BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(24)40

AND

RAVI BHOJWANI (01-18000)

DETERMINATION OF A SUBSTANTIVE HEARING
7-16 MAY & 20-21 NOVEMBER 2025

Committee Members:	Andy Brenan (Chair/Lay) Victoria Smith (Lay) Ubaidul Hoque (Lay) (7-16 May 25) Ann Barrett (Optometrist) Claire Roberts (Optometrist) (7-16 May 25)
Legal adviser:	Jayesh Jotangia (7-16 May 25) Aaminah Khan (20-21 Nov 25)
GOC Presenting Officer:	Edmund Potts
Registrant present/represented:	Yes and represented (7-16 May 25) Yes and unrepresented (20 - 21 November 25)
Registrant representative:	Trevor Archer (Counsel) (7-16 May 25) Katharine Germishuys (7-16 May 25)
Hearings Officer:	Terence Yates
Facts found proved:	1, 2(e), 3(a), 3(b), 4(c), 5, 6, 7(a), 7(b), 7(c), 7(d) and 8(a),8(b),8(c),8(d)
Facts not found proved:	2(a)(i), 2(a)(ii), 2(b), 2(c), 2(d), 4(a) and 4(b)
Misconduct:	Found
Impairment:	Impaired
Sanction:	Suspension for 9 months (With Review)
Immediate order:	Imposed

ORIGINAL ALLEGATION

The Council alleges that you, Ravi Bhojwani (01-18000), a registered optometrist whilst employed at Redacted Eyecare Limited:

1. *On or around 1 September 2022 you failed to make a referral in respect of suspected glaucoma for Patient B when it was indicated to do due to the appearance of the optic discs.*

2. *On or around 14 August 2022 you failed to*

   a. *assess, adequately or at all, Patient C's maculas in that you did not:*

      i. *undertake an OCT scan; and/or*

      ii. *use an Amsler chart;*

   b. *provide any, or any adequate, lifestyle advice to Patient C;*

   c. *provide any, or any adequate, safety netting advice to Patient C;*

   d. *measure Patient C's visual acuity;*

   e. *record Patient C's visual acuity;*

3. *On or around 29 July 2022 you failed:*

   a. *to identify vascular changes present in Patient D's eyes;*

   b. *to refer Patient D to his General Practitioner for a blood pressure assessment.*

4. *On or around 24 June 2022 you failed to obtain an adequate history in relation to Patient F's diabetes in that you did not establish:*

   a. *how long Patient F had been diagnosed with diabetes;*

   b. *how well it was controlled;*

   c. *whether Patient F was attending diabetic screening appointments.*

5. *On or around 20 May 2022 you failed to:*

   a. *retest Patient I's intra ocular pressures; and/or*

   b. *to make a referral in respect of Patient I's intra ocular pressure results when it was indicated to do so;*

   c. *advise Patient I of the examination findings consistent with age related macula disease;*

      provide any, or any adequate, safety netting advice to Patient I;

6. *On or around 21 May 2022 you failed to:*

   a. *identify a haemorrhage at Patient K's left optic disc;*

b. *make a referral in respect of the haemorrhage at Patient K's left optic disc when it was indicated to do so;*

7. *On or around 19 March 2022 you failed to:*
   a. *advise Patient L of the examination findings of vitreo-retinal traction in their right eye;*
   b. *provide any, or any adequate, safety netting advice to Patient L regarding their vitreo – retinal traction;*
   c. *carry out a visual field test on Patient L;*
   d. *make a referral for suspected glaucoma in respect of the appearance of Patient L's left optic disc when it was indicated to do so;*

8. *On or around 14 January 2022 whilst employed at Redacted Visionplus Limited you:*
   a. *failed to carry out a dilated examination of Patient M;*
   b. *did not check for tobacco dust (Shafer's sign) following pupil dilation;*
   c. *did not give safety- netting advice for symptoms suggestive of retinal detachment;*

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

PRELIMINARY ISSUES AND APPLICATIONS

Application to amend the Allegation

1. Mr Potts on behalf of the General Optical Council ("the Council"), made an application to amend the particulars in the following ways:
    - Particular 7(c) by inserting the word "central", so that it reads: [failed to] "carry out a central visual field test on Patient L".
    - Particular 7(d) by removing the words "when it was indicated to do so".
    - Particular 8(a) by inserting the word "fundus" so that it reads: [failed to] carry out a dilated fundus examination of Patient M
    - Particular 8(d) which will read: "failed to consider and / or record consideration of retinal detachment as a possible cause of Patient M's symptoms."
2. Mr Archer on behalf of the Registrant raised no objections to the application.
3. The Committee heard and accepted the advice of the Legal Adviser namely that the Council could make an application to amend the particulars and that the guiding principle was whether any proposed amendments could be made without injustice to the Registrant. In essence, the Committee was informed that it should consider fairness and prejudice to a Registrant.
4. In reaching its decision, the Committee considered Rule 46(20) of The General Optical Council (Fitness to Practise) Rules Order of Council 2013 ("the Rules").
5. The Committee allowed the amendments to be made as it concluded that the amendments were minor and inconsequential which did not change the substance of the particulars of the particular but which merely clarified them. The Committee was satisfied there was no prejudice to the Registrant, no objection to the amendments and that matters of public protection were adhered to in doing so. The particulars were therefore amended.

ALLEGATION (AS AMENDED)

The Council alleges that you, Ravi Bhojwani (01-18000), a registered optometrist whilst employed at Redacted:

1. *On or around 1 September 2022 you failed to make a referral in respect of suspected glaucoma for Patient B when it was indicated to do due to the appearance of the optic discs.*
2. *On or around 14 August 2022 you failed to*
    a. *assess, adequately or at all, Patient C's maculas in that you did not:*
        i. *undertake an OCT scan; and/or*
        ii. *use an Amsler chart;*
    b. *provide any, or any adequate, lifestyle advice to Patient C;*
    c. *provide any, or any adequate, safety netting advice to Patient C;*
    d. *measure Patient C's visual acuity;*

e. *record Patient C's visual acuity;*

3. *On or around 29 July 2022 you failed:*
   a. *to identify vascular changes present in Patient D's eyes;*
   b. *to refer Patient D to his General Practitioner for a blood pressure assessment.*
4. *On or around 24 June 2022 you failed to obtain an adequate history in relation to Patient F's diabetes in that you did not establish:*
   a. *how long Patient F had been diagnosed with diabetes;*
   b. *how well it was controlled;*
   c. *whether Patient F was attending diabetic screening appointments.*
5. *On or around 20 May 2022 you failed to:*
   a. *retest Patient I's intra ocular pressures; and/or*
   b. *to make a referral in respect of Patient I's intra ocular pressure results when it was indicated to do so;*
   c. *advise Patient I of the examination findings consistent with age related macula disease;*
   d. *provide any, or any adequate, safety netting advice to Patient I;*
6. *On or around 21 May 2022 you failed to:*
   a. *identify a haemorrhage at Patient K's left optic disc;*
   b. *make a referral in respect of the haemorrhage at Patient K's left optic disc when it was indicated to do so;*
7. *On or around 19 March 2022 you failed to:*
   a. *advise Patient L of the examination findings of vitreo-retinal traction in their right eye;*
   b. *provide any, or any adequate, safety netting advice to Patient L regarding their vitreo – retinal traction;*
   c. *carry out a central visual field test on Patient L;*
   d. *make a referral for suspected glaucoma in respect of the appearance of Patient L's left optic disc;*
8. *On or around 14 January 2022 whilst employed at Redacted Visionplus Limited you:*
   a. *failed to carry out a dilated fundus examination of Patient M;*
   b. *did not check for tobacco dust (Shafer's sign) following pupil dilation;*
   c. *did not give safety- netting advice for symptoms suggestive of retinal detachment;*
   d. *failed to consider and / or record consideration of retinal detachment as a possible cause of Patient M's symptoms.*

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

Admissions in relation to the particulars of the Allegation

6. On the first day of the hearing, the Registrant admitted particulars 1, 2(e), 5, 6, 7(c) and 8 of the particular.

7. Having regards to Rule 46(6), the Committee therefore found those particulars proved.

8. The Committee proceeded to hear evidence in relation to the remaining particulars of the Particular that were disputed by the Registrant.

Background to the Allegation

9. The Registrant has been a registered optometrist since April 2000. Between March 2021 and March 2022, he worked at Specsavers in *Redacted*(*Redacted* VisionPlus Limited) and from March 2022 to September 2022, the Registrant worked at *Redacted* in *Redacted.*

10. *Redacted* identified issues with the Registrant's clinical abilities in obtaining adequate history of patients, performing accurate refractions, performing adequate posterior segment examinations and in the assessment of retinal photographs and Optical Coherence Tomography (OCT) images. There was an internal investigation which identifyied concerns with Patients B, C, D, F, I, K and L between 19 March 2022 and 1 September 2022. The Registrant's employment was terminated on 28 September 2022 and a referral was made to the Council via a letter dated 4 October 2022.

11. On 17 October 2022, the Council received a second referral raising concerns about an examination carried out on Patient M on 14 January 2022 whilst the Registrant was working at Specsavers in *Redacted*. Patient M had reported flashes, floaters and a shadow over his left eye. He said the Registrant advised him that "[his] eyes were fine and [he] had nothing to worry about" and he informed Patient M that his next eye examination was due in two years' time.

12. On 6 June 2022, Patient M experienced a sudden loss of sight in his left eye and attended *Redacted* Specsavers. He was advised by the receptionist to attend the hospital where he was diagnosed with macula-off and total retinal detachment in his left eye.

The hearing

13. The Committee had been provided with a hearing bundle consisting of 8080 pages, a Registrant's bundle consisting of 17 pages and a complete version of *Redacted's* witness statement. All papers were read by the Committee members prior to the hearing formally commencing.

14. On behalf of the Council, Mr Potts opened the case and called Patient M first to give live evidence. Patient M adopted his witness statement dated 2 March 2023 as his evidence in chief and was asked supplementary questions about his current health. He informed the Committee that he had lost the remaining sight in his left eye following an unsuccessful surgery to re-attach his retina and cataract extraction on 8 June 2023.

15. In cross- examination, Mr Archer apologised on behalf of the Registrant to which Patient M stated that he was appreciative of the apology and thanked him for doing so.

16. Mr Potts then called Dr Kwartz as an expert witness to give live evidence. She started her evidence by stating that patient records should be a narrative of consultations or a story including a summary of key clinical findings, action plans and any advice given. Dr Kwartz directed the Committee to standard 8.2.4 of the GOC Standards for Optometrists and Dispensing Opticians (Standards) and stated that this was what was required of a reasonably competent optometrist. These Standards should be taken into consideration concerning any patient records. In addition she informed the Committee that patient records were also for the benefit of the next clinician.

17. In relation to particular 2, Dr Kwartz stated that flashes and floaters could be a sign of retinal tear or detachment. She informed the Committee that there was no criticism of how the Registrant had dealt with the examination concerning flashes and floaters. She said there were age related changes at the macula in the left eye as evidenced by white disturbances on the central retina which could be seen from the photographic images. However on observing “new evidence” (OCT macula) which was contained in the bundle but which she said she had not seen previously, she confirmed that drusen could not be seen on the OCT scan and that the scan showed mild Epiretinal Membrane (ERM) therefore she accepted there was no need for the Registrant to provide lifestyle advice to Patient C.

18. She gave evidence that there was no record of the patient’s visual acuity being tested and if it was tested, it ought to have been recorded. Dr Kwartz was of the opinion that this fell far below the standard.

19. Dr Kwartz stated that not all practices have OCT scanners and some charge for the OCT scan to be carried out, however there was a need for a Registrant pursuant to the standards to give adequate information to a patient to enable the patient to make an informed decision on whether to proceed with an additional OCT scan. Dr Kwartz acknowledged that there could be a cost implication. Dr Kwartz gave evidence that the Registrant should have informed the patient of his findings on abnormalities and advised of the need for an OCT scan. She stated that providing lifestyle advice was not relevant if there was no drusen, but monitoring would have been required for ERM.

20. With regards to particular 3, Dr Kwartz stated that Patient D showed vascular changes on the retina and this could be a sign of cardiovascular disease due to high blood pressure. She highlighted that Patient D was on a statin medication to reduce cholesterol. She informed the Committee that due to these vascular changes, it was therefore important to refer Patient D to their GP. Mr Archer questioned Dr Kwartz on whether this referral was necessary as other optometrists had not referred when similar “nipping” had been visible on the images between July 2014 and 2020 thus showing chronic changes. Dr Kwartz’s opinion was that others should have referred to a GP from 2014. Dr Kwartz was of the opinion that this fell far below the standard.

21. Referring to particular 4, Dr Kwartz gave evidence that diabetic patients can get a wide range of eye diseases including bleeds or growth of new blood vessels or diabetic maculopathy. She said that good acuity did not indicate the absence of

disease. She said that a patient can have diabetic maculopathy even if they have good visual acuity. Normal visual acuity did not indicate that problems relating to diabetic retinopathy could be ruled out. She stated that a patient can have normal acuity but significant eye disease. She said that a record should have included a comment on the patient's diabetic control and ought to have included words such as "poor, adequate, good, variable, etc". Dr Kwartz stated that the duration of diabetes and whether under the diabetic screening programme should also be recorded. She said, to be fair, some patients are poor historians and not precise but an optometrist should document that they ask the questions and record that the patient was vague or unsure. She accepted that it was not always easy with every patient but an optometrist had a duty under standard 11.2.3 to protect and safeguard patients.

22. In relation to particular 7(a) and (b), Dr Kwartz stated that vitreo-retinal traction had not been recorded. There was no recording of advice given. In her report at paragraph 7.1.34, she observed that the OCT of the right eye showed a small extent of vitreo-retinal traction. Dr Kwartz considered that on observing this finding a reasonably competent optometrist would advise their patient of the symptoms of distortion or flashes of light and floaters and give them safety netting advice. As this was not recorded, she was of the opinion that the Registrant had a case to answer for this omission.

23. Dr Kwartz in relation to particular 7(d) said there were significant features of findings of glaucoma. Patient L showed left optic disc cupping and that it was hard to ascertain the depth when looking at a 2D image of a 3D structure. Dr Kwartz said you would need to use cues and clues and look at the deflection of the blood vessels. The blood vessel at 6 o'clock figure 5 (page 72 of the bundle) was consistent with glaucoma. She said this would be an evident finding for a high street optometrist. It was put to Dr Kwartz that there was no need for a referral in these circumstances and a referral was only needed if the visual field test was abnormal. Dr Kwartz said that the NICE guidance referred to the management of glaucoma stating paragraph 1.1.5 says "or". Dr Kwartz stated that the patient definitely had optic nerve head damage which was consistent with glaucoma and required referral. Dr Kwartz had pointed out that the Registrant had acknowledged in his witness statement that there were signs of glaucoma.

24. Dr Kwartz said the risk of glaucoma was increased if there was a family history of glaucoma. Patient L did not have a family history of glaucoma. Dr Kwartz said that there were 3 main tests for glaucoma, being (1) testing the intraocular pressure (IOP), (2) visual field test and (3) a test for optic disc cupping. Dr Kwartz said that on its own, each test had challenges and there was a need to interpret the tests together for a diagnosis. In Patient L, the IOP was normal but that did not preclude glaucoma. Looking at the optic disc images a visual field test should have been done. Even in this situation, if the visual field test was normal, Patient L should still have been referred taking the NICE Guidelines at 1.1.5 into account. Dr Kwartz was of the opinion that this fell far below the standard.

25. Dr Kwartz confirmed that she had worked in a private practice setting for approximately 15 days in the last 12 months and had volunteered to perform eye examinations at a homeless charity 6-12 times a year which had been equivalent to a high street setting.

26. When asked how long an appointment could last in a high street practice, she said it could last around 20-30 minutes depending on whether the optometrist had delegated tasks to others.

27. In her report, Dr Kwartz provided her view on how she defined conduct falling below and far below at paragraphs 5.2 and 5.3. In cross examination, she confirmed that she used two sets of standards, namely Standards of Practice for the GOC (2016) and the GOC's Core Competencies used to assess pre-registration optometrists. She also reported that she drew on multiple sources to decide whether registrants were below standards judging from her own experience.

28. Professor Evans was called to give evidence on behalf of the Registrant. He adopted his report of 11 April 2025 and confirmed his understanding that his primary duty was to the Committee. He informed the Committee of his qualifications and experience in High Street practice and research. He explained the difference between hospital settings and private practice, stating that within a hospital, a practitioner would be part of a team with delegated responsibilities. But within private practice in a high street, the role was similar to the care offered by a general practitioner covering the depth of practice and being responsible for a comprehensive eye examination. He stated in terms of types of patients seen, the hospital eye service deals with a high proportion of patients with eye pathology. Community primary care optometrists mainly prescribe for refractive errors, i.e. the need for spectacles. A minority of patients have ocular pathology.

29. Professor Evans explained how he developed his definitions of "below" and far below" in his reports stating that it was from a combination of his clinical experience, research in clinical cases and feedback from Council cases on previous fitness to practise hearings.

30. In relation to particular 1, Professor Evans explained that although the risk to the patient was arguably very low because Patient B had been referred to the cataract clinic for possible left cataract surgery. His IOPs would routinely be measured and optic disc health checked at that appointment and if he had glaucoma, it would have been detected. He said the referral should have at least mentioned the risk of glaucoma. Professor Evans stated that visual field results were important because most hospital eye services would not treat glaucoma if there were no visual field defect particularly with low pressure. He stated that the left optic disc looked suspicious and had worsened in appearance since 2019 which was enough to raise a "red flag" in this case.

31. With respect to particular 2(a)(i), Professor Evans stated that this was not a routine sight test and was an Enhanced Optical Services (EOS) appointment to investigate presenting ongoing symptoms of flashes and floaters, in effect a possible tear or detachment of the retina which happens in the periphery of the eye. He stated that the expectation of an optometrist would have been to have behaved like a GP of the eye. He stated that if there was a macula problem it would likely affect acuity. However if the patient attended with symptoms of flashes and floaters, it would be appropriate for an optometrist to dilate the pupils but they would not be obliged to conduct an OCT scan.

32. Professor Evans stated in cross-examination that there would be a reasonable body of optometrists who would be worried about drusen because it was a sign of dry macular degeneration which could rapidly progress to wet macular degeneration

requiring treatment within 2 weeks. With regards to Patient C, confluent large drusen could not be seen but if the small white dots were interpreted as drusen, then it could be seen as very fine granular drusen carrying low risk of progressing to wet macular degeneration.

33. Professor Evans informed the Committee that an Amsler chart was not typically used for this type of appointment especially if visual acuity was normal. He was not critical of the Registrant's failure in this regard. Patient C did not have macular degeneration and the appointment was not in relation to this and therefore a reasonably competent optometrist would not have used this chart.

34. Regarding particular 2(c), Professor Evans stated that the appointment was to investigate flashes and floaters which would have been at the forefront of the mind of the Registrant investigating a tear or detachment. He stated that his symptoms could have been due to Posterior Vitreous Detachment (PVD) which in his opinion was harmless. Professor Evans said that PVD did carry a slight risk of tear even after the appointment so an optometrist should warn a patient and seek emergency eyecare. Professor Evans was not critical as the Registrant had recorded this.

35. In relation to particular 2(d), Professor Evans stated that in his research, it had been quantified that if optometrists did "not record", it was down to not thinking that it was important to record, did not have time to record or forgot to record. In this particular case, he was of the opinion that the Registrant had carried out the test but did not record it and although critical of this, in his opinion it was conceivable for the next practitioner to see the Registrant's findings being unhelpful and therefore carried low risk. Professor Evans was of the view that this would fall below the standards but not far below.

36. With respect to particular 3, Professor Evans stated that looking at the records of Patient D, if there had been a new finding of vascular changes then this would have been a "red flag" and a sign to refer to a GP. He stated that being on statins would have meant that the patient was under the care of a GP as well as the fact that the patient had had eye surgery by an ophthalmologist who would have undergone general medical training. Professor Evans said that GPs are so busy the last thing a GP would want was unnecessary communications. Professor Evans pointed out that the Council's Standards require Registrants to only refer appropriately because patients lose eyesight whilst on NHS waiting lists and so clogging up waiting lists could have an impact on other patients.

37. Professor Evans stated in relation to particular 4(c) that he would have expected Patient F to have attended a diabetic eye screening programme (DESP) and could not think of any reason why the Registrant did not record this. When asked about risk, Professor Evans said that there is a slight risk in not enquiring about having attended a DESP because patients may think that optometric checks replace the screening programme. For there to be harm, the patient would need to be one of the few patients to think this and the risk was incredibly low. He stated that a record of attending DESP could have been helpful.

38. In relation to particular 5(a) Professor Evans stated in his opinion, that failing to retest IOPs fell below as opposed to far below the standards since it was a slow progressing disease and that Patient I's field test was normal with raised pressures meaning the risk of developing glaucoma was low.

39. In relation to particular 5(b), Professor Evans stated that if the IOPs had been repeated and found to be normal, then there was no obligation to refer. With reference to the NICE guidelines, he said that a practitioner should not refer based on one IOP outcome, but only when elevated on repeat measures.

40. Professor Evans' opinion in relation to particular 5(c) and 5(d) was that these fell below standards as opposed to far below due to his opinion that there was no sight threatening macular pathology. He stated that a lesion required monitoring and if there was a sudden change in vision, then the advice should have been to re-attend the practice.

41. In respect of particular 6(a) and 6(b) failing to identify and failing to refer an optic disc haemorrhage, Professor Evans stated that the risk of harm was low to Patient K as the tests on this occasion on visual field tests were found to be normal and IOPs borderline.

42. With regards to particular 7(a) and (b), Professor Evans said that a record to advise Patient L of the examination of findings of vitreo-retinal traction at his appointment would not help or be useful to the next practitioner. In his opinion this was below the expected standards but not far below.

43. Professor Evans stated in relation to particular 7(c), even though the IOPs were normal, it did not take away the risk of glaucoma. The central visual field test was required due to the suspicious optic nerve findings and not performing the visual field test fell below the Standards. He stated that if the visual field test was normal, then there was no need to refer onwards.

44. On particular 7(d), Professor Evans was taken to the NICE Guidelines at paragraph 1.1.5. He said that a visual field test should have been carried out for Patient L and referral was only necessary if the visual field was abnormal. In cross examination, he gave evidence that he disagreed that the appearance of the left optic disc was abnormal and stated that it was suspicious and could be a normal variation. Professor Evans therefore concluded that it was not safe to suggest that there was damage which is why a field test was required. However, in this instance in the absence of a visual field, a referral would have been more appropriate.

45. Particular 8(a) to (b) fell far below the Standards according to Professor Evans. He stated that Patient M's pupils should have been dilated and therefore the Registrant should have been looking for tobacco dust (Shafer's sign) as this forms part of this detailed dilated examination.

46. With regards to particular 8(c), Professor Evans said that this fell below the standards because if a patient experienced change in symptoms, they would normally do something about it. He said, a failure to give safety netting advice could cause harm but he defined this risk as low.

47. With regard to particular 8(d), the Committee noted that Professor Evans had not had the opportunity to comment upon it in his report. He stated that this particular was implicit in 8(a) as a Registrant should know that these symptoms could be associated with retinal attachment.

Submission of no case to answer

48. At the close of the Council's case, Mr Archer made a submission of no case to answer on particular 2(b), 3(a), 3(b), 4, 7(a) and 7(b) pursuant to both parts of Rule 46(8), namely:

    (8) Before opening the registrant's case, the registrant may make submissions as to—

    (a) whether sufficient evidence has been adduced upon which the disputed facts could be found proved;

    (b) whether the facts, whether they are disputed or proved, could support a finding of impairment.

49. Mr Archer informed the Committee that the submission was formed on two alternative bases for each particular pursuant to Rule 46(8) that the Council had not adduced sufficient evidence on the facts which were denied by the Registrant and in the alternative, the evidence did not support serious professional misconduct on which impairment could be found in any event.

50. With regards to particular 2(b), Mr Archer submitted that there was no need to advise Patient C on lifestyle changes as there were no drusen identified.

51. With regards to particular 3(a) and (b) in relation to Patient D, Mr Archer submitted that there had been no significant changes over an 8-year period and so there was no basis to identify vascular changes. Furthermore, on previous examinations with similar findings, no other optometrist who had examined Patient D between 2014 and 2022 took any action. They had also not referred Patient D to a GP and so it was not reasonable to criticise the Registrant for not doing so.

52. With regards to particular 4, Mr Archer submitted that although the record for Patient F on 24 June 2022 did not show that the Registrant had discussed duration and control of diabetes, this did not mean that it was not discussed. He referred to another optometrist (*Redacted*) who had examined Patient F on 16 November 2022 who, he said, had also not recorded duration or control of diabetes. He submitted that the Committee should use *Redacted*'s actions as a yardstick against which to measure the Registrant's conduct. He submitted that this approach was also supported by the opinion of Professor Evans.

53. In relation to particular 7, Mr Archer stated that there was no evidence of what advice was given to Patient L as opposed to what was recorded. There was no basis to show that this was proved. There was no evidence to contradict that he did not advise Patient L or provide safety netting advice.

54. Mr Potts on behalf of the Council submitted that he did not oppose the submission relating to particular 2(b) and said Mr Archer's submissions were well-founded.

55. With regards to particular 3(a) and 3(b) in relation to Patient D, Mr Potts submitted that Dr Kwartz's findings were appropriate in this regard and had been fair and consistent with an expectation that the Registrant ought to have identified vascular changes and have referred Patient D to a GP. He also submitted that Dr Kwartz's view that other optometrists could be below the standard did not present any logical difficulty and was not inconsistent with everyday life and more than one practitioner may fall below standards in similar ways. However, this would not absolve this Registrant of his responsibilities.

56. On particular 4 and 7(a) and (b) he submitted, that if advice was not recorded, it gave rise to an inference that such advice was not given. The Registrant was still expected to use his professional judgment to decide what to record and what not to record pursuant to the standards expected of a registered optometrist. Accordingly, in the absence of a failure to record an adequate history concerning Patient F and failure to advise Patient L on examination findings, the Registrant had a case to answer on facts.

57. The Committee heard and accepted the advice of the Legal Adviser. He advised the Committee that it was not fact finding at this stage. Instead, the Committee was tasked with determining whether there was sufficient evidence on which it could find the particulars proved or in the alternative - impaired. The Committee was advised to look at the evidence holistically, without the benefit of evidence from the Registrant, by looking at the strengths, its clarity, any supporting evidence and what reasonable inferences it could draw from them, including weaknesses which would include lack of reliability and consistency with other evidence.

Decision on submission of no case to answer

Particular 2(b)

58. Dr Kwartz gave evidence to the Committee that having had the benefit of considering new evidence (OCT macula December 2022) presented at the hearing, no drusen could be identified on the OCT scan. Therefore, under the circumstances, no lifestyle advice was in fact necessary. The Committee acknowledged that the Council had not objected to the submission of no case to answer on this particular and was of the view that it was not well-founded and concluded that there was no case to answer in relation to this particular.

Particular 3(a) and (b)

59. The Committee considered both experts' views that in 8 years there had been longstanding vascular changes to Patient D's left eye. However, since the Registrant had recorded "normal" vessels for both eyes in the record card, the Committee was satisfied that sufficient evidence had been adduced upon which the disputed facts could be found proved.

Particular 4

60. The Committee concluded that there was sufficient evidence on which particular 4(a) and (b) could be proven. The Committee noted at paragraph 7.7.1 of her report Dr Kwartz's reference to details of the duration and level of control of diabetes not being documented were "minor". The Committee did not consider it met the threshold of a finding of impairment pursuant to Rule 46(8)(b).

61. In relation to particular 4(c), the Committee determined that there was sufficient evidence adduced upon which the disputed facts could be found proved. This was because the patient record made by the Registrant on 24 June 2022 does not establish whether Patient F was attending DESP appointments. In relation to impairment the Committee was satisfied that if the disputed facts were proved the particular is such, it could support a finding of impairment.

62. The Committee therefore concluded that there was no case to answer in relation to particular 4(a) and (b).

Particular 7(a) and (b)

63. The Committee noted that Patient L attended for an NHS sight test on 19 March 2022. The Committee considered the record of Patient L and noted that there was no evidence in the patient record that vitreo-retinal traction had been recorded nor that Patient L had been informed of the presence of vitreo-retinal traction or given any safety-netting advice. The Committee was satisfied that sufficient evidence had been adduced upon which the disputed facts could be found proved.

64. The Committee was satisfied that if the disputed facts were proved the particular is such that it could support a finding of impairment.

65. The Committee therefore concluded that there was a case to answer in relation to particular 7(a) and (b).

66. Mr Archer then called the Registrant to give evidence. He adopted his witness statement dated 1 May 2025 as his evidence in chief. Mr Archer took the Registrant through his CV. In evidence, the Registrant informed the Committee that he did not have any previous fitness to practise history.

67. In evidence, the Registrant stated that he had been informed that during his employment at *Redacted*, he had seen around 1400 patients having joined the opticians in March/April 2022.

68. On particular 1, the Registrant gave evidence that he had properly detected glaucoma in other patients many times using field tests and had never been criticised for field tests or not spotting glaucoma before. On this occasion, his focus was on cataracts and he said that this was an isolated mistake.

69. With regards to particular 2(a)(i) and (ii), the Registrant stated Patient C's appointment was an EOS appointment as Patient C had presented with flashes and floaters. He stated in evidence that he did not recall the eye-test he performed on Patient C and he explained his normal practice to view the macula. He said he would dilate the pupil by putting in drops to widen the viewing area and to obtain a better view of the fundus and to check for Shafer's sign in the anterior vitreous. He stated that the use of a slit lamp and Volk lens would give a good view of the retina. He informed the Committee that all Specsavers practices have an OCT, that his practise did and there was a £10 charge for an OCT test.

70. In cross-examination, the Registrant stated that it was taught at university that if something was not recorded, then it would be deemed as not being done. He stated that he records visual acuity for all his patients.

71. In relation to particular 2(c), the Registrant said that he would have provided safety netting advice to Patient C as he had dilated the pupils and the record evidenced that he had provided the leaflet on flashes and floaters.

72. In relation to particular 2(d), the Registrant could not remember measuring acuity for Patient C although he stated that his standard practise was to measure acuity for all patients and therefore it was more likely that he did, but did not record it.

73. With regards to particular 3, the Registrant could not remember this consultation. He stated that he could not see anything from the records that could indicate that an ophthalmologist would be worried about vascular changes. He gave evidence to say that although not recorded, he would have checked every fundus photograph.

74. In relation to particular 4(c) concerning Patient F, the Registrant could not recall the appointment of 24 June 2022 specifically. He could not provide any good reason for not asking or not recording that Patient F was attending a diabetic screening programme.

75. With regards to particular 5, the Registrant could not recall the appointment with Patient I. When Mr Archer asked him why he did not refer or re-test the IOP, he stated that visual fields and discs were normal and he would have set a recall appointment for 1 year when he would have re-tested the patient. With the benefit of the expert evidence, the Registrant said that he thought he put too much emphasis on the visual fields being normal and that he should have perhaps repeated using applanation tonometry. The Registrant did state he had referred many patients with abnormal pressures and fell into error on this occasion but did not know why.

76. With regards to particular 6, the Registrant said that a haemorrhage on Patient K's left optic disc would have normally been picked up and referred, but he stated that this was genuinely missed as it was not recorded in his notes.

77. In relation to particular 7(a) and (b), in his evidence the Registrant said, "If I had given a leaflet, it would have been a retinal detachment leaflet and I would have written it in the notes, but I haven't". On being reminded of the contents of his witness statement by Mr Archer, the Registrant then stated, "I usually give a leaflet out. I may not have recorded it in this instance". The Registrant was asked whether this was his belief on giving advice or not and he answered by saying that "I probably did".

78. With regards to particular 7(c) and 7(d), he admitted that he had not carried out a central visual field test on Patient L as he had not recognised that the left disc was suspicious and would have referred if he had recognised this. He also stated that if the visual field was normal, he should have referred to check vitreo-retinal traction.

79. In relation to particular 8, the Registrant did not recall the appointment with Patient M but said that he felt quite shocked and disappointed in himself. He did not know why he had not dilated the pupil at the time but said that this could have been due to the patient driving and so any eye drops would have had a deteriorating effect on visual acuity.

80. The Committee then heard closing submissions from the parties who had submitted written submissions in support. Mr Potts on behalf of the Council stated that the Registrant had admitted over a nine-month period to one particular of failing to identify a finding, three particulars of failing to refer a patient, three particulars of failing to carry out a test or examination, three particulars of failing to give advice and one particular of failing to record information.

81. Mr Potts stated that the number of failings which had been admitted was significant to the Registrant's practice as a whole. He submitted that the number of failings during a 9-month period was significant. He stated that Dr Kwartz's evidence was that there could be no reason for carrying out certain tests and or asking questions and then failing to record the information.

82. On particular 2(a), Mr Potts submitted that the Registrant did not offer an OCT which represented a failing and that in relation to particular 2(c), since Dr Kwartz had given evidence that safety netting advice should have been given, this particular should also be found proven.

83. Mr Potts informed the Committee that the Registrant had admitted particular 2(e) and given Dr Kwartz' evidence that there could be no reason for failing to record Patient C's acuity. He invited the Committee to draw an inference that the explanation for the patient's visual acuity not being recorded was that it had not been measured in the first instance.

84. With regards to particular 3(a), Mr Potts stated that the Registrant had recorded "normal" for both eye vessels in Patient D's record however if he had observed nipping, it ought to have been recorded at the same time but was not.

85. In relation to particular 3(b), Mr Potts submitted that if the Committee accepts that the Registrant failed to identify vascular changes then, relying on Dr Kwartz's opinion, a referral to a GP should have been made for a blood pressure assessment.

86. Regarding particular 4(c), Mr Potts submitted that the Registrant did not have any memory of the consultation, and if the appropriate question had been asked of the patient, according to Dr Kwartz, there was no reason to not have recorded the answer.

87. With regards to particular 7(a) and (b), Mr Potts submitted that the Registrant initially did not remember the appointment with Patient L, however when reminded, he informed the Committee that he did not have an independent memory of the appointment and therefore the evidence of the Registrant was equivocal.

88. Mr Potts submitted in relation to particular 7(d), the Council relied upon Dr Kwartz's opinion that there was glaucomatous change in Patient L's left optic disc and so a field test ought to have been carried out with a referral indicated even if the test result showed "normal".

89. Mr Archer on behalf of the Registrant submitted he had made appropriate admissions but could not admit particulars which were wrong. He stated that sometimes information was not recorded as a result of an error, oversight, distraction, or time pressure and none of those reasons were 'good reasons', but they could happen.

90. Referring to particular 2(a), Mr Archer submitted that the dispute between the parties was whether all registered competent optometrists would have conducted an OCT scan and/or used an Amsler chart at the EOS appointment with Patient C. He stated that Professor Evans was most qualified, to provide an opinion on that dispute than anybody else in these proceedings.

91. With respect to particular 2(c), Mr Archer submitted that the Registrant did give safety netting advice to Patient C as the patient record showed the "flashes and floaters leaflet given" and accordingly the particular was not correct.

92. In respect to particular 2(d), Mr Archer explained that the Registrant's standard practice was to test visual acuity and when something was part of a practitioner's standard routine every day, it would be extremely unusual for the Registrant to suddenly and inexplicably break that routine.

93. With regards to particular 3(a) and (b), Mr Archer submitted that this related to vascular changes in Patient D's left eye and the disputed issue in relation to this particular was not whether there was vascular nipping, but rather whether the Registrant failed to identify it compared to a registered competent optometrist.

94. In relation to particular 4 Mr Archer submitted, that the Registrant accepted that he did not record the information but he had said that he always asked diabetic patients about whether they were attending diabetic screening.

95. Mr Archer submitted that both experts gave evidence that the lack of a record did not mean that a test did not happen. Mr Archer said that the next optometrist did not record whether Patient F was attending screening appointments either and therefore it would be reasonable that a body of registered competent optometrists would not necessarily record such information too.

96. With respect to particular 7 (a) and (b), Mr Archer submitted that the points made in relation to this particular were very similar to the points made in relation to particular 4.

97. He stated that research from the "real world" evidenced that not all advice and tests are recorded on the patient record. Some information was more important than other information ranking quite far down on the scale of importance. He stated that sight tests in a high street practice were time-pressured, typically with 15 patients in a single day.

98. With regards to particular 7(d), Mr Archer submitted that the Registrant failed to make a referral for suspected glaucoma in respect of the appearance of Patient L's left optic disc. He stated that according to the NICE guidance, it would only have been appropriate to refer on the basis of the optic disc alone if it was damaged.

99. The Committee then heard and accepted advice from the Legal Advisor who informed the Committee of Rule 39 which said that the burden of proof rested with the Council and that the standard of proof was on a balance of probabilities pursuant to Rule 38.

100. The Legal Advisor informed the Committee that it should consider whether the evidence before it was plausible and consistent with objectively verifiable evidence. The Committee should start with the objective facts as shown by authentic, contemporaneous documents independent of the person giving evidence and use oral evidence to test it. The Legal Adviser stated that there were a number of disputed particulars, and that the Committee should consider the evidence in respect of each particular separately, however, should not ignore any background or surrounding evidence.

Determination on facts

101. Having determined that there was no case to answer concerning particular 2(b), 4(a), 4(b) by the Committee, it went on to consider the remaining disputed particular, namely 2(a)(i), 2(a)(ii), 2(c), 2(d), 3(a), 3(b), 4(c), 7(a), 7(b), 7(d).

Particular 2(a)(i) – Not proved

102. The particular was framed on the basis that the Registrant failed to assess, adequately or at all, Patient C's maculas because he did not undertake an OCT scan. The Committee noted this particular contained the word 'failed'. The Committee therefore considered what obligation was on the Registrant to perform an OCT scan at the appointment on the 14 August 2022. The Committee noted that this was an EOS appointment and it understood that the patient had attended and reported symptoms of flashes and floaters.

103. The contemporaneous record card recorded that the Registrant had performed a dilated examination and a slit lamp examination of the fundus on Patient C.

104. Neither expert who gave evidence could point to any professional obligation for a Registrant to perform an OCT scan in this situation. Dr Kwartz said that a patient had a right to refuse a scan and accepted that there may be cost implications. Both experts accepted in evidence that not every practice had an OCT scanner.

105. The Committee concluded that the Council had not established that there was any mandatory obligation upon the Registrant to perform an OCT scan in this situation and therefore the Committee could not be satisfied that he had failed to do so.

106. Therefore, the Committee determined that the Council had not discharged the burden of proof in relation to particular 2(a)(i).

Particular 2(a)(ii) – Not proved

107. The particular was framed on the basis that the Registrant failed to assess, adequately or at all, Patient C's maculas because he did not use an Amsler chart. The Committee noted this particular contained the word 'failed'. The Committee therefore considered what obligation was on the Registrant to use an Amsler chart at an EOS appointment where the patient had attended and reported symptoms of flashes and floaters. The Committee was of the view that whether the Registrant should have used an Amsler chart was dependant on whether or not he had measured visual acuity. If he had measured visual acuity, in the Committee's view it would have been unnecessary to use an Amsler chart. Conversely, if the Registrant had not measured visual acuity, then not using an Amsler chart, could be a failure. Therefore, before considering whether the Registrant had used an Amsler chart, it had to first consider whether he had measured visual acuity. It found that it was more likely than not that he did measure visual acuity (see paragraphs 114-117 below).

108. The Committee noted that there was disagreement between the experts on when the Amsler chart should be used. Dr Kwartz's view was "the test [Amsler test] was particularly apposite given that visual acuity had not been measured/documented". Professor Evans in evidence said, an Amsler chart was not typically used for this type of appointment if visual acuity was measured and was normal, then he was not critical of not doing an Amsler test in this appointment. The Committee does not know whether the patient's acuity was normal on the 14 August 2022 because the Registrant did not record it. However, the Committee has seen Patient C's record from his appointment on 6 December 2022 which shows that the acuity was measured and recorded as normal in both eyes on this occasion. The Committee

was satisfied that it was more likely than not that Patient C's vision was also normal on the 14 August 2022.

109. Given that the Committee is satisfied Patient C's vision was more likely than not to be normal on 14 August 2022, there would be no requirement according to Professor Evans for an Amsler chart to be used.

110. Therefore, the Committee determined that the Council had not discharged the burden of proof in relation to particular 2(a)(ii).

Particular 2(c) – Not proved

111. The Committee noted that Patient C had attended the appointment because he was concerned with flashes and floaters. The contemporaneous evidence in the form of the record card, demonstrated that the Registrant provided Patient C with a leaflet on flashes and floaters.

112. The Committee noted the Registrant had recorded in Patient C's record, "if any change to floaters or increase in flashing lights go to EYE CASUALTY RE PVD."

113. The Committee was satisfied that the Registrant had therefore provided adequate safety netting advice to Patient C and accordingly, did not find this particular proved.

Particular 2(d) – Not proved

114. The Committee considered the entries in Patient C's record card and noted that the Registrant had not recorded visual acuity. The Committee was invited by Mr Archer to accept that the Registrant had measured visual acuity but failed to record it.

115. The Registrant gave evidence that he had no independent recollection of his examination of Patient C. He was clear in his evidence that his standard practise was to measure visual acuity on all patients.

116. The Committee found the Registrant's account to be credible and persuasive. The Committee was satisfied that measuring visual acuity formed such an integral part of any eye examination that it seemed more likely than not that in performing a dilated examination that the Registrant would have measured visual acuity under the circumstances.

117. Therefore, the Committee determined that the Council had not discharged the burden of proof in relation to particular 2(d).

Particular 3(a) – Proved

118. Patient D had attended on the 29 July 2022 for an NHS sight test. It was not in dispute that in an eye examination, a Registrant would be expected to identify vascular changes.

119. The Committee noted that both experts had agreed that the imaging photos did show nipping or arterio-venous changes, but that the Registrant had not recorded this, but instead, recorded "normal" under the Vessels section for both eyes on the record card.

120. Accordingly, the Committee was satisfied this particular proved.

Particular 3(b) – Proved

121. The Committee has found the Registrant failed to identify vascular changes in Patient D's eyes. The Committee is satisfied that in accordance with Standard 7, a Registrant would have a duty to refer such a patient with this finding to their GP for a blood pressure assessment. The Committee noted the differing views of the experts on this point, but was satisfied in the circumstances the Registrant should have referred Patient D but failed to do so.

122. Accordingly on a balance of probabilities, the Committee determined this particular proved.

Particular 4(c) – Proved

123. The Registrant in evidence said that he had no independent recollection of the appointment with Patient F on the 24 June 2022. The Committee reviewed the patient record card completed by the Registrant for this patient and noted that he had recorded that Patient F was diabetic but there was no record of whether they were attending DESP.

124. In evidence the Registrant said that he was "hoping" to have established this and would "normally" have asked. The Committee felt that it could not attach weight to his evidence on this point given the vague nature of his responses.

125. The Committee found on a balance of probabilities it was more likely than not, that the Registrant did not obtain an adequate history in that he did not establish that Patient F was attending DESP as a matter of fact and therefore found this particular proved.

Particular 7(a) – Proved

126. The Registrant did not have any independent recollection of the appointment with Patient L on 19 March 2022.

127. Professor Evans confirmed that there was no evidence on the record of a finding of vitreo-retinal traction in the right eye. The Registrant said in evidence that, "I don't think that I gave advice on vitreo-retinal traction" and when asked by Mr Potts whether the particular was right or wrong, the Registrant responded, "I think the particular is right".

128. Given that there is no entry on the record that the Registrant had advised Patient L and taking into account his responses in evidence, the Committee was satisfied it was more likely than not that the Registrant failed to advise Patient L of the findings of vitreo-retinal traction in the right eye.

129. On a balance of probabilities, the Committee determined that the Registrant failed to advise Patient L of findings of vitreo-retinal traction and therefore found this particular proved.

Particular 7(b) – Proved

130. The Committee had already heard that the Registrant did not have any independent recollection of the appointment with Patient L on 19 March 2022. It noted that there

was no entry on the record that the Registrant had provided any safety netting advice to Patient L.

131. The Committee considered the evidence the Registrant had given in relation to this particular and noted that at first in his evidence, he stated, “If I had given a leaflet, it would have been a retinal detachment leaflet and I would have written it in the notes, but I haven’t”. On being reminded of the contents of his witness statement by Mr Archer, the Registrant then stated, “I usually give a leaflet out. I may not have recorded it in this instance”. The Registrant then stated whether this was his belief on giving advice or not, he answered by saying that “I probably did”.

132. Given there was no entry in the contemporaneous record card and taking into account his responses in evidence, the Committee was satisfied it was more likely than not that the Registrant failed to provide any safety netting advice to Patient L.

133. As a result, the Committee found particular 7(b) was proved.

Particular 7(d) – Proved

134. The Committee noted that Professor Evans had said that the appearance of cupping of the left eye disc was “suspicious” although he did not think that the optic disc by itself warranted a referral. Dr Kwartz referred to the damage as “very frank and should definitely be recognised as such by a competent practitioner”.

135. The Committee also noted that the Registrant admitted not carrying out a visual field test on Patient L and there was no record of it on Patient L’s record card. The Registrant did not identify that the left optic disc was at least suspicious. The Committee had regard to the NICE guideline 81 and noted at paragraph 1.1.5 that a referral was required if, “there is optic nerve head damage…, or a visual fields defect consistent with glaucoma…”

136. There was no evidence that the Registrant made a referral for suspected glaucoma in the left eye.

137. Accordingly on a balance of probabilities, the Committee determined that the Registrant failed to make a referral for suspected glaucoma.

Misconduct

138. The Committee has heard submissions on behalf of the Council and the Registrant. It has accepted the advice of the Legal Adviser.

139. The Committee went on to consider, whether the facts found proved amounted to misconduct.

140. The Committee heard submissions on misconduct from Mr Potts, on behalf of the Council and from Mr Archer, on behalf of the Registrant.

141. Mr Potts invited the Committee to find that the facts admitted by the Registrant and found proved by the Committee amounted to misconduct.

142. Mr Potts referred the Committee to the case law on the definition of misconduct, including the case of *Roylance v General Medical Council (No.2)* [2000] 1 A.C. 311, where it stated that:

"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 in the particular circumstances."

143. Mr Potts stated that the Committee should give proper weight to "serious professional misconduct" as defined in the case of *Nandi v GMC* [2004] EWHC 2317 (Admin), namely that conduct that would be regarded as deplorable by fellow practitioners amounted to serious professional misconduct.

144. In particular, Mr Potts submitted that the Registrant had breached the following Standards which amounted to serious misconduct:

- *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.*
- *7.1: Conduct an adequate assessment for the purposes of the optical consultation, including where necessary any relevant medical, family and social history of the patient. This may include current symptoms, personal beliefs or cultural factors.*
- *7.2: Provide or arrange any further examinations, advice, investigations or treatment if required for your patient. This should be done in a timescale that does not compromise patient safety and care.*
- *8: Maintain adequate patient records.*

145. Mr Potts invited the Committee to prefer Dr Kwartz's definitions of "below" and "far below" and on applying those definitions to the standards, the Committee should consider the overarching objective contained in Section 1 of the Opticians Act 1989.

146. Mr Potts submitted that, in the opinion of Dr Kwartz, all the allegations found proved and/or admitted fell "far below" the required Standards. He submitted that in relation to each admitted or proved particular misconduct had been made out.

147. On behalf of the Registrant, Mr Archer submitted that the Council had alleged misconduct and not of deficient performance, which were two distinct concepts and therefore said that the Committee must look at each specific part of the allegation and not as a pattern of deficient performance.

148. Mr Archer also submitted that the Committee was required to consider "seriousness" with respect to the act or omission alleged against the Registrant. Mr Archer as well as citing the same caselaw as Mr Potts' had on the definitions of misconduct and seriousness. He also referred to *R (Calhaem) v GMC* [2007] EWHC 2606 (Admin) and *Schodlok v GMC* [2015] EWCA Civ 769.

149. Mr Archer submitted that all professionals make mistakes as part of working life but that not all mistakes warranted regulatory disciplinary action. He said that falling short or even negligent on its own was not enough, but how serious the act or omission, was the key.

150. Mr Archer submitted that Dr Kwartz's definition of the terms "below" and "far below" were overly rigid and unrealistic. He stated that the Committee should not interpret it literally. He stated that optometrists should not be expected to record every detail in the record but exercised their own judgment on what to record.

151. Accordingly, he stated that Professor Evans' definitions were far more sensible and proportionate and ought to be adopted by the Committee in determining misconduct as they were more realistic.

152. The Committee heard and accepted the advice of the Legal Adviser, who reminded the Committee that misconduct was a matter for its own independent judgement and there was no burden or standard of proof to be applied at this stage. The Committee was advised that it needed to consider whether the conduct was sufficiently serious to amount to professional misconduct pursuant to the cases of Roylance and Nandi.

The Committee's Findings on Misconduct

Particular 1

153. The Committee noted Dr Kwartz's opinion that: "The omission is consistent with a standard far below the required level as glaucoma is an insidious condition which causes irreversible visual loss, so the patient was at a very definitely increased risk of harm, also there was a significant departure from the expected standard." The Committee noted that Professor Evans said that the "risk to the patient was low, arguably very low because they were going to hospital anyway. So, if they had glaucoma that required treatment it would be picked up in the near future anyway".

154. The Committee was of the view that there was a significant risk of harm to any patient where a Registrant failed to make a referral in respect of suspected glaucoma. The Registrant had referred Patient B for cataract surgery following his sight test on 1/9/22. There was no evidence in the record that the Registrant had detected glaucoma during the examination and further he failed to make a referral in respect of glaucoma. In the case of Patient B it may well have been that there was no actual harm as he was being referred for cataract surgery but that did not mean there was not a risk of harm. By failing to make a referral in respect of glaucoma when it was indicated due to the appearance of the optic discs the Registrant had placed Patient B at risk of harm.

155. The Committee was satisfied that the Registrant's failure to make a referral in respect of Patient B was serious and fell far below the standard required of a reasonably competent optometrist. Accordingly, the Committee was satisfied that conduct in this particular amounted to misconduct.

Particular 2(e)

156. The Committee noted Dr Kwartz's comment that she considered a reasonably competent optometrist would measure and record visual acuity and an omission to do so was consistent with falling far below as there is a risk of harm to the patient. In Professor Evans' opinion there was a need to record visual acuity because it could be useful for the next clinician to know the visual acuity at the appointment with the Registrant. Professor Evans was of the view that the omission falls below the standard of a reasonably competent optometrist.

157. The Committee noted that this particular related to a failure to record visual acuity. It appeared to be an isolated incident of failing to record albeit it important information. Dr Kwartz had identified that there was a risk of harm to Patient C but she did not say this was high risk of harm. Given that this particular was limited to

one incident of failure to record and there was in the opinion of the Committee a relatively low risk of harm the Committee was satisfied that this failing fell below but not far below the standard of a reasonably competent optometrist. The Committee determined that the conduct in particular 2(e) did not amount to misconduct.

Particular 3(a)

158. In her report Dr Kwartz' stated: "In not identifying Patient D's vascular changes, I consider that the Registrant's standard fell far below that of a reasonably competent optometrist, as there is an increased risk of harm to the patient of developing sequelae of cardiovascular disease." Dr Kwartz clarified in her oral evidence by sequelae she was referring to strokes and/or heart attacks. Professor Evans said that in his opinion, the vascular nipping was very subtle and he pointed out that optometrists who had seen the patient before and after Patient D's appointment with the Registrant had not recorded the nipping. In Professor Evans' view it was reasonable not to have identified Patient D as having clinically significant vascular changes and a failure to do so did not fall far below the standard.

159. In the Committee's view given the discreet longstanding vascular changes the risk to Patient D of not identifying the vascular changes was low. The Committee was aware that it is required to measure the Registrant's conduct against the Standards of a reasonably competent optometrist. It noted that four other optometrists who saw Patient D had also not identified or recorded significant vascular changes in Patient D's eyes. In the view of the Committee the Registrant's failure to identify the discrete longstanding vascular changes was not so serious an omission that it fell far below the standards of a reasonably competent optometrist. Accordingly, the Committee determined that this particular did not amount to misconduct.

Particular 3(b)

160. Dr Kwartz' said that as a Patient's General Practitioner is responsible for their overall health it is important that the GP is made aware of any vascular changes. In her opinion the Registrant's failure to refer Patient D to his GP fell far below the standard required. Professor Evans' said "since there was no clinically significant change in the fundus photographs from those at previous photographs, and the patient would have received a full medical workup before eye surgery early in 2022, it could be reasonably argued that a referral at this time would have breached GOC Standard 10.2, "Refer a patient only when this is clinically justified"".

161. In the Committee's view given the discreet longstanding vascular changes the risk to Patient D was low. The Committee noted that the Patient had been prescribed Statins and had had cataract surgery earlier in 2022. Given the vascular changes were discrete and long standing and he was on long term Statins this would suggest Patient D's GP and Ophthalmologist would have already been aware of his cardio vascular risk factors. In these circumstances the failure to refer Patient D did not represent a risk to the patient. The Committee was of the view this was not a serious failure and did not fall far below the standard required of a reasonably competent optometrist. It was satisfied the Registrant's conduct in this particular did not amount to misconduct.

Particular 4(c)

162. The Committee noted from Dr Kwartz's report that "In his management of issues relating to Patient F's diabetes, I consider that the Registrant fell far below the standard of a reasonably competent optometrist as there was an increased risk of harm to the patient." Professor Evans said that the risk of harm was "very hypothetical" and that "for there to be a risk of harm, the patient would have to be one of few who thinks there is no need for screening, and have significant diabetic changes, and those changes not be apparent in a sight test. Taken together, that is very unlikely."

163. The Committee recognised that the Registrant should have noted whether the patient was attending the DESP. It noted there was no note in the record that he had established whether Patient F was attending DESP. However, the Committee's view was that any changes would have been picked up at the next eye examination and overall the risk of harm was low because Patient F had been attending for regular NHS eye examinations and this would include an examination of the fundus to check for diabetic eye disease.

164. For this reason, the Committee was of the view that the Registrant fell below but not far below the standard of a reasonably competent optometrist. In the Committee's view a failure to establish attendance at a DESP would not be regarded as deplorable by fellow practitioners.

165. The Committee therefore determined that this particular did not amount to serious professional misconduct.

Particular 5(a) and (b)

166. The Committee noted that in Dr Kwartz's opinion, "Whilst [the Registrant] had not used contact tonometry as recommended, Patient I's intra-ocular pressure in their left eye exceeded 24mmHg and so should have been re-measured and referred, if necessary. I, therefore, aver that [the Registrant's] standard fell far below the required level as there was a risk of harm to the patient and a significant departure from standard practice." Professor Evans' opinion was that an IOP test should have been repeated or if this was not possible, then referral would have been an option. He said that not to follow either option fell below the Standard but not far below. In his view the risk of harm for the patient was very low because visual fields were normal and there was a yearly recall.

167. The Registrant admitted that he failed to retest the IOP and did not make a referral for the elevated pressure. The Committee was of the view the failures were serious as there was a high risk for Patient I's developing glaucoma. The Committee noted the view of Professor Evans that the patient had normal visual fields and normal discs on this occasion but the Committee could not be satisfied that the patient would definitely return for an eye examination each year. The Committee noted the asymptomatic nature of glaucoma, as identified by Dr Kwartz, is of particular relevance as the Registrant's failings would have left Patient I exposed to a risk of harm due to the asymptomatic nature of the disease.

168. The Committee was satisfied that the failings in particulars 5(a) and (b) were serious failings which fell far below the Standards required of a reasonably competent optometrist. In the Committee's judgment these particulars amount to misconduct.

Particular 5(c) and 5(d)

169. The Committee noted that Dr Kwartz' stated, "A reasonably competent optometrist would advise their patient of this finding and give them safety-netting advice regarding the development of visual symptoms and potential preventative measures that can be used. There is no evidence from the record that [the Registrant] counselled his patient appropriately. Therefore, I consider that his standard fell far below the required level as there was a risk of harm to the patient and a significant departure from standard practice." In Professor Evans' view the conduct fell below but not far below the standard. He said there was no sight threatening pathology of the macula and while the lesion required monitoring, the vision was not reduced and had a low risk of deteriorating without the patient being aware of it.

170. The Committee accepted that the risk of macular pathology deteriorating to a level where treatment was required and the patient not being aware of the symptoms was low. The Committee noted that both experts were in agreement that the Registrant should have advised Patient I of his examination findings and provided safety netting advice. In this instance Patient I had excellent visual acuity in both eyes and had a small lesion on the right macula and so had relatively low risk. Given these factors the Committee considered that the failures in 5 (c) and (d) fell below but not far below the standards expected of a reasonably competent optometrist. It was not satisfied that these failings amounted to misconduct.

Particulars 6(a) and 6(b)

171. The Committee noted in relation to particulars 6(a) and 6(b) Dr Kwartz's said "I consider that Patient K had a significant sign of present/incipient glaucoma in that she had large cup:disc ratios and a disc haemorrhage in her left eye. I agree with RB's strategy of testing Patient K's visual fields, but consider that the disc haemorrhage was sufficient justification for a referral to be made, irrespective of the outcome of the visual field test." In relation to particular 6(a) Professor Evans said "the haemorrhage on the left optic disc on 21 May 2022 should have been detected by any reasonably competent optometrist and the failure to detect this fell below the standard required." Concerning particular 6(b), Professor Evans stated, "the failure to refer fell below the standard required. I say below and not far below because the visual field was normal."

172. The Committee noted that the Registrant admitted he had not identified Patient K's left optic disc haemorrhage and did not make a referral for glaucoma. The Committee considered that glaucoma is an insidious disease where patients (especially with unilateral involvement) are invariably asymptomatic in the early and even in the moderate stages. The Committee was of the opinion that the failings outlined in particular 6 were serious and the Registrant's failings were such there was a significant the risk of harm to Patient K. The committee was satisfied that the Registrant's conduct fell far below the standard required of a reasonably competent optometrist and did amount to misconduct.

Particulars 7(a), and (b)

173. The Committee noted that Dr Kwartz discussed the OCT findings of the right eye showing a small extent of vitreo-retinal traction. She stated, “I consider that on observing this finding, a reasonably competent optometrist would advise their patient about the symptoms of distortion or flashes of light and/or floaters and give them safety-netting advice about seeking an urgent opinion should any of these occur.” It was her opinion that this fell far below the standard of a reasonably competent optometrist. Professor Evans stated he was of a similar opinion to Dr Kwartz that the patient should have been advised of the finding of vitreo-retinal traction. He was also of the opinion that the patient should have been given safety advice. However, he felt, that this fell below rather than far below of the standards expected of a reasonably competent optometrist.

174. The Committee was satisfied that the Registrant should have advised Patient L of vitreo-retinal traction in the right eye and provided safety netting advice. If this progresses to a retinal tear or detachment there is a severe risk of sight loss. Failure to give safety netting advice means the patient would have been unaware of the urgency of presenting for care and could have resulted in significant harm to Patient L. The Committee was satisfied that these failures fell far below the standard of a reasonably competent optometrist and did amount to misconduct.

Particulars 7 (c) and (d)

175. Dr Kwartz was of the view that the Registrant should have performed a central visual field test and made a referral to an Ophthalmologist because there was “definite glaucomatous change at Patient L’s left optic disc”. She considered that failure to carry out the test and make a referral for suspected glaucoma fell far below the required level on account of the risk of harm to the patient. She said “Glaucoma is an insidious disease where patients (especially with unilateral involvement) are invariably asymptomatic in the early and even in the moderate stages. Glaucomatous damage is irreversible, thus the importance of appropriate referral as treatment can only prevent further loss and is not able to repair damage that has already occurred”.

176. Professor Evans’ opinion was that “the appearance of the left eye optic disc cupping on 19 March 2022 was suspicious for glaucoma. Therefore, even though the intraocular pressures were normal and there was no family history of glaucoma, the visual fields should have been tested”. In his view a referral was not required and a visual field test would have been more appropriate than a referral on this occasion. In his opinion a failure to perform a central visual field test fell below but not far below the standard of a reasonably competent optometrist.

177. The Committee was satisfied that failure to perform a central visual field test and to make a referral for suspected glaucoma was serious. It agreed with the opinion of Dr Kwartz about the insidious nature of the disease and the importance of appropriate referral. The Committee was satisfied that these were serious failings which fell far below the standard of a reasonably competent optometrist and that this amounted to misconduct.

Particular 8 (a), (b), (c) and (d)

178. Dr Kwartz report states that “in not performing dilated fundoscopy and checking for tobacco dust I consider [the Registrant’s] standard fell far below that of a reasonably competent optometrist owing to a significant risk of harm to the patient”. In relation to safety netting advice she said; “In some situations, a patient presents to their optometrist with symptoms of retinal detachment. The optometrist performs dilated fundoscopy and checks the anterior vitreous for pigment cells but does not find any abnormalities. However, the patient actually has a small, very peripheral detachment that subsequently increases in size. This eventuality is the reason why it is vital for an optometrist to give their patient safety-netting advice if they do not find an abnormality”.

179. Professor Evans said “In my opinion, the symptoms described in the clinical record on 14 January 2022 mandated certain tests. Any reasonably optometrist should have dilated the pupils and, through dilated pupils, examined the anterior vitreous for tobacco dust (Shafer’s sign) and examined the peripheral retina with binocular indirect ophthalmoscopy. The clinical records and Patient M’s witness statement indicate that these procedures were not undertaken and therefore in my opinion the examination did not meet the standard of a reasonably competent optometrist”. He added that “the patient should have been given safety netting advice that if they experienced any sudden change in their symptoms then they should seek emergency eyecare”.

180. The Committee noted that both Dr Kwartz and Professor Evans were of the opinion that 8 (a), (b) and (d) fell far below the standard expected of a reasonably competent optometrist. Dr Kwartz was of the view that 8 (c) also fell far below whereas Professor Evans said that whether 8 (c) fell below or far below was a matter for the Committee’s judgement.

181. The Committee was satisfied that the failing in particular 8 both individually and collectively were extremely serious. The risk of harm to Patient M was high and, in fact, did result in harm to the Patient as he suffered a retinal detachment which resulted in permanent sight loss in the patient’s left eye. The Committee was in no doubt that the failures in particular 8 amounted to misconduct.

Impairment

182. The Committee resumed sitting on 20 November 2025 to consider whether the fitness to practise of the Registrant was currently impaired, as a result of the misconduct found, which is in relation to particulars 1, 5(a) and (b), 6(a) and (b), 7(a)-(d) and 8(a)-(d) of the Allegation.

183. The Registrant was unrepresented at this stage of the proceedings and did not give evidence. No further documentary evidence was placed before the Committee.

184. Mr Potts outlined the Council’s position on current impairment, submitting that the Registrant’s current fitness to practise is currently impaired both on the grounds of risk to the public and public interest grounds. Mr Potts referred the Committee to the Council’s ‘Hearings and Indicative Sanctions Guidance (Revised November

2021)' and the case law on impairment, in particular the case of *CHRE v (1) NMC and (2) Grant* [2011] EWHC 927 (admin).

185. Mr Potts submitted that in relation to the risk to the public, the misconduct demonstrates a high risk of serious harm to the public. Mr Potts referred the Committee to findings that the Committee had made at the misconduct stage regarding the seriousness of the misconduct in question and the significant risk of harm to the various patients concerned. He reminded the Committee that it had found that the failings in respect of particular 8 were both individually and collectively extremely serious due to the harm to Patient M, who suffered from a retinal detachment and permanent sight loss in his left eye. Mr Potts submitted that whilst the risk to the public was most starkly demonstrated by the actual harm caused to Patient M, all the other patients were also placed at risk of serious harm, demonstrating a risk to the public.

186. Turning to remediation, Mr Potts submitted that on the evidence available, the misconduct had not been remedied by the Registrant. He submitted that the Registrant's skills will have been eroded in the time that he has not been working in the profession (since 2022). Mr Potts submitted that in the circumstances it remained the position that, as the Registrant accepted when he gave evidence at the fact stage, that the Registrant's skills are "*not up to scratch*". He invited the Committee to only place limited weight on the evidence of remediation received earlier in the proceedings, as it was now more than 18 months since the last CPD course was attended. Mr Potts submitted that there was limited evidence of meaningful remediation and the risk to the public from the misconduct remained present.

187. In relation to the public interest, Mr Potts submitted that the Council also invited a finding of impairment on public interest grounds, as the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made. He said that in the particular circumstances there had been harm of the most serious kind to one patient and a high risk of serious harm to several others.

188. The Registrant did not make any submissions on impairment. In answer to questions from the Committee, the Registrant confirmed that he was not currently practising, as he had been unable to find a supervisor and had not practised as an Optometrist since 2022. He stated that if he was able to find a supervisor then it would be his intention to return to practice.

189. The Committee accepted the advice of the Legal Adviser, who advised the Committee that the question of impairment was a matter for its independent judgement taking into account all of the evidence it has seen and heard so far. She reminded the Committee that a finding of impairment does not automatically follow a finding of misconduct and outlined the relevant principles set out in the case of *Cohen v GMC* [2008] EWHC 581 (Admin), namely that it should consider if the misconduct is easily remediable, has been remedied and the risk of repetition

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

"Do our findings of fact in respect of the…misconduct, show that his fitness to practise is impaired in the sense that 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) …..."

The Committee's findings on impairment

191. In making its findings on current impairment, the Committee had regard to the evidence it had received to date, the submissions made, the Hearings and Indicative Sanctions Guidance, the Council's Standards, the legal advice given by the Legal Adviser and its earlier findings.

192. The Committee firstly considered whether the Registrant's conduct was remediable, whether it had been remedied and whether the conduct is likely to be repeated in future. The Committee noted that the misconduct which it had found related to clinical issues, in particular the examination, identification of clinical signs of possible pathology and referral of patients. 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*.'

193. The Committee was satisfied that given the clinical nature of the misconduct in this case, relating to the detection of glaucoma, detection of vitreoretinal pathology and appropriate referral of patients, this was conduct that was capable of being remedied, providing that the appropriate training and development was undertaken.

194. The Committee considered whether the misconduct had been remedied by the Registrant since it had occurred. The Committee considered the steps that the Registrant had taken to remediate, which it noted included the completion of some CPD courses between June 2022 and April 2024. However, the Registrant had not completed any training or remediation since April 2024 and had not yet completed any CPD in the current cycle.

195. The Registrant had explained that he had not been able to do so as he has not practised as an Optometrist since 2022. The Registrant would have been able to complete online CPD and webinars without requiring a supervisor. He could also have sought a placement observing in a hospital specialist clinic. The Committee considered that the remediation that the Registrant had undertaken was limited and not current or up to date. In addition, the Registrant had not provided any evidence today of any further remediation that he had undertaken.

196. The Committee considered the level of insight that had been demonstrated by the Registrant. It noted that the Registrant had accepted during his earlier evidence that he had failings in three domains and that his practice was not '*up to scratch*'. He also made admissions to some particulars of the Allegation at the outset of the proceedings and made a wholesome apology, through his then Counsel, to Patient

M, when he gave evidence. However, despite these matters, the Committee concluded that the Registrant's insight was limited. There was no evidence of reflection or developed insight into the misconduct and how to address it, so as to prevent its repetition in future. There was little evidence that the Registrant had reflected on how his misconduct had affected the profession and the public perception of it. In the circumstances, the Committee was not satisfied that the Registrant had remedied the misconduct.

197. The Committee turned to consider the likelihood of repetition. The Committee bore in mind that the Registrant has not practised since 2022, nor completed any recent targeted remediation. The Committee considered that the Registrant was largely in the same position as when the misconduct occurred, with only limited insight and had not yet undertaken the work to address the concerns in this case. The Committee therefore concluded that the risk of repetition, should the Registrant return to practice, was high.

198. Having regard to all of the above, the Committee determined that the Registrant's fitness to practice was impaired on public protection grounds.

199. The Committee next had regard to public interest considerations and to the case of *CHRE v (1) NMC and (2) Grant* [2011] EWHC 927 (admin), particularly the test that was formulated by Dame Janet Smith in the report to the Fifth Shipman Inquiry. The Committee considered that limbs (a)-(c) of this test are all engaged in this case.

200. The Committee considered that the misconduct put patients at unwarranted risk of harm, especially given that there was actual harm to Patient M and risk of harm to the other patients. The misconduct brought the profession into disrepute by the Registrant not conducting proper examinations and appropriate referrals, which led to harm to Patient M. The Committee also considered that the misconduct breached fundamental tenets of the profession as it breached several of the Council's standards, including 6.2 (appropriate referrals), 7.1 (conduct adequate assessments), 7.2 (arrange further examinations and investigations) and 8 (maintain adequate records), as it had found at the misconduct stage.

201. The Committee considered that these limbs of the *Grant* test were engaged both on the Registrant's past conduct in relation to the misconduct found proved and on the basis of being 'liable in the future to so act', given the high risk of repetition found.

202. The Committee considered whether a finding of impairment was necessary in order to uphold proper professional standards and public confidence in the profession. The Committee had found at the misconduct stage that all of the misconduct established was serious, particularly so in relation to Patient M, who had lost his sight in his left eye. The Committee considered that the Registrant's misconduct was a significant departure from the standards to be expected of a reasonably competent Optometrist. The Committee was of the view that the public would be concerned and public confidence in the profession would be undermined, if a finding of impairment was not made, in respect of the Registrant's misconduct. The Committee determined that it was necessary to make a finding of impairment in this case in order to maintain confidence in the profession and in order to uphold proper professional standards.

203. Accordingly, the Committee found that the Registrant's fitness of to practise as an Optometrist is currently impaired on both public protection and public interest grounds.

Sanction

204. The Committee went on to consider what would be the appropriate and proportionate sanction, if any, to impose in this case. The Committee received no further evidence at this stage.

205. The Committee heard submissions from Mr Potts on behalf of the Council. Mr Potts highlighted to the Committee the principles that it ought to apply in determining the appropriate sanction in this case, referring the Committee to the Council's Hearings and Indicative Sanctions Guidance. He reminded the Committee that the purpose of any sanction is to protect patients and the wider public interest.

206. Mr Potts submitted that the Council's position was that suspension was the sanction that would be appropriate and proportionate in this case. He submitted that taking no further action would be clearly inappropriate, as there were no exceptional circumstances. Furthermore, taking no action would not protect the public and neither would the imposition of a financial penalty order.

207. Turning to conditions, Mr Potts submitted that where there were shortcomings in a Registrant's practice then conditions could be appropriate. However, the Committee would need to satisfy itself that the Registrant would respond positively to retraining and remedy any deficiencies in practice, whilst protecting patients. Mr Potts submitted that the Committee could not be satisfied of this, at this stage, given its earlier findings that the Registrant had limited insight. In addition, Mr Potts highlighted that Interim conditions had been imposed in this case but the Registrant had been unable to find a workplace supervisor. He reminded the Committee that it should not impose conditions which are tantamount to a suspension, which he submitted conditions would be.

208. Mr Potts invited the Committee to consider the sanction of suspension as the appropriate and proportionate sanction to impose in this case, for a period of 12 months with a review hearing. Mr Potts submitted that this case largely satisfies the criteria listed in paragraph 21.29 of the guidance, as this was serious misconduct and a lesser sanction was not sufficient; there is no evidence of harmful deep-seated personality or attitudinal problems and no evidence of repetition.

209. Mr Potts submitted that suspension was both necessary and proportionate. It would meet the seriousness of the case and send the right message to the public and the profession. Mr Potts stated that it would not be necessary for the Committee to go on to consider erasure.

210. The Registrant was offered the opportunity to make submissions and declined to do so.

211. The Committee accepted the advice of the Legal adviser, which was for the Committee to take into account the factors on sanction as set out in the Guidance; to assess the seriousness of the misconduct; consider any aggravating and mitigating factors; and to consider the range of available sanctions in ascending order of seriousness. Further, the Committee is required to act proportionately by weighing the interests of the Registrant against the public interest.

The Committee's findings on sanction

212. When considering sanction, the Committee had regard to all of the evidence and submissions it had heard, its previous findings and the Council's Hearings and Indicative Sanctions Guidance.

213. The Committee firstly considered the aggravating and mitigating factors that were present in this case. In the Committee's view, the aggravating factors are as follows:

    i) The breadth of misconduct, in that there was a range of clinical deficiencies and breaches of the standards involving a number of patients, forming a pattern of repeated failings;

    ii) In respect of Patient M, there had been actual harm in that they had lost sight in their left eye and a high risk of harm to other patients;

    iii) The Registrant has demonstrated only limited insight and remediation. He has let his CPD requirements lapse, as he has not yet completed any CPD in the current cycle and there remains a high risk of repetition.

214. The Committee considered the following to be mitigating factors:

    i) The Registrant made admissions to some particulars of the Allegation at the outset of the hearing and in his earlier oral evidence accepted that his practice was '*not up to scratch'*;

    ii) The Registrant, through his Counsel, made a heartfelt apology to Patient M when he gave evidence;

    iii) The Registrant has engaged with the GOC and the regulatory process.

215. The Committee considered the sanctions available to it from the least restrictive to the most restrictive, starting with no further action.

216. The Committee considered taking no further action, however was of the view that there were no exceptional circumstances to justify taking no action in this case. Furthermore, it was of the view that taking no further action would not protect the public, was not proportionate nor sufficient given the seriousness of the misconduct and would not meet the public interest concerns.

217. The Committee next considered the issue of a financial penalty order. However, it was of the view that such an order was not appropriate, given that this case did not involve financial motivation or gain. Additionally, a financial penalty order would not protect the public nor meet the public interest concerns.

218. The Committee considered the Guidance in relation to the imposition of conditions. It was of the view that conditional registration would not be appropriate, as conditions would not be workable in this case. The Committee noted that the misconduct was of a type where conditions could be appropriate, as it involved identifiable clinical areas of practice in need of assessment or retraining, which conditions often seek to address. In principle, the Committee considered that conditions could be an appropriate sanction for this type of misconduct.

219. However, the Committee was mindful of its earlier findings that the Registrant had only limited insight, had not remediated and the Committee had found a high risk of repetition, which in the Committee's view would make conditions inappropriate. At this stage, the Committee could not be reassured that any conditions imposed would adequately protect the public or meet the wider public interest. Any conditions imposed would have to be robust and involve direct supervision, and it noted that the Registrant had been unable to find a supervisor and had been unable to work under interim conditions. The Committee concluded that conditions could not be devised which would be appropriate, proportionate, or workable in this case.

220. The Committee next considered suspension and had regard to paragraphs 21.29 to 21.31 of the Guidance. In particular, the Committee considered the list of factors contained within paragraph 21.29 that indicate that a suspension may be appropriate, which are as follows:

> **Suspension (maximum 12 months)**
>
> *21.29 This sanction may be appropriate when some, or all, of the following factors are apparent (this list is not exhaustive):*
>
> *a. A serious instance of misconduct where a lesser sanction is not sufficient.*
>
> *b. No evidence of harmful deep-seated personality or attitudinal problems.*
>
> *c. No evidence of repetition of behaviour since incident.*
>
> *d. The Committee is satisfied the registrant has insight and does not pose a significant risk of repeating behaviour.*
>
> *e. In cases where the only issue relates to the registrant's health, there is a risk to patient safety if the registrant continued to practise, even under conditions.*

221. The Committee considered that several of the factors in paragraph 21.29 of the guidance were applicable in this case. The misconduct was serious and it had found that a lesser sanction would not be sufficient in the circumstances. There was no evidence of harmful deep-seated personality or attitudinal problems and no evidence of repetition since the misconduct occurred. In relation to factor d), the Committee noted that it had found that the Registrant had only limited insight and there was currently a high risk of repetition. The Committee had regard to the section of the guidance on erasure and considered that many of the factors set out in paragraph 21.35, which would indicate when erasure maybe appropriate, did not apply to this case:

> ***Erasure***
>
> *21.35 Erasure is likely to be appropriate when the behaviour is fundamentally incompatible with being a registered professional and involves any of the following (this list is not exhaustive):*
> *a. Serious departure from the relevant professional standards as set out in the Standards of Practice for registrants and the Code of Conduct for business registrants;*
> *b. Creating or contributing to a risk of harm to individuals (patients or otherwise) either deliberately, recklessly or through incompetence, and particularly where there is a continuing risk of harm to patients;*

c. Abuse of position/trust (particularly involving vulnerable patients) or violation of the rights of patients;
d. Offences of a sexual nature, including involvement in child pornography;
e. Offences involving violence;
f. Dishonesty (especially where persistent and covered up);
g. Repeated breach of the professional duty of candour, including preventing others from being candid, that present a serious risk to patient safety; or
h. Persistent lack of insight into seriousness of actions or consequences.

222. The Committee was mindful that erasure is likely to be appropriate when the behaviour is fundamentally incompatible with being a registered professional and where erasure is the only sanction that would protect the public. The Committee did not consider that the misconduct in this case, whilst serious, was fundamentally incompatible with being on the register and was capable of being remediated. The Committee was of the view that erasure was not the only order that would satisfy public interest concerns and it would be disproportionate. The Committee therefore determined that a period of suspension was the necessary and proportionate sanction to impose in this case.

223. The Committee went on to consider the length of suspension to impose, noting that the Council had suggested that a 12 month suspension would be appropriate and proportionate, which is the maximum period that can be imposed. The Committee considered that the seriousness of the misconduct required a period of suspension towards the top end of the period, however it was mindful that the period should not be longer than is necessary to protect the public and meet the wider public interest.

224. The Committee balanced the aggravating and mitigating factors and had regard to the principle of proportionality, considering the impact of a period of suspension upon the Registrant. It concluded that a period of suspension of 9 months would be an appropriate and proportionate period of suspension, which would adequately mark the seriousness of the misconduct and be a sufficient period of time for the Registrant to reflect, improve his clinical knowledge, develop further insight and remediate further.

225. The Committee considered whether to direct that a review hearing should take place before the end of the period of suspension. The Committee noted that at paragraph 21.32 of the Guidance, it states that a review should normally be directed before an order of suspension is lifted, because the Committee will need to be reassured that the registrant is fit to resume unrestricted practice. The Committee was mindful of its findings at the impairment stage, relating to the Registrant's limited insight, that he had not yet fully remediated and that there remained a risk of repetition.

226. In the circumstances, the Committee considered that it was necessary and appropriate for a review hearing to be directed before the order of suspension expired. The Committee considered that the review Committee may be assisted by:

- A detailed reflective statement demonstrating reflections and insight into the impact of the misconduct upon the profession and upon public confidence in the profession;
- A Personal Development Plan that takes account of the clinical shortcomings identified in this case;

- Any evidence of further remediation addressing the clinical failings (particularly in areas of glaucoma and other ocular pathology) such as attendance at training or CPD, formal certificates and/or self-directed learning, shadowing or observing specialist clinics.

227. A review hearing will be held between four and six weeks prior to the expiration of this order. The review Committee will need to be satisfied that the Registrant:

    - has fully appreciated the gravity of the misconduct,
    - has not repeated the misconduct and has maintained his skills and knowledge and
    - that the Registrant's patients will not be placed at risk by resumption of practice or by the imposition of conditional registration.

228. Accordingly, the Committee imposed a period of suspension for 9 months with a review hearing.

Immediate Order

229. The Committee heard submissions from Mr Potts, on behalf of the Council, regarding the imposition of an immediate order. Mr Potts invited the Committee to impose an immediate order under Section 13I of the Opticians Act 1989 on the basis that such an order was necessary to protect the public and was otherwise in the public interest.

230. The Registrant was invited to make representations on this issue but declined to do so.

231. The Committee was advised by the Legal Adviser that to make an immediate order, it must be satisfied that the statutory test in section 13I of the Opticians Act 1989 is met, i.e. that the making of an order is necessary for the protection of members of the public, otherwise in the public interest or in the best interests of the Registrant.

232. The Committee bore in mind that it had found that the misconduct was serious with a high risk of harm to patients and a high risk of repetition. The Committee therefore considered that an immediate order of suspension was necessary to protect the public. Additionally, the Committee had concluded that a lengthy period of suspension was the appropriate and proportionate sanction in this case. In the circumstances, and given the serious nature of the misconduct, the Committee decided that it was also in the wider public interest that an immediate order be imposed and a member of the public would be concerned if one were not and the Registrant was able to practise unrestricted.

233. Accordingly, the Committee imposed an immediate order of suspension.

Revocation of Interim Order

234. The Committee revoked the Interim Order of Conditions that was in place.

Chair of the Committee: Andy Brennan

Signature  **Date: 21 November 2025**

Registrant: Ravi Bhojwani

Signature *present and received via email* **Date: 21 November 2025**

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.
Effect of orders for suspension or erasure
To practise or carry on business as an optometrist or dispensing optician, to take or use a description which implies registration or entitlement to undertake any activity which the law restricts to a registered person, may amount to a criminal offence once an entry in the register has been suspended or erased.
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.