BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(24)43

AND

SHAHID NAZIR (01-20683)

DETERMINATION OF A SUBSTANTIVE HEARING
29 SEPTEMBER – 10 OCTOBER 2025

Committee Members:	Sarah Hamilton (Chair/Lay) Diane Roskilly (Lay) Oluremi Alabi (Lay) Caroline Clark (Optometrist) Gemma O'Rourke (Optometrist)
Legal adviser:	Gemma Gillet
GOC Presenting Officer:	Diana Constantinide
Registrant present/represented:	Yes and not represented
Registrant representative:	N/A
Hearings Officer:	Arjeta Shabani
Facts found proved:	1a, 1bi (by admission), 1bii, 1biii, 1biv, 1c, 1d, 1f, 2 (in relation to 1bi-iv, 1d, 1f), 3a, 3b, 4, 5b, 6a, 6b, 8 & 10
Facts not found proved:	1e, 5a, 7 & 9
Misconduct:	Found
Impairment:	Impaired
Sanction:	12 month suspension – (With Review)
Immediate order:	Immediate suspension order

Preliminary Issues

1. Mr Shahid Nazir ("the Registrant") attended and was not represented. Ms Constantinide, of Counsel, attended to present the case on behalf of the General Optical Council ("the Council").

2. At the outset of the hearing, a preliminary issue was raised by the Committee to the parties concerning a declaration of interest from a member who knew one of the witnesses in the case. The potential conflict had been raised on the previous occasion before the hearing was adjourned for unrelated issues. The Committee had been differently constituted on that occasion. The Committee Chair informed the parties that the member had not worked directly with the witness although they had in the past attended the same meetings. They had seen each other at an event in March 2025, which had been attended by 200 other people.

3. The Registrant and Ms Constantinide confirmed that they did not have any objection. The Committee accepted the legal advice from the Legal Adviser. She advised the Committee that the test which it needed to apply was whether "*a fair minded and informed observer, having considered the facts, would conclude that there was a real possibility that the tribunal was biased*" citing Porter v Magill [2002] AC 357.

4. The Committee found that a fair minded observer, fully informed of the facts, would not be concerned that the limited contact the Committee member had had with the witness previously, would have any adverse influence on the Committee member's decision making. In the circumstances, the Committee determined that there was no real possibility that it would be biased in this case or that bias could be perceived and therefore there was no conflict of interest. It determined that the member could continue hearing the matter and proceeded on that basis.

5. The Committee considered the concerns raised by the Registrant in relation to the bundles of documents relied upon by the Council. The Registrant confirmed that he did not have an issue with the bundles "*as long as it was the same bundle as he had been sent*". Ms Constantinide confirmed that the Council's bundles remained the same as had been provided to the Registrant before the adjourned hearing in May 2025 and had been provided in accordance with the Rules. The Committee allowed the Registrant extra time to provide any further documentation he wanted included in his Response Bundle. The Registrant provided the Committee with his skeleton argument on his dismissal application and various documents and emails. In addition, he asked that the Committee be provided with the Council's statement of Mr A who had originally viewed the recording, which Ms Constantinide confirmed had been removed from the bundle as the contents were believed to be a duplication of information provided by other witnesses. The statement was provided to the Committee at the end of the first day.

6. As the Registrant had not agreed the Council's bundle in advance, the Committee adjourned in order to read the Council's bundles and the documents provided by

the Registrant. The Committee then heard an application from the Registrant to dismiss the proceedings. In his written application for dismissal he submitted that:

"*the process has been fundamentally unfair, prejudicial and contrary to law, with multiple breaches of my rights under the European Convention on Human Rights (Articles 6 & 8). The evidence relied upon has been unlawfully obtained, misrepresented, and manipulated, and the correspondence and internal notes reveal collusion between my employer and the Regulator, prejudgment of outcome, and deliberate suppression of disclosure*."

7. In addition, he raised issues of unfairness and data protection/governance, which he submitted arose in relation to the Council's reliance on the video recording taken by the mystery shopper. He concluded that it would be impossible to have a fair trial as a result. Ms Constantinide submitted that there was no legal basis or identification of potential prejudice, unfairness or procedural irregularity on which the abuse of process application was being made. She submitted that the Registrant's arguments fell far short of the high bar necessary to establish the exceptional circumstances necessary for his application to be successful.

8. The Committee considered and accepted the advice from the Legal Adviser which included the two categories for granting a stay on the grounds of an abuse of process, namely (i) where it is impossible to give the accused a fair trial, and (ii) where it offends the court's sense of justice and propriety to try the registrant in the particular circumstances of the case (*R v Maxwell* [2011] 1 WLR 1837) and the "exceptional circumstances" necessary (Attorney-General's Reference (no.1 of 1990 [1992] QB 630. The Committee was also referred to previous case law in which reliance on evidence procured by an undercover journalist had not been deemed an abuse of process in the context of professional disciplinary proceedings (Council for Regulation of Health Care Professions v General Medical Council and Saluja [2006] EWHC 2784 Admin).

9. The Committee first considered whether any issue of unfairness arose in relation to the Council's reliance on the video recording taken by the mystery shopper which formed the basis of particulars 1 and 2. The Committee determined that as a matter of common knowledge, retailers rely on mystery shoppers as part of their checks on the quality of the service they provide (the Committee noted that there was no evidence or suggestion that the Registrant had been targeted). The Committee noted that individuals registered with the Council have a professional duty of candour to report issues of concern. As a result, it was incumbent on the registered members who viewed the video to inform the Council of any regulatory concerns identified.

10. The Committee was unable to identify any legal, procedural or governance issues which would make the Council's reliance on the video unfair. The Committee determined that it was independent of the Council and would not be bound by any comment or opinion expressed by the Council's witnesses as to the contents of

the video or the likely outcome of the fitness to practise hearing. The Committee would be able to form its own opinion by watching the video during the course of the hearing. The Committee noted that any comments from the witnesses about the contents were based on what they had seen in the video and not on what they had been told had happened by third parties.

11. The Committee took into account the fact that the Registrant would have an opportunity to ask questions of the witnesses and provide his own account of the recording should he decide to do so. He would also have the opportunity to make submissions on the weight the panel should attach to the video evidence in due course. The Committee noted that the Registrant had been served with the Council's evidence in accordance with the rules and the legal timeframe. The hearing had been previously adjourned to allow the Registrant time to prepare his case and/or seek legal representation. The Committee could find no evidence of unfairness in relation to the service or the contents of the Council's bundles.

12. The Committee decided that there was no basis on which it could determine that a fair hearing would not be possible nor that it would be an offence to the sense of justice and propriety to continue with the hearing. It therefore followed that the exceptional circumstances were not established and the application was refused.

PARTICULAR

The Council alleges that in relation to Mr Shahid Nazir (01-20683), a registered Optometrist that:

1) On or around 28 April 2023 whilst working at [redacted] Visionplus Limited, you failed to perform an appropriate examination and/or assessment of Patient A's eyes in that you:

a. Failed to perform binocular vision testing; and/or
b. Recorded entries for the following despite these examinations not being performed:

i. *fixation disparity at distance and near;*
ii. *near point of convergence;*
iii. *ocular motility;*
iv. *pupil reactions;*

c. Failed to adequately examine the external eyes; and/or
d. Recorded 'no' for diplopia, flashes, and headaches, despite not asking the patient about these symptoms; and/or
e. Recorded 'no' to drive or words to that effect despite the patient responding yes to the question on driving; and/or

f. Recorded that you recommended contact lenses despite not raising this advice or topic within the examination; and/or

2) Your conduct as set out at 1)b; and/or 1)d; and/or 1)e and/or 1)f is dishonest in that you recorded findings from an eye examination which had not been undertaken; and/or

3) Between May 2023 and September 2023, whilst you were employed at [redacted] Domiciliary Services Limited, you conducted inadequate eye examinations and/or assessments, for some, or all of the patients listed in Schedule A, in that you:

a. Failed to perform and/or record binocular vision testing; and/or
b. Failed to measure and/or record near visual acuity; and/or

4) On or around 30 June 2023, you conducted an inadequate eye examination and/or assessment on Patient 30 in that you failed to assess and/or record visual field tests; and/or
5) On or around 23 August 2023, you conducted an inadequate eye examination and/or assessment on Patient 17 in that you:

a. Recorded "never had a stroke over right side" and "right eye vision no good," or words to that effect, despite the patients eligibility for the test being for cerebrovascular accident or stroke; and/or
b. Failed to assess and/or record a confrontation or manual peripheral visual field test; and/or

6) On or around 12 May 2023, you conducted an inadequate eye examination and/or assessment on Patient 42 in that you:

a. Failed to perform and/or record a cover test; and/or
b. Failed to record any ocular history for the patient or their family ocular history; and/or

7) On or around 19 July 2023, you conducted an inadequate eye examination and/or assessment on Patient 47 in that you recorded a conflicting entry about the presence or absence of retinal vessel 'nipping'; and/or

8) On or around 13 June 2023, you conducted an inadequate eye examination and/or assessment on Patient 14 in that you incorrectly recorded right eye cataract despite the patient having had right eye cataract surgery; and/or

9) On or around 11 August 2023, you conducted an inadequate eye examination and/or assessment on Patient 4 in that you failed to record your reasons for prescribing, despite the prescription being marginal, and the habitual visual acuity and near visual acuity not supporting the prescription; and/or

10) *On or around 19 July 2023, you conducted an inadequate eye examination and/or assessment on Patient 7 in that you prescribed varifocals despite referring the patient for cataract surgery; and/or*

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

Schedule A

KEY
Patient 1
Patient 2
Patient 3
Patient 4
Patient 5
Patient 6
Patient 7
Patient 8
Patient 9
Patient 10
Patient 11
Patient 12
Patient 13
Patient 14
Patient 15
Patient 16
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Patient 44
Patient 45
Patient 46
Patient 47

DETERMINATION

Admissions in relation to the particulars of the particular

13. The Registrant admitted particular 1(b)(i) of the particular. Under Rule 46(6) (6), as the facts have been admitted, the Committee therefore found that Particular proved.

14. The Registrant denied each of the remaining Particulars.

Background to the particulars

15. At the relevant time in regard to particulars 1 and 2 the Registrant was working in Specsavers [redacted] (trading as [redacted] Visionplus Limited) (SVL) as a locum

optometrist. In regard to particulars 3 to 10 the Registrant was an Optometric Director of a Specsavers domiciliary practice operating as [redacted] Domiciliary.

Particulars 1 & 2

16. On 28 April 2023, the Registrant performed a sight test on patient A at Specsavers [redacted]. Patient A attended the practice as a "mystery shopper" and his interactions with the Registrant during the visit were recorded (audio and visual).

17. Specsavers [redacted] reviewed the recording of the visit. Following the review, concerns emerged surrounding the standard of the eye examination and the accuracy of the Registrant's record keeping.

18. The concerns related to inconsistencies between what can be seen and heard in the recording and the records made by the Registrant. In particular, that he failed to adequately examine the external eyes and recorded entries for assessments that had not been performed on Patient A.

19. The video footage was passed to Mr B, Professional Services Consultant for Specsavers Optical. He viewed the video and the corresponding patient record and subsequently made a referral to the Council on 12 September 2023.

Particulars 3 -10

20. On 1 May 2023, the Registrant had joined [redacted] Domiciliary, Specsavers, as an Optometrist Partner. In July 2023, Ms A (now [redacted]), the Retail Director of [redacted] Domiciliary began receiving concerns from several colleagues. The concerns related to:

    i) whether his recommendations for spectacles and supplements were in the best interest of the patients;
    ii) whether his eye examinations were carried out to an adequate standard;
    iii) the accuracy of his records:
    iv) failure to ensure safety for his patients; and
    v) whether he might be causing damage to Specsavers brand/profession reputation.

21. Ms A contacted Ms B (the [redacted] Director of Specsavers's Domiciliary Services) for advice. Ms B did an initial audit of 17 of the Registrant's records from [redacted] Domiciliary, which was a combination of randomly selected records and those where patient concerns had been identified. Ms B passed her audit results to Specsavers Financial Risk Support Team (FRS).

22. Mr C (Senior Financial Risk Support Consultant for FRS) was asked to carry out an investigation into eye examinations that were performed by the Registrant between May 2023 – August 2023. In conducting his investigation Mr C gathered

evidence relating to an additional 30 patient records which were reviewed by Mr B. The investigation and the outcome are contained within the report dated 28 November 2023 which includes clinical findings from two clinicians Mr B and Ms B.

23. Following the conclusion of the investigation report these matters were referred to the Council. The Council instructed an expert, Professor Robert Harper, to independently consider these records and the mystery shopper video.

Evidence

24. The Committee read, viewed and considered:

Council's documents

- Hearing bundle dated 12 May 2025 (185 pages)
- Exhibits bundle (838 pages)
- Specsavers mystery shopper video dated 28 April 2023
- Council's Skeleton Argument (as amended dated 30 September 2025)
- a number of indexes and mapping documents to assist in navigating the bundles.

Registrant's documents

- Appendix: September 2025 Email Chain (5 pages)
- Appendix – Internal Notes & Correspondence Extracts (SN030124) (8 pages)
- Application for Dismissal dated 27 September 2025
- Email chain from GOC – appendix for SN01-20683 September 2025 (8 pages)
- Narrative Skeleton Script – Applicant's Submissions
- Statement of Mr A dated 22 April 2024

25. At the outset of the hearing the Committee confirmed with the parties the documents it had seen.

26. At the beginning of the third day, the Registrant raised concerns that the Committee had not had sight of relevant communication between Specsavers and the Council which he submitted was evidence of unfairness, collusion and included discussion relating to the alignment of witness statements. The Registrant stated that these had been provided to him by his previous representatives. He told the Committee that he had recently asked the AOP to resend the file and password to him which he would then submit to the Committee.

27. Ms Constantinide submitted that the Council had been open and transparent from the outset and there had been no attempt to suppress relevant information. She explained that the Registrant had been served with the Rule 29 bundle in November 2024 which contained all of the disclosure information. The Council then served on the Registrant the Council's hearing bundle in May 2025 and again

in advance of this hearing. This bundle contained all the evidence which the Council intended to rely upon at this hearing (it did not necessarily contain everything from the Rule 29 bundle). She submitted that the Council's bundle had not changed since May 2025 and that the Registrant had a responsibility to engage constructively and in good faith with the process and to ensure the documents he wanted to rely on were provided in good time. Ms Constantinide was concerned that the nature of the Registrant's interventions risked obstructing the fair progress of these proceedings.

28. The Committee heard legal advice on the issue which included reference to Rules 29 and 40 and its discretion to admit evidence if it is relevant and fair to do so. As the Registrant said he could not produce the documents which he wanted to rely upon, the Committee decided that it would not be appropriate to delay the proceedings at this stage. The Registrant was reminded that the Committee only had sight of the documents provided in the hearing bundles and the documents he had already provided and that it was his responsibility to provide evidence he intended to rely upon and explain the relevance and why it would be fair to admit at this late stage. The Committee informed the Registrant that if he received any further documentation from the AOP during this factual stage of the hearing which he wished to rely upon, he should send it to the Hearing Officer. The Committee would then consider whether it was fair and relevant to admit that evidence. By the end of stage one of this hearing the Registrant had not provided any further evidence.

29. The Committee heard oral evidence from Mr B (Professional Services Consultant, Specsavers), Mr C (Senior Financial Risk Support Consultant), Ms A (Retail Director, [redacted] Domiciliary, Specsavers), Ms B ([redacted] Director, Specsavers Domiciliary Services) and Professor Harper (expert witness).

Mr B

30. Mr B confirmed and adopted his witness statements dated 14 March 2024 and 10 May 2024 and the documents exhibited. The Committee and the parties confirmed that they had watched the mystery shopping video in advance of the hearing and agreed that it was not necessary to play the recording during the hearing.

31. Mr B confirmed that he provides support to the business if there are concerns which may require investigation. He had been asked to perform a review of some [30] of the Registrant's records. His approach was to consider whether the records suggested that patients were at a potential risk of harm as a result of the service the Registrant was providing.

32. In relation to Particulars 1&2, Mr B told the Committee that he examined Patient A's clinical records alongside the video of the examination. He noticed that there were records made that did not correspond with the questions he could hear the Registrant asking on the recording. He confirmed that most of the sections in the

patient's record are not auto-populated so would have required the Registrant to make an active recording, for example the muscle balance test and discussions regarding contact lenses. Mr B told the Committee that it was clear to him that the Registrant had not performed these tests but had recorded results as if he had. He believed these issues were so serious that he had to report the matter to the Council. Mr B accepted that the part of the information that related to diving was auto-populated on the patient records as "no", so although the Registrant should have amended this section, this was not the same as the active false representation for the other tests.

33. Mr B told the Committee that he had also reviewed records made by the Registrant in relation to 30 patients he had seen as part of his role as a domiciliary optometrist at [redacted]. He found that on all of the patient records the Registrant had failed to record a visual field test. He accepted that domiciliary optometrists do not have access to technology, so would have to perform tests differently than in a shop environment and sometimes not at all. For example, it is possible to do a "gross" visual field test using a finger, if it is clinically indicated.

34. When he reviewed the 30 patient records, Mr B looked for risk of patient harm which is a high bar. He said that he did not have specific regard to the Council's Standards in his review and focused on any risk of patient harm as this may require action. The store should regularly review records for record keeping etc which is a lower threshold. Mr B was taken to a written summary of his review and the aggravating factors which were recorded as follows:

- *"SN advised all 30 patients that they have lens opacities, including those who have 6/6 visual acuity in both eyes and are therefore unlikely to have any clinically significant lens opacities*
- *SN placed all 30 patients on a 12-month recall, based on the aforementioned presence of lens opacities in both eyes. This blanket recalling would not be considered reasonable in the event of a NHSE post payment verification visit.*
- *Every clinical finding e.g. optic nerve head appearance, macular appearance, is the same in both eyes for any individual patient. This is clinically impossible* [amended to highly unlikely] *and suggests a lack of care being applied when SN is examining eyes and recording his clinical findings .*
- *SN's recommends new spectacles to 100% of the 30 patients sampled, suggestive of over selling*
- *For those patients whose cataracts are potentially clinically significant there is no record of a discussion on the possibility of cataract surgery, nor were any patients recalled."*

35. Mr B confirmed that his recollection was that binocular tests were not performed in every case but that he did not think this was a patient safety issue. His concern in relation to the lens opacity records was that this was being used to justify recalling a patient in 12 months without clinical need, rather than the typical 24 months, which puts additional pressure on NHS funds.

36. In cross examination, Mr B confirmed that his witness statement was drafted after a telephone interview but that he had been sent a copy to amend before it was finalised and signed. He confirmed that he did not select the 30 patient records and believes they were provided to him by the FRS. He accepted that he did not have experience or training as a domiciliary optician, although he had provided support to the group for six months. He stated that when performing his review, he took into account the different access to equipment that would be available, for example Optical Coherence Tomography (OCT), slit lamp and visual fields testing equipment. He said that he was not aware of a different "standard" which applied to domiciliary opticians. He 100% agreed that there are limitations in domiciliary practice. During cross examination Mr B amended his opinion to say that it was highly unlikely that every clinical finding would be the same in both eyes for any individual patient, as opposed to clinically impossible.

37. Mr B said that he had no prior knowledge of the Registrant but that the concern relating to the mystery shopper and the concerns relating to his domiciliary work came to his attention in the same week. He was informed about the mystery shopping video in a telephone call with Mr D (a director in another Specsavers practice) who had been told about the contents by Mr A. Mr A was the retail director of Specsavers [redacted] who at the time of the mystery shopper video did not have the support of his clinical director due to staff absence. Mr B does not believe Mr D viewed the video.

38. Mr B was asked if he recalled making a comment internally about the likelihood of the Registrant's erasure as a result of the concerns. Mr B was unable to recall saying this but said that it is likely he said that the Registrant would almost certainly face dishonesty particulars in light of what he had seen on the video and in that situation suspension would be likely. He would definitely have advised that the concerns were sufficiently serious to refer to the regulator. Mr B did not accept that this undermined the fairness of his evidence, as he came to these conclusions after he had watched the mystery shopper video.

39. Mr B accepted that it is often the Optical Assistant (OA) who undertakes the recording of parts of a patient's record in a domiciliary setting, but added that despite this being a delegated function, the optometrist remained responsible for the accuracy of the contents of the written record. Mr B was not involved in the FRS conclusion, he only provided them with his record review. Although the mystery shopper issue fell far below the standards expected of a registered optometrist, he felt that the records he reviewed, if considered in isolation, may have been appropriate to deal with internally. He did not identify any issues of potential patient harm in the records. Mr B only reported the mystery shopper concerns to the Council.

40. Mr B said that he was not aware what, if any, training had been provided to the Registrant about domiciliary work but he would have expected an optometrist to only undertake a role within their own competencies.

41. In relation to the mystery shopper video, Mr B was asked if it would be possible to have used the fixation light on the slit lamp to act as a fixation target without necessarily giving patient verbal instructions. He agreed that it might be. He was asked if, in relation to the motility tests, it would be possible to get a patient to look up and see if both eyes are moving together. He explained that the test had both an objective and a subjective element, and the Registrant did not ask the questions for the subjective element, in addition he added that in 30 years of practice he had never heard it done this way. Mr A said that in its entirety, the Registrant spent 60 seconds on the slit lamp examination, and that it would be impossible to perform the number of tests necessary in that time. Mr B said that the muscle balance test is a very specific test, with specific equipment which he was absolutely sure the Registrant did not carry out.

Mr C

42. Mr C confirmed and adopted the contents of his witness statement dated 17 May 2024 and the associated exhibits.

43. In cross examination Mr C confirmed that the FRS investigation is a formal investigation and process that is authorised by the directors of a business following a board meeting decision. Following an investigation the FRS may recommend disciplinary steps. Mr C did not make any referral to the Council, he made recommendations to the store directors that they should take advice about whether the concerns should be referred to the Council.

44. His conclusion was that the records were inaccurate and included the results of tests inaccurately completed or recorded. Mr C is not clinically qualified so relied on the opinions of others. He based his conclusion on the evidence provided by the members of staff he interviewed and the Registrant's responses. Mr C recommended that 30 patient records be sent to Mr B and believes that the records were selected by a member of the FRS team who would have requested that the documents be sent to Mr B. Mr C was unable to recall the mechanisms of drafting his statement, but he believed there may have been a template. He cannot recall if he spoke to anyone about the process.

Ms A

45. Ms A confirmed and adopted the contents of her witness statement dated 11 June 2024 and associated exhibits. She told the Committee that she is the retail director of [redacted] Domiciliary, Specsavers. The Registrant joined her team as an optometrist partner in May 2023. She has worked as an Optical Assistant in the domiciliary situations for many years, although she is not an optometrist. She was concerned at the speed at which the Registrant conducted his tests and felt he was sales driven by recommending things to patients which were perhaps not necessary or appropriate.

46. Colleagues began to report concerns to Ms A quite soon after the Registrant started the role. For example, it had been necessary for another optometrist to visit Patient 28 to recheck a refraction prescribed by the Registrant. By August 2023, following further complaints, Ms A decided she needed to escalate the issues.

47. Ms A told the Committee that she organised a call with the Registrant on 29 August 2023 to discuss his progress and raise the concerns as she wanted a constructive and open relationship with her business partner but that this had not helped.

48. In cross examination Ms A confirmed that she had prepared and signed her statement herself. She said that she had selected the files to be sent to the FRS and included some which had been the subject of her colleague's concerns, and some at random. She said that she cannot recall if she raised concerns with him straight away but said that they did have numerous meetings about things that were missing and went through the routines. She accepted that they did not have a visual field machine at the time. She said that she did not know if he had been given any specific training for domiciliary work and does not recall him asking about training. Ms A agreed that she recalled him booking something with 3 other members of staff. She was not aware of any knowledge amongst the staff that they should be looking out for and reporting any issues with the Registrant: her focus was on the well-being of the patients and her staff.

49. Ms A told the Committee that she had only become aware that there was another ongoing concern when the Registrant himself told her, which was after she had reported her concerns. She only became aware about the other concern relating to a mystery shopper during the FRS investigation. She said that she had never seen the video and is unable to recall if she sent any emails about it. She had not been aware of any previous fitness to practise findings until the Registrant told her. Ms A accepted that she had not been happy about this as she believed it is something the business should have told her before the Registrant became her partner. She raised this with her regional manager.

50. Ms A accepted that many of the concerns arose when the Registrant was new to the role and learning the processes. She accepted that there had been a period of over a year where the team had been without an optometrist partner before the Registrant joined. She told the Committee that the office manager was responsible for the diary and that it would be usual to have between 9 and 13 patients to see in a day depending on the clinic. She accepted that issues with travel etc can arise when you are in a domiciliary role and accepted that clinics were sometimes over-booked. However, this would have been true for everyone and she expected the Registrant, as the optometrist director, to take a lead and to have spoken to the manager if he needed more time.

Ms B

51. Ms B confirmed and adopted the contents of her witness statement dated 16 May 2024 and the associated exhibits. She told the Committee that she is the

[redacted] Director of Specsavers' Domiciliary Services, which includes 42 different businesses, each with one or two individual directors. She has an overarching role across these businesses to ensure clinical performance and regulatory adherence. She explained her role as the Chair of the [redacted] Eyecare Committee and its founding principles to ensure proper standards in the domiciliary business. She explained that they established a code of practice which reflected the Council standards but with additional points relating to information sharing between businesses. The emphasis is on values of probity and honesty.

52. Ms B explained that she undertook an audit of the Registrant's records using a nationally approved method used by the NHSE. She had added additional pages which allowed the auditor to expand on the reasons for the score and concerns. Ms B felt that the use of this tool was fair as it looks for basic adequate record keeping and not perfection. She had applied the College of Optometrist's standards for record keeping.

53. Ms B audited 17 of the Registrant's records. She told the Committee that during her audit she saw repeated instances of poor record keeping which included a patient who had had cataract surgery but was still recorded as having cataracts, patients not being listened to about symptoms, inaccuracies when compared to previous records, previous records being copied across, and lack of justification for new spectacles in circumstances where no visual acuity test had been recorded. Ms B said that Ms A sent her across 10 of the patient names to include in her audit.

54. Ms B took the Committee to each of the patient records she had considered and highlighted the Particular section of concern. She explained that as a result of the recording system used at the time, if the Registrant did not record binocular vision testing then that page would not be printed out so would not appear in the bundle. When she had viewed the records she was able to see the full information on the computer system.

55. In relation to Patient 1: Ms B explained that they only had visual acuity in one eye so it would not have been clinically necessarily for the Registrant to undertake binocular vision testing. However, there is no record of visual acuity testing with their old spectacles or a near vision acuity test. Ms B agreed that she could not say definitively whether the Registrant had performed the tests, but could say that he did not record any results.

56. In relation to Patients 4, 6, 8, 9, 10, 11, 13 & 15: Ms B explained that binocular vision testing and near visual acuity testing would have been appropriate for each of the patients but was not recorded by the Registrant for the visits he undertook between May and September 2023.

57. In relation to Patients 2, 12, 14, 16 and 17: Ms B explained that there was no record of near visual acuity tests but that binocular vision testing was not or may not have been necessary.

58. In relation to Patients 5 and 7: Ms B explained that near visual acuity had been recorded but that there was no record of appropriate binocular vision testing having been carried out.

59. Ms B explained additional specific concerns in relation to particular patients. In relation to Patient 4, she was concerned that it was not clear from the records why the Registrant had prescribed new spectacles. As there was no information about his visual acuity in his old spectacles and the prescription change had been very small, it was not possible to assess if the new prescription had improved his vision at all.

60. In relation to Patient 7, Ms B was concerned that the Registrant had inappropriately prescribed two expensive sets of varifocals despite the fact the patient was awaiting cataract surgery. She explained that these would be useless to the patient after the surgery. She would have expected the surgery to take place within 18 weeks. She was also concerned that varifocals are intended to be an occupational lens and would not have been appropriate in any event. In addition, the record suggested that the patient did not use their reading glasses and there was no suggestion that they wanted to.

61. In relation to Patient 14, Ms B was concerned that records clearly state that at the time of the Registrant's appointment the patient is post cataract surgery in their right eye. However, in the ophthalmoscopy section the Registrant has reported cataracts in both eyes which must have been incorrect following the surgery. Ms B believed this was a copy and paste from the previous test record.

62. In relation to Patient 17, Ms B was concerned that the Registrant had recorded that the patient had "never had stroke over right side" despite the reason for the visit being CVA (stroke patient). Ms B explained that a stroke can affect visual field so it would have been necessary for the Registrant to have conducted a visual field test. If he did not have access to visual field testing equipment he should have undertaken a confrontation test. This had not been recorded.

63. In cross examination, Ms B confirmed that the contents of her statement were true and that she had written the document herself. She had first become aware of the concerns regarding the Registrant when Ms A had contacted her in August 2023. Ms A sent her the records: some were hand selected, but some were not. After conducting her audit, she thought there were many aspects of the tests which were missing. Due to her previous contact involvement with the Registrant, she did not want any perception of bias (positive or negative), so did not think she should be further involved in the investigation. She had become a witness of fact

at this stage because the Council had asked her to be a witness. She believed she was still able to be an impartial witness in these proceedings.

64. Ms B stated that there should have been a visual field machine in the business as all businesses had been provided with one. She wondered if Ms A might not recognise that there is one as she is not an optometrist. She believed that an average patient list for a domiciliary optometrist would be approximately 8 patients. Ms A said that she formed her conclusions based on her own review of the records and not from any comments or opinions expressed by anyone else.

65. Ms B did not agree that delegating responsibility for certain aspects of the assessment was part of the business's standard operating procedure. If parts of the assessment or completion of records are delegated they remain the responsibility of the optometrist. She believed that an optometrist should not leave the visit before tests and records are completed. She said that as a director the Registrant had the ability to dictate procedure. She told the Committee that she was sure that the process described by the Registrant was not a standard operating procedure, because these come from head office and she would have been involved in the drafting. It is the optometrist's responsibility to ensure the records are correct, regardless of what you might be told to do.

66. Ms B was asked about the training the Registrant received or should have received when he started domiciliary work. She said that she was not aware of what training he received or if he requested any. She noted that he is a qualified optometrist. She said that there was an induction programme in place now. She agreed that he might not have had the opportunity to shadow someone as there had been some staff sickness at the time. She said that she had not become aware of the mystery shopper video until after she had completed the audit. She has not seen the video and does not know what it contains. Ms B accepted that it would have been wise for Ms A to raise the concerns she had with the Registrant early on to allow him to remediate but that she would not expect a competent optometrist to need to be told to do basic tests like a near visual acuity test.

67. Following questions from the Committee, Ms B confirmed that there was no difference in the standards for record keeping in a domiciliary setting. In relation to patient 17 she said that she had thought the way the Registrant had recorded the information regarding the stroke was strange, but that had not been her main concern about that patient. Her primary concern was that there was no visual field test, no family history recorded and general lack of detail.

Professor Robert Harper

68. Professor Harper confirmed and adopted his expert report dated 8 August 2024. He confirmed his background, experience and expertise which included being an expert witness for over 20 years. He confirmed the instructions he received from the Council and the standards he applied. He said that in writing his report, he was mindful of the Council's standards, but added that there are a range of other

standards (for example NHS and professional bodies) which were also relevant. Professor Harper told the Committee that, in principle, the standards for domiciliary care and other settings are the same but that there are key differences in the way the work is done because of the setting, the type of patients and the need for portable equipment etc. Professor Harper said that he had been cognisant of this when considering the standards by which the Registrant should be judged.

69. Professor Harper was asked about the role of an optometrist and the delegation of work. He told the Committee that an optometrist remained responsible for the episode of care, including the records, but that the patient may see a number of other people to undertake some delegated tasks. These other people, including OAs would have some professional responsibility to the patient, but if the optometrist was reliant on checks by others, the optometrist must be satisfied that they had been completed and take responsibility for the records. He said that the overall responsibility remained with the optometrist throughout.

70. Professor Harper was asked about the training an optometrist should receive if changing roles/areas of practice. Professor Harper explained that the basic training of an optometrist is an undergraduate degree and a pre-registration training year, which includes assessments. After qualifying, there is an ongoing requirement for continuing professional development. He is not aware of any guidance about further training when changing roles but it is his complete expectation that every new employer should offer practical training which would set an optometrist up to deliver the service in that setting. He said that it remained the responsibility of the optometrist to raise matters and advocate for themselves to ensure they are able to discharge responsibilities and identify any training and development needs. He accepted that there have been system changes in the last years which make it tricky for optometrists to change practice areas.

71. In relation to Particular 1b(ii-iv), Professor Harper was asked if it would be possible to perform an assessment of near point convergence using a slit lamp. He explained to the Committee that in his opinion it might be possible by moving the slit lamp towards the patient, but that this would be a very informal approach. He said that the patient would need to be given very specific instructions to look at a target and that the Registrant's view of the patient would be obstructed. In his opinion this method would not meet the expected standard and a student would not be passed as competent if they performed the test this way.

72. Professor Harper was asked if it would be possible to conduct an ocular motility test using a slit lamp. He said that it would be possible, in a very substandard/crude way, to partially assess ocular motility as it would be possible to observe any restriction to eye movement. However, he explained that the correct method of testing is more subtle and refined, and involves the patient answering questions about pain/double vision at a number of different points. He said that no such questions were asked. He said that the test should be

undertaken using a pen torch without other objects restricting the patient's view. He had never heard of an optometrist using a slit lamp as a quick and easy way of testing ocular motility.

73. Professor Harper was asked if it would be possible to assess pupil reactions by using illumination without issuing any verbal instruction or using an occluder to perform a cover test. He explained that this is an objective test so it is not necessary to ask a patient any questions although he would expect an optometrist to explain what he is doing. He did not see the Registrant use an occluder on the video and there is no record of him doing so either.

74. Professor Harper was asked if it would be possible for all of the tests to be performed in 60 seconds. In his view it would not be possible to perform them adequately as the ocular motility test alone should take at least 60 seconds.

75. Professor Harper asked to correct the position in his report in relation to the concern he noted that the record incorrectly reported that Patient A did not drive, as he felt in this particular review he had done the Registrant an injustice. He explained that on his review of the documents he had found a note that records the fact that the patient is driving. There is a later point in the record that reports he is not driving so there is an inconsistency but not an omission. He told the Committee that he had only been considering if the key elements of an examination had been recorded in the patient card assessment.

76. In cross examination, Professor Harper confirmed that he relies on the report he provided to the Council. He reviewed 47 records and the record of Patient A, he did not personally select the records and does not know how they were selected. The manner in which they were selected would not change his opinion as it was a large number of records. He accepted that he could not say if other records completed by the Registrant would show the same concerns.

77. Professor Harper said that he was aware during his assessment that delegated functions were likely used but that it was not part of his instructions to investigate delegated responsibilities. He explained that the optometrist takes responsibility for the records being a true and accurate representation, even if aspects are completed by someone else. He accepted that if an OA had incorrectly recorded something or omitted information this may form part of mitigation for an optometrist but did not shift the responsibility. He agreed that it was not possible by only looking at a record to say conclusively whether or not a test had been performed.

78. Professor Harper said that he could sympathise with an optometrist who was not provided with training when switching to a new working environment like domiciliary work. However, the overall responsibility had to rest with the optometrist to ensure they are able to work in the setting, that they are offering care in accordance with standards and that they escalate concerns and/or seek training if they need to.

79. Professor Harper accepted that he had not been told in his instruction what equipment the Registrant had been provided with but said that in relation to the omission of a visual fields test, it would be possible to use a finger to do a confrontation test rather than sophisticated equipment if it was not available.

80. He said that his conclusions about the mystery shopper video were reached by viewing the recording and assessing the record card. He does not know who else viewed the recording. He said that he did not see the Registrant conducting a binocular vision test. He said that the Registrant had recorded an outcome from a fixation disparity test which had not been undertaken. He accepted that in theory an optometrist could use unconventional methods to conduct the necessary tests and still meet the required standards. However, he did not accept that using a fixation light on a slit lamp in the way suggested by the Registrant met the standard. He accepted that a reasonable body of optometrists may take a short cut on testing pupil reactions for example but that would be suboptimal and would not be clinically recommended.

81. Professor Harper said that he accepted that a Registrant should be allowed a certain period of grace when starting a new role but the fact the Registrant was new to domiciliary work did not impact his opinion. He said that such issues might provide wider context and mitigation but would not change the standards or the Registrant's responsibilities and there should be no wavering in the care provided in a domiciliary setting.

82. Professor Harper conceded that he had not appreciated the Registrant had been a director of the business during his earlier evidence to the Committee. He said that it did change his opinion, in that in the role of a director, the Registrant had an active responsibility to ensure the accuracy of records as well as the adequacy of training and processes and to effect change.

83. In response to questions from the Committee, Professor Harper explained that he had considered a number of sources in assessing the standard expected of the Registrant. He listed the basic expectations for an assessment which would include visions and an internal and external eye examination. The AOP and the College of Optometrists provide further guidance on the expected content of an assessment. He had looked at the patient records in light of these standards and checked for the core elements of the eye examination. He said that there is no sense in which an optometrist can properly say they are not aware of these components. He agreed that it may not be possible to undertake all the tests in a domiciliary setting due to complications of individual patients, but that in those circumstances the records should say it was not possible and why.

84. The Registrant informed the Committee that he did not intend to give evidence but relied on the documents he had previously provided. He provided the Committee with his written submissions on the facts which he entitled "Narrative Overview –

Fairness, Context and Professional Integrity". He confirmed that this document did not seek to introduce any new evidence but was intended to draw the Committee's attention to certain aspects of the evidence it had already heard. Within the document the Registrant had stated that there "*had been no prior findings of dishonesty or misconduct*" made against him. In light of this statement, Ms Constantinide applied to introduce rebuttal evidence of the findings made against the Registrant at a previous Fitness to Practise hearing in which particulars of dishonesty and misconduct had been found proved. The Registrant stated that the statement of good character had been cited in error by him. He objected to the information being provided and said that he had not read the previous decision as he had found it too upsetting, but that he had understood from his legal representative that there had not been any findings about dishonesty.

85. The Committee accepted the legal advice provided. It agreed that it was highly unusual for new evidence to be introduced at this stage but that it had a wide discretion, as set out in Rule 40, provided the evidence is relevant and the Committee considers it fair to do so. The Committee agreed that it needed to consider whether the probative value (in rebutting the assertion made by the Registrant) outweighed the obvious prejudicial impact of this evidence being introduced. The Committee agreed that if the new evidence could be introduced, in light of the fact the parties had not been able to formulate an agreed statement in relation to the findings, it would need to decide whether it was fair and necessary for the Council to rely on the full written determination.

86. The Committee decided that the Registrant had sought to introduce "good character" evidence to support the implied suggestion that he is less likely to have acted in the dishonest way in which he is accused. As this appeared to be an untrue assertion the Committee decided that it would be highly relevant and fair to be provided with evidence in rebuttal. However, the Committee determined that the evidence should be limited to the wording of the relevant particulars the previous committee had found proved and nothing more. Before retiring to reach a decision on the facts the Committee was provided with a partially redacted copy of the previous determination. The Committee read the particulars and the cover sheet only and satisfied itself that there had been a previous determination made against the Registrant of dishonestly recording entries for tests he had not completed and misconduct.

Findings in relation to the facts

87. The Committee heard and considered carefully the oral and written evidence, the oral and written submissions made by Ms Constantinide on behalf of the Council and the written submissions provided by the Registrant. The Committee took into account the advice of the Legal Adviser which included guidance on the burden and standard of proof, the assessment of the credibility of individuals who had given evidence, hearsay, expert evidence and dishonesty. The Committee considered each of the particulars separately.

88. In relation to the particulars of particular 1, the Committee carefully considered the Registrant's submissions in relation to the alleged unfairness created by what he asserted was the "*lack of governance and consent documentation*" surrounding the mystery shopper video and the suggestion that the video "*did not capture the full consultation or the full range of clinical activity that took place*". The Committee considered that it had heard no further evidence in relation to the alleged governance issues around the video recording since its determination on the Registrant's abuse of process argument. In light of which, the Committee did not find it necessary to revisit the issue at this stage.

89. The Committee was mindful of the fact that the Registrant had not provided any detail, document or evidence about what is said to be missing from the recording or in what way he says that the video is an incomplete visual/audio record of the consultation. The Committee carefully considered the recording and found that it could hear the audio clearly and see the Registrant's movements without any obstruction. It noted that there did not appear to be any break or gaps in the recording from the moment the mystery shopper walked into the shop to when they walked out. The Committee found that the video recording provided clear, continuous and contemporaneous evidence of what the Registrant had done and/or omitted to do and what the Registrant had said and/or omitted to say during the examination.

90. The Committee was mindful of the advice it had received in relation to its assessment of the witnesses' credibility. The Committee agreed that where there was any apparent dispute in the facts it should have careful regard to the contemporaneous documents and recordings available, which included the video recording of the Registrant's assessment/examination of Patient A and the patient records. The Committee accepted that where a witness had offered an opinion, it should treat that opinion with caution and reach its own conclusion based on all the evidence. The Committee considered the Registrant's suggestion that there had been collusion between the Council's witnesses or that they had prejudged the outcome. The Committee found that there was no evidence that this had been the case but, in any event, it would be deciding whether the Council had proved the particulars based on its own assessment of all the evidence before it including the contemporaneous evidence.

Particular 1a

1) On or around 28 April 2023 whilst working at [redacted] Visionplus Limited, you failed to perform an appropriate examination and/or assessment of Patient A's eyes in that you:

a. Failed to perform binocular vision testing; and/or

91. The Committee accepted the evidence and opinion of Professor Harper, that binocular vision testing should have been performed at Patient A's appointment. The exceptional circumstances which might have rendered the test unnecessary were not present. Furthermore, this was the patient's first appointment at the practice, he had said he had not had a sight test for 5 years and had complained about vision changes.

92. The Committee carefully considered the contents of the video recording and could find no visible footage or verbal evidence that binocular vision testing had been conducted. As detailed above, the Committee was satisfied that the recording captured the whole of the consultation. The Committee found that the Registrant had omitted basic binocular vision testing, for example using a cover test or fixation disparity test.

93. The Committee therefore found Particular 1)a proved.

Particular 1b

Recorded entries for the following despite these examinations not being performed:

i. ***fixation disparity at distance and near; (admitted)***
ii. ***near point of convergence;***
iii. ***ocular motility;***
iv. ***pupil reactions;***

94. The Committee considered Patient A's record card and agreed with Professor Harper's conclusion that the Registrant had recorded findings from checking the near point of convergence, ocular motility and pupil reactions.

95. The Committee carefully considered the contents of the video recording and could find no visible footage or verbal evidence that near point convergence or ocular motility testing had been conducted. The Committee took into account the very limited time (60 seconds) the Registrant had taken performing the slit lamp test. The Committee concluded it highly unlikely that additional tests could have been competently done in that time AND not captured in any way by the video recording.

96. The Committee noted that the Registrant did not give any evidence that he had carried out any of the examination in particular 1bii-iv, however it considered the Registrant's suggestion that it would have been possible to conduct a pupil reaction test using the illumination from the slit lamp without asking any questions of the patient. The Committee was mindful of the evidence of Professor Harper that, although sub-optimal, it may have been theoretically possible. However, given the limited time taken and the limited directions Patient A had been given about where he should look, the Committee concluded that this was insufficient to amount to a pupil reaction test.

97. The Committee therefore found particulars 1)b(ii-iv) proved. The Registrant had admitted particular 1)b(i) at the outset of the hearing.

Particular 1c

Failed to adequately examine the external eyes; and/or

98. The Committee accepted Professor Harper's evidence that the Registrant should have performed and recorded an adequate external eye examination as part of his assessment of Patient A.

99. The Committee carefully considered the contents of the video recording and could find no visible footage or verbal evidence that the Registrant had appropriately examined the external eye or lifted Patient A's eye lids at all. For the reasons set out above the Committee was satisfied that the recording captured the whole of the consultation.

100. In addition, the Committee noted that the slit lamp examination in its entirety only took 60 seconds and only involved a volk lens. The Committee recalled that Mr B had referred to the assessment as "rapid" and said that this would normally take at least 4-5 minutes. The Committee found that there was no evidence of any action or verbal cue in the recording that might suggest any external eye examination took place.

101. The Committee therefore found particular 1)c proved.

Particular 1d

Recorded 'no' for diplopia, flashes, and headaches, despite not asking the patient about these symptoms; and/or

102. The Committee considered Patient A's record card and found a record of "no" for diplopia, flashes and headaches. The Committee listened carefully to the audio of the video and found that the Registrant did not ask Patient A any questions to elicit this information and nor had Patient A volunteered the information. For the reasons set above the Committee was satisfied that the recording captured the whole of the consultation. The Committee was satisfied that this was not a pre-populated part of the patient record and would have necessitated the Registrant actively making the entry.

103. The Committee therefore found particular 1)d proved.

Particular 1e

Recorded 'no' to drive or words to that effect despite the patient responding yes to the question on driving; and/or

104. The Committee accepted the correction Professor Harper had given in his oral evidence in relation to this aspect of his expert witness report, in that the Registrant had recorded elsewhere in the record card that Patient A was a driver. The Committee found that it was able to hear the Registrant talking to Patient A about driving in the video recording.

105. The Committee carefully considered the record card as a whole and found an auto-populated section where the answer remained "no". However, given the fact the Registrant had correctly recorded the information elsewhere the Committee was not satisfied that this inconsistency reached the threshold of amounting to a failure to perform an adequate examination.

106. The Committee therefore found particular 1)e not proved.

Particular 1f

Recorded that you recommended contact lenses despite not raising this advice or topic within the examination; and/or

107. The Committee considered Patient A's record card and found that it recorded "*CL recommended yes, Reason: Reusable lenses*". The Committee listened carefully to the audio of the video and found that the Registrant did not mention contact lenses during this appointment. For the reasons set above the Committee was satisfied that the recording captured the whole of the consultation. The Committee was satisfied that this was not a pre-populated part of the patient record and would have necessitated the Registrant actively making the entry.

108. The Committee therefore found particular 1)f proved.

Particular 2

Your conduct as set out at 1)b; and/or 1)d; and/or 1)e and/or 1)f is dishonest in that you recorded findings from an eye examination which had not been undertaken; and/or

109. As the Committee had found Particular 1e not proved, it did not consider this as part of the dishonesty particular.

110. The Committee approached its consideration of the issue of dishonesty in accordance with the test established in the case of ***Ivey v Genting Casinos (UK) Ltd t/a Crockfords [2017] UKSC 67.*** The Committee reminded itself of its factual findings in relation to 1)b, 1)d and 1)f, that the Registrant had recorded findings from assessments which he had not conducted.

111. The Committee noted that it had not received a witness statement or heard evidence from the Registrant. In particular, despite admitting particular 1)b(i), the

Registrant had offered no explanation for his conduct in relation to the record he made in the absence of completing the test.

112. The Committee noted that the Registrant had over 20 years' experience as an optometrist. The Committee accepted the evidence of Professor Harper that the tests set out in the relevant Particulars should have formed part of the eye examination conducted by the Registrant. The Committee accepted the evidence of Professor Harper that the Registrant would have known that these were tests he should have completed during his assessment of Patient A and recorded in the record card. The Committee found that the Registrant, as an experienced optometrist, would be aware of the importance of accurate patient record cards. In light of the above, the Committee decided that the Registrant knew that the tests should have been completed, knew that he had not completed the tests but knowingly recorded inaccurate findings onto the record card.

113. The Committee would have expected a registrant who had a previous finding of dishonesty in relation to the accuracy of records to have been acutely aware that this behaviour should never be repeated. The Committee did not accept that the Registrant, who had been present and legally represented on the last occasion, had not been aware of this finding.

114. The Committee considered that ordinary decent people would find that an optometrist making a recording in a patient's record of a core test which he knew had not been completed, was acting dishonestly. The Committee could not find any alternative explanation of the Registrant's conduct, for example error, given the fact that the sections were not auto-populated and that the tests would have involved the Registrant making an active record. The Committee considered the suggestion which had been advanced by the Registrant that the incorrect recordings had been a result of "procedural/administrative" issues. The Committee did not accept that the additional recordings for tests which he had not done could have happened accidentally or due to administrative issues. The Committee also noted that errors or administrative issues were even less likely to occur across the multiple tests involved.

115. The Committee therefore found that the Registrant had acted dishonestly and found particular 2) proved in relation to 1)b, 1)d and 1)f.

Particular 3

Between May 2023 and September 2023, whilst you were employed at [redacted] ***Domiciliary Services Limited, you conducted inadequate eye examinations and/or assessments, for some, or all of the patients listed in Schedule A, in that you:***

a. Failed to perform and/or record binocular vision testing; and/or

116. The Committee accepted the evidence of Ms B and Professor Harper in relation to the different challenges created for an optometrist working in a domiciliary

environment, in particular in relation to access to specialised equipment and additional patient needs. The Committee remained cognisant of these challenges throughout its deliberations.

117. The Committee considered the evidence of Professor Harper, that only 3 out of the 47 patient record cards he had considered had recorded basic binocular vision testing, for example using the cover test to check ocular motility. The Committee satisfied itself that this was correct by cross referring the relevant records within the Council's bundle. The Committee found that it would be appropriate to conduct binocular vision testing in most patients unless there were exceptional circumstances (for example if a patient had a dramatic difference between eyes). The Committee was mindful that examples had been given of patients where this test would not have been appropriate, for example Ms B' evidence that it would not have been appropriate for Patient 14.

118. The Committee found that, taking into account the exceptions, the binocular vision testing would have been appropriate in the majority of the cases and there was a very high proportion where there was no record of this taking place.

119. The Committee considered the Registrant's suggestion that the test and/or the recording of the test would have been part of the delegated function given to the OAs and that he was therefore not responsible for any omission. The Committee noted that it had not received any evidence to support this suggestion. The Committee accepted the unequivocal evidence of the Council's witnesses that the responsibility for undertaking the tests and maintaining proper records remained with the optometrist throughout, regardless of any involvement of OAs. The Committee considered the Registrant's suggestion that there may have been "syncing" issues which caused the notes to fail to upload to the record. The Committee noted that it had received no evidence to support this suggestion nor any explanation as to why this would only impact part of the records.

120. The Committee agreed with the evidence of Professor Harper, that as a registered optometrist, the Registrant had a responsibility to raise any concerns he had about working practices in his new team. The Committee accepted that the Registrant's responsibility in this regard was heightened as a result of his position as Director.

121. The Committee considered whether the absence of the recording of a test proved on the balance of probabilities that the Registrant had not undertaken the test. The Committee determined that the Registrant, as an experienced optometrist would have been aware of the necessity to keep accurate records and the professional mantra "if it is not written down, it did not happen". The Committee also noted that the omission of the record was not an occasional issue and was part of patient records with detail recorded in other sections. The Committee therefore concluded that it was more likely than not that the Registrant had not performed the test at all.

122. The Committee therefore found Particular 3)a, proved.

Particular 3b

Failed to measure and/or record near visual acuity; and/or

123. The Committee considered the evidence of Professor Harper, that only 10 out of the 47 patient record cards had recorded a near visual acuity test. The Committee satisfied itself that this was correct by cross referring the relevant records within the Council's bundle. The Committee found that, given many of the patients would have been elderly in a domiciliary setting, it would be appropriate to test near visual acuity for all patients (or to have recorded why one had not been possible) and that the test and ensuring the record card was accurate would have been the responsibility of the optometrist.

124. The Committee found that, taking into account any exceptions, a near visual acuity test would have been appropriate in the majority of the cases and there was a very high proportion where there was no record of this taking place.

125. For the reasons set out above in paragraphs 120 to 122, the Committee concluded that the test and the record were the Registrant's responsibility and that it was more likely than not that the Registrant had not performed the test at all.

126. The Committee therefore found Particular 3)b, proved.

Particular 4

On or around 30 June 2023, you conducted an inadequate eye examination and/or assessment on Patient 30 in that you failed to assess and/or record visual field tests; and/or

127. The Committee accepted the evidence of Professor Harper, that it was necessary for the Registrant to test and/or record visual field tests for Patient 30 because they had recently suffered from a stroke. The Committee was satisfied that there was no recording on a visual field test section of the record card, for the relevant day, as it was blank.

128. The Committee accepted that there may have been limitations imposed on the Registrant as a result of this assessment taking place in a domiciliary setting. However, the Committee accepted the evidence of Professor Harper and Ms B, that the Registrant should have at least attempted a gross visual field test using his finger or an appropriate target if the equipment had not been available. If this had not been possible, then the reason why the tests could not have been performed should have been recorded.

129. The Committee considered that in most other respects, Patient 30's record card contained detailed notes of the tests and results. The Committee therefore

determined that if the Registrant had completed a visual field test the results would have been recorded.

130. For the reasons set out above in paragraphs 120-122, the Committee concluded that the test and the record were the Registrant's responsibility and that it was more likely than not that the Registrant had not performed the test at all.

131. The Committee therefore found Particular 4, proved.

Particular 5a

5. On or around 23 August 2023, you conducted an inadequate eye examination and/or assessment on Patient 17 in that you:

a. Recorded "never had a stroke over right side" and "right eye vision no good," or words to that effect, despite the patients eligibility for the test being for cerebrovascular accident or stroke; and/or

132. The Committee agreed with the Registrant's assertion to the Council's witnesses that his entry had some punctuation missing which would have clarified the intended meaning, e.g. if a comma had been inserted between the words "never" and "had". The Committee noted that the Registrant had not generally punctuated his comments in the free text and therefore his explanation was feasible. The Committee also noted that the Council witnesses were not of the opinion that the issue with the notes recorded by the Registrant was particularly serious.

133. The Committee therefore concluded that although the record could have been clearer this was not sufficient to render the Registrant's assessment of Patient 17 inadequate in this regard.

134. The Committee therefore found Particular 5)a, not proved.

Particular 5b

b. Failed to assess and/or record a confrontation or manual peripheral visual field test; and/or

135. The Committee accepted the evidence of Professor Harper, that it was necessary for the Registrant to test and record a confrontation or manual peripheral visual field test for Patient 17 because they had recently suffered from a stroke. The Committee was satisfied that there was no recording of such a test on the patient's record card for the relevant day.

136. For the reasons set out in paragraphs 120-122 above, the Committee concluded that the test and the record were the Registrant's responsibility and that it was more likely than not that the Registrant had not performed the test at all.

137. The Committee therefore found Particular 5)b, proved.

Particular 6a

6) On or around 12 May 2023, you conducted an inadequate eye examination and/or assessment on Patient 42 in that you:

a. Failed to perform and/or record a cover test; and/or

138. The Committee accepted the evidence of Professor Harper that it would have been necessary to undertake a cover test on Patient 42, as part of a basic eye examination. If there had been particular issues which had prevented the Registrant from undertaking the test then that should have been recorded.

139. The Committee was satisfied that there was no recording of a cover test on the patient's record card for the relevant day.

140. For the reasons set out in paragraphs 120 to 122 above, the Committee concluded that the test and the record were the Registrant's responsibility and that it was more likely than not that the Registrant had not performed the test at all.

141. The Committee therefore found Particular 6)a, proved.

Particular 6b

b. Failed to record any ocular history for the patient or their family ocular history; and/or

142. The Committee accepted the evidence of Professor Harper that recording ocular history and any family ocular history should have formed a standard part of the Registrant's eye examination of this patient.

143. The Committee noted that the record card states that at least one family member had been present at the assessment which would have allowed the Registrant another opportunity to gather the information if the patient had been unable to respond. The Committee noted that Patient 42 had dementia, and this may have caused the Registrant difficulty in eliciting correct and relevant answers from the patient. However, the Committee noted that Patient 42's son was present for the eye examination and considered that if the patient was unable to impart information the family member could have been asked relevant questions and the answers recorded appropriately.

144. For the reasons set out above in paragraphs 120-122, the Committee concluded that recording the ocular and family ocular history was the Registrant's responsibility and that it was more likely than not that the Registrant had not asked the relevant questions at all.

145. The Committee therefore found Particular 6)b, proved.

Particular 7

On or around 19 July 2023, you conducted an inadequate eye examination and/or assessment on Patient 47 in that you recorded a conflicting entry about the presence or absence of retinal vessel 'nipping'; and/or

146. The Committee noted that this was a detailed patient record card which recorded information relating to the retinal vessel "nipping" in two different places. The entries were not consistent with each other.

147. The Committee accepted the evidence of Professor Harper that although there may have been some 'copying over' from an earlier record which could have resulted in the conflicting entries, while this is certainly sub-optimal, it is not sufficient to render the eye examination inadequate.

148. The Committee therefore found Particular 7), not proved.

Particular 8

On or around 13 June 2023, you conducted an inadequate eye examination and/or assessment on Patient 14 in that you incorrectly recorded right eye cataract despite the patient having had right eye cataract surgery; and/or

149. The Committee carefully considered Patient 14's record card and found that it recorded that the patient had a right eye cataract despite having recently undergone cataract surgery. The Committee considered, for the reasons set out above in paragraphs 120-122, that the Registrant was responsible for the records being an accurate reflection of the assessment.

150. The Committee noted that the patient's recent cataract surgery was the key reason for the visit. The Registrant had recorded something that could not have been there (ie a cataract in the right eye) if the assessment had been properly carried out. The Registrant had therefore conducted an inadequate eye examination and/or assessment.

151. The Committee therefore found Particular 8), proved.

Particular 9

On or around 11 August 2023, you conducted an inadequate eye examination and/or assessment on Patient 4 in that you failed to record your reasons for prescribing, despite the prescription being marginal, and the habitual visual acuity and near visual acuity not supporting the prescription; and/or

152. The Committee carefully considered the patient record card for Patient 4 and noted that in their right eye there was a significant change in prescription that resulted in an improvement in visual acuity compared to Patient 4's current spectacles. The Committee found that this provided a clinical justification for changing the patient's prescription.

153. The Committee therefore found Particular 9) not proved.

Particular 10

On or around 19 July 2023, you conducted an inadequate eye examination and/or assessment on Patient 7 in that you prescribed varifocals despite referring the patient for cataract surgery; and/or

154. The Committee considered the evidence of Professor Harper that "the Registrant has referred the patient for consideration for cataract surgery and yet recommended and prescribed varifocals. There would appear to be little justification for prescribing new spectacles here at this stage …at face value on this record, it looks to be a decision that was unlikely to be in the patient's best interests."

155. The Committee accepted the evidence from the Council's witnesses that the patient was likely to have received cataract surgery within 18 weeks of the referral. However, the Committee considered that there may be circumstances when it could be acceptable to recommend a prescription even if it would only make a small improvement or for a short period of time, if the patient understood this.

156. The Committee considered the patient record card and concluded that there was no evidence of any benefit this patient would have received as a result of the new prescription or the choice of varifocals. The record suggests that the new prescription produced no change in distance vision and only a slight difference in the reading element. The patient was recorded as not wearing reading glasses.

157. The Committee therefore found Particular 10, proved.

Findings in relation to misconduct

158. The Committee heard submissions on behalf of the Council and the Registrant. Ms Constantinide adopted the relevant paragraphs within her skeleton argument dated 30 September 2025. In addition, she submitted that the Registrant's conduct fell far below the standards expected of registrant optometrists in that:

- The behaviour was sustained and demonstrated a deliberate disregard for the standards.
- He had misrepresented the care he had provided and distorted patient records by recording false information.
- By creating misleading records his behaviour could impact a patient's ongoing care and put obstacles in the way of future practitioners.
- Patient care and safety should be at the forefront of an optometrist's actions. Although there was no actual harm recorded, the Registrant's actions created a real risk of harm as the patients may not have received the care required.

159. Ms Constantinide suggested that the Registrant's behaviour amounted to a serious departure from the following standards of practice for optometrists and dispensing opticians:

1.1 Listen to patients and ensure that they are at the heart of the decisions made about their care
1.5 Where possible, modify your care and treatment based on your patient's needs and preferences without compromising their safety.
7.1 Conduct an adequate assessment for the purposes of the optical consultation, including where necessary any relevant medical, family and social history of the patient. This may include current symptoms, personal beliefs, cultural factors and vulnerabilities.
7.5 Provide effective patient care and treatments based on current good practice.
16.1 Act with honesty and integrity to maintain public trust and confidence in your profession.
17.1 Ensure your conduct, whether or not connected to your professional practice, does not damage public confidence in you or your profession.
17.3 Be aware of and comply with the law and regulations that affect your practice, and all the requirements of the General Optical Council.

160. The Registrant stated that he accepted the Committee's findings on the facts and that he takes full responsibility for his actions and failures. He explained that the situations arose from misunderstandings and procedural issues and not as a result of any intention or dishonesty on his part. He now realised that he needed to take more time on examinations even if a patient had no symptoms and that informal observations are not enough. He said that sometimes the forms used necessitated completing certain sections before they would close down, for example the contact lens section, and that he completed these sections for this reason and not with the intention to mislead.

161. The Registrant stated that when he started in the domiciliary setting he followed the existing internal systems and had not realised that if functions were delegated they remained the responsibility of the optometrist. He now accepted this was wrong. He apologised to the Committee for the sentence in his previous written submissions which stated he had no previous findings for dishonesty or misconduct. The sentence had been left in from the template in error and he had not realised the previous decision had included findings of dishonesty. The Registrant submitted that his conduct arose from misunderstandings. He accepted that there had been professional shortcomings but that these did not reach the high threshold for misconduct.

162. The Committee took into account the advice of the Legal Adviser which included guidance on the meaning of misconduct derived from the case of Roylance v GMC (no 2) [2000] 1 AC 311 and Nandi v General Medical Council [2004] EWHC 2317 (Admin), misconduct in the context of dishonesty particulars (Lawrence v General Medical Council [2015] EWHC 586) and the approach to be taken if the individual particulars are not serious in themselves (Schodlok v General Medical Council [2015] EWCA Civ 769).

163. The Committee accepted the advice of the Legal Adviser and noted that the decision on misconduct was a matter of judgement for the panel and that there was no burden or standard of proof. The Committee considered each particular found proved separately to determine if it fell far below the expected standard and amounted to misconduct.

164. In relation to Particular 1, the Committee found that maintaining adequate patient records is one of the key standards of practice for optometrists. The Committee noted the opinion of Professor Harper that the record keeping inconsistencies in respect of the Registrant's examination of Patient A reflected a serious concern. The Committee noted that Patient A presented as a new patient to the practice meaning this assessment was the baseline assessment and the incorrect record would mislead and misguide future practitioners.

165. The Committee considered each of the sub particulars. The Committee found that binocular vision was a key test that should have been carried out on Patient A, particularly because he had complained of poor vision at the end of the day. This was compounded by the fact that the Registrant also failed to carry out the fixation disparity at distance and near, near point of convergence, ocular motility and pupil reactions. By failing to carry out any binocular vision testing in these circumstances, the Registrant risked causing Patient A harm. The Committee found that in relation to Particular 1)a, the Registrant's failing fell far below the standard expected of a registered optometrist.

166. The Committee found that by recording entries for key examinations that had not been undertaken, the Registrant undermined the integrity of the Patient A's records and breached a core standard of the profession by failing to maintain adequate patient records. The Committee found that this put Patient A at risk of harm as it could have masked problems or misled other professionals and that in relation to Particular 1)b, the Registrant's actions fell far below the expected standards.

167. The Committee considered that an adequate external eye examination should have been conducted on Patient A, however given the lack of evidence of symptoms/history specific to the need for this test, the Committee agreed with the opinion of Professor Harper that in relation to Particular 1)c, the Registrant's failing fell below but not far below the expected standards.

168. The Committee disagreed with Professor Harper when he concluded that recording "*no*" for diplopia, flashes and headaches when Patient A had not been asked, was "sub-optimal…but not a failing falling below" the standards. The Committee found that in the context of the other failings this was part of a pattern of complete disregard for the necessary standards of the assessment. The Committee did not accept that it was merely a "record keeping inconsistency". The Committee found that this put Patient A at risk of harm as it could have masked

other problems or misled other professionals and that in relation to Particular 1)d, the Registrant's actions fell far below the standards.

169. However, the Committee agreed with Professor Harper that the incorrect record related to the contact lenses (Particular1)f) was more likely to have been a record keeping inconsistency and did not put the patient at any risk of harm. Therefore, Particular 1f did not amount to serious misconduct.

170. Considering Particulars 1)a, 1)b, & 1)d, the Committee determined that by failing to perform an appropriate assessment of Patient A's eyes the Registrant's conduct fell far below the standards and amounted to the statutory ground of misconduct.

171. The Committee found that by dishonestly adding information about test results and answers to Patient A's records which the Registrant knew related to tests not undertaken or questions not asked, the Registrant acted in a way that is likely to undermine public confidence in the profession as a whole. The public expect and are entitled to rely on the honesty and integrity of a registered optometrist, this is aggravated by the fact that the Registrant's dishonest actions are directly linked to his professional role. His actions were deliberate and repeated across a number of tests. The Committee found that he was dishonestly covering up for rushing his assessment and was not putting patient care at the forefront of his assessment. His dishonest actions fell far below the standard expected of a registered optometrist. The Committee therefore found that in relation to Particular 2, the statutory ground for misconduct was made out.

172. In relation to Particular 3)a, the Committee determined that the cover test would have been necessary to check binocular vision in the majority of the cases reviewed by Professor Harper. By only carrying out this test in 3 out of 47 assessments, despite this being a relatively quick check, the Registrant's examinations posed a risk to individual patients in relation to their eyecare. The Committee found that given the number of records involved this was not a mistake but a pattern of working. Given the likely vulnerabilities of the 47 patients whose records were assessed, the Committee determined that there was an increased chance that these risks may convert into potential harm for patients in terms of their general and/or ophthalmic wellbeing and related quality of life. The Committee found that the Registrant's assessments fell far below the standard expected and the statutory ground for misconduct was made out.

173. In relation to Particular 3)b, the Committee agreed with Professor Harper that by failing to measure near visual acuity in 37 of the 47 cases the Registrant conduct had fallen far below the standard expected. The Committee found that this was a necessary test in the majority of cases (unless there were recorded exceptional circumstances) and that the seriousness of the omission was aggravated by the fact that many of the patients were elderly and infirm. The patient records indicated elsewhere (eg notes) that they were complaining of reduced near vision and/or difficulties reading and therefore this test was relevant. The Registrant's omissions

risked potential harm to the patients' wellbeing and/or quality of life. This was not a mistake but a pattern of working. The Committee found that the Registrant's assessments fell far below the standard expected and the statutory ground for misconduct is made out.

174. In relation to Particulars 4 and 5)b, the Committee did not agree with the assessment of Professor Harper that the failure to conduct a confrontation or visual field test fell below, but not far below the standards expected. The Committee considered that checking the confrontation and visual field on a stroke patient is essential to determine whether their peripheral vision has been affected. The Committee found that there was a real risk of harm to both patients by the Registrant's omission and that his actions fell far below the standards expected and that the statutory ground for misconduct is made out.

175. In relation to Particular 6, the Committee determined that the cover test would have been a core requirement of an assessment of a new patient without a previous record. The Committee noted that Professor Harper had not offered an opinion as to whether this fell far below the expected standard. The Committee decided that by failing to carry out a core requirement of the assessment for a new patient with additional vulnerabilities (dementia), the Registrant's conduct put the patient at risk of harm and had fallen far below the standards expected. The statutory ground for misconduct was made out in relation to Particular 6)a.

176. Regarding Particular 6)b, although the Committee noted that there had been a missed opportunity to gather the relevant information as the patient's son had been present at the assessment, the Committee agreed with Professor Harper that failing to record any ocular or family ocular history in these circumstances, fell below the standard expected, but not far below.

177. In relation to Particular 8, the Committee did not agree with Professor Harper's assessment that this could be described as an "odd documentation error". The Committee considered that this was part of a pattern of behaviour where the Registrant took shortcuts in his assessments and/or record keeping and not provided appropriate care to his patients. In this case, the patient had requested a sight test because they had had recent cataract surgery. By incorrectly recording old and redundant information stating that he had seen a cataract in the right eye, which suggested an inadequate eye examination, the Registrant's actions fell far below the standards, and the statutory ground of misconduct was made out.

178. In relation to Particular 10, the Committee noted that there was no real clinical justification for the Registrant to prescribe the varifocals to the patient. This was aggravated by the vulnerabilities of the patient and the short time before cataract surgery which would render the spectacles obsolete. The Committee considered that as a director the Registrant had a financial interest in the profit of the business. The Committee determined that recommending unnecessary spectacles to a

vulnerable patient would have caused financial harm. It would also undermine the public's confidence in an optometrist to only recommend products if they are in the patient's best interest and not for financial gain to the business. The Committee found the Registrant's actions fell far below the standards expected and that the statutory ground of misconduct is made out.

179. The Committee determined that the Registrant had breached the standards as set out in paragraph 160 above.

Findings regarding impairment

180. The Committee heard submissions on the question of impairment from Ms Constantinide on behalf of the Council and received written submissions from the Registrant. It considered all of the documentary evidence before it, and the additional documents provided by the Registrant which included testimonial evidence, CPD training logs and reports provided by his work-place supervisor for the purpose of meeting his interim order requirements and a detailed reflective statement.

181. On behalf of the Council, Ms Constantinide adopted the relevant paragraphs in her skeleton argument. In addition, she submitted that although no actual harm had been caused by the Registrant's acts and omissions there had been a clear risk of harm caused to the continuity of patient care. She submitted that dishonesty falls at the more serious end of the spectrum of misconduct. She said that the previous finding of dishonesty was a serious aggravating factor and raised concerns about the Registrant's willingness and ability to comply with the standards in the future.

182. Ms Constantinide reminded the Committee that the particulars found proved arose from conduct in two separate practices and were not an isolated transgression. She said that concerns had been raised by individuals at all levels demonstrating widespread concern. She submitted that the Registrant had failed to demonstrate any real insight and there was limited evidence of remediation. As such there remained a real risk of repetition. She submitted that the threshold for demonstrating remediation is high in dishonesty cases. She further submitted that a finding of impairment was required to meet the wider public interest and maintain public confidence in the profession. She drew the Committee's attention to the principles established in caselaw outlined in her Council's skeleton argument, including in the case ***Council for Healthcare Regulatory Excellence v NMC and Grant*** [2011] EWHC 927 (admin) and ***Kimmance v General Medical Council [***2016] EWHC 1808 (Admin).

183. The Registrant provided the Committee with a written reflective statement but did not give evidence. In his statement the Registrant addressed:

- Insight and acceptance of misconduct – he accepted the Committee's findings in full and stated that he had spent "*considerable time*" considering the impact of failing to perform proper examinations and recording false/incomplete

information on the records. He accepted that he had struggled to see the situation objectively and been overly focused on procedural unfairness and witness credibility rather than reflection and acceptance at the outset of the hearing.

- Remediation and steps taken – he stated that he has actively pursued further education with targeted CPD courses and overhauled his approach to examinations and record keeping. He said he now understood that delegation does not absolve professional responsibility. He said that he has complied with interim conditions of practice for the last 2 years which had included working under supervision, submitting reports on his practice and audits. He said that no concerns had been raised during this period and the Committee was provided with his supervisory reports which had been sent to the Council in compliance with his conditions at his request. He said that the effectiveness of his remediation is evident in his practice today and that there had been "*a direct change in mindset from two years ago, where* [he] *might have felt compelled to rush or cut a corner due to time or system constraints. Now, patient welfare and accuracy trump all else in* [his] *daily decision making*".
- Honesty and integrity – he stated that he deeply regretted acting dishonestly and understood the impact this had on the profession as a whole. He submitted that he had demonstrated his honesty during the proceedings when he had immediately clarified the misrepresentation about his previous good character and taken full responsibility for the error. He said that it had never been his intention to deceive.
- Risk of repetition – he submitted that he has systematically removed any factors which led to the misconduct, prioritised thoroughness over speed and developed better time-management and organisational skills. He stated that "*this fitness to practise process has been one of the most profound experiences of my life. It has been stressful and chastening, but ultimately enlightening. I can say with absolute certainty that I never want to undergo such a process again".* He said that the evidence of his practice from the past two years supports a low risk of repetition.

184. The Committee accepted the advice of the Legal Adviser. In summary, the Legal Adviser reminded the Committee to consider whether the Registrant's fitness to practise was currently impaired; taking into account the nature and seriousness of the conduct; whether it was remediable, had been remedied and what the likelihood of repetition was. She further reminded the Committee that it should have regard to the wider public interest and whether a finding of impairment was necessary to uphold public confidence in the profession. She provided the Committee with specific guidance from the case of ***Sawati v GMC*** [2022] EWHC 283 (Admin) in relation to the suggested approach to the issue of insight when a registrant has denied the particulars.

185. The Committee had regard to the Standards it had identified as being breached, and the nature and seriousness of the acts and omissions and the dishonest conduct. It took into account the guidance in the Council's Hearings and Indicative Sanctions Guidance.

186. The Committee determined that in light of its findings on misconduct the Registrant had in the past acted in a way so as to put patients at risk of harm and brought the profession into disrepute. The Committee found that conducting adequate assessments based on the needs of the patient, maintaining accurate records and acting with honesty and integrity are fundamental tenets of the profession which the Registrant had breached.

187. The Committee considered whether the conduct was remediable and whether it had been remedied. The Committee found that the behaviour relating to the inadequate eye examinations was remediable. In deciding whether the Registrant has remedied his misconduct, the Committee had regard to the remediation undertaken and the level of insight he has shown. The Committee considered the Registrant's detailed reflective statement. The Committee was encouraged with the contents of the statement and by the positive reports provided to the Council during the interim conditions of order which suggested that positive steps had been made towards remediation. However, the Committee noted that an individual's practice when under a known spotlight is not a guarantee of future behaviour.

188. The Committee also noted that there was no suggestion that the Registrant had not been aware of the tests he needed to complete or that records needed to be accurate; rather it appeared that the Registrant knew what he was supposed to do but had chosen not to do it. The Committee found that this was an attitudinal problem which the Registrant did not appear to have addressed or reflected on.

189. The Committee accepted that the Registrant had demonstrated developing insight in his written reflections but noted that this was at odds with his position during the rest of the hearing. Although the Registrant had not given evidence, the Committee considered that the questions asked by the Registrant of the Council's witnesses implied that he tended to deflect responsibility for his own actions and minimise the seriousness of the concerns. Throughout this hearing he had categorised his record keeping failings as "*procedural or administrative rather than clinical or ethical in nature*". The Committee accepted that the Registrant had been self-representing and that the proceedings would have been very taxing to be a part of. However, the Committee felt there had been many years of missed opportunities for the Registrant to reflect on the concerns of his colleagues and in particular the recording from the mystery shopper, rather than focus on a perceived unfairness in the process by which the video recording had been sent to the Council and his perception of collusion by colleagues.

190. The Committee noted that in his written reflections the Registrant stated that he had changed his practices and now approaches records with care. However, this appeared to be at odds with the document provided to the Committee during this hearing which contained inaccuracies on key points of character and previous findings.

191. The Committee did not feel able to attach much weight to the documents provided as testimonials given their format. The Registrant explained that he had written the documents following telephone conversations with the individuals who had verbally confirmed the contents. The documents had not been signed by those individuals, two of whom were anonymised and two from immediate family members.

192. The Committee next considered whether the dishonest conduct was remediable. It determined that whilst such conduct, being attitudinal in nature, may be more difficult to remedy than other types of misconduct, it was theoretically possible for a registrant to demonstrate they had remedied their dishonest conduct. The Committee found that the Registrant had shown some very recent developing insight in his written reflection statement into the negative effect dishonesty has on the public perception of the profession. The Committee was troubled that the Registrant said that he had not read the previous Committee's findings, including on dishonesty, from his first fitness to practise hearing. The Committee considered that this potentially showed a disregard for the regulatory process and an unwillingness to develop meaningful insight and remediation.

193. The Committee was mindful of the approach endorsed in ***Sawati*** when considering the relevance of the Registrant's denial of the particulars during the hearing. The Committee found that the particular of dishonesty had been one of the main particulars, that the Registrant's denial had been comprehensive and that there had been no evidence of insight until the written reflections provided at this late stage.

194. The Committee found that the previous finding against the Registrant for dishonesty was an aggravating factor and added to the risk of the behaviour being repeated.

195. In light of the above, the Committee decided that there remains a risk of repetition of the behaviour related to the inadequate assessments and the dishonesty. Therefore, it considered the Registrant may, in the future, bring the reputation of the profession into disrepute, or breach a fundamental tenet or act dishonestly.

196. The Committee also considered whether a finding of impairment was necessary to ensure public confidence in the profession and to declare and uphold standards. It had regard to the nature of the dishonest conduct.

197. In all these circumstances, the Committee was of the view that the public interest in declaring and upholding standards for the profession outweighed any remediation, insight and remorse demonstrated by the Registrant more recently. Such dishonesty meant that there had been an unwarranted risk of harm to patients resulting from the false records. The dishonesty struck at the heart of the Registrant's professional and ethical obligations. A reasonable and well-informed

member of the public would expect a finding of current impairment, particularly in light of the fact that this is a second finding of dishonesty for similar issues (ie making false entries in patient records when clinical tests had not, in fact, been performed). Public confidence in the profession would be undermined if a finding of impairment were not made.

198. The Committee therefore found that the Registrant's fitness to practise is currently impaired.

Sanction

199. The Committee read the relevant paragraphs of the Council's skeleton argument and heard oral submissions from Ms Constantinide. She submitted that this was the Registrant's second finding of dishonesty, which lies at the top end of the gravity spectrum of misconduct. She reminded the Committee that the facts found proved involved issues which spanned two practices and had been raised by colleagues at all levels. She reminded the Committee of key aspects of their findings at the previous stages. In conclusion, Ms Constantinide submitted that a period of suspension or erasure from the register would be the fair and proportionate sanctions to impose in these circumstances.

200. The Committee heard oral submissions from the Registrant. He asked the Committee to accept the written testimonials he had provided, despite their unusual format. He apologised for the way he had presented his defence during the hearing which he said had been borne out of distress, confusion and defensiveness. He accepted that his focus had been on legal arguments without taking into account the full scope of the purpose of the hearing. The Registrant said that he had spent a lot of time reflecting on his previous actions and had taken practical steps to ensure they were not repeated. He had reviewed the standards and undertaken CPD training. He told the Committee that he remained committed to practising safely and the previous concerns do not represent him as a practitioner today.

201. The Registrant explained to the Committee that there would be a severe impact on [redacted] if he was unable to return to practice. He had built a practice in his local area over 14 years which provided an important service to members of the public in a deprived area. He informed the Committee that both "lapses" occurred about the times of [redacted] and that this may have influenced his conduct. The Registrant said that he would accept any other sanction including suspension but asked the Committee not to erase him.

202. The Committee accepted the advice of the Legal Adviser who reminded it that the choice of sanction is a matter for the Committee's independent judgment, that the purpose of sanction is not to punish the Registrant but to uphold the public interest, and that any sanction must be proportionate. The Committee took into account

the Hearings and Indicative Sanctions Guidance and all the relevant evidence and material which had been placed before it.

203. The Committee identified the following mitigating factors:

- Some evidence of developing insight towards the latter end of the hearing and some evidence of remediation;
- Evidence that the Registrant had worked well under the interim order;
- Some evidence of positive testimonials;
- No evidence of actual harm to patients;
- Likely financial hardship to the Registrant and family if prevented from practising.

204. The Committee identified the following aggravating factors:

- Previous fitness to practise finding;
- Repetition of dishonesty in relation to patient records found on the last occasion;
- Repetition of issues regarding the accuracy of records and the adequacy of assessments undertaken;
- This current misconduct occurred in two different optical settings;
- Risk of harm to patients, some of whom were vulnerable;
- Experienced practitioner acting at a director level for some of the concerns;
- Lack of acceptance of responsibility and insight until latter stages of the proceedings.

205. The Committee considered the sanction of no action but concluded that the misconduct found proved was too serious and having identified a risk of repetition, this would fail to protect the public or to uphold the standards of the profession. The Committee did not consider a financial penalty to be suitable in these circumstances.

206. The Committee considered conditional registration. The Committee took into account the fact that the Registrant had fully complied with the interim conditions of practice order. However, the Committee did not believe that the risks identified in relation to dishonesty which has now been found proved could be properly met by workable, proportionate conditions. The Committee was mindful that it had also now found that the Registrant had known what to do regarding testing and record keeping but had chosen not to do it. The Committee also considered that the misconduct had been underpinned by attitudinal issues, including that of dishonesty, which conditions would struggle to mitigate. The Committee also concluded that the confidence in the profession and the regulator would not be upheld if a sanction of conditional registration was imposed on a registrant for a second fitness to practise finding in relation to dishonesty.

207. The Committee went on to consider a sanction of suspension and was guided by paragraph 21.29 of the Council's Indicative Sanctions Guidance. The Committee found that there had been a serious instance of misconduct where a lesser sanction was not sufficient. The Committee found that there was evidence of attitudinal problems, including dishonesty.

208. The Committee was concerned that the facts found proved had only come to the attention of the regulator as a result of observations by the Registrant's colleagues, either on a mystery shopper video or in person. The Committee understood that the Registrant was currently a sole practitioner with his own practice and that there was a real risk that, in the absence of professional observation, he may return to taking short cuts in his assessments and creating inaccurate records. The Committee carefully considered whether the facts found proved resulted in a fundamental incompatibility with the Registrant remaining on the register at all. The Committee was mindful that the dishonesty finding had been limited to one incident in this hearing and, although always serious, was not at the highest level of dishonesty, as there had been no patient harm or financial benefit to the Registrant in Particular 2.

209. The Committee was satisfied that the Registrant has demonstrated some developing insight but was very much at the beginning of that process. The Committee noted that even at the final stage when making his submissions on sanction the Registrant still sought to shift responsibility to the OAs he had worked with in relation to the Committee's findings on Particular 10.

210. The Committee carefully considered whether the sanction of erasure was necessary in these circumstances. The Committee recognised that this is a sanction of last resort and on a finely balanced assessment of all of the relevant information concluded that a period of suspension is the appropriate and proportionate sanction to protect the public and uphold the standards of the profession. The Committee considered that a period of 12 months is necessary given all of the above.

211. The Committee considered that a period of suspension would protect the public and allow the Registrant an opportunity to genuinely remediate and demonstrate lasting effective insight. It would also uphold public confidence in the profession.

212. The Committee directs that there be a review of the suspension order four to six weeks prior to the expiration of this other. It is likely that the Review Committee may be assisted by evidence that the Registrant:

- Has read this determination in full and has fully appreciated and reflected on the gravity of the misconduct and the Committee's findings at all stages;
- Has undertaken targeted CPD training on honesty, accepting personal responsibility, ethical standards, professionalism and the importance of accurate record keeping.

- Has produced signed and dated testimonials from named patients and non-family members who confirm that they are aware of this Committee's findings.
- Has maintained his skills and knowledge and
- That the Registrant's patients will not be placed at risk by resumption of practice

Immediate order

213. Given its findings, the Committee then invited submissions on whether it was necessary to impose an immediate suspension order to cover the 28 day period or, if any appeal is lodged, the period until the appeal is resolved.

214. The Committee heard submissions from Ms Constantinide on behalf of the Council who submitted that it is necessary for the protection of members of the public, upholding public confidence and the Registrant's own best interests.

215. The Registrant did not object to the Council's submissions other than in relation to the order being in his own interest. He informed the Committee that he intends to appeal the decision based on the procedural and governance issues but not in relation to the integrity of the Committee and thanked the Committee for its fairness.

216. The Committee accepted advice from their Legal Adviser that an immediate order can only be made if the Committee is satisfied that such an order is **necessary** for the protection of members of the public, otherwise in the public interest or in the best interests of the Registrant.

217. This is a case where the Committee has found that there is incomplete insight, and there remains a risk to the public. The Committee therefore considered that an immediate order is required to protect the public.

218. The Committee also considered that in a case where the misconduct was so serious that a suspension is required, the public would expect there to be interim measures in place during the appeal period, in order to maintain confidence in the professional and uphold standards. In light of this, the Committee has decided that there is a need for interim measures to be put in place during the appeal period.

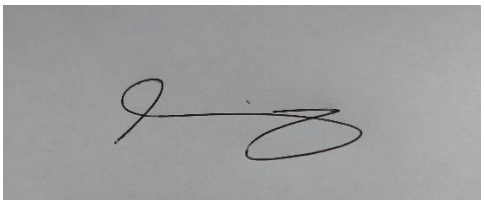
219. The Committee considered that an immediate conditions of practice order would not be appropriate for the same reasons as had been given in its decision on the substantive order.

220. The Committee therefore determined that the Registrant's registration be suspended on an immediate basis.

Revocation of interim order

221. The Committee hereby revokes the interim order for conditional registration that was imposed on 20 October 2023.

Chair of the Committee: Sarah Hamilton

Signature  **Date: 10 October 2025**

Registrant: Shahid Nazir

Signature ……present via video link …… **Date: 10 October 2025**

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