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

**GENERAL OPTICAL COUNCIL**

**F(25)27**

**AND**

**NASIR BUTT (01-22319)**

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**DETERMINATION OF A SUBSTANTIVE HEARING**
**13-20 April 2026**

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| **Committee Members:** | Sara Nathan (Chair/Lay)<br>Joy Tweed (Lay)<br>Jacqueline Telfer (Lay)<br>*Louise Gow (Optometrist) – recused before Stage 1.*<br>Kalpana Theophilus (Optometrist) |
| **Legal adviser:** | Kelly Thomas |
| **GOC Presenting Officer:** | Holly Huxtable |
| **Registrant present/represented:** | Yes and represented |
| **Registrant representative:** | Alex Mills (Counsel)<br>Chloe Jeram (AOP) |
| **Hearings Officer:** | Arjeta Shabani/Taz Chisango/Anwar Henry |
| **Facts found proved:** | Admitted allegations 1a)i, 1a)ii, 1b), 1c), 1d), 1e), 1g)i, 1g)ii, 1g)iii, 1h)i, 1h)ii, 1h)iii, 1i)i, 1i)ii and 1i)iii.<br><br>Proven allegations, 1g)iv and 2 (in relation to dishonesty in 1i)). |
| **Facts not found proved:** | Allegation 1f) – dismissed following application of no case to answer.<br><br>Allegation 2 (in relation to dishonesty in 1g) and 1h)). |

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| **Misconduct:** | Found in relation to 1a)i, 1a)ii, 1b), 1c), 1d), 1e), 1g)i-iv, 1i)i-iii and 2 (in respect of the dishonesty in 1i) only) |
| **Impairment:** | Impaired with regards to public interest only |
| **Sanction:** | 6 months suspension order<br>(Without Review) |
| **Immediate order:** | Not imposed |

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## ALLEGATION

*The Council alleges that you Mr Nasir Butt (01-22319), a registered Optometrist:*

*1) On 5 January 2024, you performed a sight test on Patient A and you:*

*(i) Did not perform a slit lamp examination of the anterior eyes;*

*(ii) Did not perform an ophthalmoscopic examination of the peripheral and/or nasal fundi;*

*b) Failed to accurately ascertain Patient A's history and symptoms, namely you:*

*(i) Did not ask Patient A about her general health;*

*(ii) Did not establish issues relating to the quality control of Patient A's hypertension;*

*c) Failed to identify vascular changes to Patient A's right eye and/or left eye;*

*d) Failed to refer Patient A back to her GP, despite this being clinically indicated;*

*e) Communicated to Patient A that "the blood vessels look nice and healthy on both sides", despite there being clinical evidence to suggest hypertensive retinopathy;*

*f) Failed to record details of those involved in Patient A's optical consultation;*

*g) Recorded in Patient A's clinical record that she was not experiencing the following symptoms even though you had not ascertained this information from Patient A:*

*(i) Absence of diplopia; and/or*

*(ii) Floaters; and/or*

*(iii) Flashes of light; and or*

*(iv) Any other problems*

*h) Recorded in Patient A's clinical record that you performed the following tests, despite the fact that you had not, namely:*

*(i) Cover test at distance; and/or*

*(ii) Testing of ocular motility; and/or*

*(iii) Pupil reactions*

*i) Recorded in Patient A's clinical record that you performed an examination of the internal and/or external eyes, despite the fact you had not, namely:*

*(i) Examined the anterior eyes; and/or*

*(ii) Ocular adnexa; and/or*

*(iii) Peripheral retinas*

*2) Your conduct at g)(i) and/or (ii) and/or (iii) and/or (iv) and/or h)(i) and/or (ii) and/or (iii) and/or i)(i) and/or (ii) and/or (iii) was:*

*a) Inappropriate; and/or*

*b) Dishonest, in that Patient A's clinical record does not reflect a genuine representation of the examination that took place*

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

**PRELIMINARY ISSUES**

**Conflict for Committee member**

1. One member of the Fitness to Practise Committee, Ms Gow, an Optometrist member, raised a potential conflict. Ms Gow noticed that Professor Bruce Evans had provided clinical guidance for this matter. Ms Gow outlined that she had

worked in Professor Evans' private optometry practice for 25 years up until 2021. Ms Gow had worked directly with Mr Evans in a small practice where they had adjacent consulting rooms. Whilst Ms Gow had not worked with Professor Evans since 2021, and had no plans to work with him in the future. Ms Gow said that she considered Professor Evans as a friend and they occasionally meet socially. Ms Gow stated that she also occasionally seeks clinical advice from Professor Bruce via a WhatsApp group for practitioners.

2. Ms Huxtable on behalf of the General Optical Council (*"the Council")* raised objections to Ms Gow continuing to sit on the Committee. In considering the case of *Suleman v GOC (2023) EWHC 2110(Admin),* having heard the information supplied by Ms Gow, Ms Huxtable submitted that this is not a tenuous link but the Committee member and the witness have worked closely together for a substantial period up until 2021, are friends and meet socially, and therefore a fair minded, informed observer might well perceive there to be a potential bias. Ms Huxtable indicated that it was open to the Committee to continue without Ms Gow and remain quorate.

3. Mr Mills, on behalf of the Registrant submitted that it was a matter for the Committee to decide.

4. The Legal Adviser advised the Committee to consider the principles in the case *Suleman* and also those in *Porter v Magill [2002] 2 AC 357*, as to '*whether the fair minded and informed observer, having considered the facts, would conclude that there was a real possibility that the tribunal was biased. And…the appearance of independence and impartiality is just as important as the question of whether these qualities exist in fact. Justice must not only be done but be seen to be done'.* The Legal Adviser also referred to the case of *Locabail (UK) Ltd v Bayfield Properties [2000] IRLR 96* in advising the Committee that the test is objective, i.e. would a reasonable independent observer, in full possession of the facts, consider that there was a real possibility of bias, arising from the relationship between Ms Gow and Professor Evans.

5. In relation to whether the Committee could continue without Ms Gow, the Legal Adviser outlined *Rule 25* of the *General Optical Council (Committee Constitution Rules) Order of Council 2025*:

   *"The quorum of the Fitness to Practise Committee shall be—*

   *(a)one registered optometrist or registered dispensing optician; and*
   *(b)two lay persons."*

6. The Committee decided that a fair-minded observer, in possession of the facts from Ms Gow, may consider that there was a real possibility of bias and therefore decided it was not appropriate for Ms Gow to continue to sit as a Committee member on this substantive hearing. Ms Gow left the online hearing room.

7. The Committee decided that it was able to continue without Ms Gow according to the *Rules*, and that it would be in the interests of the Registrant to proceed to reach a timely resolution. In the absence of any objections, the Committee

decided to proceed with four members. Following this decision, the Committee consisted of three lay members and one registrant member.

**Application to amend allegation/withdraw particulars**

8. Ms Huxtable, on behalf of the Council, made an application under *Rule 46(20)* of the *Rules* to better particularise Allegation 2, to withdraw "inappropriate" and to allege that the Registrant knew the records did not reflect a genuine representation of the examination. Ms Huxtable submitted that the proposed amendment did not materially differ from that referred to the Committee and the Registrant has been provided with notice of this, therefore it can be made without prejudice to the Registrant.
9. Ms Huxtable also applied to withdraw particular 1(b)(ii) notably "*did not establish issues relating to the quality control of Patient A's hypertension"* on behalf of the Council. Ms Huxtable stated that the Council's expert Dr Kwartz did not consider this fell far below the requisite standard and also that the Registrant had recorded the hypertension from the patient.
10. Mr Mills, on behalf of the Registrant, raised no objections to the proposed amendments.
11. The Committee received and accepted advice from the Legal Adviser who advised that under *Rule 46(20): "where it appears to the Fitness to Practise Committee at any time during the hearing, either upon the application of a party or of its own volition, that—*

    *a. the particulars of the allegation or the grounds upon which it is based and which have been notified under rule 28, should be amended; and*
    *b. the amendment can be made without injustice,*
    *it may, after hearing the parties and consulting with the legal adviser, amend those particulars or those grounds in appropriate terms."*

12. The Committee considered the prejudice to the Registrant and balanced this against the overarching objective of protection of the public, and decided that the allegations should be amended, as the proposed allegations better reflected the evidence.

**Application to consider conflict**

13. Mr Mills, on behalf of the Registrant raised a further conflict issue. Mr Mills indicated that another Committee member, Ms Theophilus, had sat on a previous hearing which involved Dr Kwartz and Professor Evans. Ms A had also been a witness in that case. In that hearing, the issue of conflict had been raised because Ms Theophilus had declared that she knew both Dr Anna Kwartz and Professor Bruce Evans in a professional capacity as they are fellow examiners at the College of Optometrists OSCE circuits. Ms Theophilus had stated that she had never worked on a one-to-one basis with either expert. Mr Mills indicated that

he was not suggesting that Ms Theophilus should recuse herself in this hearing but that the Committee be given advice that it must base its decisions solely on the evidence received in these proceedings and that Committee members must not discuss anything that has taken place in earlier proceedings. Ms Huxtable raised no objections.

14. The Legal Adviser agreed that this was appropriate advice to give the Committee in these circumstances and endorsed the advice outlined by Mr Mills.

15. The Committee accepted the legal advice and proceeded to make its decisions purely on the basis of evidence in these proceedings.

## AMENDED ALLEGATION

*The Council alleges that you, Mr Nasir Butt (01-22319), a registered Optometrist:*

*1) On 5 January 2024, you performed a sight test on Patient A and you:*

*a) Failed to carry out an internal and/or external examination of Patient A's eyes, namely you:*

*i) Did not perform a slit lamp examination of the anterior eyes;*

*ii) Did not perform an ophthalmoscopic examination of the peripheral and/or nasal fundi;*

*b) Failed to accurately ascertain Patient A's history and symptoms, namely you did not ask Patient A about her general health;*

*c) Failed to identify vascular changes to Patient A's right eye and/or left eye;*

*d) Failed to refer Patient A back to her GP, despite this being clinically indicated;*

*e) Communicated to Patient A that "the blood vessels look nice and healthy on both sides", despite there being clinical evidence to suggest hypertensive retinopathy;*

*f) Failed to record details of those involved in Patient A's optical consultation;*

*g) Recorded in Patient A's clinical record that she was not experiencing the following symptoms even though you had not ascertained this information from Patient A:*

*i) Absence of diplopia; and/or*
*ii) Floaters; and/or*
*iii) Flashes of light; and or*
*iv) Any other problems*

*h) Recorded in Patient A's clinical record that you performed the following tests, despite the fact that you had not, namely:*

*(i) Cover test at distance; and/or*
*(ii) Testing of ocular motility; and/or*
*(iii) Pupil reactions*

*i) Recorded in Patient A's clinical record that you performed an examination of the internal and/or external eyes, despite the fact you had not, namely:*

*(i) Examined the anterior eyes; and/or*
*(ii) Ocular adnexa; and/or*
*(iii) Peripheral retinas*

*2) Your conduct at g)(i) and/or (ii) and/or (iii) and/or (iv) and/or h)(i) and/or (ii) and/or (iii) and/or i)(i) and/or (ii) and/or (iii) was dishonest, in that you knew Patient A's clinical record did not reflect a genuine representation of the examination that took place;*

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

**Admissions**

16. The Allegations were read in full to the Registrant.
17. The Registrant admitted allegation 1a)i, 1a)ii, 1b), 1c), 1d), 1e), 1g)i, 1g)ii, 1g)iii, 1h)i, 1h)ii, 1h)iii, 1i)i, 1i)ii and 1i)iii.
18. The Registrant denied Allegation 1f), 1g)iv and 2.
19. The Committee therefore found Allegations 1a)i, 1a)ii, 1b), 1c), 1d), 1e), 1g)i, 1g)ii, 1g)iii, 1h)i, 1h)ii, 1h)iii, 1i)i, 1i)ii and 1i)iii proved by admission as per *Rule 40(6)* of the *Rules*.

## DETERMINATION

### Background

20. The Registrant is an Optometrist who, at the material time, was employed as a locum at Specsavers, [redacted] ("*the Practice*").

21. On 5 January 2024, Patient A attended the Practice as a "mystery shopper". The Registrant performed a sight test on Patient A, and the interaction was recorded (audio and visual -exhibit FC/01).

22. The "mystery shopper" footage was initially reviewed by Ms A, the Ophthalmic Director of the Practice. She noted that the Registrant recorded that he had used the slit lamp to check the external and internal eye when he had not done so. The Practice raised concerns with Specsavers Professional Services Team about the standard of the eye examination and veracity of the Registrant's record keeping.

23. A referral was subsequently made to the Council on 21 February 2024 which stated that the "mystery shopper" footage does "not suggest an internal and external eye examination were performed while the records reflected that these had in fact been performed".

24. The Council obtained the expert opinion of Dr Anna Kwartz. In her report dated 21 January 2025, Dr Kwartz considered Patient A's records for the examination on 5 January 2024 and broadly concluded that:

    a. There is no evidence that the Registrant examined the anterior or posterior eyes;

    b. The Registrant failed to identify vascular changes and refer Patient A to her GP accordingly;

    c. The Registrant failed to maintain adequate patient records in that he documented a history that he had not ascertained, and documented tests/examinations that he had not performed.

### Submissions and advice on facts

25. Ms Huxtable opened the case on behalf of the Council and set out the background to the case. The Council relied on the audio and visual recording and the evidence of Dr Kwartz.

26. The mystery shopper footage exhibit FC/01 was played from 9 minutes in to 17 minutes.

27. Dr Kwartz was called to give evidence. Dr Kwartz affirmed the contents of her report dated 21 January 2025. In evidence concerning her expertise, she stated that she continues to work in a community high-street setting several times per month, typically at least three. Her medico-legal practice is predominantly in civil work, accounting for approximately 80% of her instructions, with regulatory work

forming a smaller proportion. In General Optical Council (GOC) matters, Dr Kwartz stated that she is instructed mainly by the Council, with a small number of instructions for Registrants. She confirmed that her experience includes extensive observation of sight tests in primary care settings.

28. In relation to disputed allegation 1(g)iv, Dr Kwartz accepted that the patient record accurately reflected that Patient A did not report any other problems during the consultation and that there was no disparity between the record and the video footage. However, she maintained that the clinician had not actively asked whether the patient had experienced other symptoms, such as flashes or floaters, and distinguished between the accuracy of the record and whether appropriate questioning had taken place.

29. As to allegation 1f), Dr Kwartz maintained that the standard requiring recording of who conducted pre-screening had not been met, but accepted that if supplementary evidence demonstrated that the practice could retrospectively identify the staff member responsible (for example through audit trails, rota systems, or log-ins), her criticism would fall away. She confirmed that the GOC Standards applied equally to locums as to employed Optometrists.

30. On the categorisation of conduct as falling below or far below the required standard, Dr Kwartz explained that this involved an element of expert judgment rather than objective criteria, informed by her experience of comparable expert evidence. She accepted that patient-specific clinical context was relevant to assessing risk and that low or minimal risk would generally support a finding of "below" rather than "far below".

31. Dr Kwartz maintained her opinion that the failures identified in this case, particularly those relating to the identification and management of vascular retinal changes and the absence of appropriate referral, represented a significant departure from the standards of a reasonably competent primary care optometrist and taken together, fell far below those standards. In re-examination and in response to committee questions, Dr Kwartz reiterated that chronically elevated blood pressure could be inferred from the retinal photographs, that this posed a real risk to Patient A notwithstanding GP involvement, and that the absence of symptoms did not negate the need for appropriate history-taking, examination, and referral.

**SUBMISSION OF NO CASE TO ANSWER**

32. At the conclusion of the Council's case, Mr Mills, on behalf of the Registrant, made a submission of no case to answer in respect of allegations 1f) and 1g)iv.

33. Mr Mills summarised the case of *R v Galbraith [1981] 1 WLR 1039* and submitted that considering the written evidence, the oral evidence from Dr Kwartz and the agreed set of facts, there was no evidence upon which a properly directed Committee could find the facts proved.

34. In respect of allegation 1f) Mr Mills submitted that the origin of the allegation can be found in the report of Dr Kwartz at paragraph 9.1. Mr Mills highlighted the

Agreed Facts, which referred to a previous decision whereby it was agreed by Ms A (also a witness in this case), giving evidence in relation to the [redacted] store (the same store in this matter) and its processes between the dates of 17 December 2023 and 2 February 2024 (relevant to this allegation on 5 January 2024), which confirmed that "*if they needed to identify who had conducted the pre-screening tests this information could be found out from checking who had logged into the system to conduct the tests, the rota and also the 'hub' part of the system*."

35. In her oral evidence, Dr Kwartz agreed that if that were the case, there would be adequate recording of who conducted the pre-screening test to meet the General Optical Council requirement. Given this evidence, Mr Mills submitted that there were no failings on behalf of the Registrant, and therefore no evidence upon which to find the matter proved.

36. In respect of allegation 1g)iv, Mr Mills submitted that this is purely a record keeping allegation. Mr Mills submitted that the video evidence confirmed that Patient A did not report 'any other problems,' and the patient record reflects the same. Mr Mills submitted that the Registrant had therefore recorded an accurate patient record as it reflected the correct position of the information he had. Mr Mills submitted that the issue as to whether Patient A should have been asked if there were any other problems is a separate one.

37. Mr Mills submitted that Dr Kwartz's comment at paragraph 8.4.2 of her report that there were fundamental disparities between the video and patient record does not apply to allegation 1g)iv, as the witness was not asked the question. Mr Mills submitted that there is no evidence to support allegation 1g)iv and therefore this allegation should also be dismissed.

38. Ms Huxtable, on behalf of the General Optical Council ("the Council") submitted in relation to Allegation 1f) that it was accepted that there was adequate information from the Agreed Facts and the oral evidence of Dr Kwartz to identify who conducted the pre-screening for Patient A and invited the Committee to make its own findings in this regard.

39. In respect of allegation 1g)iv, Ms Huxtable opposed the application of no case to answer. Ms Huxtable accepted that the video evidence confirmed that Patient A did not volunteer or report 'any other problems' during the consultation.

40. However, Ms Huxtable submitted that the particulars of allegation 1g)iv make clear that there are further elements for the Committee to consider, namely that whether the Registrant 'had not ascertained [whether there were any other problems] from Patient A.'

41. Ms Huxtable submitted that the allegations were drafted clearly and Dr Kwartz had referred to this omission in her report at 8.4.4 as falling far below the required level. Ms Huxtable submitted that this is a key part of allegation 1g)iv, and the Committee should interpret the allegation to be considered as a whole when considering the issue of whether there is a case to answer.

42. The Committee heard and accepted advice from the Legal Adviser, who outlined the *General Optical Council Fitness to Practise Rules 2013* ("*The Rules")* at *Rule*

*46 (8*), and the test of *Galbraith.* The Committee was advised to consider the two limbs in *Galbraith,* firstly under limb 1, to consider whether there is no evidence upon which the Committee could make a finding, or under limb 2, to consider where there is some evidence, but it is so poor that it would be unsafe to make a finding, the evidence being of a tenuous character, for example because of inherent weakness or vagueness or because it is inconsistent with other evidence.

43. In reaching a finding, the Legal Adviser advised the Committee to look carefully at allegations 1f) and 1g)iv and to consider the written evidence, the oral evidence of Dr Kwartz and the Agreed Facts. The Legal Adviser outlined that the thresholds to meet in *Galbraith* and *Rule 46(8)* were high, and that it is not for the Committee at this stage to make findings of fact. At this stage, the Committee should consider, as per *Rule 46(8): (a) whether sufficient evidence has been adduced upon which the disputed facts could be found proved; and (b) whether the facts, whether they are disputed or proved, could support a finding of impairment.*

**Findings on no case to answer**

44. The Committee heard and accepted the advice of the Legal Adviser. The Committee reminded itself that at this stage, it was not required to test the strength or credibility of the evidence but to consider whether there was some evidence upon which a properly directed Committee could find the facts proved. The Committee was mindful of the need to guard against conducting a premature evaluation of the merits.

45. In respect of allegation 1f), the Committee found that both parties, by virtue of the Agreed Facts, accepted that there was sufficient information recorded to identify who had conducted the optical consultation (pre-screening) at the [redacted] store on 5 January 2024. Dr Kwartz had agreed in her oral evidence that if that were agreed, the Registrant had not failed to meet the General Optical Council requirement to record those involved. For those reasons the Committee concluded there was no evidence upon which to reach a finding of impairment and allegation 1f) was dismissed.

46. In respect of allegation 1g)iv, the Committee considered the wording of the Allegation carefully. The Committee interpreted the elements of the allegation to be set out in three parts, each of which it assessed as to whether the Council had provided any evidence in support.

47. Firstly, the Committee assessed whether there was any evidence from the Council that the records were inaccurate in that the Registrant had recorded that Patient A was not experiencing 'any other problems.' Secondly whether there was any evidence from the Council that there was a duty on the Registrant to ascertain this information from Patient A, and thirdly, whether the Council had provided any evidence that the Registrant had failed to ascertain such information.

48. The Committee accepted that the first element related to record keeping and noted that the Council's evidence amounted to the video footage which contained no evidence of any discussion of 'any other problems' and in that regard the patient record made by the Registrant reflected the same.

49. In respect of the second element, the Committee considered whether the Council had provided any evidence that the Registrant had a duty to ascertain whether Patient A had experienced 'any other problems.' The evidence of Dr Kwartz in her report of 21 January 2025 set out her clinical opinion in this regard at paragraph 8.2.2: "*It is vitally important that an optometrist asks about their patient's general health… "* In her clinical report, Dr Kwartz had referenced the College of Optometrists Guidance on the routine eye examination. In her oral evidence Dr Kwartz also summarised why, in her opinion, there was a duty on the Registrant to ask Patient A whether she had 'any other problems.'

50. In relation to the third issue as to whether the Registrant failed in that duty, the Committee noted the video evidence which appeared to lack such an enquiry. Further, Dr Kwartz set out in her clinical opinion why this was a failure on behalf of the Registrant. At paragraph 8.2.2 Dr Kwartz states "*I am critical of the fact that [the Registrant] did not specifically ask a question regarding Patient A's general health, as she could be living with or have a history of other health conditions, in addition to hypertension."*

51. The Committee considered that the wording of the allegation, when taken together with the report from Dr Kwartz, indicated that allegation 1g)iv created an inherent need to assess these issues before making a finding on this allegation, and was not purely a record keeping allegation.

52. The Committee considered that the four parts to allegation 1g) were concerning the same failures, i.e. that the Registrant had allegedly recorded findings where he had not made a positive enquiry of Patient A that he had a duty to make.

53. The Committee reminded itself that it was not making any findings of fact but applying the test in *Galbraith,* namely whether there was 'no evidence' upon which to make a finding of impairment. The Committee considered Allegation 1g)iv in the round and concluded that the Council's evidence, taken at its highest, was capable of supporting the allegation. The Committee found that a decision on the facts should be made after hearing all the evidence rather than being dismissed at the half-time stage.

**Registrant's case**

54. Professor Evans was called to give oral evidence and affirmed and adopted his report dated 20 November 2025 as his evidence. He confirmed that, having heard the evidence of Dr Kwartz, he had not changed his opinions. As to experience, he stated that he now works one day per week in clinical practice, and this reflected the latter stage of a long career predominantly spent in primary care optometry. He explained that his approach to categorising conduct as falling below or far below the required standard was informed both by his clinical experience and by research he conducted between 2005-2008 using trained

actors presenting anonymously as patients, alongside review of consultation records, his experience in expert witness work (including GOC matters), and feedback from fitness to practise Committees. He confirmed that his approach had evolved over time.

55. In relation to allegation 1(g), Professor Evans explained that questions about flashes and floaters ought generally to be asked, whereas questions about diplopia were less routinely expected, given its rarity and the likelihood that patients would volunteer such a symptom if present. He considered the failure to ask about flashes and floaters to fall only just below the standard, emphasising the low risk posed in this case because Patient A did not have high myopia and the likelihood of retinal detachment was therefore low.

56. In relation specifically to allegation 1g)iv in respect of "any other problems", Professor Evans explained that much depended on the clinician's questioning style: a broad, open approach at the outset could reasonably allow a patient to volunteer concerns, whereas a closed, targeted approach required an opportunity later in the consultation for the patient to raise additional issues. Professor Evans' criticism in this case centred on the record stating "no other problem reported" where, in his view, the closed questioning approach did not adequately support that conclusion. He assessed both the failure to ask certain questions and the resulting inaccuracies in the record as falling below, but not far below, the standard, with an extremely low risk of harm.

57. On allegations concerning record-keeping and retinal findings, Professor Evans accepted that some optic disc and retinal vascular changes visible on the images were significant and should have been observed and documented, and that the GP should have been informed by letter. However, Professor Evans considered the risk of harm to have been low because Patient A was already receiving treatment for hypertension, and there was no evidence before the Committee that her blood pressure was poorly controlled at the time of the examination. Professor Evans rejected Dr Kwartz's formulation of "far below" insofar as it relied on any increased risk of harm or aggregation of minor departures, expressing the view that such an approach set too high a threshold for routine optometric practice.

58. While Professor Evans accepted that multiple inaccuracies in a single record represented a significant departure from the required standard, he emphasised that, viewed in context, the consultation for Patient A addressed the patient's primary presenting concern and did not amount to conduct that fell far below the standard expected of a reasonably competent optometrist.

**Application for parts of hearing in private**

59. Prior to the Registrant's oral evidence, Mr Mills made an application for some parts of the hearing to be heard in private as there were references in the papers, and might be in the oral evidence, to private matters concerning the Registrant's family.

60. Ms Huxtable raised no objections.

61. The Committee heard and accepted the advice of the Legal Adviser, who outlined the relevant guidance, which can be found in *Rule 25* of the *General Optical Council Fitness to Practise Rules 2013* (*"the Rules").* In particular, the Rules allow for parts of the hearing to be in private in the interests of the maker of an allegation, the interests of any patient or witness concerned, in the interests of the Registrant, and in all circumstances, including the public interest.

62. The Committee decided that there were clearly parts of the hearing which would relate to the personal circumstances of the Registrant and his family. On that basis the Committee decided that those parts of the hearing should be heard in private. The parties must go into private session during those parts of the hearing only.

63. In his oral evidence the Registrant adopted his written statement dated 16 March 2026 and confirmed that there were no corrections or updates. He explained that the consultation with Patient A did not follow his usual structured order, and stated that, as shown on the video footage, he moved between different sections of the Socrates computer system rather than progressing sequentially, which was inconsistent with his standard practice developed over fifteen years. The Registrant attributed this to significant personal distraction at the time, arising from [redacted] and repeated calls from his wife before and during the clinic. He accepted that his focus was not fully on the patient and that, with hindsight, he should have excused himself or informed his employer.

64. An issue arose as to whether Ms Huxtable, on behalf of the Council, was entitled to ask further questions in cross examination relating to the previous finding against the Registrant in 2018, which had been introduced by the Registrant in his witness statement dated 16 March 2026. The Legal Adviser advised that any further information should be tested by the Committee carefully as to whether it was fair and relevant, as per *Rule 40(1)* to ensure fairness to the Registrant and to the Council. After hearing submissions from Mr Mills, the Committee concluded that the proposed questions were fair and relevant and Ms Huxtable was allowed to ask the five limited questions proposed.

65. In oral evidence in relation to record-keeping, the Registrant accepted that he failed to ask a number of questions that should ordinarily have been covered during the consultation and which he normally would ask. He explained that the Socrates system contains pre-set touch buttons allowing negative responses to be recorded and that he pressed these without asking the corresponding questions. He maintained that this occurred automatically and unintentionally, rather than deliberately, and denied dishonesty. In respect of other symptoms, such as flashes or floaters, he stated that there was only a positive touch button for these and that active typing of 'no' would have been required. He accepted that accurate records are fundamental to clinical practice and that inaccurate records carry a risk of harm and could mislead other Optometrists.

66. When challenged about the number and scope of inaccurate entries, the Registrant accepted that multiple errors were made across different aspects of the record but maintained that this was the result of distraction and "auto-pilot" rather than conscious falsification. The Registrant stated that the examination

was unusually brief and that, having since seen the video footage, he recognised that he had rushed the appointment and failed to examine the images as thoroughly as he should have done. He accepted that, had he given the patient his full attention, the errors would not have occurred.

67. In her closing submissions, Ms Huxtable submitted in respect of Allegation 1g)iv that the wording of the allegation was sufficiently clear for the Council to make their decision on the facts. Ms Huxtable submitted that the main decision was in relation to allegation 2, that of dishonesty. The core issue for the Committee was whether the Registrant was under such a high degree of stress that he was acting on "autopilot", making entries without awareness or deliberation, or whether he knowingly made a series of false entries that did not accurately reflect what occurred in the consultation and were therefore dishonest. The Council bears the burden of proving dishonesty on the balance of probabilities and Ms Huxtable submitted that the latter interpretation is correct.

68. In support of this, the Council relied on the Registrant's own evidence and the nature and number of the inaccuracies. The Registrant had admitted there were nine false entries, spanning three areas - history, tests and examinations, and this included entries in relation to tests which were not performed. The Registrant had accepted that some entries required active typing rather than simple screen taps, undermining the suggestion of automatic or unconscious recording. Ms Huxtable submitted that the consultation involved an ongoing interaction with the patient, including an explanation of OCT imaging, which the Council says is inconsistent with a rushed or disengaged state of mind.

69. Ms Huxtable submitted that the asserted stress relating to [redacted] is undermined by evidence that travel arrangements were not made until approximately three weeks later. Against the background of the Registrant's prior fitness to practise history, the Council submits that accurate and truthful record-keeping ought to have been at the forefront of his mind. While no motive is advanced or required, the Council contends it is implausible that so many false entries were made unknowingly, and that the Registrant must have known the records were inaccurate and dishonest.

70. Mr Mills, on behalf of the Registrant, submitted that the Committee must apply the burden and standard of proof to each particular allegation and focus strictly on the matters in issue. The 2019 fitness to practise findings should be considered only for the limited purpose identified by the Council and explored in cross-examination, namely whether the Registrant would have been particularly attentive to record-keeping. The Council have not made submissions in relation to evidence of propensity or credibility, and, in any event, Mr Mills submitted they are incapable of establishing either. The earlier case concerned a single, different episode of dishonesty relating to a Council inquiry, and the previous Committee expressly described the Registrant as credible and gave him credit for his admissions. If the Committee considers the findings more broadly, it is invited to take into account evidence of the Registrant's good practice since mid-2024.

71. In relation to allegation 1(g)iv, Mr Mills submitted that the dispute turns on interpretation. Properly interpreted, Mr Mills submitted that the allegation is

confined to record-keeping alone and does not allege a clinical failure to ask a question. The Committee has already accepted that the record was not inaccurate, with the consequence that the allegation must fail. This interpretation is supported by the wording of the allegation, the structure of the other particulars, the GOC's own skeleton argument, the framing of allegation 2, and Dr Kwartz's report, which refers to a disparity between records and footage rather than a failure of clinical practice. Mr Mills submitted that it follows that allegation 2, insofar as it relies on allegation 1(g)iv, must also fail.

72. As to dishonesty, Mr Mills submits that the evidence supports the Registrant's account that he was distracted by pressing family circumstances and acted on "autopilot" during a very short and incomplete consultation. His evidence was detailed, consistent, candid and not undermined by contemporaneous documents or the video footage. Mr Mills submitted that no motive for deliberate falsification has been identified, and it is inherently implausible that the Registrant would engage in spontaneous dishonesty for no benefit. Mr Mills submitted that the electronic, touchscreen nature of the records makes inadvertent errors during distraction plausible.

73. Looked at in the round, Mr Mills submitted that the Council has not proved that the Registrant knew at the time that the entries were inaccurate, and the allegation therefore fails before the application of *Ivey*. Alternatively, even if such knowledge were found, ordinary decent people, taking account of the circumstances, would not regard the conduct as dishonest.

74. The Legal Adviser advised the Committee that, at the fact-finding stage, the burden of proof rested on the Council to prove each disputed allegation on the balance of probabilities. Each particular allegation had to be considered separately, although the Committee was entitled to evaluate the evidence in the round. While reasonable inferences could be drawn from the evidence, the Committee was reminded that it must not speculate. It was required to assess all oral and documentary evidence for reliability, accuracy, and credibility, and to provide clear reasons for its findings.

75. In evaluating evidence, the Committee was advised to give most weight to contemporaneous documents and undisputed facts before considering witness demeanour, in accordance with *Dutta v GMC* [2020] EWHC 1974 and *Byrne v GMC* [2021] EWHC 2237 (Admin). It was further advised that credibility should not be assessed solely on demeanour and that credibility may be divided (*Khan v GMC* [2021] EWHC 374 (Admin)).

76. Where expert evidence was disputed, the Committee was required to identify which opinion it preferred and explain why, and not to reject expert evidence without clear and compelling reasons (*Cullen v GMC* [2005] EWHC 353 (Admin); *Rimmer v GDC* [2011] EWHC 3438 (Admin)).

77. In relation to dishonesty, the Committee was directed to apply the two-stage test set out in *Ivey v Genting Casinos* [2017] UKSC 67. It was required first to determine the Registrant's actual knowledge or belief as to the facts at the time, and then to assess whether the conduct would be regarded as dishonest by the standards of ordinary decent people. The Registrant did not need to have

appreciated that his conduct was dishonest by those standards. The Legal Adviser emphasised that negligence alone was insufficient and that dishonesty required something more than carelessness or error.

78. During its deliberations and before any decisions, the Legal Adviser provided further advice to the Committee in the hearing. The Committee was further advised that a finding of dishonesty does not automatically follow from proof of factual inaccuracies (*Raychaudhuri v GMC* [2018] EWCA Civ 2027; *Maxfield Martin v SRA* [2022] EWHC 307). The Legal Adviser advised that the Committee should distinguish falsity from dishonesty by considering whether the Registrant knowingly made statements he knew to be untrue and whether he acted dishonestly in doing so. Relevant authorities confirmed the importance of considering alternative explanations for erroneous records, including negligence, inadvertence, distraction, habit, or automated practice (*Lavis v NMC* [2014] EWHC 4083; *Marten v NMC* [2016] EWHC 2183 (Admin)). The absence of motive was not determinative and did not preclude a finding of dishonesty (*Webb v SRA* [2013] EWHC 2078 (Admin)).

79. Mr Mills further submitted following the legal advice that in relying on *Maxfield-Martin v SRA* and *Raychaudhuri v GMC*, there is a critical distinction between knowledge of falsity and dishonesty, and a finding of a knowingly false statement does not mean that dishonesty necessarily followed. Further Mr Mills submitted that the making of a statement knowing that it was false could not automatically be equated with dishonest misleading of a colleague. While accepting that absence of motive does not preclude a finding of dishonesty (*Webb v SRA*), Mr Mills submitted that lack of motive remains a powerful evidential factor when assessing whether dishonest intent has been proved.

80. Ms Huxtable re-iterated the test in *Ivey* and submitted that the Committee should err on the side of caution when looking at pre-Ivey 2017 case law.

**Findings of fact**

81. The Committee accepted the advice of the Legal Adviser, considered all of the oral and written evidence and the submissions of the parties.

82. The Committee first assessed the evidence as per the guidance in the cases of *Dutta, Byrne* and *Khan* in assessing the most independent or contemporaneous account. The Committee considered the most contemporaneous evidence to be that of the video footage exhibit FC/01, the facts of the admitted offences and the Agreed Facts.

83. The Committee placed neutral weight on the previous finding made against the Registrant in 2019, and in any event only considered this within the parameters outlined, as to whether the Registrant ought to have been more aware of the necessity to produce accurate records.

*Allegation 1g)iv On 5 January 2024, you performed a sight test on Patient A and recorded in Patient A's clinical record that she was not experiencing "any other problems" even though you had not ascertained this information from Patient A*

84. The Committee reminded itself of its findings following the no case to answer submission that the video footage contained no evidence of any discussion of 'any other problems' and in that regard the patient record made by the Registrant reflected the same.

85. The Committee considered the second part of the allegation that the Registrant had not ascertained this information from Patient A. The Committee noted the evidence of Dr Kwartz and Professor Evans who agreed that there was a duty on the Registrant to make the enquiry of Patient A as to whether there were 'any other problems,' and outlined the risks of not doing so. The Committee also noted the Registrant's oral evidence. When asked by Mr Mills whether the Registrant believed this question should have been asked, the Registrant replied "*I would usually ask as part of my assessment. There is a button on the screen which records it. I would normally ask a question about any other issues at the beginning or at the end of the patient consultation. In relation to my normal eye testing routine it should have been asked. I would normally.*"

86. The Committee decided that the Registrant had a duty to ascertain information from patient A as to whether there were any other problems, and that as he accepted, he had failed to do so.

87. The Committee therefore found the facts of allegation 1g)iv proved.

*Allegation 2 Your conduct at g)(i) and/or (ii) and/or (iii) and/or (iv) and/or h)(i) and/or (ii) and/or (iii) and/or i)(i) and/or (ii) and/or (iii) was dishonest, in that you knew Patient A's clinical record did not reflect a genuine representation of the examination that took place*

88. The Committee understood that the experts were not able to assist as to why the admitted misconduct had occurred, therefore were not of assistance as to whether the Registrant had been dishonest. The Committee also reminded itself that it is not for the Registrant to prove or disprove any element of the case, but for the Council to prove its case on the balance of probabilities. The Committee was mindful of the test in *Ivey* throughout.

89. The Committee noted the video footage and the expert opinion of Dr Kwartz, in particular at paragraph 8.4.2 of her report which dealt with each of the matters relevant to allegation 2, namely 1g), 1h) and 1i). Dr Kwartz had noted:

> *"8.4.2. There are some fundamental disparities between the patient record and the video footage of the examination:*
>
> *i. Mr Butt documented issues in the history which he had not ascertained from his patient: the absence of diplopia, floaters, flashes of light or any problems.* [Allegation 1g)]
> *ii. Mr Butt documented that he had performed a cover test at distance, testing of ocular motility and pupil reactions, when none of these examinations was undertaken.* Allegation 1h)]

*iii. Mr Butt documented that he had examined the anterior eyes, ocular adnexa and peripheral retinas, when he had not done so."* [Allegation 1i)]

90. The Registrant had given a clear account as to why he says the admitted failings had occurred, namely that [redacted]. The Registrant continued to receive [redacted] calls from his wife throughout the following day on 5 January 2024 which continued throughout the appointment with Patient A.

91. As a result, the Registrant admitted that he was distracted in his consultation with Patient A, failed to carry out certain examination elements, and did not scrutinise the fundus photographs thoroughly as he ordinarily would. The Registrant accepted that this resulted in an inaccurate record and an examination that fell below the standard expected of him. The Committee found this account to have been consistent throughout proceedings.

*Dishonesty in relation to allegation 1g)*

92. The Committee had found allegation 1g)iv proved and all other elements of 1g) had been admitted and proved. The findings proved that the clinical record for Patient A contained entries stating that she was not experiencing the following symptoms: absence of diplopia, floaters, flashes of light, and any other problems; when in fact the Registrant had failed to ascertain this information.

93. The Committee considered the evidence of the screenshots and the video footage and was assisted by the Specsavers Socrates screenshots provided by the Registrant. The Committee noted from the evidence that the clinical records were populated by the Registrant by him typing in an additional 'no' against the default entry button on the Socrates system for two of the four symptoms.

94. The Committee took into account the Registrant's evidence that, at the relevant time, he was experiencing the family difficulties outlined, and that he was distracted when completing the entries. In particular in relation to allegation 1g) the Registrant stated that he tapped the on-screen buttons "*without really thinking about it."* The Committee noted during this portion of the video footage that questions were put to Patient A and the answers were input as they were heard. The Committee noted, from the Socrates record screenshots, that the information recording allegations 1g)i-iv was contained on a single screen of default option buttons. The Committee concluded that the inaccurate entries could be explained by the Registrant's distraction.

95. In deciding whether the facts found proved dishonesty, the Committee applied the test set out in *Ivey*. At stage 1, the Committee was required to determine the Registrant's actual knowledge or belief as to the facts.

96. The Committee distinguished between the deliberate act of manually recording a positive assertion with details that a patient was not experiencing those symptoms without having made those enquiries, and the activation of a minimal entry which populated those fields by default. The Committee was not satisfied that, when using the minimal answer 'no' for each of those tests, that the

Registrant was in a state of mind to appreciate that the resulting entries constituted a positive assertion that he had actively explored and excluded each of the symptoms listed in the allegation.

97. In those circumstances, although the entries did not accurately reflect information that had been expressly obtained from Patient A, the Committee, on balance, accepted that the Registrant did not deliberately record information intending to mislead. The Committee therefore concluded that the Registrant did not possess a dishonest state of mind and that stage 1 of the *Ivey* test was not met.

98. The Committee therefore found there was no dishonesty in relation to allegation 1g).

*Dishonesty in relation to allegation 1h)*

99. The facts of allegation 1h) had been admitted and proved.

100. The Committee considered the evidence of the screenshots and the video footage and was assisted by the screenshots provided by the Registrant. It accepted that the clinical record for Patient A included entries recording that the Registrant had performed a cover test at distance, testing of ocular motility, and pupil reactions. The Socrates screenshots record that the information was contained on two screens with three default option buttons in total.

101. The Committee again took into account the Registrant's evidence that, at the relevant time, he was affected by the family difficulties outlined, and that this impaired his concentration when completing the clinical record. The Committee concluded that the inaccurate entries could be explained by the Registrant's distraction.

102. In deciding whether the facts found proved amount to dishonesty, the Committee applied the test set out in *Ivey*. At stage 1, the Committee was required to decide the Registrant's actual knowledge or belief as to whether he knew or believed that he was recording that specific clinical tests had been performed when they had not.

103. The Committee again distinguished between the deliberate act of manually recording that specific tests, namely a cover test at distance, testing of ocular motility, and pupil reactions, had been carried out when the Registrant knew that they had not, and the activation of an automated recording function which populated those entries by default. The Committee was not satisfied that, when using the "one-click" function, that the Registrant was in a state of mind to appreciate that the resulting entries amounted to a positive assertion that each of the listed tests had in fact been performed.

104. In those circumstances, although the entries did not accurately reflect information that had been expressly obtained from Patient A, the Committee, on balance, accepted that the Registrant did not deliberately record information intending to mislead. The Committee therefore concluded that the Registrant did not possess a dishonest state of mind and that stage 1 of the *Ivey* test was not met.

105. The Committee therefore found there was no dishonesty proved in relation to allegation 1h).

*Dishonesty in relation to allegation 1i)*

106. The facts of allegation 1i) had been admitted and proved. The clinical records therefore showed that an examination of the internal and/or external eyes had been performed, which included an examination of the anterior eyes, ocular adnexa, and peripheral retinas.

107. The Committee took into account the Registrant's evidence that, at the relevant time, he was affected by the family difficulties outlined, and that this impaired his concentration when completing the clinical record.

108. The video demonstrated that the images of the internal eye were visible on a separate screen to the Socrates system. The Registrant was not seen to look at these until the point of explaining them to Patient A. There was a significant time before the explanation during which the Registrant stated "*I'm just going to put a few notes on*". This appeared to be before he looked at the images. The Committee found that completion of the internal and external eye entries required navigation across five different screens and tabs within the Socrates software, as demonstrated in the screenshots. Two of these screens required the manual selection of data pertaining to the 'C:D ratio' and 'A/V ratio'. It is evident that the Registrant would have had to input multiple sections of information into multiple screens, for example typing in 'normal as seen' several times, selecting 'copy left to right' for the vitreous, optic disc, healthy coloured margins and vessels entries, as well as selecting options for the ratios. Had the tests been conducted, the Registrant would have had to, as a minimum, move equipment and turn the room lights off, and assess Patient A's eyes on the slit lamp to check the health of her eyes. The Committee found that the omission of these steps would have been plainly obvious to the Registrant.

109. Whilst the Committee had already made findings that the account the Registrant had given in relation to the pressing family matters was credible, the Committee did not consider that the impact of the distraction could have been to a level affecting his ability to comprehend the extensive scope and nature of his omissions and recorded examinations in allegation 1i). The Committee did not consider that the entries made by the Registrant could reasonably be attributed to inadvertence or a lack of appreciation of the content generated.

110. The Committee was satisfied that this was not a case of a minimal or automated default entry being generated without reflection. Rather, the Committee found that the recording of these examinations involved a sequence of conscious actions requiring sufficient time, attention, and affirmative input.

111. In those circumstances, the Committee was satisfied, on balance, that the Registrant knew that the entries relating to examination of the anterior eyes, ocular adnexa, and peripheral retinas were not completed and found that the Registrant deliberately recorded information intending to mislead. The Committee

therefore concluded that the Registrant did possess the requisite dishonest state of mind and that stage 1 of the *Ivey* test was met.

112. The Committee then considered stage 2 of the *Ivey* test in relation to allegation 1i). The Committee found, on balance, that even taking into account the family circumstances, deliberately recording information recording the performance of detailed internal and external eye examinations which had not been carried out, and was intended to mislead, would be considered, in the Committee's view, as dishonest by the standards of ordinary decent people.

113. Accordingly, the Committee concluded that the Registrant's conduct in respect of allegation 1i) was dishonest.

114. In conclusion the Committee found allegation 2 proved in relation to allegation 1i).

**Submissions and advice on misconduct**

115. Ms Huxtable submitted that the Committee should find misconduct when applying established authorities which describe a serious falling short of professional standards, whether arising within clinical practice or through morally culpable, disgraceful conduct bringing the profession into disrepute (*Roylance v General Medical Council (No. 2) [2000] 1 A.C. 311; R (Calhaem) v General Medical Council [2007] EWHC 2606 (Admin); Remedy UK Ltd v General Medical Council [2010] EWHC 1245 (Admin); Nandi v GMC [2004] EWHC 2317 (Admin)*).

116. The Committee was invited to have regard to the GOC *Standards of Practice for optometrists and dispensing opticians,* in particular standards 1, 2, 7, 8, 16, 17 and 19. She said the Committee should consider the expert evidence of Dr Kwartz, who considered the Registrant's clinical failures to fall far below acceptable standards and to constitute serious misconduct under the first limb identified in *Remedy*, with the dishonesty alleged at allegation 2 separately engaging the second limb as morally culpable and disgraceful. Ms Huxtable placed particular emphasis on the failure to identify vascular changes and to refer the patient appropriately, notwithstanding arguments advanced by Professor Evans as to the low risk arising from a lack of GP referral. Ms Huxtable submitted that medication to control hypertension does not negate the duty to refer once relevant changes are identified. She submitted that if the Committee accepts Dr Kwartz's evidence, the conduct must properly be regarded as serious and deplorable by fellow practitioners, such that a finding of misconduct is justified.

117. Mr Mills submitted that misconduct is ultimately a matter for the Committee's judgment, but accepted that dishonesty will amount to misconduct, albeit at the lower end of seriousness in this case, being unplanned, short-lived, a single episode, for no gain, and posing low risk to the patient. Mr Mills further accepted that the record-keeping failures are likely to be found to have fallen far below the required standard, even though both experts agreed that the risk arising from those errors to this patient was low. Mr Mills emphasised that the Registrant has accepted his failings from the outset and apologised, and that the Committee's task at this stage is to assess whether the proven matters cross the threshold of

serious professional misconduct, and if so, the degree of seriousness, having regard to the expert evidence and the Committee's own judgment.

118. Mr Mills reminded the Committee that misconduct must be serious (*Roylance*), that mere negligence does not suffice (*Calhaem*), and that administrative failures such as record keeping will usually fall within poor performance rather than misconduct unless the negligence is gross (*Remedy*). He submitted that the Committee should confine its analysis strictly to the pleaded allegations and not take a global or cumulative view of the consultation. While acknowledging that multiple record-keeping errors may properly be examined in context, Mr Mills submitted there is no clear authority permitting aggregation of non-serious matters to find serious misconduct, save in a very unusual case (*Schodlok; Ahmedsowida*). On the clinical allegations, he highlighted the divergence between the experts on risk and on what constitutes "far below" the standard, noting internal inconsistencies in Dr Kwartz's evidence on risk and Professor Evans's consistent view that the risks were low. He added that the Committee does not have to prefer one expert throughout, but may decide that one is preferred in one charge and another elsewhere. Mr Mills submitted that low risk is highly relevant to seriousness, that the Committee is not bound by either expert's thresholds, and that any breaches found should be assessed individually, without appropriate aggregation or reliance on standards (such as *Standard 19*) which do not properly arise on the pleaded case.

119. The Legal Adviser outlined that even where the parties agree that there should be a finding of misconduct as per *Rule 46,* it is still a matter for the Committee to decide. The Legal Adviser outlined the case law and the *Hearings and Indicative Sanctions Guidance ("the Guidance")* at *Paragraphs 15.5-15.9* in relation to misconduct, reminding the Committee of the descriptions of misconduct in the cases of *Roylance* and *R (on the application of Vali) v General Optical Council (2011) EWHC 310 (Admin).* The Committee should consider each of the proven allegations in turn and decide whether each amounted to serious misconduct.

120. The Legal Adviser advised that, following *Schodlok v GMC* [2015] EWCA Civ 769, it is in principle possible for multiple findings of non-serious misconduct to amount cumulatively to serious misconduct, but only in an unusual and exceptional case, and this approach has attracted judicial criticism. If cumulation is adopted, the Committee must give clear reasons and consider the number and similarity of the findings and whether the case was advanced on a cumulative basis. Reliance was also placed on *Ahmedsowida v GMC*, where a tribunal was criticised for failing properly to apply the *Schodlok* principles. Accordingly, the threshold for cumulation is a high one.

121. Finally, the Legal Adviser stated that misconduct was a matter for the Committee's own independent judgement and no burden or standard of proof applied. The Committee should only move on to the impairment stage if it found serious misconduct.

**Findings on misconduct**

122. The Committee accepted the advice of the Legal Adviser and considered the case law and *Guidance,* as well as the written and oral submissions. The Committee was satisfied that the Registrant's conduct engaged a number of the Council's *Standards of Practice*. In particular, the Committee found that *Standard 1.7* was engaged, in that the Registrant failed to encourage the patient to answer relevant questions, so as to place the patient at the centre of the consultation. *Standard 2* was engaged on an overarching basis due to deficiencies in effective communication. Under *Standard 7*, the Committee found that the Registrant failed to conduct an adequate assessment (*Standard 7.1*), did not adequately check that the care provided was compatible with other treatments by failing to enquire appropriately about relevant medical matters (*Standard 7.4*), and therefore did not provide effective care and treatment (*Standard 7.5*). *Standard 8* was engaged on an overarching basis, due to inadequate record-keeping. The Committee further found that *Standard 16.1* was engaged, as a result of the dishonest conduct found proved, which reflected a failure to act with honesty and integrity. *Standards 17.1* and *17.3* were engaged in that the Registrant's conduct undermined public confidence in the profession and failed to meet the standards required by law. The Committee did not consider that *Standard 19* was relevant and agreed with Mr Mills' submissions on this point.

123. In comparing the expert evidence, the Committee preferred the approach of Dr Kwartz, which it found to be more rigorous, careful and detailed overall. Her evidence demonstrated a structured analysis of the clinical issues, including a clear exploration of the distinction between compliant and non-compliant patients, and a proper recognition that Patient A had merely stated what medication she was prescribed, without being asked to provide any information as to the duration and compliance.

124. By contrast, the Committee found that Professor Evans' evidence was at times relatively dismissive and appeared to rest on assumptions, for example a presumption that the GP would have been effectively monitoring Patient A and that she was compliant with treatment, which the Committee considered to be unreliable assumptions without any information from Patient A. The Committee also noted a lack of consistency in Professor Evans' categorisation of risk and seriousness, including difficulty reconciling references to significant or moderate to high risk with his conclusion that the conduct was not far below the standard, and his suggestion that conduct would only be "far below" if concerning a substantial failure, or repeated over several occasions. This, he said was a single examination.

125. While the Committee accepted that not every breach of a standard must amount to a falling far below the required standard, it found Dr Kwartz's evidence on the seriousness of the departures, particularly where there was a risk of harm, to be better reasoned and more persuasive. The Committee compared the experts' evidence in relation to each individual allegation before reaching a conclusion on misconduct.

*Allegation 1a)i*

126. The Committee preferred the evidence of Dr Kwartz at paragraph 8.2.4 and agreed that performing a slit lamp examination of the anterior eyes was a fundamental examination required by College of Optometry Guidance, and necessary to detect potentially serious eye disease. The Committee decided that Professor Evans's evidence placed undue emphasis on the absence of reported symptoms. The Committee concluded that this failure created a real risk of harm, fell far below the required standard, and amounted to serious misconduct.

*Allegation 1a)ii*

127. The Committee found that the Registrant failed to perform an ophthalmoscopic examination of the peripheral and nasal fundi. It preferred Dr Kwartz's evidence that this omission was particularly serious given the vascular changes present (paras 8.2.4 and 8.2.6), and noted Professor Evans's acceptance in oral evidence that part of Patient A's eye would not have been examined by the Registrant. The Committee concluded that this fell far below the required standard and amounted to serious misconduct.

*Allegation 1b)*

128. The Committee found that the Registrant failed to accurately ascertain Patient A's history and symptoms by not asking about her general health. The Committee preferred the evidence of Dr Kwartz at paragraph 8.2.2, where she explained that enquiring into general health is vital given the potential systemic causes of ocular findings. It rejected Professor Evans' characterisation of the consultation as "routine" rather than symptom-led. The Committee found that this failure fell far below the standard expected and amounted to serious misconduct.

*Allegation 1c)*

129. The Committee found that the Registrant failed to identify vascular changes in the fundus photographs. It preferred Dr Kwartz's detailed analysis at paragraphs 8.2.5 and 8.2.6, which identified three abnormalities that should have been recognised given Patient A's age, and found Professor Evans' evidence at paragraph 72 inconsistent, given his concession that at least one such change ought to have been noted. The failure exposed the patient to a sight-threatening risk and amounted to serious misconduct.

*Allegation 1d)*

130. The Committee found that the Registrant failed to refer Patient A to her GP despite clear clinical indications. While both experts agreed that referral was required, the Committee preferred Dr Kwartz's assessment at paragraph 8.2.7 of the potential systemic risks arising from non-referral, and rejected Professor Evans' assumption that GP monitoring or medication compliance could be inferred. The Committee considered the evidence of Dr Kwartz that this failure

carried the potential risk of harm to Patient A in not detecting an episode such as a potential stroke or a heart attack. The Committee found that this omission fell far below the required standard and amounted to serious misconduct.

*Allegation 1e)*

131. The Committee saw in the video footage that the Registrant incorrectly reassured Patient A that her blood vessels were "nice and healthy." The Committee preferred Dr Kwartz's evidence at paragraph 8.2.9 that this reassurance was inaccurate, misleading, and carried a risk of harm by discouraging further investigation, and did not accept Professor Evans's more benign interpretation. This conduct fell far below expected standards and amounted to serious misconduct.

*Allegation 1g)i-iv*

132. The Committee considered each of the particulars separately although as the findings were the same, it decided to record the findings in the determination together.

133. The Committee found that the Registrant recorded the absence of symptoms which he had not ascertained from Patient A. The Committee preferred Dr Kwartz's evidence at paragraphs 8.4.2 and 8.4.4 that recording unverified negative findings is a significant departure from standards and carries a risk of harm, and rejected Professor Evans's view in his report at paragraph 44 that seriousness depended on repetition. The Committee found that these failures fell far below the required standard and amounted to serious misconduct.

*Allegation 1h)i*

134. The Committee found that the Registrant recorded having performed a cover test at distance when he had not done so. In this respect, the Committee noted Patient A's excellent visual acuity (indicating satisfactory binocular vision) and preferred Professor Evans's evidence at paragraphs 84–86 that, in the absence of relevant symptoms, the risk of harm to this patient was low, and concluded that this amounted to conduct which fell below, rather than far below the *Standards,* although did not amount to serious misconduct.

*Allegation 1h)ii-iii*

135. The Committee considered each of the particulars separately, but because the conclusions were the same, it recorded the findings in the determination together.

136. The Committee found that there was no obligation to perform testing of ocular motility or pupil reactions in the circumstances of this patient. Both experts were aligned on this point (Dr Kwartz at her paragraph 8.3.4; Professor Evans at paragraphs 84–86), and the Committee concluded that no misconduct arose.

*Allegation 1i)i-iii*

137. The Committee considered each of the particulars separately although as the findings were the same, it decided to record the findings in the determination together.

138. The Committee found that the Registrant recorded having examined the anterior eyes, ocular adnexa and peripheral retinas when he had not done so. It preferred Dr Kwartz's evidence at paragraphs 8.4.2 and 8.4.4 that such recording is misleading, creates unsafe and unreliable records, and carries a risk of harm. It rejected Professor Evans' view (paras 86–90) that the absence of proven harm reduced seriousness. In his oral evidence Professor Evans agreed that inaccurate record-keeping can, in some circumstances, create a risk of harm by misleading other Optometrists as to the seriousness of a patient's condition, and could cause a risk of harm to some patients. The Committee found that this conduct fell far below the required standard and amounted to serious misconduct.

*Allegation 2*

139. The Committee reminded itself that it was only considering dishonesty in relation to allegation 1i). It had found that the Registrant knowingly recorded examinations and findings which had not been performed, and was therefore dishonest. Dishonesty being a fundamental breach of professional standards. The Committee concluded that this conduct constituted serious misconduct.

140. The Committee did not go on to consider the issue of cumulation, as it was only allegation 1h)i that fell into the category of non-serious misconduct.

141. In conclusion, the Committee found that the conduct in Allegations 1a)i, 1a)ii, 1b), 1c), 1d), 1e), 1g)i-iv, 1i)i-iii and 2 (in respect of the dishonesty in 1i) only) amounted to a serious departure from the *Standards* expected of a competent Optometrist and decided that the Registrant's conduct amounted to serious misconduct within the meaning of *section 13D(2)(a)* of the *Act*.

**Submissions and advice on impairment**

142. Ms Huxtable submitted that the Committee should find that the Registrant's fitness to practise was currently impaired. She submitted that fitness to practise proceedings were not punitive of the Registrant but protective of the public, requiring a forward-looking assessment, while properly taking account of past misconduct in accordance with *Meadow v GMC[2007] 1 All ER 1*. The Council submitted that the Committee should apply the approach set out in *CHRE v (1) NMC and (2) Grant [2011] EWHC 927 (Admin)*, and that all four limbs of the *Grant* test were engaged, given the serious clinical failures in the care of Patient A and the deliberate creation of false patient records, which placed patients at

unwarranted risk of harm, brought the profession into disrepute, and breached fundamental tenets of the profession and were also dishonest.

143. The Council submitted that the Registrant's conduct related to core professional standards, that accurate clinical assessment and record-keeping were fundamental to patient safety and public confidence, and that the dishonest aspect of the conduct was attitudinal and not easily remediable. Ms Huxtable submitted that the Registrant had demonstrated insufficient insight and remediation, that deliberate dishonesty was among the most serious forms of professional misconduct, and that it was very rare for such cases of dishonesty to avoid a finding of current impairment. The Council further submitted that a finding of impairment was required both to protect the public from ongoing risk and to uphold professional standards and maintain public confidence in the profession, even if the Committee was to conclude that the likelihood of repetition was limited.

144. Ms Huxtable emphasised that false or inaccurate clinical records have the potential to place patients at risk of harm and undermined confidence in the Registrant's ability to practise safely. She submitted that, notwithstanding the Registrant's completion of targeted CPD and engagement in reflection, there had been insufficient remediation and insight to address the ongoing risk arising from serious clinical failings.

145. Ms Huxtable submitted that the Council's primary concern related to dishonesty, which she submitted was attitudinal in nature and therefore difficult to remediate. This was the second occasion on which the Registrant had been found dishonest in relation to record-keeping, and the Council argued that, although the circumstances differed, the misconduct demonstrated a troubling pattern of repeated behaviour. It was submitted that the Registrant had not learned from the previous finding, could not be relied upon to maintain accurate records, and continued to pose a significant risk to the public. Accordingly, the Council invited the Committee to find that the Registrant remained impaired in order to protect the public and to uphold professional standards and public confidence in the profession.

146. Mr Mills, on behalf of the Registrant, accepted that in light of the finding of dishonesty the Committee was likely to make a finding of impairment on public interest grounds. However, relying on *Grant* and subsequent authorities, he submitted that while the criteria relating to past conduct were engaged, the Committee should not conclude that the Registrant was liable to repeat such behaviour in the future. He argued that the dishonesty found was not attitudinal, did not demonstrate a propensity to falsify records, and arose from a single incident in highly specific and unusual circumstances. He said both the clinical failings and the dishonesty were capable of remediation, had been remedied, and were highly unlikely to recur, with context being central to understanding how the misconduct arose and how it had since been addressed.

147. Mr Mills further submitted that the Registrant's denial of dishonesty should not be treated as a lack of insight, relying on *Yussuf v GMC [2018] EWHC 13 (Admin)* and *Sawati v GMC [2022] EWHC 283 (Admin)*. He emphasised that admission of

misconduct is not a prerequisite for insight, particularly in a "secondary fact" case where the dispute concerned whether dishonesty rather than honest error best explained the inaccuracies. The Committee had accepted the Registrant's account of the surrounding circumstances, and the findings were nuanced rather than indicative of blatant or manufactured dishonesty. In all other respects, the Registrant had made candid admissions, accepted his failings, and demonstrated insight through reflective evidence prepared prior to the findings, which addressed the gravity of dishonesty, its impact on patients and public confidence, and the safeguards now in place to ensure sound judgement under pressure.

148. Mr Mills invited the Committee to place substantial reliance on the Registrant's sustained remediation, including nearly two years of supervised practice under an interim order, eight uniformly positive supervisor reports, multiple informed references from professional colleagues, and extensive targeted CPD in ethics, probity, and clinical practice. Mr Mills submitted that such sustained positive practice was inconsistent with any attitudinal dishonesty and demonstrated that risks had been addressed in practice, not merely asserted. He distinguished the 2018 dishonesty as planned and deliberate, unlike the unpremeditated conduct in this case, and noted that the Registrant had demonstrated effective remediation following the previous case. In those circumstances, Mr Mills submitted that the risk of repetition—both clinical and in relation to dishonesty—was low, that there was no ongoing risk to patients, and that a finding of impairment was only necessary on public interest grounds, not public protection.

149. The Committee heard and accepted advice from the Legal Adviser who outlined *Paragraphs 16.1* to *16.7* of the *Guidance*. The Legal Adviser advised the Committee to consider the two separate elements of impairment namely the public interest component, which concerns the reputation of the profession and upholding professional standards, and the public protection component which concerns the risk to the public of repetition. She advised the Committee to consider any insight displayed by the Registrant as set out in *Cohen v GMC (2008) EWHC 581*. The Legal Adviser also highlighted the four questions in the *Grant* case.

150. The Legal Adviser addressed the issue of dishonesty in impairment with the case of *PSA v HCPC and Ghaffar (2014) EWHC 2723 (Admin)* in which the Court held that "*A finding of impairment does not, of course, necessarily follow upon a finding of dishonesty, although it is accepted by the Panel that it will be a frequent one.*" The Legal Adviser also referred to the case of *PSA v (1) GMC (2) Uppal (2015) EWHC 1304 Admin* which confirmed that a finding of dishonesty does not always mean that impairment is inevitable.

151. The Legal Adviser further advised the Committee that at the impairment stage, there is no burden or standard of proof, but ultimately it is a question of judgement for the Committee alone.

**Findings on impairment**

152. The Committee heard and accepted the legal advice, considered the *Guidance* at *paragraphs 16.1* to *16.7*, the *Cohen* case and the four questions in the *Grant* case, namely:

> *a. 'Has [the Registrant] in the past acted and/or is [he] liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
> *b. Has [the Registrant] in the past and/or is [he] liable in the future to bring the medical profession into disrepute; and/or*
> *c. Has [the Registrant] in the past breached and/or is [he] liable in the future to breach one of the fundamental tenets of the medical profession;*
> *d. Has [the Registrant] in the past acted dishonestly and/or is [he] liable to act dishonestly in the future.'*

153. The Committee also considered the GOC's overriding objective, and gave equal consideration to each of its limbs as set out below:

> *"To protect, promote and maintain the health, safety and well-being of the public, to protect the public by promoting and maintaining public confidence in the profession and to promote and maintain proper professional standards and conduct."*

154. The Committee first considered the questions in the *Grant* case with regard to the Registrant's *past* behaviour.

155. The Committee had decided that there were both clinical failings in this case as well as a dishonesty matter in respect of allegation 1i), both of which gave rise to potential concerns for Patient A and the wider public interest. The Committee decided that honesty is a core standard of any reasonably competent optometrist and found that the Registrant had fallen far below *Standards 1, 2, 7, 8, 16 and 17* for reasons already outlined. The Registrant's actions had placed Patient A at potential risk of harm and undermined the reputation of the profession amongst members of the public, professional colleagues and patients. The Committee therefore found that the Registrant had, in the past, a) put Patient A at unwarranted risk of harm, b) brought the optical profession into disrepute, c) breached one of the fundamental tenets of the profession, and d) had, in the past, acted dishonestly.

156. The Committee then went on to consider the issues in the case of *Cohen* as found at *Paragraph 16.1* of the *Guidance.*

157. Firstly, the Committee considered whether the conduct which led to the allegation is remediable. The Committee considered that clinical failures are remediable. Although it is difficult to remediate a finding of dishonesty, the Committee considered that the Registrant's misconduct is potentially capable of being remediated.

158. Secondly, the Committee considered whether the conduct has been remedied. The Committee considered there was evidence of personal insight, summarised in the Registrant's reflection statement dated 1 April 2026: *"Being emotionally distracted lead me to make the mistakes I made. It was not planned…. I fully*

*accept that any situation in which a patient or third party questions whether a sight test was properly carried out risks undermining trust. That insight has been central to my reflection over the past two years. This process has reinforced my understanding that professional integrity must not only exist — it must be clearly demonstrated and evidenced."* The Registrant also gave oral evidence which demonstrated further insight, commenting that he was aware that he should make patients his priority where there were competing demands on his attention, and that he now spends some time on daily reflection.

159. The Committee also noted the substantial external evidence of efforts of the Registrant to remediate. Firstly, the Registrant had been working under a GOC conditions of practice interim order for the last two years without incident. Secondly, the Registrant's supervisor had provided a full series of comprehensive reports, including a patient feedback form and personal development plan which demonstrated excellent compliance under supervision. The Committee found these reports helpful and inferred that the supervisor must have been impressed by the Registrant for him to have gone to the trouble he had clearly done to provide detailed, comprehensive and supportive reports over such a sustained period. Thirdly, five positive testimonials had been provided from professionals who were clearly made aware of the allegations, and fourthly, the Registrant had completed targeted relevant CPD training.

160. The Committee considered whether there was a risk of repetition. The Committee noted a distinction between the clinical allegations and the dishonesty allegation. The Registrant has addressed the risk of repetition through sustained remediation, including close clinical supervision for two years, extensive daily practice, and targeted CPD directly relevant to the allegations. The supervisor reports, oral evidence, and informed references consistently confirm that his clinical practice is safe, developed, and not currently impaired. The Committee noted the example the Registrant gave of other recent, comparable, family pressures and how he had dealt with these very differently from those in the allegations. The Committee concluded that the remedial action undertaken met with its concerns with regard to clinical practise. The Committee did not consider there to be a future risk of repetition with regard to clinical failings.

161. In assessing the risk of repetition in respect of dishonesty, the Committee considered the previous finding against the Registrant in 2018, which related to record-keeping and dishonesty. The Committee accepted that, while relevant, the current findings did not support a conclusion that the Registrant has a general propensity for dishonest behaviour. The Committee noted that the earlier misconduct involved a planned and deliberate attempt to conceal a clinical failing, whereas the conduct in the present case arose in an unplanned context. The Committee further accepted that the circumstances were unusual, arising from unexpected family difficulties, and distinguished in nature from the conduct underlying the 2018 finding.

162. The Committee considered the finding of dishonesty in respect of allegation 1i). It was satisfied that the conduct was a brief and unpremeditated episode, occurring in the context of unexpected disruption, and was materially different from the deliberate and planned dishonesty found in 2018. The Committee did not

consider the behaviour to reflect a deep-seated or attitudinal failing, noting the Registrant had engaged fully in the internal investigation and had engaged with these proceedings. The Committee considered that the Registrant had demonstrated insight and reflective engagement in his candid oral and written evidence. The Committee concluded that there was a low risk of repetition of dishonesty in the future.

163. The Committee then returned to the *Grant* questions with reference to the Registrant's *future* risk. The Committee acknowledged that the conduct took place on only one day, over a few minutes and appeared to be whilst the Registrant had been distracted due to the [redacted] issues of a family member. However, the Committee had found that the Registrant's actions were dishonest and were a serious falling short of the *Standards.* As the Committee made a finding that there was no risk of repetition with regards to clinical issues, it concluded that limb a) is not engaged.

164. The Committee has outlined the evidence of remediation and insight to enable it to conduct a risk assessment as to whether such conduct will be repeated in the future. The Committee considered that the steps the Registrant had taken to remediate had gone some way towards demonstrating remediation, although it concluded that there was still a low risk of repetition with regards to dishonesty and therefore limbs b), c) and d) were engaged with regard to future risk.

165. The Committee then considered the public interest element. The patient's record contained false entries and did not reflect a genuine representation of the examination that was conducted. The Committee reminded itself of its findings that the actions in allegation 1i) were carried out dishonestly.

166. The Committee also noted the *Hearings and Indicative Sanctions Guidance ("the Guidance") at paragraph 17.1: "Dishonesty is particularly serious as it may undermine confidence in the profession."* The Committee decided that an informed and fair-minded member of the public, if they were apprised of the facts, would be very concerned by the Registrant's misconduct, and would reasonably conclude that a finding of impairment was necessary to promote and maintain public confidence in the profession and proper professional standards and conduct.

167. The Committee therefore found that the public interest elements of impairment were present and concluded that it was therefore necessary in the public interest to make a finding of impairment of fitness to practise in order to uphold professional standards and public confidence in the profession.

168. The Committee therefore found that the Registrant's fitness to practise as an Optometrist is currently impaired on public interest grounds only.

**Submissions and advice on sanction**

169. Ms Huxtable, for the Council, submitted that the appropriate sanction was one of erasure.

170. Ms Huxtable outlined the case law from her written skeleton argument. In applying those principles, Ms Huxtable submitted that the appropriate mitigating features were the absence of actual harm to Patient A and the Registrant's engagement with the regulatory process and admissions of clinical failings. Against this, Ms Huxtable submitted that the aggravating features were significant: serious clinical failings compounded by falsification of patient records, creating a real risk of harm, and amounting to misconduct at the higher end of seriousness. She submitted that the misconduct was attitudinal and dishonest in nature and could not be addressed by conditions, and that the case was too serious for no further action, a fine, conditional registration, or suspension.

171. Relying on the Guidance, Ms Huxtable submitted that the Registrant's behaviour represented a serious departure from professional standards, involved persistent dishonesty and a risk of harm, and was fundamentally incompatible with continued registration. In those circumstances, the Council submitted that erasure was the only appropriate and proportionate sanction to maintain professional standards and public confidence.

172. Mr Mills submitted that erasure would be a disproportionate response and that the appropriate sanction was either conditional registration or, in the alternative, a short period of suspension. He accepted the aggravating features identified by the Committee: multiple clinical failings, dishonesty and a previous fitness to practise history, but submitted that these required careful evaluation in context. He submitted that the dishonesty in this case lay at the lower end of the spectrum: it was a single, spontaneous, unplanned incident, not covered up, and not found by the Committee to be deep seated or attitudinal. The previous finding, whilst relevant, was distinguishable from the present case and did not represent repetition of the same conduct or escalation.

173. By contrast, Mr Mills submitted that there was substantial mitigation, including that the misconduct related to one consultation, arose in unusual circumstances, caused no actual harm, and had not been repeated over a significant period, including nearly two years of supervised practice. Mr Mills relied on the Registrant's strong references, positive supervisor reports, insight, remorse, low risk of repetition, substantial admissions, and continued commitment to high professional standards. He submitted that erasure would unnecessarily remove a competent and useful practitioner where public protection did not require it.

174. Relying on the Indicative Sanctions Guidance, Mr Mills emphasised that there is no presumption of erasure in cases of dishonesty and invited the Committee to have regard to the factors at paragraphs 22.6 of the Guidance, all of which pointed away from erasure in this case. He submitted that conditions of practice were workable, proportionate and sufficient to protect the public, particularly given the absence of deep seated attitudinal issues, the effectiveness of previous supervision, and the Committee's ability to impose practical and measurable conditions. Alternatively, he submitted that a short suspension of 3–4 months would adequately mark the seriousness of the misconduct and satisfy the public interest, given the Committee's findings of insight, low risk of repetition and lack of ongoing risk to patients. Erasure, he submitted, was not necessary to maintain

public confidence or professional standards, and was not the only means of protecting the public within the meaning of paragraph 21.37 of the Guidance.

175. The Legal Adviser referred to the Guidance at Paragraphs 20-23 and 13F - 13H of the Opticians Act 1989 in outlining the sanctions available to the Committee. The Legal Adviser stated that the purpose of sanctions is not to punish, but the Committee should consider proportionality and balance the interests of the public against those of the Registrant, although the interests of the profession take precedence according to Bolton v Law Society (1994) 1 WLR 512.

176. The Legal Adviser also outlined Paragraphs 22.4 to 22.6 of the Guidance in relation to sanctions on dishonesty. The Legal Adviser advised that the Committee should consider the aggravating and mitigating factors, and then, according to Paragraph 8.3 of the Guidance, work through the sanctions starting with no order and then the least restrictive first, erasure only being appropriate where actions are fundamentally incompatible with being a registered professional, and if it is the only means of protecting patients and/or maintaining public confidence in the optical profession as outlined in Paragraph 21.37 of the Guidance.

**Findings on sanction**

177. In reaching its decision on sanction the Committee took into account the legal advice, the submissions from both parties, the facts found proved and its previous findings on misconduct and impairment. Throughout its deliberations the Committee had regard to the Guidance, in particular paragraphs 20-23, as well as the overarching objective.

178. The Committee considered the Guidance at paragraph 14.3 and considered the following to be aggravating features:

- This is the second instance of a finding of dishonesty relating to record keeping.
- There was a potential risk of harm to Patient A.

179. The Committee considered the Guidance at paragraph 14.2 and considered the following to be mitigating factors:

- Patient A did not suffer actual harm.
- The Registrant has fully engaged with the regulatory process and broadly admitted the clinical failures.
- The Registrant has complied with a conditions of practise interim order over a period of two years with no repetition.
- The positive reports and testimonials demonstrate that the Registrant is a useful and competent member of the profession.
- The Registrant has expressed remorse, and his insight is well developed.

- The misconduct occurred during unusual and unplanned family circumstances.
- The dishonesty occurred during a single consultation over a short period of time.

180. The Committee considered and weighed the aggravating and mitigating factors above when applying the Guidance at paragraph 8.3 and considered the possible sanctions, starting with the least severe.

181. The Committee considered taking no further action but decided, having regard to the Guidance, that there were no exceptional circumstances to justify doing so, as to take no action would not reflect the seriousness of the dishonest misconduct and therefore it would be inappropriate.

182. The Committee considered a financial penalty and noted that the Registrant did not gain financially from this misconduct. In any event, the Committee decided that a financial penalty would not reflect the seriousness of the misconduct.

183. The Committee next considered a period of conditional registration. The Committee discussed whether there were appropriate, proportionate, workable, and measurable conditions which would meet the Committee's concerns relating to the possible repetition of the Registrant's dishonest misconduct. The Committee noted the Guidance at Paragraph 21.25 in relation to conditions:

*"Conditional registration may be appropriate when most, or all, of the following factors are apparent (this list is not exhaustive):*

*a. No evidence of harmful deep-seated personality or attitudinal problems.*
*b. Identifiable areas of registrant's practise in need of assessment or retraining.*
*c. [not relevant].*
*d. Potential and willingness to respond positively to retraining.*
*e. Patients will not be put in danger either directly or indirectly as a result of conditional registration itself.*
*f. The conditions will protect patients during the period they are in force.*
*g. It is possible to formulate appropriate and practical conditions to impose on registration and make provision as to how conditions will be monitored."*

184. The Committee concluded that a conditional registration order was not appropriate because the impairment finding was not based on clinical competence or remediable clinical deficiencies. There had been no finding of impairment on clinical grounds, and the misconduct was instead rooted in dishonesty and public interest considerations. As such, conditions directed at clinical practice would not properly address the nature of the concerns identified.

185. The Committee further concluded that conditions would not sufficiently satisfy the public interest. Although the dishonesty was not at the most serious end of the spectrum, the misconduct was nonetheless too serious to be satisfactorily addressed by conditions. A conditional registration order would fail to mark the

seriousness of the conduct or maintain public confidence in the profession and the regulatory process.

186. The Committee moved on to consider a suspension order and the relevant factors in the Guidance contained within paragraph 21.29 namely:

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 the incident.
d. The Committee is satisfied the registrant has insight and does not pose a significant risk of repeating behaviour.
e. [not relevant]

187. The Committee decided that factors a), b), c) and d) were engaged. The Committee had already made findings that there was no evidence of harmful deep-seated personality or attitudinal problems. There had been no repetition since the incident occurred. The Committee had found that there was a low risk of repetition and that this did not amount to a significant risk of repeating the misconduct. The Committee was satisfied that the Registrant had demonstrated insight. It therefore concluded that all of the relevant factors in respect of suspension applied.

188. The Committee went on to test this proposition against the sanction of erasure and the relevant sections of the Guidance at paragraph 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. [not relevant];
> d. [not relevant];
> e. [not relevant];
> 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."

189. The Committee noted that factor a) was relevant in so far as any finding of dishonest misconduct is serious. For factor b), the Committee did not consider

there to be a continuing risk of harm to patients. For factor g) the Committee did not consider there to be any breach of the duty of candour.

190. Clearly factor f) was relevant to this case. However, the Committee found that the dishonesty was not persistent or covered up and was not at the upper end of seriousness. It distinguished the conduct from the previous finding of dishonesty, concluding that this was a different and lower level of wrongdoing, which did not amount to a complete breakdown of trust between the Registrant and the profession. The Committee decided that any sanction imposed needed to reflect that trust had not been wholly lost. In reaching that conclusion, the Committee noted that the dishonesty occurred on a single occasion, over a very short period, conferred no benefit to the Registrant, and was not repeated or concealed. Taken together, those features meant that the conduct could not properly be characterised as persistent or covert dishonesty. Finally, the Committee had found that there was insight and therefore h) was not engaged.

191. The Committee therefore concluded that two of the factors in respect of erasure applied.

192. The Committee acknowledged that dishonesty is serious. The Committee was mindful that erasure would only be appropriate where the conduct is fundamentally incompatible with being a registered professional, and if it is the only means of protecting patients and/or maintaining public confidence in the optical profession. The Committee weighed up each of the factors in paragraphs 21.29 (suspension), and 21.35 (erasure) and for the reasons above, on balance, took the view that to erase the Registrant would be disproportionate.

193. The Committee therefore decided that the sanction of suspension would strike the appropriate balance of upholding the public interest in maintaining professional standards against the interests of returning a competent professional to practise. The Committee found that a lesser sanction would not mark the seriousness of dishonest misconduct.

194. The Committee decided that six months would be the most appropriate length in order to maintain public confidence in the profession and to maintain proper professional standards. The Committee considered that this also will allow the Registrant time to reflect and develop insight into the seriousness of the misconduct.

195. The Registrant will therefore be suspended from the register for a period of six months.

**Review hearing**

196. The Committee decided that a review hearing was not necessary in light of the Registrant's lengthy compliance with previous conditions and the remediation already undertaken to meet the identified clinical concerns. Those conditions had already addressed the clinical issues, and the sanction imposed was sufficient to mark the seriousness of the dishonesty and to uphold public confidence and professional standards.

197. The Committee was satisfied that the risk of repetition was low, that there were no specific courses or remedial steps which would usefully be monitored at review, and that a further hearing was therefore unnecessary. It also noted that the Registrant would be able to continue undertaking CPD and maintain professional skills during the period of sanction without the need for formal review.

**Immediate order**

198. Ms Huxtable submitted that an Immediate Order would be necessary in this case as this is a matter of a serious nature and it would be otherwise in the public interest having regards to the Committee's findings on impairment. An Immediate Order would cover the appeal period, after which the substantive order will take effect if no appeal is lodged under Section 13I of the Opticians Act 1989.

199. Mr Mills submitted that an immediate order was not necessary because it is not otherwise in the public interest, as the findings indicate that there is no ongoing risk requiring intervention. He submitted that if it were inevitable that there should be an immediate order when sanction is imposed then it would be in the legislation, which it is not.

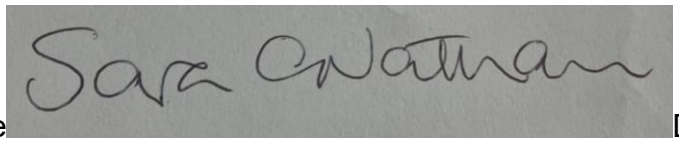
200. The Committee heard and accepted advice from the Legal Adviser, namely that the Committee should refer to Paragraphs 23.1-23.5 of the Guidance. The Committee may impose an immediate order if it decides that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the Registrant.

201. The Committee concluded that an immediate order was not necessary because there was no pressing public interest justification for immediate suspension or restriction. It was satisfied that there was no ongoing risk requiring urgent intervention and that the substantive sanction sufficiently addressed public confidence in the profession. The absence of an immediate order also allowed a short period for any necessary alternative arrangements for the Registrant's professional commitments to be put in place, which the Committee considered appropriate in the circumstances.

**Revocation of interim order**

202. The Committee hereby revokes the current existing interim order for conditional registration that was imposed on 17 May 2024.

**Chair of the Committee: Sara Nathan**

Signature  Date: 20 April 2026

Registrant: Nasir Butt

Signature *present and received via email* Date: 20 April 2026

| FURTHER INFORMATION |
| --- |
| **Transcript** |
| A full transcript of the hearing will be made available for purchase in due course. |
| **Appeal** |
| Any appeal against an order of the Committee must be lodged with the relevant court within 28 days of the service of this notification. If no appeal is lodged, the order will take effect at the end of that period. The relevant court is shown at section 23G(4)(a)-(c) of the Opticians Act 1989 (as amended). |
| **Professional Standards Authority** |
| This decision will be reported to the Professional Standards Authority (PSA) under the provisions of section 29 of the NHS Reform and Healthcare Professions Act 2002. PSA may refer this case to the High Court of Justice in England and Wales, the Court of Session in Scotland or the High Court of Justice in Northern Ireland as appropriate if they decide that a decision has been insufficient to protect the public and/or should not have been made, and if they consider that referral is desirable for the protection of the public.<br><br>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).<br><br>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 Floor 29, One Canada Square, London, E14 5AA or, by telephone, on 020 7580 3898. |