BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(26)09

AND

MICHAEL BEARD (01-16313)

DETERMINATION OF A SUBSTANTIVE HEARING
25-28 AUGUST & 01-02 SEPTEMBER 2026

Committee Members:	Ms Louise Fox (Chair/Lay) Mr Kevin Connolly (Lay) Ms Amanda Webster (Lay) Ms Caroline Clark (Optometrist) Ms Louise Gow (Optometrist)
Legal adviser:	Ms Aaminah Khan
GOC Presenting Officer:	Mr Jon Trussler
Registrant present/represented:	No and not represented
Hearings Officer:	Ms Natasha Bance
Facts found proved:	1(a), (c), (d), 2(a)-(d) on a failing to record basis, 3(a)-(d) on a failing to record basis, 4(a)–(e) on a failing to record basis, 6(a)-(d) on a failing to record basis, 9, 10(a)-(f), 11(a), (b), 12, 13(a), (b)
Facts not found proved:	1(b), 5, 7, 8(a) – (d), 14
Misconduct:	Found in respect of all facts found proved apart from particular 12
Impairment:	Impaired
Sanction:	Suspension for 9 months – (With Review)
Immediate order:	Imposed

Proof of service

1. As the Registrant did not attend the hearing, nor was he represented, the Committee heard an application from Mr Trussler, on behalf of the General Optical Council ('the Council'), for the matter to proceed in the Registrant's absence. First, the Council was required to satisfy the Committee that the documents had been served in accordance with Section 23A of the Opticians Act 1989 and Rule 61 of the General Optical Council (Fitness to Practise) Rules 2013 ('the Rules'). The Committee had before it a service bundle, containing documents relating to the service of the Notice of Hearing.

2. Mr Trussler outlined the Council's attempts to correspond with the Registrant and made reference to the documents in the service bundle. Mr Trussler informed the Committee that the Registrant had not responded to any attempts to contact him from the Council's hearings team.

3. However, there had been recent contact between the Registrant and the Council's interim orders team. Telephone discussions had occurred between a member of the interim orders team and the Registrant on 12 and 21 August 2026, during which the Registrant asked about the substantive hearing. In the telephone call on 21 August the Registrant stated that he could not attend the substantive hearing as he had "*a lot going on in his life*", including his [redacted] issues. The Registrant had also referred to recently moving address.

4. Additionally, the Registrant had sent emails to the Council's interim orders team, the most recent email having been sent at 9.03am on the first day of the hearing. In this email the Registrant asked if he could be permitted to submit a witness statement, which he would prepare today and have ready for tomorrow.

5. The Committee was provided with copies of the relevant telephone attendance notes documenting the conversations with the Registrant and his recent emails.

6. Mr Trussler submitted that from the recent correspondence with the Registrant, it cannot be the case that he was unaware of the substantive hearing and it could not be said that he had not received the Notice of Hearing. Mr Trussler highlighted that the Notice of Hearing was sent by recorded delivery well before the date that the Registrant changed his registered address with the Council. Mr Trussler invited the Committee to find that there had been good service in accordance with the Rules.

7. The Committee accepted the advice of the Legal adviser, who referred the Committee to the Rules on service of the Notice of Hearing, the requirement that at least 28 days notice should be given for a substantive hearing and acceptable methods of service.

8. The Committee had regard to the documentation before it regarding service contained within the service bundle. The Committee noted that the Registrant had

been served with the Notice of Hearing over 28 days ago, on 10 July 2026, which was sent by registered delivery to his then postal address registered with the Council. That correspondence had been signed for and the signature which had been recorded by the post office was the Registrant's surname.

9. The Committee was satisfied, in the circumstances, that there had been effective service of the Notice of Hearing and that all reasonable efforts had been made to notify the Registrant of the hearing, in accordance with the Rules.

10. Before proceeding further in the Registrant's absence, the Committee noted that the Registrant had indicated that he would not be attending due to [redacted] issues, however it was not clear if the Registrant understood that he could make an application for an adjournment. Additionally, the Registrant had asked whether he could submit a written statement.

11. The Committee requested the Hearings Officer to make contact with the Registrant to clarify his position on the issue of the hearing proceeding in his absence and whether he was seeking an adjournment. In addition, the Committee requested that, if the Registrant wished to provide a statement, this be provided by 9am on the second day of the hearing. In an email sent in response, the Registrant stated that "*I confirm that I would rather not attend hearing and I am happy for hearing to commence in my absence*." He also confirmed that he would like to provide a written statement and he would do so before 9am the next day.

12. The Committee subsequently received a written statement from the Registrant, at the start of the second day of the hearing, which it has considered.

Proceeding in the absence of the Registrant

13. The Committee then went on to consider whether it would be in the public interest to proceed in the Registrant's absence in accordance with Rule 22, which states that:

> **"*Proceeding in the absence etc. of the registrant***
>
> *22. Where the registrant is neither present nor represented at a hearing, the Fitness to Practise Committee may nevertheless proceed if—*
> *(a) it is satisfied that all reasonable efforts have been made to notify the registrant of the hearing in accordance with section 23A(a) and rule 61; and*
> *(b) having regard to any reasons for absence which have been provided by the registrant, it is satisfied that it is in the public interest to proceed."*

14. Mr Trussler, on behalf of the Council, submitted that it was clear that the Registrant was aware of the hearing today, the fact that it was the substantive hearing and there was no good reason not to proceed in his absence. Mr Trussler acknowledged that there had been some last minute engagement by the Registrant

with the interim orders team but not the hearings team, despite having been directed to them.

15. The Committee accepted the advice of the Legal adviser, who referred the Committee to the guidance on proceeding in a Registrant's absence in the Council's 'Hearings and Indicative Sanctions Guidance' (updated June 2026)('the Guidance'). She referred the Committee to the cases of *R v Jones* [2002] UKHL and *General Medical Council v Adeogba* [2016] EWCA Civ 162, which outlined the principles to apply when considering an application to proceed in absence. The Legal adviser advised that the Committee had a discretion as to whether to proceed in absence, which should be exercised with great care. The Committee should have regard to any reasons for absence which have been provided by the Registrant, and consider, whether in the circumstances, it is in the public interest to proceed. The Legal adviser advised the Committee that it should take into account the public interest and fairness to the Council as well as fairness to the Registrant.

16. The Committee had regard to the fact that the Registrant was aware of the substantive hearing and he had indicated in his recent email that he did not wish to attend the hearing but wished to provide a written statement instead, which he had then submitted to the Committee. He also had indicated that he was "*happy for hearing to commence in his absence*." The Registrant had been made aware that he could make an application for an adjournment and had not done so. In the circumstances, the Committee considered that adjourning the hearing would serve no useful purpose. The Committee was mindful that witnesses were on standby ready to give evidence. Furthermore, these were serious allegations and it was in the public interest to determine them without undue delay.

17. The Committee determined that it would be in the public interest for the hearing to proceed in the Registrant's absence.

Preliminary Issue – amendment of Allegation

18. Mr Trussler made an application to amend a date in the originally worded Allegation, as it was inaccurate when compared with the patient records.

19. Mr Trussler submitted that by granting the application to amend the Allegation it would correct a typographical error in particular 12 of the Allegation regarding the date of the sight test, which would not cause any prejudice to the Registrant. Mr Trussler informed the Committee that the Hearings Officer had been asked to send an email to the Registrant to ask whether he had any objections to the amendment application but a response had not as yet been received.

20. In relation to the amendment application, the Legal Adviser advised that the Committee had a discretion under Rule 46(20) to make amendments, at any stage of the hearing, either on an application by a party or of its own motion, if satisfied that the amendment can be made without injustice and that issues of prejudice and fairness had to be considered from both parties' perspectives and the interests of

justice. Whilst ordinarily both parties would be invited to make representations on such an application, by the Registrant having decided not to attend he had lost the opportunity to do so and the Legal Adviser advised that the Committee having decided to proceed in absence could proceed to decide the amendment application without having heard from the Registrant on the issue.

21. The Committee considered the amendment application and was satisfied that there would be no injustice to the Registrant in making the amendment sought, which was a slight amendment to correct the date of a sight test in respect of Patient 8 and made no material change to the Allegation. The Committee considered that it was in the interests of justice that what was being alleged was accurate and the correct date could be seen from the patient records. The Committee considered that the date of the sight test could be amended without causing injustice to the Registrant. Accordingly, the Committee determined to grant the application to amend the particular, so that the date in particular 12 of the Allegation would now read '6 June 2024' instead of '6 July 2024'.

ALLEGATION (AS AMENDED)

The Council alleges that in relation to you, Michael John Beard (01- 16313), a registered Optometrist, whilst you were employed at Specsavers [redacted]:

1) On or around 7 October 2022, you conducted a sight test on Patient 1 and you:

a. Failed to accurately assess the fundus/macular with either an examination method (direct or indirect ophthalmoscopy) and/or with interpretation of the findings from ocular imaging; or

b. In the alternative to 1a) above, failed to check any ocular imaging obtained on the day;

c. Failed to detect signs of suspected wet AMD in the right eye;

d. Failed to urgently refer for specialist macular opinion;

2) On or around 28 November 2024, you conducted a sight test on Patient 2 and failed to perform and/or record the following, despite the patient presenting for a recheck due to intermittent diplopia:

a. An assessment of the patient's spectacle prescription;

b. An assessment of the patient's visual acuities;

c. An assessment of the patient's binocular vision;

d. An assessment of the patient's ocular motor balance;

3) On or around 23 December 2024, you conducted a sight test on Patient 2 and failed to perform and/or record the following, despite the patient presenting for a further recheck due to intermittent diplopia:

a. An assessment of the patient's spectacle prescription;

b. An assessment of the patient's visual acuities;

c. An assessment of the patient's binocular vision;

d. An assessment of the patient's ocular motor balance;

4) On or around 28 November 2024, you conducted a sight test on Patient 3 and failed to perform and/or record the following, despite the patient having a history or retinal detachment and presenting with concerns about their vision:

a. Intraocular pressures;

b. Refraction;

c. An assessment of visual acuities;

d. An assessment of the external eye;

e. An assessment of the internal eye;

5) On or around 28 November 2024, you failed to advise Patient 3 about his visual symptoms and/or the potential significance of the findings to his care;

6) On or around 21 December 2024, you conducted a sight test on Patient 4 and failed to perform and/or record the following, despite the patient presenting with deteriorating vision:

a. An assessment of the external eye;

b. An assessment of the internal eye;

c. An assessment of visual acuities with a pin hole test;

d. An assessment of the patient's near ocular motor balance;

7) On or around 21 December 2024, you failed to provide Patient 4 with a clear management plan to indicate that a discussion had taken place about referral;

8) On or around 23 December 2024, you conducted a sight test on Patient 4 and failed to perform and/or record the following, despite the patient presenting with deteriorating vision:

a. An assessment of the external eye;

b. An assessment of the internal eye;

c. An assessment of visual acuities with a pin hole test;

d. An assessment of the patient's near ocular motor balance;

9) Between 21 December 2024 and 23 December 2024, you failed to refer Patient 4 to the Hospital Eye Service to investigate unexplained reduced vision in each eye;

10) On or around 6 July 2023, you conducted a sight test on Patient 5 and you:

a. Failed to adequately record your assessment of the patient's right macular;

b. Failed to adequately assess the patient's internal eye;

c. Failed to detect signs of suspected retinal detachment;

d. Incorrectly identified that the patient had wet AMD;

e. Failed to adequately interpret/and or seek advice regarding the interpretation of the patient's OCT imaging;

f. Failed to make a next day referral for suspected macula retinal detachment;

11) On or around 23 April 2024, you conducted a sight test on Patient 6 and you:

a. Failed to adequately record the patient's macular status;

b. Failed to adequately interpret/and or seek advice regarding the interpretation of the patient's OCT imaging;

12) On or around 6 ~~July~~ June 2024, you conducted a sight test on Patient 8 and you failed to refer for further investigation at a sub-specialist macular clinic, despite the patient presenting with reduced visual acuity in the left eye;

13) On or around 24 January 2025, you conducted a sight test on Patient 9 and you failed to maintain adequate patient records in that you:

a. Did not to record which eye had ptosis;

b. Recorded normal findings on the external eye examination, contradicting the suggestion that the patient had a ptosis;

14) On or around 24 January 2025, you failed to refer Patient 9 and/or record a referral to the hospital Eye Service for ptosis and reduced visual acuity;

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

DETERMINATION

Admissions in relation to the particulars of the allegation

22. The Registrant was not present nor represented and he made no admissions in his written witness statement. Therefore there were no admissions made to the Allegation. The Registrant was formally identified in his absence and the Allegation was read into the record.

Background to the allegations

23. The Registrant is an Optometrist who registered with the Council on 16 January 1997. At the time of events giving rise to the allegations, the Registrant was employed as an Optometrist at Specsavers in [redacted].

24. The Registrant faces allegations relating to clinical concerns and record-keeping failures, arising from his examination of eight patients, Patients 1-6, 8 and 9 (there being no patient 7). The examinations subject of the allegations took place between October 2022 and January 2025 and involved a range of patients from children to elderly patients.

25. The first concern in time relates to a sight test that the Registrant conducted on Patient 1, a 74 year old patient, on 7 October 2022, when it is alleged that the Registrant failed to accurately assess the fundus/macular of the patient by an appropriate method or alternatively did not check any ocular imaging obtained that day. It is alleged that the Registrant failed to detect signs of suspected wet age-related macular degeneration (AMD) in Patient 1's right eye, which is alleged to have been clearly visible on the OCT scan taken that day. Further, it is alleged that the Registrant failed to urgently refer Patient 1 for specialist macular opinion, which it is alleged that an average competent Optometrist would have made. Two years later in October 2024, Patient 1 was seen by a different Optometrist and a referral was made, however this was much later than it should have been and Patient 1's condition had deteriorated significantly.

26. Further clinical concerns arose following a sight test that the Registrant conducted on Patient 5, a 68 year old patient, on 6 July 2023, who had attended following a recall having noticed deteriorating vision. It is alleged that the Registrant failed to adequately assess the patient's internal eye, failed to record the assessment of the patient's right macular and failed to detect signs of suspected retinal detachment, instead incorrectly identifying that Patient 5 had wet AMD. Patient 5 was subsequently seen 12 weeks later by community Ophthalmology services and was diagnosed with right macula-off rhegmatogenous retinal detachment Had the

Registrant correctly detected a retinal detachment on 6 July 2023 it is the Council's case that an emergency referral to Ophthalmology would have been indicated.

27. The Registrant conducted a sight test on Patient 6 on 23 April 2024, in which it is alleged that the Registrant failed to record the patient's macular status and failed to adequately interpret, or seek advice regarding the interpretation of, Patient 6's OCT imaging. Patient 6 had been referred by her GP for a sight-test following injections for wet AMD and she had not been seen by the Hospital Eye Service (HES) clinic since April 2023, with no further follow up appointments booked. It is alleged that the fundus picture and OCT images of Patient 6's left eye showed recent haemorrhaging, indicating that it was not 'dry' but had potentially reactivated, requiring reassessment in a specialist macula clinic.

28. On 6 June 2024, the Registrant conducted a sight test on Patient 8, a 78 year old patient, who had presented with reduced visual acuity in the left eye. The Registrant advised Patient 8 that no change in spectacles was required and recommended a 12 month follow up, providing the patient with an Amsler chart for self-monitoring. Patient 8's left visual acuity was reduced to 6/12 and the retinal photographs of Patient 8 showed a frank 'egg-yolk' like macula lesion at the back of the left eye, suggestive of adult vitelliform macula dystrophy (AVD). The Registrant had written AMD adjacent to macula on the record. It is alleged that the Registrant failed to refer Patient 8 for further investigation at a sub-specialist macular clinic when he ought to have done so, in order for a definitive diagnosis to be established.

29. On 28 November 2024, the Registrant conducted a repeat eye examination on Patient 2, a patient in his early nineties, who had returned for a recheck following an eye test in August 2024 and who was presenting with intermittent diplopia. The Registrant also re-tested Patient 2 on 23 December 2024. It is alleged that in these two appointments the Registrant failed to perform and/or record an assessment of the patient's spectacle prescription, visual acuities, binocular vision and ocular motor balance.

30. On 28 November 2024, the Registrant also conducted a sight test in relation to Patient 3, a 78 year old patient who was presenting with concerns about bright lights, yellow vision and left eye floaters. Additionally, Patient 3 had a history of retinal detachment. It is alleged that the Registrant omitted key parts of the eye examination including intraocular pressures, refraction, assessment of visual acuities and assessment of the internal and external eye and/or failed to record the same. Further, it is alleged that the Registrant failed to advise Patient 3 about his visual symptoms and/or the potential significance of the findings to his care.

31. On 21 December 2024, the Registrant conducted a sight test on Patient 4, an 11 year old girl. The Registrant also examined Patient 4 on 23 December 2024 and 28 January 2025. Patient 4 presented with a deterioration in vision and had a history of an earlier referral to a 'visual stress' clinic. It is alleged that at the first of the three appointments the Registrant conducted elements of the eye examination but not other elements, which were not recorded on the patient record, as set out in the Allegation. It is alleged that the Registrant failed to perform these tests and/or

failed to record them. It is also alleged that the Registrant failed to provide Patient 4 with a clear management plan, to indicate that a discussion had taken place about referral.

32. Patient 4 reattended two days later on 23 December 2024 and the patient record does not contain any information detailing findings from any tests/examinations completed and it is similarly alleged that these were not performed and/or recorded. A third eye test was conducted by the Registrant in January 2025. A complaint was subsequently made by Patient 4's mother during January 2025 regarding a delayed referral, as she had understood that the Registrant would be making a referral to their GP and to HES and she had to chase this. It is alleged that the Registrant failed to refer Patient 4 to HES to investigate the unexplained reduced vision in both eyes.

33. On 24 January 2025, Patient 9, a child approaching their 5th birthday, attended for a sight test with the Registrant. Patient 9 was noted to have a slight ptosis (drooping of the eye lid) and reduced visual acuity. The Registrant was sufficiently concerned about the ptosis to refer Patient 9, however it is alleged that the Registrant failed to refer and/or record a referral to HES for ptosis and reduced visual acuity. Further, it is alleged that the Registrant did not maintain adequate patient records for Patient 9 in that he did not record which eye had ptosis and recorded normal findings on the external eye examination part of the patient record, which contradicted the suggestion that Patient 9 had ptosis.

34. On 8 April 2025, the Council received a referral from Specsavers [redacted] concerning the Registrant and his management of these 8 patients, which stated that they were raising concerns regarding the Registrant's competence in identification and management of ocular disease and record-keeping.

The hearing

35. The Committee had before it a bundle of documentary evidence, which included the witness statements, minutes of various meetings with the Registrant and his employer, minutes of meetings with Ms A regarding her complaint, audit reports, the referral to the Council by Specsavers [redacted], patient records for the eight patients subject of the Allegation, disciplinary meeting records and various correspondence between the Registrant and Specsavers [redacted].

36. The Registrant provided the Committee with a witness statement dated 25 August 2026, which the Committee had regard to. In summary, the Registrant's statement gave background to the concerns, setting out that he had worked at Specsavers [redacted] for approximately 17 years, mostly under a previous director who retired in 2023 and for the first 14 years at the practice no significant professional or disciplinary concerns were raised regarding him.

37. The Registrant did not address the specific allegations in this case, but acknowledged generally that there were issues with aspects of his record-keeping. He stated that he fully recognised the importance of maintaining high standards of patient care, accurate clinical records and public confidence in the optical

profession and did not seek to minimise the concerns raised, but wished to provide the Committee with the wider context in which the concerns arose.

38. In his statement, the Registrant highlighted that when the initial complaint was made to the management team he was not suspended and continued to practise. Further audits were carried out in respect of his record-keeping and no issues were identified which prevented him from practising, which suggested that he was not seen as an immediate or unacceptable risk to patient safety.

39. The Registrant explained that he was forced to retire in April 2025 because of his [redacted], which was substantially affected by his experience of the disciplinary process and management of the concerns regarding his record-keeping. He considered that the investigation had become disproportionate to the underlying concerns. The Registrant highlighted that he was not referred to the Council by the management team whilst he remained employed and the referral was only made after he had left the practice. The Registrant referred to how NHS England had been content for him to practise, subject to a medical assessment taking place and he indicated that he would provide the Committee with correspondence from NHS England.

40. The Council relied upon evidence in the form of witness statements and exhibits from the following lay witnesses:

    i) Witness A (Ophthalmic Director, Specsavers [redacted]);

    ii) Witness B (Retail Dispensing Director, Specsavers [redacted]);

    iii) Witness C (HR Manager, Specsavers [redacted]);

    iv) Ms A (mother of Patient 4).

41. Witness B and Witness A attended the hearing to give live evidence and to answer questions from the Committee. The Committee's questions concerned when the practice became aware of the Registrant's [redacted] issues and what support was provided for him and related matters. As some of these questions related to the [redacted] of the Registrant the Committee sat in private session whenever the [redacted] of the Registrant was being considered, which the Council raised no objection to.

42. The remaining lay witnesses, Witness C and Ms A, did not attend to give oral evidence, as neither the Council nor the Committee had any questions for these witnesses.

43. The Council called Dr Robert Harper as an Expert witness, who attended and was questioned by Mr Trussler, on behalf of the Council and the Committee. Dr Harper produced an expert report dated 25 October 2025 and an addendum expert report dated 13 March 2026 (following a review of additional patient records of Patient 2). Dr Harper confirmed the contents of his reports and stated that he had read the witness statement provided by the Registrant and it had not changed any of his opinions or conclusions as set out in his reports.

44. In closing the Council's case, Mr Trussler submitted that the evidence in this case was unchallenged by the Registrant. In his witness statement there was some level

of acceptance that his record-keeping was "*not up to scratch*" but this was not sufficient to amount to an admission and it would not be safe to find that the Registrant had admitted any of the allegations.

45. Mr Trussler highlighted sections of the expert evidence of Dr Harper and reminded the Committee that Dr Harper had been provided with all of the witness statements, exhibits and patient records in the case. Mr Trussler submitted that a lot of what the Registrant had set out in his witness statement was mitigation.

46. Mr Trussler reminded the Committee that the burden of proving the allegations rests with the Council and submitted that there was more than sufficient evidence before the Committee for it to find all the allegations proved and he invited the Committee to find the allegations proved.

47. The Committee accepted the advice of the Legal adviser that the burden of proving a disputed allegation was on the Council, to the civil standard of the balance of probabilities. In particular, the Legal adviser gave advice regarding considering each particular of the allegations separately and in turn, that reasonable inferences can be drawn from the surrounding circumstances, and that the Committee should not speculate about what evidence it has not heard.

48. The Legal Adviser reminded the Committee that where a 'failure to' was alleged, the Committee had to be satisfied that the Registrant was required to so act before considering whether he had failed to act in the manner alleged. Additionally, the Legal Adviser advised the Committee in relation to the Registrant's good character, as he had no previous regulatory findings against him, which can be relevant in relation to credibility and propensity.

The Committee's findings in relation to the facts

49. The Committee considered all of the evidence in this case, including the documentary evidence, the oral evidence of the witnesses Witness A and Witness B, the written witness evidence of Witness C and Ms A and the expert evidence of Dr Harper (both oral and his reports). The Committee also considered the submissions from Mr Trussler, on behalf of the Council and the witness statement of the Registrant.

50. The Committee had regard to the Registrant's account as set out in his witness statement provided at the outset of the hearing and also his account given in local interviews. The Committee noted that in his witness statement the Registrant had not directly addressed the specific concerns that are set out in the Allegation. He had provided relevant background and contextual information and had appeared to acknowledge that there were shortcomings in aspects of his record-keeping (although he did not address the wider concerns such as failing to refer patients). However, in the Committee's view these comments were not sufficient to amount to any admissions to any part of the Allegation.

51. The Committee further noted that the Registrant had been served with the evidence in this case, including the expert evidence of Dr Harper and he not sought to challenge or dispute that expert evidence in any way.

52. The Committee considered each particular of the Allegation in turn.

1) On or around 7 October 2022, you conducted a sight test on Patient 1 and you:

a. Failed to accurately assess the fundus/macular with either an examination method (direct or indirect ophthalmoscopy) and/or with interpretation of the findings from ocular imaging; or

b. In the alternative to 1a) above, failed to check any ocular imaging obtained on the day;

c. Failed to detect signs of suspected wet AMD in the right eye;

d. Failed to urgently refer for specialist macular opinion;

53. The Committee was mindful that where an allegation pleads a failure to act, the Committee needs to first be satisfied that there was a duty upon the Registrant to so act. The Committee considered that the General Optical Council's Standards of Practice for Optometrists and Dispensing Opticians and the guidance from the College of Optometrists set a requirement for an Optometrist to carry out an adequate assessment during a sight test.

54. The Committee was satisfied that in relation to Patient 1 this duty included assessing the fundus/macular with an appropriate examination method. Further, if signs of a condition, such as suspected wet AMD, are present and reasonably detectable, the Committee was satisfied that there was a duty for these to be identified and an urgent referral made for specialist macular opinion.

55. The Committee had regard to the expert evidence of Dr Harper, as set out in his reports. Dr Harper is of the opinion that on the OCT scan taken of Patient 1 at this visit there is frank (i.e. clearly visible) evidence of lesions visible which is consistent with suspected wet AMD in Patent 1's right eye. Additionally, the retinal photograph taken the same day shows small haemorrhages temporal to the macula in the right eye, which Dr Harper explains is also consistent with suspected wet AMD and would very likely be visible upon internal examination of the right eye. Dr Harper states in his evidence that, "*Despite the absence of symptoms and loss of vision at this time, it would have been expected that an average competent Optometrist would have made an urgent referral for a specialist macular opinion in this case*."

56. The Committee accepted the evidence of Dr Harper, who it considered to be a clear and balanced expert witness, and it was satisfied that there was an obligation upon the Registrant in the circumstances to act as set out in the Allegation.

57. In relation to whether the Registrant did fail to so act, Dr Harper stated in his report that the Registrant was responsible for checking the findings from any ocular imaging taken on the day. However, he goes on to say that, "*It is not clear whether the Registrant did view Patient 1's OCT and fundus images, but then failed to spot the frankly suspect findings, or, whether they did not view the images taken at the time."* The Committee noted that Particular 1(a) and (b) had been put in the alternative to cover these two possibilities.

58. The Committee agreed with Dr Harper that it was not clear whether the Registrant had viewed the OCT and fundus images or not and it was of the view that there was no evidence that the Registrant had not viewed them. The Committee was mindful that the Council had the burden of proving the allegations on the balance of probabilities, which is more likely than not. The Committee was not satisfied in relation to Particular 1(b), that it had been proved as being more likely than not, that the Registrant had failed to check the ocular imaging obtained on the day.

59. The Committee was however satisfied on the evidence before it that the Registrant had failed to accurately assess the fundus/macular with an examination method and with interpretation of the findings from ocular imaging, as he had not accurately assessed Patient 1's macular status. The Committee noted that the Registrant had indicated that Patient 1's eyes were normal and healthy, when that was not the case. Further, he had failed to detect signs of suspected wet AMD in the right eye and failed to urgently refer for specialist macular opinion, as no referral was made until the patient was seen two years later by a different Optometrist.

60. Therefore, the Committee found particular 1(a), (c) and (d) of the Allegation proved.

2) On or around 28 November 2024, you conducted a sight test on Patient 2 and failed to perform and/or record the following, despite the patient presenting for a recheck due to intermittent diplopia:

a. An assessment of the patient's spectacle prescription;

b. An assessment of the patient's visual acuities;

c. An assessment of the patient's binocular vision;

d. An assessment of the patient's ocular motor balance;

61. The Committee noted that in relation to Patient 2, whilst the Registrant has completed parts of the patient record, no test results for the tests at a) – d) are documented for this visit in the patient record. There were copies of fundus photographs taken on this visit for Patient 2 and the Registrant had opened the patient record on the Specsavers Socrates system. The Committee was satisfied on the basis of the expert evidence that there was a duty on the Registrant to perform these assessments as part of Patient 2's sight test.

62. In relation to whether the Registrant failed to perform the assessments in question, Dr Harper states in his report that, "*It is not entirely clear if there was an examination which was not recorded or whether tests were undertaken and not recorded to have been undertaken*."

63. The Committee noted that it is alleged that the Registrant failed to perform the tests and/or record them. The Committee considered that the evidence was clear that the tests had not been recorded by the Registrant, as they had not been documented in the patient record, with these parts of the record being blank.

64. However, the Committee was not satisfied, on the balance of probabilities, that the Registrant had not performed these tests. The Committee noted that the tests were relevant tests to perform for a patient complaining of diplopia (double vision). The Committee considered that there was no evidence that the tests were not performed.

65. Whilst the patient record was blank for these tests, the Committee was not satisfied that this in itself was sufficient evidence to infer that the Registrant had not completed them, as it was equally likely that the Registrant had performed them but had omitted to record the results in the patient record.

66. The Committee had formed the view of the evidence of the Registrant's Specsavers colleagues that not sending patient referrals and record-keeping concerns, such as not recording tests fully were the concerns identified by Specsavers in this case, rather than clinical concerns that the Registrant was not performing tests that he should have been. The patient complaints provided to the Committee related only to failures to make referrals and there was no suggestion that the Registrant had not completed relevant tests.

67. Additionally, the Registrant had raised his concerns throughout the local investigation and disciplinary that he did not have sufficient time during the day to complete his record-keeping and was having issues with using the computer, also making reference to his practice of making handwritten notes.

68. The Committee was mindful that the Council had the burden of proving the allegations on the balance of probabilities, which is more likely than not. The Committee was not satisfied that it had been proved as being more likely than not, that the Registrant had failed to perform the tests in question. The Committee considered that it was more likely that the Registrant had performed them and not recorded them.

69. Accordingly, the Committee found particular 2 proved on the basis of failing to record a) – d).

3) On or around 23 December 2024, you conducted a sight test on Patient 2 and failed to perform and/or record the following, despite the patient presenting for a further recheck due to intermittent diplopia:

a. An assessment of the patient's spectacle prescription;

b. An assessment of the patient's visual acuities;

c. An assessment of the patient's binocular vision;

d. An assessment of the patient's ocular motor balance;

70. The Committee noted that this allegation is identical to particular 2, but relating to the subsequent appointment with Patient 2, which took place on 23 December 2024. On this occasion the Socrates examination record is completely blank across all sections apart from the demographic details of Patient 2 and it is recorded that the Registrant is named as the 'Optician'. Fundus photographs were also taken on this date and it is clear that the Registrant was accessing the patient record on this date, from the audit evidence, which showed access between 12.25 and 13.54 hours.

71. The Committee noted that the Council checked with Specsavers whether there were further records available for Patient 2 and no other relevant records were identified for this appointment.

72. The Committee noted the opinion of Dr Harper, which was that "*the Registrant has at least failed to assess and/or failed to record his assessment of Patient 2's spectacle prescription, their visual acuities and their binocular status*." The Committee considered that reference to the binocular status included an assessment of the patient's ocular motor balance, based upon other comments by Dr Harper in relation to Patient 2. The Committee was satisfied on the basis of the expert evidence that there was a duty on the Registrant to perform these assessments as part of Patient 2's further recheck sight test due to intermittent diplopia.

73. As with particular 2 above, the allegation is pleaded in the alternative that the Registrant failed to perform and/or record the assessments in question. The Committee considered this allegation separately but came to the same conclusion as with particular 2. Whilst it was clear that these assessments had not been recorded on the patient record, which was blank, there was insufficient evidence to find on the balance of probabilities that the assessments had not been performed for the same reasons as set out for particular 2 above.

74. Accordingly, the Committee found particular 3 proved on the basis of failing to record a) – d).

4) On or around 28 November 2024, you conducted a sight test on Patient 3 and failed to perform and/or record the following, despite the patient having a history or retinal detachment and presenting with concerns about their vision:

a. Intraocular pressures;

b. Refraction;

c. An assessment of visual acuities;

d. An assessment of the external eye;

e. An assessment of the internal eye;

75. The Committee was satisfied on the basis of the expert evidence of Dr Harper that there was a duty on the Registrant to perform these assessments as part of Patient 3's sight test in which the patient presented with symptoms that could not be explained by the earlier triage appointment and which warranted a full investigation. The Committee was satisfied that the tests in question at a) – e) were expected tests that ought to have been conducted by a reasonably competent Optometrist given Patient 3's history and presenting concerns.
76. The Committee noted that it is alleged that the Registrant did not perform these tests and/or did not record them. The Committee noted that the Registrant had accessed the Socrates examination record for this patient and has completed parts of the patient record, including documenting the reason for visit and symptoms.
77. The Committee considered that the evidence was clear that the Registrant had not recorded the assessments, as they had not been included in the patient record. However, whilst the patient record was blank for these tests, the Committee was not satisfied that this in itself was sufficient evidence to infer that the Registrant had not completed them, as it was equally likely that the Registrant had performed them but had omitted to record the results in the patient record.
78. The Committee had regard to its earlier findings that the evidence of the Registrant's Specsavers colleagues was that concerns related to referrals and record-keeping rather than clinical concerns that the Registrant was not performing tests that he should have been.
79. The Committee considered that it was at least equally likely that the Registrant had performed the tests in question but had omitted to document them on the patient record. The Committee concluded that there was insufficient evidence to find on the balance of probabilities that the assessments had not been performed for the same reasons as set out above.
80. Accordingly, the Committee found particular 4 proved on the basis of failing to record a) – e).

5) On or around 28 November 2024, you failed to advise Patient 3 about his visual symptoms and/or the potential significance of the findings to his care.

81. The Committee was satisfied on the basis of the expert evidence of Dr Harper that there was a duty on the Registrant to advise Patient 3 about his visual symptoms and/or the potential significance of the findings to his care.
82. However, the Committee considered that there was no evidence that the Registrant had not given this advice to Patient 3. None of the concerns raised by the Registrant's colleagues related to the Registrant failing to give patients

appropriate advice and no concerns had been raised regarding his wider clinical competent (other than in relation to making the referrals and record-keeping concerns).

83. Whilst there is no record within the patient records of such advice being given, for the same reasons as above, the Committee did not consider that it was reasonable in this case to draw an inference from that that the advice had not been provided. The Committee was not satisfied that there was sufficient evidence to establish on the balance of probabilities that the Registrant had failed to advise Patient 3 as alleged.

84. The Committee noted that there was no alternative allegation that the Registrant had failed to record such advice.

85. Accordingly, the Committee found particular 5 of the Allegation not proved.

6) On or around 21 December 2024, you conducted a sight test on Patient 4 and failed to perform and/or record the following, despite the patient presenting with deteriorating vision:

a. An assessment of the external eye;

b. An assessment of the internal eye;

c. An assessment of visual acuities with a pin hole test;

d. An assessment of the patient's near ocular motor balance;

86. The Committee was satisfied on the basis of the expert evidence of Dr Harper that there was a duty on the Registrant to perform the assessments set out in the Allegation in respect of Patient 4, an 11 year old girl who had presented with deteriorating vision.

87. The Registrant recorded parts of the patient examination, for example measurement of unaided vision in each eye and binocularly, visual acuities at distance and near and the distance vision ocular motor balance. However, the elements of the eye examination at a) – d) were not recorded and these would usually be expected. The Committee noted that there was a second appointment made for Patient 4 for two days later for the Registrant to undertake a cycloplegic refraction (using eye drops to relax muscles), which the Committee considered was reasonably a continuation of the sight test.

88. The Committee noted that it is alleged that the Registrant did not perform these tests and/or did not record them. The Committee considered that the evidence was clear that the tests had not been recorded by the Registrant, as they had not been documented in the patient record, with these parts of the record being blank. However, the Committee found that it was not necessarily the case that this meant that tests had not been performed.

89. The Committee considered the witness evidence of Ms A, who is the mother of Patient 4, and who was present during the sight test. She stated that Patient 4 was examined by the Registrant and he told them that her vision had changed significantly from her last eye test, but he felt that was not a true reading and he wanted her to return in two days for eye drops to be put in. The Committee noted that the subsequent complaint of Ms A related to the delayed referral and her evidence did not suggest that tests had not been performed.

90. Additionally, the Committee noted that the Registrant had recorded a result for Patient 4's distance ocular motor balance and it is usually tested at the same time as the near ocular motor balance. The Committee considered that it would be unusual to test for one and not the other. The Committee concluded that it was more likely that the Registrant undertook both tests but only recorded the distance and omitted to record the near measurement.

91. The Committee considered that it was at least equally likely that the Registrant had performed the tests in question but had omitted to document them on the patient record. The Committee concluded that there was insufficient evidence to find on the balance of probabilities that the assessments had not been performed for the same reasons as set out above.

92. Accordingly, the Committee found particular 6 proved on the basis of failing to record a) – d).

7) On or around 21 December 2024, you failed to provide Patient 4 with a clear management plan to indicate that a discussion had taken place about referral;

93. The Committee had regard to the witness statement of Ms A, who explained that the outcome of the appointment on 21 December 2024 was that the Registrant wanted them to re-attend for a sight test two days later on 23 December 2024, so that eye drops could be put into Patient 4's eyes to "*take the eyes back to the beginning so he could get a proper reading*." The Committee considered that it was apparent that Ms A understood the management plan at that stage.

94. The Committee considered that at the appointment on 21 December 2024 there was a verbal management plan at that time, however that was to continue the sight test two days later to undertake a cycloplegic refraction rather than to refer at that stage. There was no evidence that a referral had been discussed at the first appointment on 21 December 2024 and the Committee considered that it was reasonable to continue the sight test two days later for the cycloplegic refraction to be undertaken before discussing referring. The Committee had regard to the expert evidence of Dr Harper, who stated that, "*it is reasonable for an Optometrist to rebook a patient back in for completion of an eye examination/to undertake additional checks, although it would be expected that the record of the examination of 21st December 2024 would spell out that this was planned*."

95. In light of the above, the Committee considered that the Registrant had provided a clear management plan for the follow-up appointment two days later and it was not satisfied that at the appointment on 21 December 2024 there was a duty upon the Registrant to discuss referral with Patient 4 and her mother at that time. The referral was subsequently discussed with Ms A at the follow-up appointment on 23 December 2024 and she appeared to understand that there would be a referral (but it was delayed by the Registrant).

96. The Committee therefore considered that this allegation was not supported by the evidence and found particular 7 not proved.

8) On or around 23 December 2024, you conducted a sight test on Patient 4 and failed to perform and/or record the following, despite the patient presenting with deteriorating vision:

a. An assessment of the external eye;

b. An assessment of the internal eye;

c. An assessment of visual acuities with a pin hole test;

d. An assessment of the patient's near ocular motor balance;

97. The Committee considered whether the Registrant was under a duty to conduct these assessments again at the appointment with Patient 4 on 23 December 2024, when Patient 4 was returning for a cycloplegic refraction to be undertaken.

98. The Committee was of the view that the appointment on 23 December was a continuation of sight test commenced on 21 December 2024, for supplementary testing (the cycloplegic refraction). The Committee took the view that whilst there was a duty for these assessments to be performed when Patient 4 presented for a sight test in December 2024, if they were performed at the first appointment on 21 December 2024, they would not need to be repeated at the continuation appointment two days later.

99. The Committee noted that this was also the view of Dr Harper who stated that it would be reasonable to expect an Optometrist to examine ocular structures (i.e. internal and external eye examination) "*at the time of prescribing new spectacles, i.e. at one or other of the December 2024 visits*." Therefore, the Committee concluded that the duty arose at one of the appointments but not both. Having found that there was such a duty at the 21 December 2024 appointment in respect of particular 7, the Committee was not satisfied that there was also a duty to so assess on the 23 December 2024.

100. Accordingly, the Committee found particular 8 not proved.

9) Between 21 December 2024 and 23 December 2024, you failed to refer Patient 4 to the Hospital Eye Service to investigate unexplained reduced vision in each eye;

101. The Registrant did not refer Patient 4 until after the third visit which took place on 28 January 2025. The Committee agreed with the opinion of Dr Harper that there ought to have been a referral to HES after the December 2024 appointments rather than after the third appointment in late January 2025. Dr Harper referred to this delayed referral as being a "*very casual approach to the timeliness of referral, also a serious matter falling far below the standard expected of a reasonably competent Optometrist*."

102. The Committee was satisfied on the evidence before it, including the expert evidence of Dr Harper and the evidence of Ms A regarding the referral, that there was a duty on the Registrant to have referred arising by 23 December 2024, to investigate the unexplained reduced vision in both of Patient 4's eyes. It appears from the Registrant's notes in the patient record that he had intended to urgently refer Patient 4 but the Registrant failed to do so. This is supported by the evidence that Ms A complained about the referral not having been carried out.

103. Accordingly, the Committee found particular 9 proved.

10) On or around 6 July 2023, you conducted a sight test on Patient 5 and you:

a. Failed to adequately record your assessment of the patient's right macular;

b. Failed to adequately assess the patient's internal eye;

c. Failed to detect signs of suspected retinal detachment;

d. Incorrectly identified that the patient had wet AMD;

e. Failed to adequately interpret/and or seek advice regarding the interpretation of the patient's OCT imaging;

f. Failed to make a next day referral for suspected macula retinal detachment;

104. The Committee was satisfied on the basis of the expert evidence of Dr Harper that there was a duty on the Registrant to adequately assess Patient 5's internal eye and to adequately record that assessment.

105. In relation to this allegation, it is apparent that the Registrant had assessed the patient's internal eye and macular, as he had noted in the patient records that it looked normal (despite the Registrant identifying macula pathology and mistaking signs of a suspected retinal detachment for wet AMD). The Committee considered

that given the contradiction in the patient record, the Registrant had not adequately recorded his assessment of Patient 5's right macular.

106. The Committee accepted the expert evidence of Dr Harper that the Registrant ought to have considered that Patient 5 had a suspected retinal detachment based upon the OCT appearance. Dr Harper was of the opinion that whilst interpreting an OCT is not an entry level competency for Optometrists, if that service is offered then practitioners need to be able to interpret an OCT or escalate to a colleague for advice if they are uncertain. Further, Optometrists are required under the Council's Standards to work within their competence.

107. The Committee agreed with the expert evidence of Dr Harper that the Registrant was required to have detected signs of suspected retinal detachment and that he ought to have made a next day referral for suspected macula retinal detachment.

108. Accordingly, the Committee found particular 10 proved.

11) On or around 23 April 2024, you conducted a sight test on Patient 6 and you:

a. Failed to adequately record the patient's macular status;

b. Failed to adequately interpret/and or seek advice regarding the interpretation of the patient's OCT imaging;

109. The Committee was satisfied on the basis of the expert evidence of Dr Harper that there was a duty on the Registrant to adequately record Patient 6's macular status and to adequately interpret and/or seek advice regarding the interpretation of the patient's OCT imaging.

110. The Committee considered the patient records and noted that the Registrant had written 'AMD' with no description of the condition, for example whether it was dry, wet, atrophic or active. The fundus picture showed that their wet AMD was not 'dry' post previous treatment and was suspicious of reactivation. Additionally, there were haemorrhages present which the Registrant did not record. The Committee concluded that by the Registrant only entering 'AMD' this was an inadequate recording of the patient's macular status.

111. In relation to the interpretation of the OCT imaging, the Committee noted that this was a challenging interpretation for the Registrant given the patient's history as recognised by Dr Harper, who stated that it would be raising the bar too high to expect the Registrant to have undertaken this interpretation himself. However, it was the view of Dr Harper, with which the Committee agreed, that the Registrant ought to have sought advice on the interpretation of the OCT imaging and he failed to do so.

112. Accordingly, the Committee found particular 11 proved on the basis that the Registrant failed to seek advice.

12) On or around 6 ~~July~~ June 2024, you conducted a sight test on Patient 8 and you failed to refer for further investigation at a sub-specialist macular clinic, despite the patient presenting with reduced visual acuity in the left eye;

113. The Committee agreed with the view of Dr Harper that a reasonably competent Optometrist would have referred Patient 8 for further investigation at a sub-specialist macular clinic. The Registrant did not refer but provided the patient with an Amsler chart to review their vision and check for distortion, assuming that they have dry AMD, when Dr Harper's view was that they very likely did not have that condition and needed to be assessed in a sub-specialist macular clinic in secondary care. The Committee accepted Dr Harper's expert view that the Registrant failed to refer appropriately and accordingly found particular 12 proved.

13) On or around 24 January 2025, you conducted a sight test on Patient 9 and you failed to maintain adequate patient records in that you:

a. Did not to record which eye had ptosis;

b. Recorded normal findings on the external eye examination, contradicting the suggestion that the patient had a ptosis;

114. The Committee considered that there was a requirement for the Registrant to have documented which eye had ptosis so that accurate and adequate patient records are maintained and he recorded 'ptosis' but did not record which eye.

115. The Committee also considered that there was clear evidence that the Registrant had recorded normal findings on the 'external eye examination' section of the patient record, which contradicted that the patient had a ptosis. The Committee was satisfied that this resulted in the patient record for Patient 9 being inadequate.

116. Accordingly, the Committee found particular 13 proved.

14) On or around 24 January 2025, you failed to refer Patient 9 and/or record a referral to the hospital Eye Service for ptosis and reduced visual acuity.

117. In relation to the referral of Patient 9, the Committee noted that Dr Harper had found that the outcome of Patient 9's case was not clear to him from the evidence in the bundle and that there was no copy of the referral information/referral letter. Furthermore, Dr Harper highlighted that there is no specific allegation made by Specsavers in relation to Patient 9 in their referral/complaint to the GOC.

118. The Committee noted that the referral from Specsavers referred to other patient referrals not having been referred but it was not clear if Patient 9 was included in

those and there did not appear to have been a complaint from or on behalf of Patient 9 in respect of a lack of referral. The Committee concluded that it was not clear from the evidence before it whether there had been a referral or not by the Registrant to HES in respect of Patient 9. The Committee therefore was not satisfied that a failure to refer had been proved on the balance of probabilities in respect of Patient 9.

119. In relation to a failure to record a referral, the Committee considered that it appeared from the entries made by the Registrant on the patient record that he had identified that a referral was necessary for Patient 9 and had intended to make a referral. The Committee considered that there was ambiguity around whether what the Registrant had written in the patient record regarding referral was sufficient to amount to a recording of the referral. In light of this the Committee was not satisfied that the Council had proved that the Registrant had failed to record a referral to HES in respect of Patient 9.

120. Accordingly, the Committee found particular 14 not proved.

Misconduct

121. The Committee proceeded to consider whether the facts found proved amounted to misconduct, which was serious.

122. The Committee heard oral submissions from Mr Trussler, on behalf of the Council, expanding upon his written submissions in his skeleton argument.

123. No further material was put before the Committee on behalf of the Registrant at this stage. The Registrant was sent a copy of the facts determination at the end of the facts stage and was invited to submit any further documents he wished to put before the Committee. However, no further response from the Registrant was received.

124. Mr Trussler stated that whilst there is no formal definition of “misconduct” it has been defined in caselaw as an act or omission which falls short of what is proper in the circumstances, whether deliberate or reckless. However, there is a minimum level of seriousness, and the falling short must be serious, for example, if it would be regarded as deplorable by fellow practitioners.

125. Mr Trussler reminded the Committee that it had made some findings based upon a failure to record assessments but in respect of other allegations, clinical failings had been found proved. Mr Trussler invited the Committee to find that on the basis of the facts found proved, the Registrant’s failings were sufficiently serious to meet the threshold for misconduct, taken both individually and cumulatively.

126. In his skeleton argument, Mr Trussler submitted that it is open to the Committee to consider any non-serious failings cumulatively for the purposes of assessing whether there is misconduct in this case, if satisfied that the limited circumstances in the case of *Ahmedsowida v GMC* [2021] EWHC 3466 apply. Mr Trussler invited the Committee to consider the issue of cumulation should it be appropriate to do so.

127. Mr Trussler invited the Committee to find that there had been serious breaches of the standards, which amounted to misconduct.

128. The Committee heard and accepted the advice of the Legal adviser, who referred the Committee to the section on misconduct in the Hearings and Indicative Sanctions Guidance (updated June 2026). The Committee was reminded that misconduct was a matter for its own independent judgement and no burden or standard of proof applied at this stage. Further, that the Committee needed to consider whether the conduct was sufficiently serious to amount to professional misconduct.

129. The Legal Adviser advised that the threshold of serious misconduct has been described in the case of *Meadow v GMC* [2006] as being conduct which would be regarded as deplorable by fellow practitioners. However, it does not necessarily require moral turpitude; an elementary and grievous failure can also reach the threshold of serious misconduct, as can conduct that would be regarded as negligent, if sufficiently serious (as per *Calhaem, R (on the application of) v General Medical Council* [2007] EWHC 2606 (Admin)).

130. The Legal Adviser gave advice to the Committee on the issue of whether it was permissible for the Committee to take a cumulative approach to finding serious misconduct, given that the expert evidence of Dr Harper in respect of some patients was that some of the Registrant's failings fell below, but not seriously below, the standards expected.

131. The Legal Adviser also referred the Committee to the case of *Schodlok v GMC* [2015] EWCA Civ 769, which suggests that it may be permissible, in an appropriate case, for a tribunal to undertake the exercise of cumulating findings of misconduct on some charges to make a determination of serious misconduct on others. However, the more recent case of *Ahmedsowida v The General Medical Council* [2021] EWHC 3466 (Admin), stated that in relation to cumulation for a finding of serious misconduct,

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

132. The Legal Adviser advised that based upon these authorities, it was open to the Committee for a cumulative approach to be taken in an appropriate case, in the limited circumstances suggested in *Ahmedsowida.* However, these authorities would need to be carefully considered and there ought to be a sufficiently large series of failings which were all not serious misconduct, which when taken together could amount to serious misconduct.

The Committee's findings on misconduct

133. The Committee had regard to the "*Council's Standards of Practice for Optometrists and Dispensing Opticians*", effective from April 2016 ('the Standards'). The Committee considered that the following standards applied and been breached by the Registrant's conduct:

- *Standard 6.1 Recognise and work within the limits of your scope of practice, taking into account your knowledge, skills and experience*
- *Standard 6.2 Be able to identify when you need to refer a patient in the interests of the patient's health and safety, and make appropriate referrals*
- *Standard 7.2 Provide or arrange any further examinations, advice, investigations or treatment if required for your patient. This should be done in a timescale that does not compromise patient safety and care*
- *Standard 7.7 When in doubt, consult with professional colleagues appropriately for advice on assessment, examination, treatment and other aspects of patient care, bearing in mind the need for patient confidentiality*
- *Standard 8.1 Maintain clear, legible and contemporaneous patient records which are accessible for all those involved in the patient's care*
- *Standard 8.2.4 As a minimum record…the details and findings of any assessment or examination conducted*
- *Standard 8.2.5 As a minimum record…details of any treatment, referral or advice you provided, including any drugs or optical device prescribed or a copy of a referral letter*
- *Standard 17.1 Ensure your conduct, whether or not connected to your professional practice, does not damage public confidence in you or your profession.*

134. The Committee was satisfied that in respect of all of the above standards, the conduct of the Registrant which it had found proved, had fallen below the expected standards of what was proper in the circumstances of a reasonably competent Optometrist.

135. The Committee was mindful that not every falling short of the standards was sufficient to amount to misconduct, as it must be serious. The Committee went on to consider whether the Registrant's failures were serious in relation to each part of the Allegation that it had found proved.

136. The Committee had regard to the expert evidence of Dr Harper, who in both his oral and written evidence had given his expert opinion on whether the failings fell below or far below the standards expected of a reasonably competent Optometrist. The Committee noted that Dr Harper was of the opinion that in respect of Patients 1, 3, 4, 5 and 6 (for failing to seek advice regarding the interpretation of the OCT) the conduct fell far below what was expected in the circumstances of a reasonably competent Optometrist.

137. The Committee noted that in relation to the conduct found proved in respect of Patient 2 (for a failure to record), Patient 6 (for failing to record macular status) Patient 8, and Patient 9, Dr Harper had considered that the conduct in question fell below, but not far below, the standards to be expected of a reasonably competent Optometrist.

138. The Committee was mindful that whilst Dr Harper had given a view on whether the conduct was below or far below the standards expected, this was ultimately a decision for the independent judgement of the Committee.

Particular 1 of the Allegation (Patient 1)

139. In Dr Harper's opinion the Registrant's conduct in respect of Patient 1, in respect of failing to recognise the suspicious OCT/retinal findings from the examination on 7 October 2022, reflects a serious failing and one that fell far below the standard expected of a reasonably competent Optometrist. Dr Harper considered that an average competent Optometrist would have made an urgent referral for specialist macula opinion in this case. He stated that,

> "*Two years later in October 2024, Patient 1's vision had declined to 'CF' (count fingers) and a referral was made by a different Optometrist, sadly much later than it could have been, given the missed opportunity in October 2022. It is evidence from the images taken 2 years later in October 2024 that Patient 1's condition had deteriorated significantly, a matter likely associated with a much poorer visual outcome/prognosis for Patient 1*."

140. The Committee agreed with the evidence of Dr Harper and considered that this was a serious clinical failing which had serious consequences for the patient in that the referral was significantly delayed and their sight subsequently deteriorated. The Registrant had failed to detect signs of suspected wet AMD and failed to urgently refer, indicating that the patient's eyes were normal and healthy when that was not the case. The Committee considered that fellow practitioners would find this conduct deplorable and had no doubt that this sufficiently serious as to amount to misconduct.

Particulars 2 and 3 of the Allegation (Patient 2)

141. The Committee noted that in relation to Patient 2, Dr Harper had stated that,

> "*If the checks were carried out, and the omission related to record keeping only, and was a 'one-off', then this matter would be less serious, falling below, but not far below, the standard expected of a reasonably competent Optometrist*."

142. The Committee had found particulars 2 and 3 proved on the basis that the Registrant had likely carried out the assessments in question but that he had failed

to record the assessments on the patient record. The Committee found that this occurred at both appointments with Patient 2 on 28 November 2024 and 23 December 2024.

143. The Committee agreed with the assessment of Dr Harper, that if the assessments were carried out and this was solely a record-keeping issue then this fell below, but not far below the standards expected, when considered on its own. Accordingly, this conduct was not sufficiently serious as to amount to misconduct when considered in isolation. However, the Committee noted that as non-serious misconduct the issue of cumulation arises, as considered further below.

Particular 4 of the Allegation (Patient 3)

144. The Committee accepted the evidence of Dr Harper who was of the opinion that the Registrant's record keeping in respect of Patient 3 fell seriously below the standards expected due to Patient 3's history and the potential significance of the examination findings. Dr Harper stated that in relation to Patient 3:

"*In the event that the scenario is one where the Registrant undertook these assessments and failed to document their findings, then this matter is still serious and also falls far below the standards expected of a reasonably competent Optometrist, owing to Patient 3's history, his presentation with visual symptoms, and the potential significance of the examination findings to his care and possible need for referral.*"

145. The Committee considered that in relation to Patient 3, whilst it had found that the Registrant had likely performed the assessments, the failure to document them was serious misconduct, as the failure to record them could have been significant in respect of Patient 3's ongoing care given the patient's history of retinal detachment. Failing to record the assessments with this patient was of potentially greater significance, with greater potential risk of harm to the patient, which increased the seriousness. In reaching this view, the Committee accepted the evidence of Dr Harper in his report referred to above.

146. Accordingly, the Committee was satisfied that the Registrant's conduct in respect of this particular of the Allegation was serious and amounted to misconduct.

Particulars 6 and 9 (Patient 4)

147. In relation to Patient 4, the Committee accepted the evidence of Dr Harper that, in his expert opinion, the Registrant's conduct, by failing to record his assessments of a patient who had attended with deteriorating vision and by failing to make a referral to HES for further investigation relating to the patient's unexplained reduced vision, both fell far below the standards expected of a reasonably competent Optometrist. Dr Harper stated that in relation to Patient 4,

"*In my view the record keeping in this case is very seriously flawed overall, suggesting a lack of competence in this domain of practice, and reflective of failures*

falling far below the standard expected of a reasonably competent Optometrist. There is also an apparently very casual approach to the timeliness of referral, also a serious matter falling far below the standard expected of a reasonably competent Optometrist."

148. The Committee was satisfied, based upon the evidence of Dr Harper, who gave clear, balanced and measured evidence, that the record-keeping failures in respect of Patient 4, an 11 year old child, were very seriously flawed overall. This was a worsening scenario, in that Patient 4 was presenting with deteriorating vision, with potentially undiagnosed diabetes and symptoms that could be neurological. The Committee considered that these factors and potential risks made the poor record-keeping in this instance sufficiently serious as to amount to misconduct.

149. Similarly, in relation to the failure to refer Patient 4 (particular 9), the Committee considered that there were potentially serious consequences in relation to the failure to refer Patient 4 and considered that this was clearly conduct that fell far short of the standards expected of a reasonably competent Optometrist. Therefore, the Committee was satisfied that this amounted to misconduct.

Particular 10 (Patient 5)

150. The Committee considered that the Registrant's misdiagnosis of Patient 5 was serious, as although it was not a classic presentation of a retinal detachment, nonetheless the Registrant ought reasonably to have detected from the clinical signs and the images that Patient 5 had a suspected retinal detachment and not wet AMD.

151. The Committee accepted the evidence of Dr Harper that this failing was seriously below the standards expected. Dr Harper stated that in respect of Patient 5:

"*The Registrant has failed to make adequate notes of his assessment of Patient 5's right macula; he has failed to adequately assess the internal eye/interpret the OCT image and/or to escalate to a colleague to support his assessment of Patient 5's imaging. These failings each fall far below the standard expected of a reasonably competent Optometrist. As a consequence of these failings, the Registrant used the incorrect pathway to make an urgent referral for suspected wet AMD instead of an emergency/or next day referral for what ought to have been a suspected macular off retinal detachment, with this matter also reflective of a serious failing falling far below the expected standard."*

152. The Committee accepted the expert view of Dr Harper that this was a serious falling short of the standards expected. Accordingly, the Committee was satisfied that the conduct in particular 10 was serious and amounted to misconduct.

Particular 11 (Patient 6)

153. In relation to particular 11 a), the Registrant's failure to record Patient 6's macular status, Dr Harper considered that this fell below, but not far below, the standards to be expected of a reasonably competent Optometrist. The Committee agreed

with this assessment and considered that the conduct in particular 11 a) was not sufficiently serious as to amount to misconduct when viewed in isolation. The issue of cumulation is considered further below.

154. However, the Committee was satisfied that in relation to particular 11 b), failing to arrange for adequate interpretation of Patient 6's macular images, particularly in light of Patient 6 having reduced vision and apparently not having any ongoing HES care, that this was a serious failing. It agreed with the assessment of Dr Harper that, "*the Registrant's omission here falls far below the standard expected, putting Patient 6 at risk of significant progressive loss of vision in her left eye*."

155. Accordingly, the Committee was satisfied that the conduct in respect of particular 11 b) was serious and amounted to misconduct.

Particular 12 (Patient 8)

156. The conduct found proved in respect of Patient 8 was a failure to refer for further investigation at a sub-specialist macular clinic, despite the patient presenting with reduced visual acuity in the left eye.

157. The Committee had asked Dr Harper in his oral evidence to explain further why he was of the view that the failure to refer Patient 8 was below, but not far below, the standards expected. Dr Harper gave evidence that the Registrant had mitigated his failing by having a management plan to monitor the patient, with an earlier review suggested and he provided the patient with an Amsler chart to review their vision and check for distortion. Furthermore, Dr Harper considered that making the differential diagnosis would not be expected and this was not an entry level competence.

158. The Committee was satisfied with the explanation given by Dr Harper and accepted his evidence that it would be harsh to find in the circumstances that the failing was far below the standards expected. Accordingly, the Committee did not find that this amounted to misconduct.

Particular 13 (Patient 9)

159. In relation to particular 13, the Committee found proved that there were record-keeping failures in that the Registrant did not record the eye which had ptosis and recorded normal findings on the external eye examination section of the record, which contradicted the finding that the patient had ptosis.

160. Dr Harper was of the view that these record-keeping failures were below, but not far below, the standards expected of a reasonably competent Optometrist. The Committee agreed with this assessment when considering the conduct on its own.

161. In light of the above, in relation to the particulars that were found proved in respect of Patients 1, 3, 4, 5 and 6 (in respect of Particular 11 b) the Committee was satisfied that the Registrant's conduct was serious and fell sufficiently far below the

standards expected of a reasonably competent Optometrist to amount individually to misconduct, in each instance.

162. In relation to the proved conduct in respect of Patients 2 (particulars 2 a) – d) and 3 a) – d)), 6 (in respect of Particular 11 a)), 8 and 9, the Committee found that this conduct fell below, but not far below, the standards to be expected of a reasonably competent Optometrist.

163. The Committee next considered the issue of cumulation in respect of the non-serious conduct. The Committee noted that most of the conduct in respect of these patients related to record-keeping failures, with the conduct in respect of Patient 8 being a failure to refer for further investigation at a sub-specialist macular clinic.

164. The Committee had agreed with the assessments of Dr Harper regarding seriousness when considering these matters in isolation or as a 'one-off'. However, it noted that the Registrant had repeatedly made record-keeping omissions over an approximate 9 month period. In respect of the record-keeping errors involving Patient 2 these were repeated across two sight tests a month apart. The Committee considered that these record-keeping errors indicated a pattern of behaviour across several of the Registrant's patients and that it did not give a true reflection of the Registrant's conduct to solely view these in isolation. Furthermore, the Committee considered that by repeating record-keeping errors, this increased the seriousness of the conduct, as it became a more significant issue the more it is repeated.

165. The Committee was mindful of the case of *Ahmedsowida v GMC,* and the earlier case of *Schodlok v GMC [2015] EWCA Civ 769* and the Legal Advice it had received, as set out above. In the circumstances of this case, the Committee was satisfied that it was appropriate to take a cumulative approach to the Registrant's conduct in relation to the record-keeping allegations for Patients 2 (particulars 2 and 3), 6 (in respect of Particular 11 a), and 9 (particular 13 a) and b)) and found that these also, when taken together, amounted to misconduct that was serious. The Committee did not include the conduct at particular 12 (Patient 8) as that was of a different nature to the record-keeping and did not consider it part of the same series of incidents.

166. The Committee was satisfied, having considered the legal authorities and legal advice received, that this was a proper and appropriate case to take the cumulative approach in respect of the record-keeping failures which were not individually serious enough to amount to misconduct, given the range of patients affected and the similarity of the concerns across those patients.

167. Accordingly, the Committee found that all of the facts found proved (with the exception of particular 12) do amount to misconduct which is serious.

Impairment

168. The Committee went on to consider whether the Registrant's fitness to practise is currently impaired by virtue of his misconduct.

169. The Committee heard submissions from Mr Trussler on behalf of the Council, who submitted that the Registrant's fitness to practise is currently impaired given the Registrant's failure to fully engage in these proceedings. Mr Trussler reminded the Committee that when determining current impairment, the Committee must look forward and not back.

170. Mr Trussler referred the Committee to his skeleton argument in which he set out the factors to consider from the case of *Cohen v GMC* [2008] EWHC 581 (Admin), namely whether the conduct is easily remediable, whether it has been remedied and whether the conduct is likely to be repeated.

171. Mr Trussler submitted that the Registrant's conduct had not been remedied by the Registrant, as he had not demonstrated that any steps to remediate had been taken. Mr Trussler stated that whilst the Registrant in his witness statement had expressed a willingness to undertake further CPD or training, he had not provided any evidence of what, if any, he had actually undertaken.

172. Mr Trussler submitted that, in the circumstances, given that nothing had been put forward by the Registrant in terms of remediation, the issue of current impairment was '*clear cut'*. Mr Trussler invited the Committee to find that the Registrant's fitness to practise was currently impaired.

173. The Committee accepted the advice of the Legal adviser who advised the Committee that the question of impairment was a matter for its independent judgement taking into account all of the evidence it has seen and heard so far. She reminded the Committee that a finding of impairment does not automatically follow a finding of misconduct and outlined the relevant principles set out in the cases of *CHRE v (1) NMC and (2) Grant* [2011] EWHC 927 (admin) and *Cohen v GMC* [2008] EWHC 581 (Admin).

The Committee's findings on impairment

174. The Committee considered whether the Registrant's conduct was capable of being remediated, whether it had been remediated and whether there is a risk of repetition of the conduct in future.

175. The Committee was of the view that the nature of the conduct in this case, namely clinical failings and record-keeping concerns, was capable of being remediated in principle, with insight and remediation.

176. However, the Committee considered that there was no significant insight demonstrated by the Registrant in this case. The Committee was of the view that whilst the Registrant had acknowledged in his witness statement that there were shortcomings in his practice, he limited these to record-keeping issues and did not address the wider concerns such as identifying macular pathology accurately and referring appropriately. The Committee was of the view that the Registrant had failed to engage with the wider clinical concerns arising in the case.

177. In addition, it appeared that the Registrant had not reflected to any degree on the consequences of his actions. For example, much of the Registrant's witness statement concerned the impact upon himself; there is no indication that the Registrant has reflected upon or shown insight into the impact of his actions upon the patients concerned and the risks to patient safety. The Committee noted that he has only made limited reference in his witness statement to the impact of his conduct upon the reputation of the profession.

178. Further, the Committee was concerned that the Registrant had not provided evidence of having taken any steps to remediate his conduct. The Committee noted that it had before it evidence from a workplace audit which showed that there had been some improvement in the Registrant's record-keeping after the initial concerns were identified. However, this did not fully address matters as further concerns arose, escalating towards the end of his employment as he struggled to cope.

179. The Committee noted that the Registrant had expressed a willingness to undertake further training in his witness statement. However, there was no evidence of the Registrant having completed any recent CPD or training, targeted to address the specific concerns in this case, nor is there any evidence to demonstrate what the Registrant has learned from any such courses undertaken.

180. The Committee considered that it had not received any evidence that the Registrant fully understood the seriousness of the matters which have been found proved, the potential consequences for patient safety and what he would need to do to address the concerns raised in this case. There was no evidence that the Registrant had changed his practice and if allowed to return to unrestricted practice the Committee was of the view that there would be a significant risk to the public.

181. The Committee concluded that the Registrant's insight into his conduct was limited, and he still has significant work to do in this respect in order for the Committee to be reassured that he has remediated his misconduct.

182. The Committee considered the risk of repetition. It was of the view that the Registrant's conduct had put patients at risk of harm in the past and the Committee was concerned that without further reflection, insight and remediation, he would do so again in future. Given the lack of evidence of insight and remediation by the Registrant to address the failings, the Committee was of the view that there was a high risk of repetition.

183. Considering all of the above, the Committee was satisfied that the Registrant's fitness to practise is currently impaired on public protection grounds.

184. The Committee next turned to consider the public interest and had regard to the case of *CHRE v (1) NMC and (2) Grant* [2011] EWHC 927 (admin) and the test that was formulated by Dame Janet Smith in the report to the Fifth Shipman Inquiry, which is considered to be an appropriate approach for panels considering impairment (framed in respect of doctors but applicable to Optometrists):

"Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:

a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or

b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or

c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession;

and/or d….."

185. The Committee was of the view that limbs (a)-(c) of the test in *Grant* are engaged in this case, both in respect of the Registrant's past conduct and also in relation to the Registrant being '*liable in the future'*, given the risk of repetition, to put patients at unwarranted risk of harm, bring the profession into disrepute, and breach a fundamental tenet of the profession.

186. Further, given the serious nature of the conduct, which concerned several serious clinical failings, resulting in potential harm to patients, the Committee concluded that the public would be extremely concerned if no finding of impairment was made, and this would undermine the public interest. The Committee determined that it was also necessary to make a finding of impairment in this case in order to maintain confidence in the profession, and the Regulator and in order to uphold proper professional standards.

187. Accordingly, the Committee found that the fitness of the Registrant to practise as an Optometrist is currently impaired.

Sanction

188. The Committee went on to consider what would be the appropriate and proportionate sanction, if any, to impose in this case. The Committee received no new material at this stage, including from the Registrant who did not engage any further in the proceedings.

189. The Committee heard submissions from Mr Trussler on behalf of the Council. Mr Trussler highlighted to the Committee the principles that it ought to apply in determining the appropriate sanction, if any, in this case. These included the purpose of imposing a sanction, which is not to punish the Registrant, but to protect the public and the wider public interest factors of maintaining public confidence in the profession and upholding proper professional standards and conduct.

190. Mr Trussler reminded the Committee to apply the approach of starting with consideration of the least restrictive sanction and that the sanction imposed must be the least onerous to protect the public and meet the public interest.

191. Mr Trussler submitted that the difficulty in this case for the Committee was that it had found that the misconduct was capable of being remediated but there was a lack of engagement by the Registrant with the fitness to practise process. Mr Trussler highlighted parts of the Committee's findings at the impairment stage, including that the Registrant had failed to understand the seriousness of his actions and the impact upon patients. The Committee had found a lack of insight other than into the record-keeping concerns and that there was a risk of repetition.

192. Mr Trussler acknowledged that there was a willingness expressed in the Registrant's witness statement to undertake courses but he had not been specific as to what he had in mind. Mr Trussler submitted that the lack of remediation coupled with the lack of insight and engagement, was why the Council had taken the regrettable position that erasure would be the only appropriate sanction. Mr Trussler submitted that as matters stand the Committee can have no confidence that the Registrant will remediate the concerns arising in the case.

193. Mr Trussler referred the Committee to paragraph 20.41 of the Hearings and Indicative Sanctions Guidance ('the Guidance'), which states that erasure cannot be imposed where impairment is only by reason of adverse physical or mental health. Mr Trussler submitted that this was not the case here, as the Registrant only referred to his [redacted] after the workplace investigation and there was no evidence that the misconduct was due to [redacted]. Mr Trussler acknowledged that the Registrant had suffered stress and anxiety due to these proceedings, which he stated was commonly the case. However, no medical evidence had been provided to show that the Registrant's [redacted].

194. Mr Trussler submitted that the Council's position was that the only sanction that would be appropriate and proportionate in this case was erasure.

195. When asked by the Committee regarding aggravating and mitigation factors, Mr Trussler stated that there was a risk to the public arising from the conduct, but rather than being an aggravating factor, this was a feature of the Allegation itself. Mr Trussler submitted that in relation to mitigating factors, the Committee could take note that the Registrant is prepared to undertake remediation but the Committee should keep in mind the persistent lack of insight beyond record-keeping. Further, the Registrant had expressed a wish to practise again.

196. The Committee accepted the advice of the Legal Adviser, which was that the purpose of imposing a sanction was to protect the public. It was not intended to be punitive but inevitably it may have that effect. The Committee was advised to take into account the factors on sanction as set out in the Guidance; to assess the seriousness of the misconduct; consider any aggravating and mitigating factors; and to consider the range of available sanctions in ascending order of seriousness. The Legal Adviser advised the Committee to consider, if imposing conditions or a suspension, whether a review hearing was required.

197. Further, the Committee was advised that it was required to act proportionately by weighing the interests of the Registrant against the public interest. Public interest considerations include protecting the public, maintaining public confidence in the profession, and maintaining proper standards of conduct and behaviour.

The Committee's findings on sanction

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

i) In respect of two of the patients concerned there was significant actual harm as a result of their delayed referrals;

ii) The Registrant has not demonstrated the timely development of insight and it remains limited. In particular, the Registrant's lack of insight into the risk to patients and consequences of the misconduct.

The Committee considered the following to be mitigating factors:

i) The Registrant has had a long career, with no prior fitness to practise history;

ii) The Registrant cooperated with the workplace investigation and was responsive, for example some improvements were seen following a record-keeping audit.

199. The Committee considered the personal mitigation, which the Registrant detailed in his witness statement, including his perception of the disciplinary proceedings, the pressure that he felt he was under and his [redacted] towards the end of his time working at Specsavers [redacted]. The Committee considered whether these issues and the level of support that he was provided with by his employer, were mitigating features in this case.

200. The Committee considered that whilst it accepted that the Registrant was struggling whilst at work, the evidence from his managers at Specsavers was that they only became aware of his [redacted] issues after the disciplinary process had started at a welfare meeting on or around March 2025, after the misconduct had occurred. In the circumstances, the Committee did not consider that these issues amounted to a mitigating factor.

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

202. The Committee considered taking no further action as set out in paragraphs 20.7 to 20.12 of the Guidance. It was of the view that there were no exceptional circumstances to justify taking no action in this case. It further considered that taking no further action would not protect the public, was not proportionate nor sufficient given the seriousness of the misconduct and would not meet the public interest concerns.

203. The Committee considered the issue of a financial penalty order. However, it was of the view that such an order was not appropriate, given that it would not protect the public nor meet the public interest concerns. Furthermore, the Committee noted

that this penalty may be appropriate in cases involving financial motivation or gain, which were not features of this case.

204. The Committee considered the Guidance in relation to the imposition of conditions. The Committee noted that the misconduct was of a type where conditions could be appropriate, as it involved identifiable clinical areas of practice in need of assessment or retraining, which conditions often seek to address. The Committee further noted that the Registrant had indicated in his witness statement a willingness to work under conditions, including supervision.

205. However, the Committee bore in mind the seriousness of the misconduct and that two patients were harmed by the Registrant's failure to accurately diagnose and/or appropriately refer them. Additionally, the Registrant had only shown limited insight into the record-keeping errors and had not acknowledged nor developed insight into his clinical failures, the patient harm caused or the wider consequences of his actions on confidence in the profession. The Committee had also found that there was a risk of repetition, the Registrant had not remediated the misconduct and he had only engaged to a limited degree.

206. The Committee concluded that imposing conditions, even if it imposed stringent conditions for a lengthy period, would not sufficiently address the public interest concerns identified given the seriousness of the misconduct. The Committee concluded that conditions could not be devised which would be appropriate, proportionate and adequately address the public interest concerns in this case.

207. The Committee next considered suspension and had regard to paragraphs 20.33 to 20.35 of the Guidance. In particular, the Committee considered the list of factors contained within paragraph 20.33, that indicate that a suspension may be appropriate, which are as follows:

Suspension (maximum 12 months)

20.33 This sanction may be appropriate when some, or all, of the following factors are apparent (this list is not exhaustive):

a. A serious instance of misconduct where a lesser sanction is not sufficient.

b. No evidence of harmful deep-seated personality or attitudinal problems.

c. No evidence of repetition of behaviour since incident.

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

e. In cases where the only issue relates to the registrant's health, there is a risk to patient safety if the registrant continued to practise, even under conditions.

208. The Committee considered that several of the factors listed in paragraph 20.33 of the Guidance were applicable, which indicated that a suspension may be appropriate. The relevant factors that applied were a), b) and c). In relation to d),

the Committee had found at the impairment stage, that the evidence of insight was limited, in that the Registrant had acknowledged shortcomings in respect of his record-keeping failures but had not yet developed insight into the wider clinical concerns relating to misdiagnosis and delayed referrals. Factor e) was not applicable.

209. The Committee was mindful that not all of the factors in paragraph 20.33 are required to be present for a suspension to be appropriate, noting that the guidance states that a suspension may be appropriate when 'some, or all', of the factors were present and that the list was not exhaustive.

210. The Committee concluded that a suspension order was appropriate and sufficient to address the public interest concerns that it had identified. It considered that a suspension would adequately mark the seriousness of the Registrant's conduct, maintain public confidence in the profession and declare and uphold proper standards of professional conduct and behaviour. Further, a period of suspension would give the Registrant the opportunity to reflect and develop his insight further and to take steps to remediate the misconduct.

211. The Committee took into account that the Registrant had indicated in his witness statement an intention to return to practice and it had found that the misconduct was capable of being remediated, should the Registrant wish to address the concerns. The Committee considered that the Registrant ought to have the opportunity to reflect upon the Committee's findings and take available meaningful steps to remediate, which he would be able to do during a period of suspension.

212. The Committee considered the Council's position that erasure was the only appropriate sanction.

213. The Committee had regard to paragraph 20.42 of the Guidance, which states that, "*Erasure from the register is appropriate if it is the only means of protecting patients and/or maintaining public confidence in the optical profession*."

214. The Committee, having formed the view that a period of suspension may be appropriate, was not of the view that erasure was the only means of protecting the public or maintaining public confidence in the profession. Furthermore, the Committee was not satisfied that, whilst serious, the misconduct of the Registrant was fundamentally incompatible with being on the Register given that the Registrant had shown some (albeit limited) insight and engagement, and indicated a willingness to remediate and return to safe practice. The Committee had also concluded that the misconduct was capable of remediation. In the circumstances, the Committee considered that erasure would be disproportionate.

215. The Committee therefore concluded that the proportionate and appropriate sanction in this case that would protect the public and sufficiently meet the public interest was one of suspension. In reaching this decision the Committee considered the impact upon the Registrant of not being able to practise whilst suspended. However, the Committee was satisfied that the impact upon the Registrant was outweighed by the need to protect the public and the wider public interest of maintaining confidence in the profession.

216. In relation to the length of the order, the Committee determined that, having considered the nature and seriousness of the misconduct, and having balanced the aggravating and mitigating factors, it would be appropriate and proportionate to suspend the Registrant for a period of 9 months. The Committee considered that this period would reflect the seriousness of the misconduct and also allow the Registrant sufficient time to reflect, develop insight further and carry out the necessary remediation required to address the concerns arising in this case.

217. The Committee considered whether to direct that a review hearing should take place before the order expired. The Committee noted that the Guidance states that a review should normally be directed before the end of the order, because the Committee will need to be reassured that the Registrant is fit to resume unrestricted practice.

218. The Committee bore in mind that it had found that there remained a risk of repetition of the conduct, as the Registrant had limited insight and had not yet remediated. The Committee considered that in the circumstances, and given the length of the suspension imposed, a review hearing was appropriate and should take place before the period of suspension expires. This will enable a future review Committee to consider whether the Registrant has engaged and carried out the work required to return to practice safely. A future reviewing Committee would also be able to consider all of the options available to it, should the Registrant not engage.

219. The reviewing Committee will need to be satisfied that the Registrant:

(i) has fully appreciated the gravity of the misconduct,

(ii) has maintained his skills and knowledge and

(iii) that the Registrant's patients will not be placed at risk by the resumption of unrestricted practice.

220. Whilst the Registrant did not wish to attend this substantive hearing, the reviewing Committee would be assisted by the Registrant's attendance at the future review hearing. In addition, this Committee considers that it would assist the reviewing Committee if the Registrant was able to provide for the review hearing the following:

(i) A detailed reflective statement, reflecting upon the findings of this Committee, the harm to patients and what he would do differently in future;
(ii) Any evidence of remediation i.e. that the Registrant has addressed the clinical failings that are identified in this determination such as through CPD or other training or self-directed learning;
(iii) Any testimonials and/or references;
(iv) Any other evidence that the Registrant considers may assist.

Immediate Order

221. The Committee heard submissions from Mr Trussler, on behalf of the Council, who invited the Committee to impose an immediate order. Mr Trussler submitted that as the Committee had found current impairment and a risk to the public, an immediate order was justified.

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

223. The Committee had regard to the section of the Guidance regarding immediate orders and considered the statutory test. The Committee bore in mind that it had found that the misconduct was serious and there was a risk to the public, in light of the limited insight and lack of remediation. The Committee was therefore concerned that if no immediate order was made, the Registrant could return to unrestricted practise during any appeal period. The Committee therefore concluded that an immediate order was necessary to protect members of the public in this case.

224. Additionally, given the serious nature of the misconduct, the Committee decided that it was also otherwise in the wider public interest that an immediate order be imposed. Accordingly, the Committee imposed an immediate order of suspension.

Interim Order

225. The Committee revoked the existing interim order.

Chair of the Committee: Louise Fox

Signature **Date:** 02 September 2026

Registrant: Michael Beard

Signature *Registrant not present, sent via email* **Date:** 02 September 2026

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

Further information about the PSA can be obtained from its website at www.professionalstandards.org.uk or by telephone on 020 7389 8030.
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.