.

328. Professor Barnard informed the Committee that the sight test in the NHS is modest taking 20 to 25 minutes. Intuitive Colorimetry was not part of the NHS and would take time. The NHS sight test pays a limited fee and is functional.

329. Mr Hanson asked the witness whether in his opinion he was aware of professional tension between Hospital and Community optometrists in this case. He said that he was.

330. The Chair asked about convergence and divergence and the difference between distance and far views.

331. Professor Barnard told the Committee they were comparative in nature with differences in the measurements between distance and near. To correctly allocate, one needed different sizes in the measurements. He stated that the measurement obtained depends on the test that is carried out. One person may say there is an imbalance in near and distance, and another person may say there is no difference.

332. The Chair asked whether in circumstances where a prescription is given as an add-on whether that is evidence of a diagnosis. Professor Barnard told the Committee that if a prism was given, and tests were carried out, this would indicate that a diagnosis was given.

333. The witness was asked to read pages 22, 19, 26 (paragraph 10) 28 (paragraph 13), page 75 (paragraph 8), page 95) paragraphs 10 and 11) of the main bundle being the hospital witness statements and parents' statements which suggested that they felt there had been a misdiagnosis and that the glasses were not helpful. The Chair asked for clarity as to whether the Registrant was trying to be helpful to the patients considering the view expressed in these paragraphs.

334. Professor Barnard told the Committee it depends on how you define helpful. The patient may have symptoms or may not have symptoms. There was no corroboration. The hospital said the functional problems were psychosomatic. Professor Barnard's opinion was that the Registrant got the diagnosis correct and the hospital did not. In his opinion, the Registrant referred correctly. Professor Barnard explained that the basis for this opinion, considering that he had not seen the Patient, was that misdiagnosing to such a degree would take the highest level of incompetence.

335. The Chair referred the witness to paragraph 196 (internal page 26) of his supplementary report. He was asked what he meant in paragraph 196.

336. Professor Barnard said there was no actual harm, so any failure was not far below the standard expected.

337. The Chair asked whether a risk of harm alone would still be sufficient to find that it was far below the standard.

338. Professor Barnard stated that there was always going to be some risk. If anything is more than minimal, the risk will be far below.

339. Ms Ellis referred the witness to paragraph 194 (page 26) of his addendum report. She asked Professor Barnard whether a failure to do a statutory requirement fell far below. Professor Barnard indicated it did.

340. Ms Ellis also asked Professor Barnard whether there was a risk to the whole profession of people taking innovative procedures.

341. He said that he did not think so. He added that "*the Registrant used techniques similar to other procedures. The Registrant is using another system that is similar. His note of reading tests is quite innovative; that may be valid. He compares the rate of reading without the colour. Yes, this was possibly not valid. Some educational psychologists don't think it's valid."*

342. There were no questions from Ms Hinton arising from the questions from the Committee.

343. Following the questions from the Committee Mr Archer asked him when he looked at the prescriptions could he deduce the eye problems he diagnosed.

344. Professor Barnard said he could and gave the Mallet test as an example. The tests were carried out by orthoptists. There was input from ophthalmology.

345. Mr. Archer asked about the distinction between orthoptists and optometrists.

346. He said that optometrists check the health of the eye and the role of refractions. Orthoptists were interested in muscles. Paralysed muscles tend not to be involved in fixation disparity and there was not much work done by optometrists.

Submissions on behalf of the Council on Facts

347. Ms Hinton on behalf of the Council referred the Committee to her written closing submissions set out in document C18. She referred to the document in her oral submissions and summarised paragraphs 1 to 17.

348. The concerns about the Registrant were raised by ophthalmologists, optometrists and orthoptists working in the hospital. The particulars concerned a number of issues including misdiagnosis. The Council relied on the absence of records and also expert opinions as part of the evidence. She highlighted that the Committee was not required to find all the particulars proven. The Committee had to be satisfied on the balance of probabilities. She referred to the standard of proof set out in paragraphs 13.5 to 13.7 of the FTP guidance on outcomes.

349. The particulars concerned children with vulnerabilities. The Registrant did not record his methods. The Council maintained that the Registrant did not get informed consent. The techniques he used were not standardised. It was not possible for two optometrists to agree on his techniques. The Registrant provided nutritional advice outside his expertise which should have been referred to nutritionists.

350. While the Council acknowledged there was no malign intention, instead the Registrant was arrogant in his approach. Professor Barnard referred to him as an *"inventor".* The Registrant's method of recording was such that it was not possible to understand it. It could not be said that his diagnoses are correct on the balance of probabilities.

351. The Registrant denies that he did not perform internal and external examinations. Both experts agreed that it was particularly important that Patients' clinical needs were met and that consent was properly obtained.

352. Ms Hinton submitted that the Registrant has fallen foul of the guidance of the College of Optometrists. The Council were not alleging there were no records. However, the Registrant's methodology was not clear. Ms Hinton referred to the College guidance in the document and what the Registrant should have recorded. It was unclear how the Registrant reached the decisions he did. The Committee was invited to find the particulars proven.

353. The Registrant repeatedly failed to carry out internal and external examinations. The Registrant fell far below the expected standards expected for a reasonably competent optometrist. Internal and external examinations were not done for Patient 4. Significantly, the Registrant saw Patient 4 more than once. He habitually did not record the tests and did not say why. He denied he did so in document R18.

354. She submitted that Professor Barnard confirmed that the failure to carry out the examinations meant that the Registrant fell far below the standards expected of a reasonably competent optometrist. She further submitted that prescribing glasses without recording the test results is poor practice.

355. There were inaccurate records for Patient 1. There was also the absence of clear records for Patient 2. Similarly, the Council maintained that the Registrant did not carry out or record an internal or external eye exam for Patient 3. She submitted that the Registrant saw patient on six occasions, but no external or internal examinations were recorded for the Patient.

356. In terms of the prescribing allegations, Ms Hinton submitted the Registrant had prescribed prisms for Patient 2 on various dates in the record. Prisms were also prescribed for Patient 3. Ms McCrudden was of the view that Patient 4 was asymptomatic and a reasonably competent optometrist would not have advised a prescription for Patient 4. She submitted that the Registrant fell below the standards expected of a reasonably competent optometrist.

357. With regard to the misdiagnosis evidence, Ms Hinton submitted that the Committee should consider all the evidence before it. She submitted that a careful analysis of the evidence was required. The Council relied on the expert evidence regarding Patient 1 that there was inadequate evidence for the diagnosis. The Registrant fell far below the standard expected of a reasonably competent optometrist in June 2020.

358. When it came to Patient 2, there was also insufficient evidence for the Registrant's diagnosis. The experts agreed that there was no recorded evidence to support the diagnosis. Similarly, there was no recorded evidence to support a diagnosis for Patient 3 and Patient 4. In these circumstances, the Registrant fell for below the standard expected of a reasonably competent optometrist.

359. Ms Hinton addressed the Committee on the allegations concerning consent. She invited the Committee to find that the Registrant did not get the consent of all the Patients. She submitted that the Registrant fell far below the standard expected of a reasonably competent optometrist.

360. As regards the other allegations related to matters outside the extent of the Registrant's expertise, she submitted that he fell below the standards expected. She referred the Committee to paragraph A 202 of the guidance from the College of Optometrists about the tests to carry out key information that should be given.

361. Ms Hinton stopped at paragraph 17 of her written submissions. She highlighted that paragraphs 18 to 35 provided a detailed analysis and chronology and included all the evidence relied upon by the Council.

362. There were no questions from the Committee to Ms Hinton.

Submissions on behalf of the Registrant on Facts

363. Mr Archer on behalf of the Registrant referred the Committee to his written submissions on facts set out in document R 20. He submitted that the Registrant was an extremely accomplished optometrist with more than 45 years of clinical and academic experience. His specialist interest was in binocular vision. The Registrant had no adverse fitness to practice history whatsoever.

364. Mr Archer highlighted that not all witnesses were expert witnesses. They could not all give evidence that was expert evidence. He referred to the hospital witnesses at paragraphs 8, 9 and 10 of his submissions document.

365. Mr Archer summarised the 4 sets of allegations against the Registrant (misdiagnosis, prescribing, failing to adequately record assessments, failing to carry out external or internal eye examinations or failing to record such examinations). There were also allegations that the Registrant failed to obtain informed consent and that he acted outside of his expertise.

366. In relation to the allegations of misdiagnosis (1, 4, 9 and 12,) Mr Archer referred in his written submissions to the expert evidence of Ms McCrudden and Professor Barnard. He highlighted at paragraph 22 that the word diagnose means to identify the nature of an illness or other problem. *"Misdiagnose means to make an incorrect diagnosis so to incorrectly identify the nature of an illness or other problem".* He further submitted at paragraph 23 that there is no evidence that Mr Griffiths incorrectly identified the nature of the eye conditions in the case.

367. As regards the particulars concerning prescribing lenses that were not clinically indicated (2, 5, 10, and 13), Mr Archer referred to the expert evidence of Ms McCrudden. At paragraph 27 he highlighted that while it was accepted the Registrant's notes cannot easily be followed and this was a valid criticism, this was different to prescribing lenses that were not clinically indicated. He also referred to the expert evidence of Professor Barnard. He highlighted that at paragraph 186 of his addendum report it was now his *"opinion that these allegations cannot or should not be proved".*

368. Mr. Archer made submissions concerning the particulars (3, 6, 11 and 14) that the Registrant failed to adequately record his assessment of binocular vision. At paragraphs 33 to 36 Mr Archer referred to the evidence of the Registrant. Here Mr Archer set out of the details of the tests performed by Mr Griffiths as well as explaining his system of recordkeeping. He submitted that it could not be correctly said that the registrar failed to *"adequately record the assessment of these patients binocular vision".*

369. Mr Archer highlighted at paragraph 38 that particulars 7, 8 and 31 (iii) had been dismissed.

370. Mr. Archer addressed the Committee on the particulars (15 to 22) of failing to carry out external and internal eye examinations and alternatively failing to record such examination at paragraphs 47 to 70, Mr. Archer set out the details of the appointments and examinations that were carried out for each of the 4 patients. He submitted that it was not the case that it was necessary for the Registrant to conduct an internal and external examination at every one of the appointments. At paragraph 71 of his written submissions, he submitted that it could not be said that this amounted to a failure that no reasonably confident optometrist would have repeated.

371. Mr. Archer also set out his submissions regarding the particulars 23, 25, 27, and 29 that the Registrant did not obtain informed consent from the patients' parents. Mr. Archer highlighted the Registrant admitted he failed to record discussions in relation to obtaining informed consent. He had as a result, admitted to particulars 24, 26, 28 and 30. However, the Registrant could not accept that he did not have those conversations with the parents.

372. At paragraph 73, he highlighted that the only people who were present at the appointments were the patients, their parents, and the Registrant. At paragraph 76, Mr Archer referred to the requirement to obtain informed consent in the Standards of practice Part 3. He also reminded the Committee of the evidence given by the Registrant about his standard procedure.

373. Mr Archer then turned to particular 31(i) concerning the particular that the Registrant advised Patient 4's mother that Patient 4 had or was disposed to dyslexia.

374. At paragraph 84 Mr. Archer submitted that the Registrant was not diagnosing dyslexia. He submitted that there was a "*correlation between visual anomalies and dyslexia"*. The Registrant was not saying that patient 4 was dyslexic. The Registrant was *"simply signposting the correlation in an attempt to be helpful".*

375. Mr. Archer made submissions on particular 31(ii) concerning the particular, the Registrant provided dietary advice and recommended a book called the "Plant Paradox".

376. At paragraphs 85 to 90 of his written submissions Mr. Archer highlighted that the patient's mother did not mention the book in her witness statement. The particular was based on what the Registrant wrote in the supplementary section of the prescription. He submitted that whether giving the name of a book amounted to giving dietary advice was highly questionable. He highlighted in his written submissions that the Council had not presented any evidence to explain the content of the book.

377. Mr. Archer referred to the Registrant's good character. He submitted that this assisted the Registrant in that it added to the Registrant's credibility and was relevant to propensity. This was a factually complex hearing. He highlighted that there were some criticisms and some admissions from the Registrant.

378. Following questions from the Committee about paragraph 37 of his submissions and whether he intended to use the word "adequate", Mr Archer submitted that

the Registrant's records of the assessment of patients was adequate. However, he accepted there was room for improvement.

Legal Advice

379. The Legal Adviser said the Committee was considering an Allegation involving 31 particulars against the Registrant. He reminded the Committee that (i) the Amended Allegation appeared at document C15; (ii) it had already determined there was no case to answer for particulars 7, 8, and 31(iii); and (iii) particulars 24, 26, 28 and 30 were already admitted.

380. The burden of proving the disputed facts is on the Council. The Registrant does not need to disprove anything in the Allegation. The standard of proof required is the civil standard, that is on the balance of probabilities. The Legal Adviser referred the Committee to the guidance on evidence and the standard of proof at paragraphs 13.1 to 13.17 of the Hearings and Indicative Sanctions Guidance for the Fitness to Practise Committee. He advised that the more serious the allegation, the more cogent is the evidence required to overcome the unlikelihood of what is alleged and therefore to prove it (Re Dellow's Will Trusts [1964] 1 WLR 451, 455).

381. The particulars of failure against the Registrant (Particulars 3, 6, 11, 14, 15, 16, 17, 18, 19, 20, 21, 22, 24, 26, 28, 30) required a two-stage approach. Firstly, the Committee needed to consider if a duty or obligation exists upon the Registrant to act in that manner, is established. Secondly, if a duty or obligation is established, to go on to consider if a failure is established in respect of it. The Committee should have regard to *Standards of Practice for Optometrists and Dispensing Opticians* and the *Guidance for Professional Practice Knowledge, Skills and Performance* from the College of Optometrists.

382. The meaning of "misdiagnosis" is not set out in the guidelines or standards. The Committee should apply the ordinary dictionary definition and meaning. The meaning of diagnosis is "to identify the nature of an illness or problem". The meaning of misdiagnosis is "an incorrect diagnosis of an illness or other problem".

383. The Committee was also advised to apply the ordinary dictionary definition and meaning of adequate. The common ordinary meaning of adequate is "satisfactory or acceptable in quality and quantity".

384. The Committee must consider all the evidence carefully. It must decide the case only on the evidence heard or is properly before it. All the evidence should be considered alongside each other to enable the Committee to consider and assess it in its totality. When assessing the evidence of all the witnesses and the Registrant, the Committee will need to consider; (i) the reliability of their evidence, (ii) the weight you give it, (iii) differences or discrepancies that arise, and (iv) their relevance if they do arise.

385. The Legal Adviser reminded the Committee that some of the evidence it has before it is hearsay evidence. Hearsay evidence is essentially an account from a witness who has not given live evidence in the proceedings. Their evidence has not been tested in cross-examination and neither has the Committee been able to ask the witness any questions.

386. The Committee was advised on the critical distinction between the admissibility of hearsay evidence, and the weight to be attached to it. In the cases of *Ogbanna, Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin) and *El Karout v Nursing and Midwifery Council* [2019] EWHC 28 (Admin) the court highlighted the two distinct stages to assessing fairness when considering hearsay evidence in regulatory proceedings. The first is its admissibility. The second stage is its weight.

387. There is no dispute between the Council and the Registrant about the admissibility of the Council's hearsay evidence. The Registrant does not object to the Council relying on the hearsay evidence. The issue for the Committee is the weight that it should give it as appropriate. The Committee should have regard to the considerations relevant to weighing of hearsay evidence at s.4(2) of the Civil Evidence Act (1995). In estimating the weight, if any, to give to the hearsay evidence relied upon by the Council, the Committee should have regard to any of the circumstances from which any inference can reasonably be drawn as to the reliability or otherwise of the hearsay evidence.

388. The Committee was advised that when it comes to the credibility and reliability of all the witnesses, it should not assess witness credibility exclusively on their demeanour when they gave evidence. In particular, a witness's veracity should be tested by reference to the objective fact(s) proved independently of their testimony, where this is possible, in particular by reference to the documents in the case. In assessing reliability, the Committee should make a rounded assessment of a witness's reliability, rather than approaching their reliability in respect of each particular in isolation from the others.

389. The Committee was referred to *Dutta v GMC* [2020] EWHC 1974 (Admin) where at paragraph 39 the court highlighted the best approach from a from a judge "to base factual findings on inferences drawn from documentary evidence and known or probable facts".

390. The Registrant has no fitness to practise history, and it may be appropriate to give a good character direction. In *Sayer v General Osteopathic Council* [2021] EWHC 370 (Admin) at paragraph 131 the court considered the relevant legal principles on "good character". It was not the function of the Legal Adviser to give "directions" to the members of the Committee; rather it is to give advice. The court concluded "In professional disciplinary proceedings, on the authorities, there is no rule or, even standard practice, that in every case a good character direction should be given by the Legal Adviser. "There may be cases where it is appropriate to give such a direction; for example, where dishonesty is a central issue. The question in each case is whether on the facts of the particular case such a direction should be given".

391. Good character is not of itself a defence to an allegation. Good character can properly be material, and is material, at the facts finding stage of the Committee's deliberations when considering the Registrant's credibility (*Wisson v. Health Professions Council* [2013] EWHC 1036 (Admin)). It is not limited to allegations of dishonesty.

392. The Registrant's 'good character' arises from no previous findings against him by the Council. In general terms, 'good character' is capable of being counted in the Registrant's favour in two ways. The Committee may decide that good character evidence supports the Registrant's credibility, and so is something which the

Committee should take into account when deciding whether they believe his evidence (the 'credibility limb'). Good character evidence may also mean that the Registrant is less likely to have done or, less likely to have failed to do what is alleged against him (the 'propensity limb'). The weight that the Committee attach to this at the fact-finding stage is a matter for the Committee.

393. Where a Committee becomes aware of previous investigations or findings, the Committee should put those from its collective mind. (*Enemuwe v Nursing and Midwifery Council* [2015] EWHC 2081 (Admin)).

394. However, the Committee must, of course, consider all the evidence that has been placed before it that bears on each fact which remains in dispute. It is one thing that it as a Committee can consider.

395. The Committee are entitled to come to a conclusion on the disputed facts based on the whole of the evidence that the Committee has considered. This includes the expert evidence that is relied upon and that has been called by the Council and the Registrant. The Committee should consider the expert evidence in its proper perspective. It is before the Committee as part of the evidence as a whole, and to assist it on matters that are likely outside its experience and knowledge.

396. The paramount duty of an independent expert is to assist the Committee on matters within the expert's own expertise. This duty overrides any obligation to the party that instructs or pays the expert. Expert evidence should be the independent product of the expert. Experts should consider all material facts, including those which might detract from their opinion and should provide objective, unbiased opinion on matters within their expertise.

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

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

Findings on facts

399. The Committee considered the Registrant's good character. The Committee found the Registrant to be a credible and honest witness who managed the challenges of giving lengthy evidence well and appeared to the Committee to be fair and candid about the issues. Throughout the Committee's consideration of each of the particulars, it separately considered the legal advice around credibility and propensity with regards to the Registrant's evidence including the likelihood of him having committed the breaches alleged. The Committee applied due weight to the Registrant's good character in its consideration of each of the particulars. This written determination does not repeat this consideration under each separate

particular specifically, in order to avoid repetition and add to this already lengthy document.

Particulars 1, 4, 9, and 12 (Misdiagnosis)

400. The Committee considered particulars 1, 4, 9 and 12. These particulars concerned the alleged misdiagnosis of Patients 1, 2, 3, and 4 with divergence insufficiency and/or convergence excess and/or accommodation insufficiency.

401. The Committee applied the dictionary definitions of; (i) diagnosis as "identifying the nature of a problem", and (ii) misdiagnosis as the "incorrect diagnosis of a problem". The Committee also very carefully considered the meanings of "*divergence*" and "*convergence*" with respect to eye position and accepted the description in the expert report and in the oral evidence of Professor Barnard.

402. The Committee understood the term *divergence*, when used with the terms insufficiency or excess describes the eye position for distance vision. The problem is at the far distance. Divergence referred to the eye position with a distance view. When eye position was too far apart, there was an excess. When eye position was too close together, there was an insufficiency.

403. The Committee also understood the term *convergence* when used with the terms insufficiency or excess, referred to the eye position with a near view. When eye position was turned inwards too much, there was an excess. When eye position was turned in too little, there was an insufficiency.

404. The Committee understood the important comparative nature of convergence and divergence as a comparison between distance and near vision. To correctly identify a problem with divergence or convergence and excess or insufficiency, it was necessary for any professional to have different measurements between distance and near vision for a Patient.

405. The Committee carefully considered and assessed all evidence of the experts and all the other witnesses. The Committee concluded that there was a lack of clear evidence from both experts, Ms McCrudden and Professor Barnard, that the Registrant misdiagnosed any of the 4 Patients as alleged in particulars 1, 4, 9, and 12. For example, in her expert report at paragraph 5.2.4 (page 213) Ms McCrudden is of the opinion that the Registrant included "insufficient clinical evidence" for Patient 1 on all occasions. However, she did not conclude the Registrant misdiagnosed Patient 1 or Patients 2, 3 or 4. Similarly, Professor Barnard did not conclude that the Registrant misdiagnosed any of the 4 Patients included in the allegations.

406. The Committee also concluded there was insufficient evidence of a diagnosis in the Registrant's notes. However, there was clear evidence of a diagnosis from the prescription. This was supported by the expert evidence of Professor Barnard that the prescription was a way to assess the diagnosis.

407. The Committee also considered and assessed the statements, and letters exhibited by the other witnesses. It accepted that based on the hospital records and statements from the professionals, there is clear evidence of a diagnosis from the Registrant. The Committee also concluded that the evidence from the hospital witnesses demonstrated clearly that they disagreed with the Registrant's diagnosis regarding Patient 1.

408. The Committee noted that the Registrant first saw Patient 1 on the 30 June 2020 and wrote a letter summarising his diagnosis to the Parent dated the 11 April 2022. Patient 1 was subsequently seen by 2 different orthoptists at the hospital; on the June 2022, 28 June 2022, and there was a hospital review on the 18 July 2022. Ms F (hospital optometrist) carried out an examination on the 9 June 2022 and Mr B (hospital orthoptist) carried out an examination on the 9 June 2022.

409. The Committee also considered that in her statement, Ms B (Consultant Opthamologist) highlighted that *"I was able to see that* [Ms F] *(hospital optometrist)'s examination on 9 June 2022 and* [Mr B] *(hospital orthoptist)'s examination on 9 June 2022 had showed normal convergence with good visual acuities in both eyes."*

410. In addition, the Committee noted the Registrant wrote a report on the 30 November 2022 after he saw Patient 1 earlier on the 25 November 2022. The report again states Patient 1's diagnosis.

411. The Committee concluded that the evidence it had carefully considered supported the conclusion that there was a disagreement between the hospital witnesses and the Registrant with respect to his diagnosis.

412. However, the Committee concluded that although there was evidence that the professionals at the hospital disagreed with the Registrant's diagnosis, it accepted the experts' evidence that testing Patients on different times, in different environments and using different tests can materially impact the results and therefore the diagnosis. For example, Patient 1 was seen at the hospital on the 9 June 2022. This was 2 months after the Registrant saw the Patient. Consequently, the Committee found that the Council had presented insufficient evidence to discharge the burden of proof for particulars 1,4,9, and 12. These particulars were unproven.

Particulars 2, 5, 10, and 13 (prescribing lenses when not clinically indicated)

413. The Committee considered that in order to assess these particulars, according to Professor Barnard's oral evidence, it was beneficial to assess whether the glasses prescribed were actually helpful to the Patients.

414. The Registrant's notes indicated that the glasses were helping the Patients and the hospital note for Patient 1 indicated the Patient preferred the Registrant's prescriptions and glasses over the hospital prescription.

415. However, the Committee noted that in Patient 2's parent's witness statement, they were critical of their experience of the Registrant's prescription process. They said that it *"often felt like a trial-and-error basis to improve their (Patient 2's) vision*".

416. The Committee carefully considered the expert reports of Professor Barnard and Ms McCrudden. The Committee noted Ms McCrudden concluded in her expert report at pages 214 to 218 (paragraphs 5.1.6, 5.1.10, 5.1.13 and 5.16) that there was insufficient evidence to support the clinical indications for the prescriptions for all 4 Patients.

417. In addition, the Committee also noted in the joint report with Professor Barnard dated the 22 June 2025, Ms Mc Crudden concluded that there was insufficient detail of tests and results to show the clinical indication for prisms /varifocal lenses

for Patients 1, 2 and 4 on any of the relevant dates. Furthermore, the agreed report indicated that there was poor record-keeping which meant that there was no clear indication of the necessity for the prescription.

418. The Committee also considered the addendum report of Professor Barnard on these particulars. While the Committee found Professor Barnard's expert report and joint expert report of considerable assistance, his addendum report was less helpful particularly around prescriptions.

419. The Committee concluded Professor Barnard focused on the complexities of the Particulars instead of on the Particulars themselves. The Committee also concluded that his responses to its questions around the distinction between adult and child patients included examples that were extreme and which the Committee concluded appeared to be prevarication.

420. The Committee is aware that the decision whether to find the particulars about the prescribing of the prisms and the varifocals proved or otherwise was for it to make. The Committee is concerned that Professor Barnard made a statement that appeared to supplant the decisions of the Committee.

421. The Committee would record that it was also relevant that Professor Barnard lost some credibility with his addendum report particularly paragraph 161 where he stated *'My view has changed. I am unable to assert that these prescriptions were not clinically indicated'.* The Committee noted that his change of opinion did not appear to be fully explained and only indicated that Patients' subjective perceptions should determine whether a prescription was clinically indicated. The Committee considered that he did this without acknowledging the challenges of Patients with specific additional needs.

422. It was clear to the Committee based on the evidence in the records that the Registrant and the clinicians at the hospital found different results for Patients 1, 2 & 3 clearly showing a disagreement among experienced professionals. In this consideration, the Committee fully acknowledged that the hospital clinicians were only witnesses of fact, and it did not consider their evidence to be anything other than statements of what they found in their tests.

423. The Committee also carefully considered the Registrant's evidence on the reasons why he prescribed prisms and varifocals for the 4 Patients. His evidence to the Committee was that his approach was as follows: *"This is based on experience and something to try and left with a dilemma as to do something or nothing*; *"So prescriptions was on same principle subjectively and in the attempt to try something and in the knowledge that it was not going to do any harm, unless prism isn't appropriate in which case the patient would complain"; "Largely subjective, but not tested in traditional way, rather than doing nothing".*

424. He also told the Committee that "*This is a patient who I felt had real trouble seeing binocularly and didn't know if this was underlying problem or lack of ocularity and thought I had to do something. I thought with general lassitude, I thought it might be worth trying something to help those two mechanisms which were a reading add and a prism" …"You learn nothing by doing nothing".*

425. The Committee noted that for Patient 3 the experts in the agreed report indicated that there was some evidence for prescribing the varifocal that they could identify. However, the experts identified insufficient evidence for the prism prescription.

The Committee accepted the joint experts' evidence that there was no recorded evidence to support the clinical indication for prescribing prisms for Patient 3.

426. Consequently, the Committee found particulars 2, 5, and 13 proved on the balance of probabilities.

427. The Committee also found particular 10 proven as to the prism only as the experts found some evidence for varifocals.

Particulars 3, 6,11, and 14 (failing to record binocular vision assessments)

428. The Committee applied the ordinary dictionary meaning of adequate as 'satisfactory or acceptable in quality and quantity' and accepted Mr Archer's comment that this was to be judged by the standards of a reasonably competent optometrist.

429. The Committee carefully considered the Registrant's oral evidence. The Registrant himself acknowledged that he found it difficult to follow his own records sometimes. For example, he explained his entries for Patient 1 (30 June 2020)) and told the Committee *"My writing isn't very good. I think it says 'log' on there"* and *"The next measurements are not very clear."*

430. When he explained his entries for Patient 2 (pages 189-190) to the Committee he had difficulty following his records. He admitted '*I'm now grasping at straws'.*

431. The Committee also considered the Registrant's evidence regarding his approach to keeping records. He told the Committee *"I don't write my records to enable anyone to understand them. But that doesn't stop me from making them as clear as I can. Sometimes I don't describe all of the tests because of time constraints. Hindsight is wonderful. To me its routine to use a particular test. I do them all the time. Recording is a distraction from the problem that is in front of me which I am trying to solve."*

432. The Committee also took account of the expert evidence of Ms McCrudden and Professor Barnard. Both experts expressed clear views that there was a paucity of notes. In the joint experts' report, Professor Barnard refers to the Registrant's *'habitual failure to record the test methods and results'* for Patient 1.

433. The Committee noted that Ms McCrudden's expert opinion in the joint report was that the Registrant failed to adequately record binocular vision details for Patient 1 during the relevant period that had to be considered.

434. For Patient 2 she concluded there were *'minimal details'* recorded for binocular vision assessments on some visits and *'no details recorded at all'* on others.

435. The Committee also noted Ms McCrudden reported there was an "*incomplete record for Patient 3's binocular vision assessment on the 28 July 2022"*.

436. The Committee also considered Professor Barnard's addendum report in which he remained critical of the Registrant when he concluded that in his opinion *"there was a failure to make adequate records"* with respect to these 4 particulars about Patients 1, 2, 3, and 4.

437. Based on all the evidence it had carefully considered and assessed, the Committee found that that the Registrant had, on the balance of probabilities, failed to adequately record the binocular assessments for Patients 1, 2, 3, and 4.

Accordingly the Committee found particulars 3, 6,11, and 14 were all found proven on the 'adequately' basis.

Particulars 15, 17, 19, and 21 (failing to carry out external/internal eye examinations) and alternative Particulars 16, 18, 20, and 22 (failing to record external/internal examinations)

438. The Committee noted that the Patient 1 had 4 appointments with the Registrant from the 30 June 2020 to the 25 November 2022.

439. In his evidence to the Committee about the visit on the 30 June 2020 he said *"There is no record in these notes of an internal eye examination. The purpose of the appointment was to discuss the problems the patient was having with their glasses. They had been discharged from hospital because there had been no 3D vision. I had a suspicion of binocular disability. I did not always undertake an eye examination at every patient consultation".*

440. He also told the Committee the purpose of the consultation on 19 January 2021 was to check the patient's binocular vision, and the prism. He said he did not carry out an internal or external eye examination during this consultation. He said *"I didn't do the examinations however when you do a retinoscopy you can detect the level of acuity. It gives you a feel for the health of the eye."*

441. The Committee also considered the expert evidence of Professor Barnard. At paragraph 6.15.1 – 6.15.3 of his report he concluded that there is no evidence that an external and or internal examination was carried out on any of the dates by the Registrant during the relevant period for Patient 1. His expert opinion is that unless there are reasons why it was not possible to carry out such examinations, which should have then been recorded, these failures fell far below the standard expected.

442. Professor Barnard did not change his view in his addendum report with respect to paragraph 6.15.3 of his original report or the reasons.

443. The Committee concluded on the balance of probabilities there was a duty on the Registrant to carry out the internal and external examinations for Patient 1. He admitted that he had not done so. Accordingly, the Committee found particular 15 proved.

444. As particular 16 was in the alternative to 15, the Committee did not have to determine the factual basis of it.

445. The Committee noted that Patient 2 had lots of appointments with the Registrant during the period from the 27 April 2013 to the 23 July 2022. This was a period of 9.5 years of appointments with the Registrant and there was a requirement that annual assessments should be completed.

446. The Committee carefully considered the appointment records with Patient 2, and the Registrant's comments about these appointments when he gave his evidence to the Committee. The appointments with the Registrant were as follows, as stated in the Registrant's written closing submissions:

27/4/13 – 'Oph difficult' - attempted ophthalmoscopy attempt but could not do it as eyes still wandering. No able to complete internal eye exam. 15/6/13 - Partial ophthalmoscopy – could not do full internal exam as eye wandered off

17/8/13 - Used ophthalmoscope – right and left media clear – could not ever see disc – never came into view as eye kept swapping

18/1/14 - Ophthalmoscopy difficult.

447. The Registrant explained in his closing submissions that when *"he covered one eye Px 2 started using the other eye and both eyes started moving, which made it very difficult to bring internal features into the eye. As Px 2 was light sensitive. Mr Griffiths did not pursue it too much.*

7/6/14 - Ophthalmoscopy not attempted".

448. The Registrant, further explained on the next occasion *'he did not think it was fair to ophthalmoscopy on this occasion'.*

'13/1/15 - Ophthalmoscopy not attempted as it had been unproductive in the past'.

449. The Committee also carefully considered the records of appointments with Patient 2 and the Registrant's evidence to the Committee about the visits in his closing submissions.

'6/6/15 - Internal exam conducted with ophthalmoscope – fundas reflex clear, vessel regular – however it was still difficult to see details like CD ratio due to movement in her eyes all the time.

9/1/16 – Opthalmoscopy not conducted for same reasons as before, and also because Mr Griffiths had done it on the previous test. For the sake of not putting Px 2 under too much stress with light and not being overly concerned with her performance.

1/6/16 - Ophthalmoscopy conducted – fundas clear, discs not seen due to fixation difficulties – PERRLA (pupils equal, round and react to light, accommodation) – this is a standard reference (it appears in Annex 2 of the College of Optometrist Guidance which lists standard ophthalmic abbreviations [R5, PDF 190-191].

14/10/17 – Ophthalmoscopy conducted – fundi clear – discs not seen because patient could not fixate – PERRLA

23//11/18 – Ophthalmoscopy conducted – I was able to get a better look at the fundas on this occasion. I even got a fleeting glance of the discs, but fixation was still a problem

23/7/22 - "bright fundas reflect" – indicates ophthalmoscopy'.

450. The Committee noted that Patient 2 was a child who is vulnerable and with reduced vision. It concluded that from the 27 April 2013 to the 13 January 2015 the Registrant had not conducted a successful internal or external eye examination of the Patient.

451. The Committee found that a period of around 2 years had passed where no internal or external examination was conducted. This was a long time not to check the eye health of a vulnerable patient for any pathology.

452. The Committee concluded that the Registrant should have found an alternative method of conducting an internal and external eye examination during this period or could have at least referred the Patient to another professional. The Committee concluded that there was a risk to Patient 2 from the lack of internal and external eye examination particularly as they exhibited signs of reduced vision. The Registrant's inability to conduct an internal and external examination during this

considerable period did not appear to have been mitigated by the Registrant in any way.

453. Consequently, the Committee found particular 17 proved.

454. As particular 18 was in the alternative to 17, the Committee did not have to determine the factual basis of it.

455. The Committee considered the 2-month period between the 28 July 2022 and the 17 September 2022 for Patient 3. The Committee examined the purpose of the visit on the 28 July 2022. In his oral evidence to the Committee, about the visit the Registrant said *"I have noted first of all that on the 18 July 2022, this patient had an eye examination at the hospital, it's at page 105. I saw the patient on the eye plan on the 28 July*." In addition, he told the Committee *"I've made a note about a school visual assessment and also about advising on dietary matters".*

456. The Committee concluded that on the balance of probabilities there was insufficient evidence of a duty on the Registrant to carry out a sight test on the 28 July 2022.

457. The Committee then examined the purpose of the visit on the 17 September 2022. It reviewed the Registrant's oral evidence about the visit. In his evidence to the Committee, he said *"This was the patient's second visit. It would have been a full binocular assessment".*

458. The Committee concluded that on the balance of probabilities this was not a visit for a full sight test but was a school vision assessment which was distinct from a full sight test and as such there was no duty on the Registrant to carry out an internal and/or external eye examination. Consequently, the Committee found particular 19 unproved.

459. As the Committee found that there was no duty arising on the Registrant to carry out an internal and/or external exam during the 2-month period, the Committee determined that there was no requirement to record and as such find particular 20 not proved.

460. The Committee noted the 18-month period it had to consider for Patient 4 was from the 1 August 2018 to the 18 February 2020. This involved 6 appointments with the Registrant.

461. The Committee examined each of the appointments in turn. It noted the following examinations set out in the expert report of Ms McCrudden.

'*01/08/2018 Internal conducted only*

28/08/2018 Rx issued.

17/11/2018 Rx issued.

4/05/2019 Rx issued. No ext or int examinations recorded.

28/8/2019 Rx issued. No ext or int examinations recorded.

17/08/2019 Rx issued. No ext or int examinations recorded.

18/02/2020 Rx issued. No ext or int examinations recorded'

462. The Committee considered both the Registrant's evidence and that of the experts with respect to the duty to carry out the examination. The Committee took account of the clinical records for the 1 August 2018 and the 17 November 2018. Although

an internal examination was only carried out on the 1 August 2018, the Committee noted the conclusions of Ms McCrudden which were referred to at paragraphs 70(a) and 70(b) of the Registrant's Submissions.

a.*"1/8/18 [207-9] – When I asked Ms McCrudden about the record of this appointment, she said, "There is perfectly adequate information of the internal eye examination there". [14 July 2025, p.36F]. Ms McCrudden also said, "I am not overly critical about nothing being recorded for the external. As I say, a lot of people would record a red eye by default, unless the patient had some sort of symptom that suggested you needed to be recording details." [14 July 2025, p.36G] (see also p.37A)."*

b.*"17/11/18 [206] – Ms McCrudden also accepted that the record of the internal and external examination was adequate on this occasion: "I'm not critical of what was recorded then" [14 July 2025, p.37C]*

463. The Committee noted that although Professor Barnard appeared to indicate in his expert report that no eye examination was carried out for this date, Ms McCrudden reported that it was carried out.

464. The Committee carefully considered the period from the 17 November 2018 (when the internal and external examination was last carried out) to the 18 February 2020. In his expert report, Professor Barnard refers to the regulations laid out under The Sight Testing Regulations (1989). These state that *"when a doctor or optician tests the sight of another person, it shall be his duty to carry out an external and internal examination of the eyes."* The Committee also noted Professor Barnard's oral evidence that internal and external eye examinations should be carried out at least every 12 months.

465. Professor Barnard concluded that the Registrant's failure to carry out an internal or external examination on Patient 4 on the 5 May 2019, 28 August 2019, and the 18 February 2020, fell far below the standard expected.

466. In regard to the visit on the 17 August 2019, Professor Barnard noted that the Registrant recorded Patient 4 had been to hospital and noted *'retinal dystrophy'* and a note of apparent physiological tests. At paragraph 6.21.17 he concludes that the Registrant was legally required to carry out an internal or external examination. However, he also concludes that his failure to do so did not fall far below the standard expected.

467. Having assessed all the relevant witness evidence and records for Patient 4 the Committee noted that on the 17 August 2019 there is insufficient evidence that an external eye examination was completed at the hospital appointment related to Patient 4. There is some evidence of an internal examination (e.g. retinal dystrophy). The Registrant would not have information at the time of his examination as to whether an internal and external eye examination had been completed at the hospital and it was on the balance of probabilities unreasonable for him to presume that such examinations were completed.

468. The Committee found that the Registrant was under a duty to carry out an internal or external examination during the 18-month period where there was no evidence that one had been conducted. It also found that the Registrant failed to do so on the 5 May 2019, 28 August 2019, and the 18 February 2020.

469. Consequently, the Committee found particular 21 proved. As particular 22 is in the alternative, the Committee did not have to determine the factual basis of it.

Particulars 23, 25, 27 and 29 (obtaining informed consent)

470. The Committee first considered the issue of patient consent and the guidance from the College of Optometrists Guidance for Professional Practice. The Committee noted the distinction between the requirement for a practitioner to gain (i) standard consent from a patient to treatment and (ii) to obtain written consent *"if the treatment is part of a research programme or is an innovative treatment designed specifically for the patient's benefit"* (paragraph C27(d) page 154-155 of the Guidance). Ms McCrudden also references the Guidance in her expert report (page 239 paragraph 2.7).

471. The Committee next considered whether (i) the Registrant's tests were new and innovative and (ii) whether he was required to explain them to each of the Patients' parents and (iii) If the tests were new and innovative, the Committee had to consider whether the Registrant did explain the test to the Patient's parent and obtain their consent.

472. In his evidence, the Registrant stated he had created tests. Many of these were not familiar to the experts. He also indicated they were his own published ideas and tests.

473. The Committee considered that based on his evidence and that of the experts he appeared not only to use novel and innovative tests but also used tests in a novel way. During his evidence to the Committee about Patient 1 and the appointment on the 30 June 2020, the Registrant referred to the *"CRST test"* when he explained his entries in the records. He told the Committee that it *"is a measurement of the patient's ability to read characters instead of words. It is called a CRST test and I developed it."*

474. The Registrant also referred to the *"dynamic fixation test"*. In addition to describing the test, the Registrant told the Committee *"I helped to develop this test and patented it"*. However, he explained *"the patient understood the test very well".*

475. When the Registrant explained the Patient note entries for the appointment with Patient 3 on the 17theptember 2022, he explained that *"I see that I carried out a Rice test. This is a test using the brock string. It's a measure of fixation disparity and it showed very clearly that the right eye was suppressed or had switched off."*

476. The Committee also considered the expert evidence of Ms McCrudden and Professor Barnard with regard to whether the Registrant was undertaking research. In her oral evidence, Ms McCrudden's view was that she did not think any part of the Registrant's tests was part of research. However, she did consider that when she read the reports and records, they were certainly out with normal practice.

477. Ms McCrudden also considered that "innovative" is not the standard prescribing rationale and treatment protocols and was therefore out with normal practice. This was the case when she read the Registrant's reports as to why things were advised. Her opinion was that this was certainly not in the remit of what is taught or, how conditions are managed.

478. In relation to Patient 1 Ms McCrudden stated she had regarded some of the words used by the Registrant in his patient records to be 'novel.' She referred to her notes and explained that the words *"This is likely to be associated with the stress caused by a muscle imbalance (divergence insufficiency) and the consequent stretching effect across the cornea"* to be novel words. She explained this was because she not previously come across this as an explanation for an astigmatism. For her this was innovative.

479. She also told the Committee that Patient 2 was prescribed prisms and whilst this may not be 'novel' in itself, she considered that it may be 'novel' because she could not understand the reasons behind the prescription.

480. In relation to Patient 3, Ms McCrudden's opinion was that when the Registrant prescribed tinted lenses for the Patient, he would have required consent to do that. In her opinion, it was not a standard prescription.

481. The Committee noted Ms McCrudden's opinion on the issue of Patients giving consent orally and giving implied consent. She considered that fully obtaining consent was important here as in all the circumstances these were not normal treatments that are given from most optometrists. She confirmed that a Patient resting their chin on the rest after the procedure was explained as an example of the Patient giving implied consent for a standard test.

482. The Committee considered Ms McCrudden's report. She concluded that given the Registrant was advising non-evidenced treatments, it was her opinion that appropriate informed consent was not obtained and recorded. Furthermore, she also concluded that the Patients and their carers were not given sufficient information and were fully appraised of all the facts. She considered that the Registrant was citing references which were low level quality evidence. In her opinion this could be misleading to Patients or carers. If non-evidenced treatments are recommended it was her further opinion that Patients should be fully advised of the facts and any potential risks.

483. The Committee also considered Professor Barnard's evidence. At paragraph 6.23.7 he considers that *"There are some interventions that may be considered "controversial" or Innovative. This includes the use of colour to manage visual stress syndrome (e.g., Cerium Precision tints prescribed following Intuitive Colorimetry). Patients (parents) should be informed of the current thinking on such interventions"*

484. The Committee accepted the body of research and the experts' opinions about the consent required between standard and non-standard tests. The Committee considered in accordance with the experts' oral evidence that it was important to clearly obtain, and evidence consent when using non-standard "novel and innovative" tests.

485. The Committee considered that the Registrant should have explained the novel and non-standards tests he used with all the Patients to the Patients' parents. In using tests that were outside of standard practice, he had to get clear consent for these tests and treatment.

Patient 1

The Committee noted that there was no evidence from the parent for Patient 1. Therefore, there was no evidence the Registrant did not obtain consent for his tests. Consequently, the Committee found particular 23 not proved.

Patient 2

486. The Committee concluded that the Registrant used novel or innovative treatments with Patient 2. At paragraph 11 of her witness statement Patient 2's parent's evidence is as follows; *"At no stage was there any substantive explanations given or provided about the research that had been undertaken or the rationale for the basis of the assessment and recommendations being made. At times it did feel like there was a trial and error approach being taken to see what would and wouldn't work."*

487. The Committee found that on the balance of probabilities that the Registrant did not explain the treatment and obtain parental consent adequately. The Committee found particular 25 proved.

Patient 3

488. The Committee concluded the Registrant used a novel or innovative treatments with Patient 3. At paragraph 12 of her witness statement Patient 3's parent's evidence is as follows; *"There were a number of tests performed on Patient 3. I am unable to tell if these were any different from those tests she had at previous assessments at the hospital. I do not recall anything that stood out specifically as I was focused on getting her cooperation and keeping her entertained throughout the appointment."*

489. The Committee concluded it was unclear from this evidence that the non-standard test was not explained. The Committee found particular 27 not proved.

Patient 4

490. The Committee concluded that the Registrant used new and innovative treatment with Patient 4. However, the Committee noted that in her witness statement, Patient 4's parent was unable to recall whether the Registrant mentioned research to her.

491. The Committee was not satisfied on the balance of probabilities that the Registrant did not explain the treatment and did not find Particular 29 proved.

492. The Committee considered Mr Archer's and the experts' evidence based on research that patients were notoriously poor at recalling details around consent. However, they noted the distinction between that research and the current circumstances. In this case, the statements around consent were not from Patients but were from parents of vulnerable children who were paying considerable sums as they were concerned over their child's challenges at school. Therefore, the Committee gave the research little weight and focused on the actual evidence.

Particulars 24, 26, 28 and 30 (recording discussions about informed consent)

493. The Registrant admitted each of these particulars. The Committee found these proven on the basis of his admissions for each.

Particular 31(i) (acting outside of expertise)

494. The Committee considered the Registrant's oral evidence. He stated that there was a *"connection between drug industry and NHS and that health and vital research isn't being done because it doesn't include a drug and pharmaceutical companies are not going to profit by it"*.

495. In addition, he also told the Committee that *"psychologists are diagnosing something as dyslexia with no cause understanding and medicine calls it a disease without knowing what causes it".* He also stated *"I never pretended to diagnose dyslexia as my personal view is it doesn't exist".*

496. Significantly, the Registrant told the Committee that *"I agree that I did act outside the scope of my expertise".* The Committee noted that he wrote it on a prescription for Patient 4. The Committee considered the prescription for Patient 4 on page 263 dated 1 August 2018. The Registrant's notes in the prescription show *"predisposed to high myopia and binocular conflict (dyslexia)'.* Considering Patient 4's parent's statement and the potential ambiguity in the Registrant's prescription notes, the Committee considered that the parents of Patient 4 may not have been absolutely clear that the Registrant was referring to a 'predisposition' for dyslexia.

497. The Committee also considered the expert evidence of Ms McCrudden and Professor Barnard. Ms McCrudden's expert evidence was that *"the only way dyslexia can be formally diagnosed is through a diagnostic assessment carried out by a certified dyslexia assessor"*. Her opinion was that *"as an Optometrist, Mr Griffiths is not working within his limits of competence diagnosing dyslexia. Optometrists are not qualified to diagnose dyslexia".*

498. The Committee also carefully considered Professor Barnard's expert report. They noted the following conclusions that were relevant to its determination of this particular.

At paragraph 6.31.5 *"The Registrant does not appear to have noted that Patient 4 was dyslexia but rather predisposed".*

At paragraph 6.31.12 *"I am critical that the Registrant used the phrase 'predisposition to dyslexia' if the impression he gave had been that the visual anomalies might be a cause of possible dyslexia".*

At paragraph 6.31.14 *"I confirm that if an optometrist suspects an educational problem may be due to dyslexia, it is entirely within his scope of practice to suggest to a parent that advice be sought from a specialist such as an educational psychologist."*

At paragraph 6.31.9 *"The term 'predisposed' used here does not accurately reflect current understanding of the relationship between dyslexia and visual anomalies which is that visual problems do not cause dyslexia but appear to be more prevalent in that group."*

At paragraph 6.31.8 *"At page 1166/257 of the bundle, the Registrant's notes: ….physiological muscle imbalance would have a significant effect on his tracking (reading ability - predisposition to dyslexia) and positional sense (predisposition to dyspraxia) because of the effect on the stability of his dominant aiming eye.*

499. The Committee also had regard to the General Optical Council's Standards of Practice for Optometrists and Dispensing Opticians April 2016. It noted that Section 6.2 of the Standards states the following; *"Ensure that you have the required qualifications relevant to your practice*". In addition Section 6.3 states the following *"Recognise, and work within, your limits of competence".*

500. The Committee considered that although the note on the prescription was ambiguous, in any event, the use of the term 'predisposed' appears to imply something within the Patient that could develop into dyslexia. The Committee considered there was a difference between the Registrant placing a comment in the notes in the prescription and indicating to the Parent that the Patient might have an educational need. The Committee concluded that the two were different.

501. The Committee regarded this was outside of the Registrant's expertise and an educated guess. This was not something to include in a prescription where there were also diagnoses and comments around clinical binocular issues.

502. Having carefully assessed the evidence, the Committee found particular 31(i) proved on a balance of probabilities.

Particular 31(ii) (acting outside of expertise)

503. The Committee first considered whether the Registrant provided dietary advice when recommending the book entitled 'The Plant Paradox' to Patient 4's parent.

504. The Committee concluded that they had received sufficient evidence that the book is dietary in nature. The Registrant made several comments about this in his oral evidence to the Committee that it considered relevant.

505. The Registrant stated the following;

"I feel a duty to recommend something that might help"

"For example arthritis is beginning to be understood as process with lectin called gluten and my concern is that I am sure the medical profession is aware of this connection and why don't they instigate research into this possible connection. Why isn't it done. I have to ask myself about where most doctors research comes from in terms of drugs and most of it comes from the drugs companies. Possibly interest in finding a cure that doesn't concern a drug"

"I believe people have different sensitivities to gluten and Dr Gundrie believes we are all affected by them

"it's a recommendation based on my own interest in nutrition"

"Plant Paradox indicates and why patients, like patient 4, who was rotund, can't avoid cakes and biscuits containing sugar and protein gluten. I can't keep it to myself as diet connected to ocular health and nutrition, so I believe that not wrong to suggest to someone to whom I recognise these signs".

506. The Committee noted that the book title was in the supplementary information section of the prescription dated the 1 August 2018.

507. On the basis of the Registrant's own admission, the Committee concluded that on the balance of probabilities, 'The Plant Paradox' provided dietary advice.

508. The Committee then considered whether this was outside of the Registrant's expertise. It noted that Professor Barnard's expert evidence at paragraph 6.31.21 was the following; *"I am unable to comment on the appropriateness of the Registrant recommending this book when a. I am not an expert on the advice provided by the book b. the context of how and why the Registrant recommended it c. whether or not the Registrant explained his level of expertise, formal or otherwise and"*

509. The Committee were provided with considerable information about the book and its unorthodox views e.g. the Registrant said in oral evidence that the author *"found with science studies and patients with even critical heart conditions, that patients could heal themselves if causative factors were removed"*. The Committee also took into account the Registrant's knowledge, skills and experience and his interest in the unorthodox book. The Committee concluded that the Registrant showed considerable passion and interest in the topic, and they took on board the way the Registrant described it to them. The Committee noted that a lot of the content had nothing to do with optical matters but discussed neural tissue and heart genetic issues and genetically modified food. The Committee concluded, based on the Registrant's evidence that the book was not directly related to eye health or within the expertise of an optometrist.

510. The Committee considered that the more technical, specialist and controversial were a book's contents, the greater the expertise that would be expected prior to recommendation.

511. For these reasons, the Committee found this particular proven on the balance of probabilities.

Misconduct

512. The Committee next considered whether the facts found proved amounted to the statutory ground of misconduct.

Submissions on behalf of the Council

513. Miss Hinton made submissions on misconduct on behalf of the Council. She referred to her note and table on closing submissions and summarised some parts to the Committee.

514. Ms Hinton referred to rule 46(12) of the fitness to practice rules and section 13D 2(a) and (b) of the Opticians Act (1989). If the facts proved were less than misconduct, the Committee could go on to consider deficient professional performance as another ground.

515. She further submitted that on the basis of the facts proved, it was necessary to mark a finding of misconduct and go on to consider if the Registrant's fitness to practise was impaired.

516. Ms Hinton submitted that there was no statutory definition of misconduct and referred to several authorities on the approach the Committee should take and what they should consider with respect to deciding it.

517. In *Roylance v. General Medical Council* the court referred to a falling short of standards. She submitted that the falling short must be serious and a high degree was required (*R (on the application of Vali) v General Optical Council [2011] EWHC 310 (Admin*). A single act was less likely to be misconduct.

518. In *Roylance v. General Medical Council* the court referred to misconduct as being a word of general effect involving some act or omission which falls short of what would be proper in the circumstances. The court referred to the rules and standards expected to be followed. She submitted that this was particularly important in this case, as the Committee had heard from 2 expert witnesses.

519. In *GMC v Calhaem* the court said negligence did not constitute misconduct, but if particularly grave, could be misconduct.

520. Ms Hinton referred the Committee to her note and table on closing submissions and summarised the Council's position. She highlighted that the Committee needed to look at the Registrant's conduct both individually in relation to the Patients and also taken together.

521. There were four child Patients involved and the period concerning them was around 10 years. There were five categories of activities done or not done.

Prescribing

522. Ms Hinton submitted that there were no clear indications that the right standards were followed for record-keeping. The Registrant kept poor records. His prescriptions lacked a rationale and fell below the standards required.

Failing to record

523. Ms Hinton submitted that the Registrant's records were hard to follow.

Failing to carry out internal and external eye examinations

524. Ms Hinton submitted that that there was a statutory duty on the Registrant to carry out internal and external eye examinations unless there were good reasons not to do so. She also submitted that there was a risk of harm to Patient 2. Ms Hinton further submitted that the Registrant's omissions were serious and justified a finding of misconduct.

Consent

525. Ms Hinton submitted that that the Allegation had been proven for patient 2. She submitted that the Registrant used a novel test without clear consent and proper documentation was required.

Acting outside of expertise

526. Ms Hinton submitted that there was a substantial amount of evidence that the Registrant was acting outside of his expertise. He recommended a dietary book outside of his expertise.

527. Ms Hinton referred to the table in her submissions and the experts' conclusions in relation to the standards. She distinguished between those standards where the experts found the Registrant fell below the standards and those where he fell far

below. She submitted that where his conduct was found to be far below this amounted to misconduct. Where the conduct was just below, this could amount to deficient professional performance.

Submissions on behalf of the Registrant

528. Mr Archer submitted that there was no reference to deficient performance in the particulars and this should be ignored. This was a misconduct case.

529. He submitted that not every failing was misconduct. He referred to the case of *Roylance v. General Medical Council* and highlighted the courts qualification that the conduct had to be *"professional misconduct"* and *"serious".*

530. He referred to the case of *GMC v Calhaem* where the court made clear that mere negligence did not constitute misconduct.

531. He also referred to the case of *Nandi v. General Medical Council* where the court said that serious must be given its proper weight and was conduct which would be regarded as *"deplorable"* by fellow practitioners.

532. Mr Archer submitted that the authorities said the threshold for misconduct is set at a high-level. Negligence on its own was not sufficient to be misconduct. Fitness to practice was not concerned with mistakes or negligent acts.

533. Mr Archer submitted that the Committee needed to consider what had been admitted or found proved by the Committee. He submitted that the Registrant had never acted in bad faith but had been trying his best with the Patients. He submitted that most was not misconduct, but some of it was.

Particulars 2, 5, 10, and 13.

534. Mr Archer highlighted that the Committee had found these particulars were proven on the basis of insufficient data. One parent said the Registrant had a trial and error approach. The experts agreed that no harm had been caused. It had not been suggested that the Registrant dishonestly prescribed for the Patients. He was trying his best to help complex patients. His approach was 'you learned nothing if you tried nothing'.

535. Mr Archer further submitted that at all times, the Registrant was motivated to help the Patients. It was important for the Committee to see that his conduct was firstly, an honest attempt to assist his Patients and secondly, no harm was caused to them. No patient was placed in danger. One patient found the lenses more helpful than those prescribed by the hospital.

536. He submitted that the threshold for misconduct was high and was not reached in respect of the particulars concerning the prescribing of lenses.

Particulars 3, 6, 11, and 14

537. Mr Archer submitted that it was not the case that there were no records but rather, the records were inadequate and there was inadequate record-keeping.

538. Mr Archer submitted that the Registrant's interaction with his Patients was more important and more of a focus than keeping the records. In complex cases there was a challenge with taking detailed records when a practitioner was focusing on the Patients. Mr Archer continued that fellow practitioners may be critical, but it was unlikely that they would consider it deplorable. Mr Griffiths used handwritten

notes and accepted that others found it difficult to read these and indeed he found it difficult to read these sometimes himself. However, this did not amount to misconduct as it did not meet the high threshold.

539. He further submitted that no Patient suffered harm.

Particulars 15, 17 and 21

540. Mr. Archer submitted that the Registrant accepted that misconduct was made out on the facts proven for these Particulars.

541. He submitted that as regards Patient 1, the failure had to be seen in the context that the Patient had visits at the hospital and the Patient had received internal and external examinations on other appointments.

542. As regards Patient 2, this concerned a period of 9 ½ years. The failure related to a period of 1 year and 9 months. He submitted that Mr Griffiths attempted to do ophthalmoscopy but had been unsuccessful and the Committee had found that he needed to do more.

543. In relation to Patient 4, he submitted that that the Registrant failed over a 9 month period. He further submitted that the extent of the misconduct was therefore limited in scope.

Particular 25

544. Mr Archer submitted that this was not so serious such that other members of the profession would find it deplorable and therefore the Committee cannot find that it is misconduct.

545. He also submitted that failing to obtain consent is more serious and so, it does not reach the threshold of serious professional misconduct that other practitioners would find deplorable. He added that there was no risk of harm.

Particular 31(ii)

546. Mr Archer submitted that Mr Griffiths was a curious individual who read widely. Mr Griffiths considered that one could learn from others. He accepted that he should have been clearer but was fascinated by the ideas in the book.

547. Mr Archer submitted that recommending the book was not so serious such that it justified being serious professional misconduct that fellow practitioners would find deplorable. He also submitted that the ideas in the book might become mainstream at some time in the future.

548. Following Mr Archer's submissions, the Chair clarified with Mr Archer that in relation to particular 21 (Patient 4) that although Mr Archer referred to a period of 9 months in his submissions, the Patient did not receive an internal or external eye examination for a period of 1 year and 3 months (17 November 2018 to the 18 February 2020).

Legal Advice

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

550. The Committee was advised that the case against the Registrant was brought on the basis of misconduct and not deficient performance. The Committee, having

made findings of fact, now had to go on to consider misconduct and not deficient performance.

551. If misconduct was found, the Committee had to go on in the next stage of the hearing to consider impairment.

552. The Committee was advised that not every case of misconduct results in a finding of impairment (*Cohen v GMC 2008 EWHC 581*). 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.

553. The Legal Adviser referred the Committee to the distinction made in *R (Remedy UK Ltd) v. General Medical Council [2010] EWHC 1245 (Admin)* between (i) misconduct in the exercise of professional practice and (ii) outwith the course of professional practice itself. The Committee was concerned with misconduct falling within the first limb of this distinction, as it arose in the context of the Registrant's professional practice as an Optometrist.

554. 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.

555. 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".

556. 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"*.

557. In *Nandi v. General Medical Council [2004] EWHC 2317 (Admin)* the court emphasised that in assessing seriousness, the Committee should consider the following;

"the need to give it proper weight, observing that in other contexts it has been referred to as "conduct which would be regarded as deplorable by fellow practitioners".

558. In *GMC v Calhaem [2007] EWHC 2606 (Admin)* the court made clear 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"

559. The Legal Adviser also advised the Committee 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 particulars.

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

561. In response to questions from the Committee about whether it was permissible for it to take a cumulative approach to finding serious misconduct, the Legal Adviser clarified that the Committee were required to consider each of the proven particulars and determine separately whether it constituted serious professional misconduct.

562. In addition, the Legal Adviser referred to the guidance in the cases of *Schodlok v GMC [2015] EWCA Civ 769, Ahmedsowida v The General Medical Council [2021] EWHC 3466 (Admin)* regarding the exercise of cumulative findings of misconduct.

563. In *Schodlok v GMC [2015] EWCA Civ 769* the court stated the following;

"That it may be permissible, in an appropriate but rare case, for a tribunal to undertake the exercise of cumulating findings of misconduct on some charges to make a determination of serious misconduct on others".

564. In *Ahmedsowida v The General Medical Council [2021] EWHC 3466 (Admin)*, the court stated the following;

"If that is permissible at all, the exercise is supposed to involve the cumulation of non-serious with other non-serious misconduct findings; not of one non-serious misconduct finding with another finding(s) of misconduct that is serious in its own right. In the latter context, there is no good reason to cumulate; the quality of the conduct is already correctly expressed, without the need for any cumulation."

565. The Legal Adviser clarified that the approach the Committee should use was to consider each proven particular separately and determine whether each constituted misconduct.

566. The Committee was further advised that it was open to it to take a cumulative approach in an appropriate case, in the limited circumstances suggested in *Ahmedsowida*. However, based on these authorities, there ought to be a large number of failings, of a *similar* nature, which were all not serious misconduct, rather than cumulating a mixture of serious and non-serious misconduct.

567. There was no disagreement from parties as to the advice given to the Committee about the approach it should take in determining the issue of misconduct and to determine each of the proven particulars separately.

568. In response to further questions from the Committee, the Legal Adviser clarified that the Committee should consider the 2016 version of The Standards of Practice for Optometrists and Dispensing Opticians (2016).

Committee's findings on misconduct

569. In making its findings on misconduct, the Committee had regard to the evidence it had received, the submissions made by the parties, and the legal advice given by the Legal Adviser.

570. The Committee considered the Council's Standards of Practice for Optometrists and Dispensing Opticians Standards (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 Allegation and considered each Allegation in turn.

Particulars 2, 5, 10, and 13 (prescribing lenses when not clinically indicated)

571. The Committee considered each of the particulars which it had found proved. It also reminded itself that the threshold for misconduct was high.

572. The Committee accepted the Registrant's oral evidence that he was doing his best for Patients 1, 2, 3, and 4 and concluded that he was motivated to assist all of them. The Committee acknowledged that he had multiple interactions with all 4 Patients, and it appeared their Parents had trust in him as a professional.

573. The Committee noted that there was no evidence that he intentionally cut corners or evidence of any actual harm to the 4 Patients.

574. However, the Committee accepted the joint experts' report that the Registrant's conduct in prescribing prisms and varifocals for Patients 1, 2 and 4 (particulars 2, 5, and 13) when it was not clinically indicted fell far below the standard expected of a reasonably competent optometrist. The Committee also accepted the joint experts' report that for Patient 3, the Registrant's prescribing did not fall far below.

575. The Committee noted that Professor Barnard did not address Particulars 2, 5, 10 and 13 about Patients 1, 2, 3 and 4 in his addendum report. The Committee also noted, as stated earlier, that Professor Barnard focused in his addendum report on actual harm whereas the Committee were concerned with the risk of harm associated with the Registrant's conduct.

576. In addition, the Committee was concerned by the Registrant's 'trial and error' approach to his prescribing and it noted the high number of glasses that were prescribed over a short period of time for all the Patients.

577. The Committee reminded itself that it was especially important for any optometrist to comply with the relevant professional standards. The Committee considered that taking a 'trial and error' approach was unacceptable. The Committee concluded that the Registrant was always required to have a clear clinical indication as to why he was prescribing in the way that he did, but found he had not provided any clear explanation.

578. The Committee considered *Standard 7 'Conduct appropriate assessments, examinations, treatments and referrals'* of the Council's Standards. The Committee had particular regard to Standard 7.6 and concluded that the Registrant breached the Standard which states;

'7.6. Only provide or recommend examinations, treatments, drugs or appliances if these are clinically justified and in the best interests of the patient. Give patients information about all the relevant options available to them, including the option of no further treatment or intervention, in a way they can understand'.

579. In relation to the Registrant's 'trial and error' approach to prescribing, the Committee was further concerned that this would undermine public confidence and trust in the profession, as well as damage its reputation.

580. The Committee concluded that it needed to mark the seriousness of the Registrant's conduct and the importance of prescribing when clinically justified and in the Patient's interest.

581. Based on the above, the Committee concluded that the facts found proved for Patients 1, 2, and 4 (particulars 2, 5, and 13) were sufficiently serious to amount to misconduct.

582. In addition, having accepted the joint experts' report on Patient 3 (particular 10) that the Registrant's prescribing did not fall far below the standard, the Committee concluded that the facts found proved were not sufficiently serious to amount to misconduct.

Particulars 3, 6, 11, and 14 (failing to record binocular vision assessments)

583. The Committee considered that it was a fundamental requirement that an optometrist maintained adequate Patient records to allow and provide for continuity of care for the Patient. This was clearly set out in Standard 8 of the Council's Standards.

584. The Committee concluded that the Registrant particularly breached Standard 8.2.4 in failing to adequately record the binocular vision assessments for Patients 1, 2, 3 and 4.

585. The Committee considered that of particular note in Standard 8 are as follows;

'8.2 As a minimum, record the following information'

'8.2.4 The details and findings of any assessment or examination conducted'

586. The Committee considered the seriousness of the Registrant's breach of the Standards. It appreciated that there are challenges with keeping and recording Patients' records during an examination, but it considered that it was vital that Patients' records were clear and legible.

587. The Committee concluded that including the detailed information about binocular vision assessments was important. While the Committee noted the importance of test results on prescriptions, it considered that it was important to record the methodology used in getting to the prescription, particularly to ensure continuity of care by other professionals.

588. The Committee concluded that the binocular vision assessment was even more important for Patients 1, 2, 3, and 4. This was because their cases were complex, and because they were all vulnerable children. In addition, the Registrant had multiple appointments with all of them, some over a considerable period of time

and hence effective record-keeping was vital to aid the recall of Patient care previously given.

589. The Committee noted that Patients 1, 2, 3, and 4 came to the Registrant for additional treatment and so it was vital for the Registrant to keep clear records for each of them to ensure that other professionals were able to follow and understand all the Patients' records he made.

590. The Committee considered that it was significant that on the Registrant's own evidence he could not read some of his own notes in the Patient records or identify the tests used. The Committee also considered that this failing would have a serious impact on the reputation of the profession.

591. The Committee noted that while the Registrant's oral evidence to it was that he had a good memory of Patients 1, 2, 3, and 4, it concluded that there was a risk that this could fade and he may in time misinterpret his own records. This, the Committee concluded, was a concern because of the risk of harm to the Patients if the Registrant was unable to manage their care and there was no continuity of care.

592. The Committee concluded that the facts found proved for Patients 1, 2, 3 and 4 (particulars 3, 6, 11 and 14) and the Registrants breach of the Standards were sufficiently serious to amount to misconduct.

Particulars 15, 17, 21 (External and internal eye examinations)

593. The Committee acknowledged that the Registrant accepted in his closing submissions that misconduct was made out on the facts found proved regarding the eye examinations for Patients 1, 2 and 4.

594. In addition, the Committee concluded that the failures admitted by the Registrant were serious. It concluded that there was a real risk of harm because of the considerable periods of time that important eye examinations were not undertaken for vulnerable child patients. The Committee noted that the experts recommended that an internal and external eye examination should be completed at least every 12 months.

595. On the basis of the above, the Committee concluded that the facts found proved for Patients 1, 2 and 4 (particulars 15, 17, and 21) were sufficiently serious to amount to misconduct based on the Registrant's admissions.

Particular 25 (obtaining informed consent)

596. The Committee considered the requirements around consent in *Standard 3 (Obtain valid consent)*. It concluded that the Registrant breached in particular Standards 3.1, 3.1.4 and 3.3 by not obtaining informed consent from Patient 2's parent.

597. The relevant part of Standard 3 includes;

'3.1 Obtain valid consent before examining a patient, providing treatment or involving patients in teaching and research activities. For consent to be valid it must be given:

3.1.4 By an appropriately informed person. Informed means explaining what you are going to do and ensuring that patients are aware of any risks and options in terms of examination, treatment, sale or supply of optical appliances or research they are participating in. This includes the right of the patient to refuse treatment or have a chaperone or interpreter present

3.3 Ensure that the patient's consent remains valid at each stage of the examination or treatment and during any research in which they are participating'.

598. The Committee found that the Registrant had failed to get consent for carrying out non-standard techniques. The Committee reminded itself that obtaining consent was a core standard and it was a fundamental tenet of the profession that it was obtained.

599. In addition, the Committee considered the experts evidence and noted they concluded that the Registrant's failure was serious and fell far below the acceptable standards.

600. The Committee also considered that the Registrant used non-standard techniques with Patient 2 who was a vulnerable child. The Committee considered that it was even more important to obtain, and to demonstrate obtaining, informed consent when using non-standard treatments.

601. The Committee further considered Patient 2's parent's evidence that the Registrant's approach was trial and error and that she did not seem to know what was going on because no substantive explanation was given to her.

602. The Committee determined that confidence and trust in the profession would be undermined if informed consent was not obtained.

603. The Committee concluded that it was particularly serious for the Registrant to embark on the use of novel and non-standard tests and techniques without telling Patient 2's parent and obtaining her consent.

604. The Committee concluded that the facts found proved for Patient 2 (particulars 25) and the Registrant's breach of Standards including 3.1, 3.1.4 and 3.3 were sufficiently serious to amount to misconduct.

Particulars 24, 26, 28, and 30 (failing to record consent)

605. The Committee considered the requirements around *Standard 8 (Maintain adequate patient records)* and in particular Standards 8.2 and 8.2.6. It concluded that the Registrant breached these standards by not recording the required consent.

606. The relevant parts of Standard 8 are as follows:

'8.2 As a minimum, record the following information;

8.2.6 Consent obtained for any examination or treatment'.

607. The Committee gave the Registrant credit for admitting his failure to record consent for Patients 1, 2, 3 and 4.

608. The Committee considered that recording consent was fundamental to any patient interaction, and it was best practice to do so clearly. The Committee also considered that failing to record consent was not as serious as not obtaining it.

609. However, the Committee did not accept the Registrant's reasoning that recording was too difficult. The Committee considered that it was not an acceptable explanation for not keeping detailed records on Patient consent that it was challenging to record and was an alternative to focusing on the Patient. The Committee further considered that practitioners were expected to overcome such challenges in recording in order to mitigate risk and follow the expected standards.

610. The Committee concluded that the facts proved on the basis of the Registrant's admissions for Patients 1, 2, 3, and 4 (particulars 24, 26, 28, and 30) and the Registrant's breach of Standards including 8.2.6 were sufficiently serious to amount to misconduct.

Particular 31(i) (acting outside of expertise)

611. The Committee considered the requirements around *Standard 6 (Recognise, and work within, your limits of competence)* and in particular, Standards 6.1, 6.2 and 6.3. It concluded that the Registrant breached these standards based on the facts found.

612. The relevant parts of Standard 6 are as follows:

'6 Recognise, and work within, your limits of competence

6.1 Recognise and work within the limits of your scope of practice, taking into account your knowledge, skills and experience.

6.2 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.

6.3 Ensure that you have the required qualifications relevant to your practice'.

613. The Committee accepted that the Registrant, as an experienced optometrist, had legitimate views about Patient 4's reading difficulty. However, it was important that the Registrant's views were expressed carefully and sensitively to the Patient 4's parent and that he carefully considered how he gave his advice.

614. The Committee considered that if the Registrant suspected that Patient 4 had difficulty reading and was predisposed to dyslexia, then it was open to the Registrant to make the professional suggestion to Patient 4's parent that their child should be referred to a specialist.

615. It was clear to the Committee that the Registrant was not qualified to conclude that Patient 4 was 'predisposed to dyslexia'. The Committee noted that the Registrant did not undertake any test to justify including 'predisposed to dyslexia' on the prescription.

616. The Committee concluded that the way in which the Registrant acted outside his competence was serious. In particular, the Committee concluded it was serious because when the Registrant wrote a diagnosis (predisposed to) on a prescription, the recommendation moved from a suggestion to a diagnosis.

617. The Committee considered that there was a distinction between the Registrant acting outside of the scope of his expertise in his diagnosis for Patient 4 and his

recommendation to Patient 4's parent regarding the book 'The Plant Paradox'. The Committee concluded that whereas the book recommendation can be regarded as a suggestion for further reading, the apparent diagnosis, 'predisposition to dyslexia', was clearly outside of the Registrant's scope, expertise and competence.

618. The Committee concluded that the facts found proved for Patient 4 (particulars 31 (i)) and the Registrant's breach of Standards including 6.1, 6.2, and 6.3 were sufficiently serious to amount to misconduct.

Particular 31(ii) (acting outside of expertise)

619. The Committee considered the requirements around *Standard 6 (Recognise, and work within, your limits of competence)* and in particular Standard 6.1.

620. Standard 6.1 states as follows:

'6.1 Recognise and work within the limits of your scope of practice, taking into account your knowledge, skills and experience'

621. The Committee noted that the Registrant strongly promoted the book when he gave his oral evidence to the Committee including the unorthodox views in it. The Committee considered that the more extreme the views and content in the book were, the more serious it was for the Registrant to promote it.

622. The Committee considered that including dietary advice through a book recommendation in an area outside of the Registrant's area of expertise was serious. However, the Committee had no evidence from Patient 4's parent about the conversation she had with the Registrant.

623. The Committee concluded that ascertaining the risk of harm in recommending a book to Patient 4's parent was difficult. It concluded that recommending a book to the Parent is unlikely to damage the reputation of the profession, even if the book has extreme views.

624. While the Committee concluded the Registrant had acted outside the scope and area of his expertise in recommending the book 'The Plant Paradox' and in doing so breached Standards including 6.1, it determined that this was not sufficiently serious to find misconduct.

Impairment

625. The Committee went on to consider the issue of impairment.

Submissions on behalf of the Council

626. Ms Hinton, on behalf of the Council invited the Committee to find the Registrant was impaired.

627. She submitted that the Committee should consider the Registrant's remediation bundle against the Committee's findings on misconduct and its reasons set out from paragraph 571 of the decision (page 85 onwards).

628. She acknowledged that the Council accepted that the Registrant had been working to improve his professional performance since the matter was investigated. The Registrant had shown he had undertaken work and undertaken further training. He had complied with the supervision that had been imposed.

629. Ms Hinton submitted that the Council had several concerns about the Registrant's fitness to practise despite this progress. She highlighted that the Registrant's focus was predominantly on record keeping. She submitted that poor record keeping alone did not lead to his misconduct.

630. She invited the Committee to consider the extent of his insight into the totality of the behaviour. It needed to consider whether the material the Registrant relied upon provided sufficient reassurance that he is currently fit for practise.

631. Ms Hinton referred the Committee to several supervision reports about the Registrant included in his remediation bundle. She referred to the final report document prepared by the Registrant's supervisor at page 36. In July 2025, Ms Hinton highlighted that the supervisor was supportive of Mr Griffiths. This was on the basis that in her view his record keeping was sufficient to meet the standards. Ms Hinton acknowledged that there was at that time, no requirement for perfection.

632. Ms Hinton further submitted that the Council was concerned however, that the position was different from July 2025 onwards. The Registrant was not consistent in his audits. She referred the Committee to the audit for August 2025 and a month later on page 38. The results of the audit were not as good because the report stated that;

> *"In two cases this month VAs were not recorded. In one record ocular history was not noted. In two cases medications were not noted although the implication was that none were being taken. In one instance there was no record of family ocular history and finally one record had no note of external examination. I would have hoped for a more sustained improvement following June's excellent audit".*

Ms Hinton submitted that this was an example of these elements either being missed, or not documented by the Registrant.

633. She referred the Committee to the report on the Registrant for October 2025 on page 39. She highlighted that the Registrant's supervisor recorded no medication was noted on one record, although in fairness, the implication was that none were being taken. In one record, family ocular history was not noted. In two records, there was no explicit mention of near binocular vision status*, "but the manifest deviations present at distance was measured and recorded in both cases. One record had no note of an external examination"*.

Ms Hinton submitted that based on what was reported, breaches were still occurring.

634. Ms Hinton also referred the Committee to the report for November 2025 on page 40. The Registrant's supervisor highlighted that the results were slightly better than for September 2025. Ms Hinton referred to the detail in the report and that on one record, there was no mention of the advice given to the patient in one record, family ocular history was not noted, and in another, the patient's ocular history was

not noted. Again, in these two cases, there were extensive notes from previous appointments. The supervisor noted consistent effort in improving record keeping.

635. Ms Hinton referred the Committee to the supervisor's report for December 2025 on page 41 of the Registrant's remediation bundle. The supervisor concluded that *"the records and audit show consistent effort in improved record keeping and contain good levels of detail of tests performed. It is wonderful to see a perfect audit and I am sure that this standard can be maintained"*.

    Ms Hinton submitted that the supervisor's report showed that the Registrant was at that time capable of meeting professional standards.

636. Ms Hinton referred to the report for January 2026 on page 42 of the Registrant's remediation bundle. The supervisor reported in this report that the results were not as good as the report for November 2025. In particular Ms Hinton drew the Committee's attention to the supervisor's comments about the Registrant and that *"general health was not recorded on two occasions, visual acuity was not noted for 3 patients and there was no advice written down once……..ocular health was omitted once and medication twice. Binocular vision at near was not noted for one patient and there was no record of external eye examination on two occasions. So that was the case for 3 patients there".*

637. Ms Hinton submitted that the Committee should still be concerned. While the Registrant's performance was of course not expected to be perfect every time, he was still not at a level whereby he was able to consistently meet the required standards. Ms Hinton highlighted that there was no recent letter from the Registrant's supervisor similar to the letter she prepared in July 2025 when she vouched for the Registrant's ability to meet the appropriate standards.

638. Ms Hinton made submissions to the Committee on the Registrant's level of insight. She referred the Committee to the Registrant's reflections starting on page 94 of R21. She invited the Committee to consider the insight that the Registrant had shown into the totality of the conduct.

639. She submitted that in terms of the prescribing, the Committee was invited to look carefully at whether the Registrant had demonstrated full insight into the misconduct that was found proved against him. She highlighted that he only touched upon aspects of it and the Committee's finding that there was a trial-and-error approach taken. However, she submitted the focus of his personal statement seemed to be very much on the poor record keeping rather than the performance and necessity to perform tests.

640. Ms Hinton highlighted paragraph 578 of the Committee's decision in relation to the prescription of lenses when not clinically indicated. The Committee found the Registrant had a trial-and-error approach to his prescribing and noted the high number of glasses that were prescribed over a short period of time for all the patients. She emphasised that it was a matter for the Committee whether the Registrant's insight on this trial-and-error approach to prescribing was sufficient.

641. Ms Hinton concluded by referring the Committee to the Hearings and Indicative Sanctions Guidance (2021) and the approach to impairment set out at paragraphs 16 and 22. She submitted that the trial-and-error approach of the Registrant to prescribing and the high number of glasses that he prescribed over a short period of time, both of which concerned the Committee and referred to paragraph 578,

were only touched upon by the Registrant. She submitted that the Committee should find that the Registrant's fitness to practise was currently impaired.

Submissions on behalf of the Registrant

642. Mr. Archer submitted that the proceedings had a huge impact on the Registrant. He had lived under the cloud of the investigation for three years. It had not been easy for him. Mr Archer highlighted that the Committee found that the Registrant had been motivated to assist the patients in this case and there was no evidence he intentionally cut corners.

643. Mr Archer further submitted that the Registrant provided a high standard of care to these patients. The proceedings had a very significant effect on him. He submitted that the Registrant was not complacent regarding his misconduct, he took his role and his responsibility to his patients very seriously and took these proceedings very seriously.

644. Mr Archer stated that the Committee had to consider the risk going forward from today. The misconduct in the case was historic. The Allegation ranged from December 2012 to November 2022 and were more than three years old. Mr Archer stated that the majority of the misconduct in the case related to record keeping. There were no particulars of the Allegation of misdiagnosis that were made out. He added that there was insufficient clinical data recorded to justify the prescription of prisms and varifocals. The Registrant failed to properly record binocular vision assessment and to carry out internal eye examinations at sufficiently frequent intervals. He had failed to obtain or to document informed consent.

645. Mr Archer submitted that these failures all related to the Registrant's methodology. He started with a blank sheet of paper, and he was not prompted to record the essential information in a format that could easily be understood by others. He submitted that these failures were very simple to remedy.

646. Mr Archer highlighted that the Registrant had been subject to interim conditions and his performance has been regularly monitored, with supervisor-produced reports. Mr Archer submitted that the Registrant could show that his record keeping has improved immeasurably. He also submitted that the improvements were embedded in the way that the Registrant currently practises.

647. Mr Archer submitted that the Registrant's supervisor's reports show clear improvement over time. He referred to the report from May 2023 on page 15 of the Registrant's remediation bundle. The supervisor identified in the report that *"In the Clinical Indicators section, the four areas in which notes were missing a majority of the time were Ocular History, Medications, Binocular Vision assessment at near and External Examination. The Admin Procedures section showed problems in having the name of the current GP or GP practice and the notes lacked the initials or name of the testing optometrist. I marked most of the record cards as legible but it should be noted that the records are not always easy to decipher and do require some careful reading. I gave verbal feedback to Mr Griffiths about these initial findings.*"

648. Mr Archer submitted that after one year, the Registrant showed that he was able to sustain the pattern of improvement. Mr Archer referred to the May 2024 report

on page 26 in the remediation bundle. The supervisor wrote the following; *"April was an excellent month. The KPIs were at 100% for the first time. Full marks were achieved in ten of the eleven relevant quality metrics. The only omission this month was not noting medication in a patient in excellent health. The implication was clear that no medications were being taken but this was not written. This was by far the best month so far. It has been good to see the steady improvement over time and I hope that this standard will be maintained".*

649. Mr Archer referred to the supervisor's report for July 2025 at page 36 and which had already been referred to by Ms Hinton. The report was prepared after more than two years of supervision. Mr Archer highlighted sections of the report to the Committee including;

> *"I have no doubt that Mr Griffiths has demonstrated and maintained an improvement in the accuracy and completeness of his record keeping". At the beginning of this process he was scoring 94% in the key performance indicators and that has gone up to 98%. (As measured using the Quality in Optometry record audit template). I am happy to say that I feel that his current standard of record keeping reaches the expected professional standards set by the GOC".*
>
> *"Mr Griffiths has complied fully with the interim conditions set by the GOC during this process as I understand them. He has not examined the eyes of any patients under the age of 16 and he has asked me to perform audits on his records throughout the period. (These audits were performed monthly but I missed a few months last year as I misunderstood the need for the auditing to continue until the time of the hearing)".*

650. Mr Archer also highlighted the supervisor's conclusion in July 2025 that; *"In my opinion, I do not think that Mr Griffith's record keeping is a risk to his fitness to practise. I believe that this issue has been sufficiently addressed by the interim measures".* Mr Archer submitted that in July 2025, the Registrant had demonstrated, insight, had fully remediated and there were no significant concerns about his record keeping over a sustained period of time while supervised.

651. Mr Archer submitted that there were some dips in performance, but they coincided with the periods when the Registrant was engaged or focussed on the hearings for these proceedings. He further submitted that it was not unusual for a person's performance to dip slightly when they are under great pressure, as the Registrant had been during this process. He added that the dips were temporary, but he had shown sustained improvement over a long period of time. He submitted that these improvements were now embedded in the way that the Registrant practises.

652. Mr Archer further submitted that the Registrant had engaged extensively with completing CPD, including courses that were focused on the misconduct in his case. He referred to the certificates at pages 49 to 51 of the remediation bundle as examples. Mr Archer emphasised that the Registrant had dedicated weeks of his time to further learning, and set out very detailed and comprehensive reflections, which explained how his approach had changed in the way he prescribed spectacles.

653. Mr Archer highlighted that the Registrant was now more conscious of the need to be clear about the limits of his expertise as an optometrist and of the dangers of

straying into other areas. Dyslexia assessments were not part of his practice and he makes appropriate referrals.

654. Mr Archer referred the Committee to the Guidance and paragraph 16 on the approach the Committee should take to impairment. He submitted that the Registrant's misconduct was remediable. He highlighted that the misconduct in the case did not involve any fundamental character flaw or any cognitive impairment or medical problem. It arose from concerns about the Registrant's record keeping methodology which were the easiest of all to remedy.

655. Mr Archer submitted that the Registrant's misconduct had been remediated. He referred to the standard of record keeping that had greatly improved and maintained over a period of years. Mr Archer added that the Registrant would now only prescribe prisms when they were indicated by the standard binocular vision tests, and would collaborate with the hospital before prescribing in unusual circumstances.

656. Mr Archer submitted that with regard to consent, the Registrant would inform the families of any risks, as well as ensuring that they know that they could withdraw from the process at any stage. The Registrant would give patients guidance about alternatives and information about the short and long term costs.

657. Mr Archer referred to the School Vision booklet and leaflets at pages 85 to 93 of the Registrant's remediation bundle. The Registrant would offer the patients the opportunity to ask further questions, and only if the patient was perfectly comfortable with what would happen, would request that they sign a consent form.

658. Mr Archer further submitted that nothing in the particulars gave any reason to conclude that the Registrant's fitness to practise remained impaired today. He had fully engaged with these proceedings which have lasted for many months now. Mr Archer highlighted that the proceedings had dominated the Registrant's life for several years and that he had undertaken a great deal of work outside of the hearing dates.

659. Mr Archer submitted that the Registrant's misconduct was not likely to be repeated. He highlighted that the Registrant has waited a very long time for a resolution to these proceedings during which he has shown he has deeply reflected. He has developed insight, and he has changed the way that he practises. The Registrant was not an arrogant or dogmatic person but rather open-minded. Mr Archer further highlighted that this was likely a reason that patients found him easy to engage with. He referred the Committee to the Registrant's remediation bundle for the evidence of his remediation and the loyal patients who valued his service and help when others could not.

660. Mr Archer further submitted that the Registrant was a very reflective person who had reflected deeply on the issues in these proceedings. He maintained that the Registrant had demonstrated that he had changed the way that he practises and the changes had become embedded in his practice. He submitted that a Registrant who takes appropriate steps to address concerns that are raised in these proceedings may be no less fit to practise than a Registrant who has never faced a complaint. This applied in this case.

661. In conclusion, Mr Archer submitted that the concerns in the case are remediable, they have been remedied, and they are not likely to be repeated. Therefore, the Registrant's fitness to practise was not currently impaired.

Legal Advice

662. 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.

663. 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 or 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".*

664. The Legal Adviser also set the three-part test set out in *Cohen v GMC* [2008] EWHC 581 (Admin) to determine if the Registrant was currently impaired. This included considering if the misconduct is easily remediable, whether it has been remedied and, the risk of repetition.

665. The Legal Adviser also 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.

> "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)……..*"

666. 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.

667. In CHRE v (1) NMC and (2) Grant [2011] EWHC 927 (Admin) the High Court considered the case of Cohen and stated:

> *"The Committee should therefore have asked themselves not only whether the Registrant continued to present a risk to members of the public, but whether the need to uphold proper professional standards and public confidence in the Registrant and in the profession would be undermined if a*

finding of impairment of fitness to practise were not made in the circumstances of this case."

668. 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.

669. The Legal Adviser further advised the Committee on insight in its consideration of impairment and the registrant's understanding of the nature and gravity of their misconduct. He referred the Committee to *CHRE v* (1) *NMC* and (2) *Grant* [2011] EWHC 927 (Admin) para 116 and the approach of the court: *"When considering whether fitness to practise is currently impaired, the level of insight shown by the practitioner is central to a proper determination of that issue".*

670. The Legal Adviser further referred the Committee to *General Medical Council and another v Bramhall* [2021] EWHC 2109 (Admin) when court identified that: *"Insight goes to the subsequent development of fair, objective understanding of the nature and gravity of the misconduct. It typically requires demonstration of a degree of empathetic identification with the perspective of others: victims, professional colleagues, the public (including other patients)….."*

671. In *Hyder v General Medical Council* [2024] EWHC 2945 (Admin), Mr Justice Eyre stated that: "*It is necessary for insight to be particular rather than general and of practical application as well as merely theoretical. The relevant insight has to be with reference to the particular actions and the particular misconduct of the doctor whose conduct is in question. As Andrew Baker J said in Khetyar at [49]:"… insight requires that motivations and triggers be identified and understood, … and any assessment of ongoing risk must play close attention to the doctor's current understanding of and attitude towards what he has done."*

672. The Legal Adviser concluded by advising the Committee 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.*

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

Findings on Impairment

674. 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, the submissions of Ms Hinton on behalf of the Council and the submissions of Mr Archer on behalf of the Registrant and the Registrant's remediation documents. The Committee also carefully considered the Hearings and Indicative Sanctions Guidance, the Council's Standards of Practice for Optometrists and Dispensing Opticians (from April 2016), and its earlier findings.

675. 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'.*

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

677. The Committee then went on to assess whether the Registrant had remediated his misconduct. The Committee noted that, based on the information it had considered in the Registrant's supervisor's reports, there were dips in his performance in January 2026. However, the Committee noted Mr Archer's submissions that the Registrant was [redacted] during some of the performance dips. Despite the performance dips, the Committee considered that he had responded well to his supervisor's feedback and criticism. In addition, the Committee considered that the performance dips were not consistent, and his supervisor appeared comfortable with them and overall, was supportive of the Registrant. The Committee also noted that the Registrant intended to liaise and collaborate with hospital colleagues on difficult cases which indicated that he had changed his way of working.

678. The Committee concluded that in relation to the misconduct around his record keeping, acting outside of his expertise, and failing to obtain informed consent, as well as the clinical concerns and the risk of patient harm the Registrant had carried out a lot of work to reflect on and address his misconduct. The Committee considered that he had shown sufficient insight such as to be able to largely remediate his misconduct.

679. The Committee carefully considered the risk of repetition. The Committee noted that the Registrant had focused the development of his insight on record keeping. The Committee noted that the Registrant had considered that his patient records were previously "*chaotic and unintelligible*". The Committee considered that the Registrant's failings were not only around patient record keeping but also included prescribing lenses when they were not clinically indicated. The Committee was concerned that the Registrant did not appear to fully appreciate that the particulars and determination of the Committee included in its findings concerns over his use of novel tests and his trial-and-error approach to prescribing. The Committee considered that the Registrant appeared to have demonstrated in his reflection document little appreciation or understanding that publishing details of a novel test, or a novel use of a test, even through peer review was insufficient to render it as an acceptable test to use freely in the profession and his practice.

680. The Committee also noted the number of dips in the Registrant's record keeping after 18 months from the first report. In particular, the Committee noted that the supervisor's reports recorded that there were still some records with no external eye examinations based on 12 random patients that had been picked. The Committee could not conclude there would be no risk of repetition of this in the future.

681. However, the Committee acknowledged that the Registrant had engaged fully with the regulator and with the proceedings. These proceedings had required him to review the entire methodology he used in his practice with child patients.

682. The Committee considered that the Registrant had shown remorse and accepted many of the failings he had to face in the proceedings. The Committee also acknowledged that the Registrant had been sincere, honest, and respectful of his professional obligations in his reflections. The Committee concluded that the

Registrant had demonstrated sufficient care for his patients throughout the hearing and had simply drifted into certain poor ways of working in his practice.

683. Based on a careful consideration of everything in the round, the Committee determined that the Registrant had developed sufficient insight, had undertaken sufficient remediation and had demonstrated genuine remorse such as to remediate his misconduct. Therefore, despite the limitations in some of his reflections and insight, the Committee concluded that there was a low future risk that the Registrant would repeat it. Therefore, the Committee were satisfied that a finding of impairment was not necessary on the grounds of public protection.

684. The Committee then considered 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.

685. The Committee determined that the public interest was satisfied through the extensive work and steps that the Registrant had completed, his engagement throughout with the process, reports from his supervisor, patient testimonials and his self-reflection. The Committee considered that an informed and fair-minded member of the public, if they were appraised 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.

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

Warning

687. The Committee was minded to give the Registrant a Warning as to the Registrant's future conduct or performance and the Committee heard submissions from the parties with regard to any such Warning and the duration of it.

Submissions on behalf of the Council

688. Ms Hinton referred the Committee to paragraph 20 of the Indicative Sanctions Guidance. She submitted on behalf of the Council that a warning was appropriate and necessary, in the public interest and would serve as a helpful deterrent to the Registrant. It would not restrict the Registrant's practice.

689. She further submitted that the length of the warning was not limited in the statutory provisions and was open ended. She submitted that it should be for as long as possible based on the Committees findings particularly around insight and impairment.

Submissions on behalf of the Registrant

690. Mr Archer on behalf of the Registrant submitted that there was no need for a warning. This was because the Registrant had the Committee's comments in the determination which he was perfectly willing to take on board.

691. Mr Archer referred the Committee to paragraph 20.7 of the Indicative Sanctions Guidance. He submitted that the factors there indicated that no warning was

necessary. The Registrant had; expressed genuine regret for his misconduct, shown insight, and had a long and good practice history.

692. Mr Archer further submitted that the Registrant had taken appropriate rehabilitative steps and achieved the goal that the Committee required of him. He added that issuing a formal warning would serve no useful purpose. Any warning imposed on the Registrant would be disproportionate and unnecessary. Mr Archer maintained that paragraphs 681 and 682 highlighted the deficiencies in reflection and insight shown. These have been noted and he will reflect and address them, as he has shown when taking on board previous Committee concerns. Therefore, there is no need for a warning.

693. Mr Archer also submitted that should the Committee give the Registrant a warning, that this should be for the shortest period of time.

Legal Advice

694. The Committee heard and accepted the advice of the Legal Adviser, who referred to Section 13F (5) of the Opticians Act 1989 and to the relevant part of the Council's Indicative Sanctions Guidance.

Finding on Warning

695. The Committee carefully considered whether a Warning was necessary and appropriate.

696. The Committee was satisfied that a Warning should be given in this case, specifically as the insight shown had limitations as highlighted in paragraphs 681 and 682 above. A Warning would serve to clarify for the Registrant where his insight was deficient and would highlight to the Registrant and the public what actions were still required according to the Committee's determination on misconduct. The Warning will assist the Registrant to be clear that if repeated these breaches would likely result in a finding of impaired fitness to practise.

697. The Committee had regard to the following passages from the Council's Hearings and Indicative Sanctions Guidance:

"20.6 Factors when a finding of no impairment has been made and a Warning may be appropriate:

a. A clear and specific breach of the Standards of Practice.

b. The particular conduct, behaviour, or performance approaches, but falls short of the threshold for current impairment.

c. Where the concerns are sufficiently serious that, if there were a repetition, they would likely result in a finding of impaired fitness to practise.

d. There is a need to record formally the particular concern(s)".

698. The Committee was satisfied that all the above factors were evident in this case.

699. The Committee also considered the paragraph 20.7 of the Guidance:

"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".

700. The Committee identified the following mitigating factors in this case.

- Genuine expression of regret
- Exemplary history on fitness to practice
- Rehabilitative and corrective steps taken

701. The Committee decided to give the Registrant a Warning as follows:

'You must reflect on the determination of the Committee that the prescribing allegations found proven (Allegations 2, 5, 10 and 13) were distinct to the record-keeping allegations. You must not continue to consider the prescribing allegations as simply 'record-keeping errors' as they resulted from a failure to comply with the relevant professional standards, taking a 'trial and error' approach and using novel and unproven tests.

You must note that self-publication, even in a peer-reviewed publication, is insufficient to justify the use of innovative tests or the use of tests in an innovative way.

Tests should only be considered as standard by reference to a considered large body of practitioners and not by self-publication, even in a peer reviewed publication.

You must comply with the College of Optometrists Guidance for Professional Practice 3, 4 (C273 and C294) which advises that written consent should be obtained from a patient if an innovative treatment designed specifically for the patient's, or a general group of patients', benefit is being advised. Therefore, Patients must be advised where a test being used is innovative or novel (by the definition above in this warning). Consent not only depends on the matters in your reflection for example, giving the understanding of the process of examination, the tests that would be undergone, the purpose of these tests and the expected outcome, but you must also obtain specific consent for the use of any test which is not considered standard by a large body of practitioners'.

702. The duration of this Warning will be for 3 years so that it will expire on the 26 February 2029. This is a reasonable and proportionate period, favourable to other guidance around warnings within the GOC regulations, is appropriate for the seriousness of the misconduct and proportionate to the period of misconduct.

Revocation of Interim Order

703. The Committee revoked the Interim Order of Conditions that was in place.

Chair of the Committee: Gaon Hart

Signature **Date: 27 February 2026**

Registrant: Geraint Griffiths

Signature *present and received via email* **Date: 27 February 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.