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

**GENERAL OPTICAL COUNCIL**

**F(25)01**

**AND**

**DENTON BARCROFT (01-10825)**

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**DETERMINATION OF A SUBSTANTIVE REVIEW**
**17 November 2025**

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| **Committee Members:** | Clive Powell (Chair/Lay)<br>Tasneem Dhanji (Lay)<br>Ann McKechin (Lay)<br>Alexander Howard (Optometrist)<br>Maninder Gupta (Optometrist) |
| **Legal adviser:** | Kelly Thomas |
| **GOC Presenting Officer:** | Holly Huxtable |
| **Registrant:** | Present and represented |
| **Registrant representative:** | Rebecca Vanstone<br>Instructed by Katie Holland (AOP) |
| **Hearings Officer:** | Anwar Henry |
| **Outcome:** | Not impaired |

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**DETERMINATION**

1. The Registrant was present and represented and accepted service of the papers. No preliminary issues were raised.

2. It was acknowledged by the Committee that according to *Rule 25(2)* of the *General Optical Council (Fitness to Practise) Rules Order of Council 2013 ("the Rules")* any matters relating to the physical or mental health of the Registrant will remain in private.

3. The Registrant provided a reflective statement (undated).

**Background**

4. The Registrant practised as an Optometrist from 1981 to 2023. Redacted.

5. In 2022 Patient A made a complaint in relation to the adequacy of care received from the Registrant on three occasions: 23 May, 30 May and 8 June 2022.

6. Patient A first attended Redacted ("the Practice") on 23 May 2022 because she required new glasses and vision in her left eye was blurred. She informed the Registrant that she was type 1 diabetic. The Registrant conducted a sight test and fitted Patient A with new glasses. He further prescribed eye drops.

7. Patient A returned to the Practice on 30 May 2022 because vision in her left eye had worsened. She again informed the Registrant that she was diabetic and that she had an appointment with the Diabetic Screening Service. The Registrant carried out an assessment and advised Patient A to continue taking the eye drops.

8. The previous Committee found that on 8 June 2022, Patient A had a further consultation with the Registrant, and the Registrant assured Patient A that there was not a problem, and he further prescribed her eyedrops.

9. Patient A attended the diabetic screening clinic on 9 June 2022. Her visual acuities were significantly reduced in both eyes. Moreover, vitreous haemorrhages were seen in both eyes. She was referred to the Hospital Eye Service ("HES") where she was subsequently diagnosed with bilateral proliferative diabetic retinopathy with vitreous haemorrhages.

10. Patient A has since undergone multiple episodes of eye laser treatment and had vitreoretinal surgery.

11. At the substantive hearing between 21 – 29 July 2025, the Registrant admitted, and the following facts were found proved:

> *"The Council alleges that you, Mr Denton Barcroft (01-10825), a registered Optometrist:*

1. *On 23 May 2022 you attended to Patient A, and you:*

   *(a) Failed to identify and/or record the new vessels at Patient A's optic discs suggesting signs of proliferative diabetic retinopathy;*

   *(b) Failed to make an urgent referral to the Hospital Eye Service, despite this being clinically indicated;*

   *(c) Failed to perform and/or record a dilated fundus examination of Patient A's eyes, despite this being clinically indicated;*

   *(d) Failed to provide advice and/or record your advice to Patient A about the significance of her diabetic retinopathy so she could make an informed choice about next steps in her clinical journey;*

   *(e) Failed to accurately document Patient A's visual symptoms in that you did not record:*

      *i. Patient A saying her left eye was blurry;*

      *ii. Patient A complaining of reduced vision;*

   *(f) Failed to make further enquiries and/or record the findings of further enquiries in relation to Patient A's visual symptoms, at e) above, namely:*

      *i. The onset of the symptom(s);*

      *ii. The nature of the symptom(s); and/or*

      *iii. The duration of the symptom(s);*

   *(g) Failed to establish and/or record the level of control of Patient A's diabetes;*

   *(h) Failed to provide advice and/or record your advice to Patient A in respect of her ceasing contact lens wear until her corneal staining had healed.*

2. *On 30 May 2022 you attended to Patient A, and you:*
   *(a) Failed to identify and/or record signs of proliferative diabetic retinopathy;*
   *(b) Failed to make an urgent referral to the Hospital Eye Service, despite this being clinically indicated;*

*(c) Failed to perform and/or record a dilated fundus examination of Patient A's eyes, despite this being clinically indicated;*
*(d) Failed to provide advice and/or record your advice to Patient A about the significance of her diabetic retinopathy so she could make an informed choice about next steps in her clinical journey;*
*(e) Failed to accurately document Patient A's visual symptoms in that you did not record:*

*i. Patient A indicating that she was type 1 diabetic;*
*ii. Patient A saying her left eye was blurry;*
*iii. Patient A complaining of reduced vision.*

*(f) Failed to make further enquiries and/or record the findings of further enquiries in relation to Patient A's visual symptoms, at e) above, namely:*

*i. the onset of the symptom(s);*
*ii. the nature of the symptom(s); and/or*
*iii. the duration of the symptom(s).*

*(g) Failed to establish and/or record the level of control of Patient A's diabetes.*

*3. On 8 June 2022, [if] Patient A attended the practice you:*

*(a) Failed to identify and/or record signs of proliferative diabetic retinopathy;*
*(b) Failed to make an urgent referral to the Hospital Eye Service, despite this being clinically indicated;*
*(c) Failed to perform and/or record a dilated fundus examination of Patient A's eyes, despite this being clinically indicated;*
*(d) Failed to provide advice and/or record your advice to Patient A about the significance of her diabetic retinopathy so she could make an informed choice about next steps in her clinical journey;*
*(e) Failed to accurately document Patient A's visual symptoms in that you did not record:*

*i. Patient A indicating that she was type 1 diabetic;*
*ii. Patient A complaining of reduced vision;*

*(f) Failed to make further enquiries and/or record the findings of further enquiries in relation to Patient A's visual symptoms, at e) above, namely:*

*i. the onset of the symptom(s);*
*ii. the nature of the symptom(s); and/or*
*iii. the duration of the symptom(s).*

*(g) Failed to establish and/or record the level of control of Patient A's diabetes.*

12. Following the findings of facts, the Committee found the Registrant's fitness to practise impaired by reason of misconduct and imposed a 4 month

suspension on the Registrant's practice. The order is due to expire on 26 December 2025.

**Findings regarding impairment**

13. Ms Huxtable, on behalf of the GOC, submitted that the previous Committee had determined that the Registrant's misconduct was remediable. Ms Huxtable acknowledged that the Registrant had provided the GOC with confirmation of his intention not to return to practice as an Optometrist, and some further reflections on catalysts for his misconduct. Ms Huxtable also acknowledged that the Registrant had completed relevant evidence of further professional development, in particular two CPD sessions on diabetic retinopathy.

14. However, Ms Huxtable submitted that the Registrant had not produced sufficient evidence of maintaining his skill set and had not worked in a clinical situation for a prolonged period. On this basis, the GOC submitted that the Registrant's fitness to practise remained impaired.

15. Ms Vanstone, on behalf of the Registrant, submitted that there was not current impairment. Ms Vanstone referred to the three suggestions of the substantive Committee for the Registrant to demonstrate.

16. Firstly, confirmation of the Registrant's intention not to return to practice as an Optometrist was specifically addressed this in his reflective statement. The Registrant has had some health difficulties and made a decision to retire prior to December 2023. The Registrant has since sold his practice and had his name removed from the Health Board Performer's List.

17. Secondly, the Registrant has supplied further reflections on catalysts for his misconduct and/or potential consequences. At the substantive hearing the Registrant recognised the real issue, namely that he made an incorrect clinical decision that Patient A's dry eyes were associated with contact lens use rather than diabetic retinopathy. The Registrant had recognised the need for a referral but had not recognised the urgency required. The Registrant provided further details of his reflection in his reflective statement.

18. Thirdly, the Registrant has now supplied evidence of further professional development. The Registrant had completed further CPD as early as June 2022 after he was made aware of what had happened but before he was notified of investigation and before Patient A had even made a complaint. The Registrant had stated "*I was aware that Ocular Surface Disease was more prevalent in diabetic patients, but I was unaware that Ocular Surface Disease would be an indicator of advanced diabetic retinopathy*."

19. The Registrant had, since the substantive hearing, provided evidence of a CPD course in August 2024 which included the criteria for referral with reference to the Scottish grading, and further CPD in April 2025 specifically regarding the treatment of diabetic retinopathy.

20. Ms Vanstone submitted that this is a single patient case for a Registrant with an otherwise unblemished 40-year career. The Registrant's failings have been recognised at a public hearing with a four-month suspension which has met the concerns of the previous Committee to ensure upholding of public interest and professional standards. Ms Vanstone submitted that the Registrant continues to engage, has engaged in appropriate CPD training, and this demonstrates that there is no realistic prospect of repetition. The Registrant stated, "*Ever since the event, my actions and failings have been constantly on my mind."* Ms Vanstone therefore concluded that there was no risk of repetition and it was not necessary to make a finding of impairment.

21. The Legal Adviser outlined that the guidance in relation to substantive order review hearings can be found at *Paragraphs 24.1-24.5* of the *Hearings and Indicative Sanctions Guidance ("the Guidance").* The case of *Clarke v General Optical Council [2017] EWHC 521 (Admin)* established that a review hearing will be dealt with as a substantive hearing and will commence at the impairment stage. Impairment needs to be considered afresh, as well as the principle that retirement or an intention to retire is generally not relevant to a finding of impairment of fitness to practise.

22. The cases of *Abrahaem v GMC EWHC 183 (Admin)* and *Khan v GPhc [2016] UKSC 64* confirm that in a substantive review hearing, there is a persuasive burden upon a Registrant to demonstrate that they are fit to resume unrestricted practice. The Legal Adviser advised that the Committee should consider the current fitness of the registrant to resume practice, judged in light of what they have, or have not, done since the substantive hearing and whether they remain impaired.

23. The Legal Adviser also outlined *Paragraphs 16.1 to 16.7* of the *Guidance* in relation to impairment. The Legal Adviser advised the Committee to consider the two separate elements of impairment namely the public component, which concerns the reputation of the profession and upholding professional standards, and the personal component which concerns the risk of repetition and insight displayed on the part of the Registrant as in *Cohen v GMC (2008) EWHC 581***.** The Legal Adviser also highlighted the four questions in the *Grant* case. Finally, the Legal Adviser advised the Committee that at the impairment stage, there is also no burden or standard of proof, but ultimately it is a question of judgement for the Committee alone.

24. The Committee accepted the advice of the Legal Adviser, considered the GOC bundle served, the reflective statement from the Registrant and the submissions by both Counsel. The Committee noted that the previous substantive Committee had excluded sub-particulars 1(c) 2(c) and 3(c) from its findings of misconduct. Whilst this Committee was bound by those findings, this Committee reminded itself that it was not bound by the findings on impairment or sanction.

25. The Committee considered the *Guidance* at *paragraphs 16.1 to 16.7*, the cases of *Clarke* and *Cohen* and the four questions in the Grant case, namely:

    *a. 'Has [the Registrant] in the past acted and/or is [he] liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

    *b. Has [the Registrant] in the past and/or is [he] liable in the future to bring the medical profession into disrepute; and/or*

    *c. Has [the Registrant] in the past breached and/or is [he] liable in the future to breach one of the fundamental tenets of the medical profession;*

    *d. has in the past acted dishonestly and/or is liable to act dishonestly in the future.*

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

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

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

28. The Committee considered that limb a) of the *Grant* case was engaged because Patient A had, *in the past* put Patient A at unwarranted risk of harm given the admitted findings of the substantive Committee. The deficient acts and omissions of the Registrant had occurred on more than one occasion, and were identified by Dr Kwartz as falling '*far below'* the standards expected of a registered optometrist. The Committee determined that failing to make an urgent referral, in the context of not conducting and/or recording an adequate history, symptoms and examinations was serious.

29. The Committee considered limb b) of the Grant case, whether the Registrant had *in the past* brought the profession in disrepute. The Committee accepted that the Registrant's failings on these three occasions in 2022 had a significant impact on Patient A and could undermine public confidence in the profession. The Committee concluded that the Registrant had in the past brought the profession into disrepute.

30. The Committee considered under limb c) of the Grant case whether the Registrant had *in the past* breached one of the fundamental tenets of the profession. The Committee considered the Registrant's acts to have fallen far below those contained in the *2016 Standards of Practice for Optometrists and Dispensing Opticians ("the Standards"),* namely *Standards* 1, 5, 6, 7 and 17. The Committee determined that the Registrant had in the past breached one of the fundamental tenets of the profession.

31. The Committee did not consider that limb d) of the *Grant* case was engaged, there being no dishonesty findings.

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

33. Firstly, the Committee considered *whether the conduct which led to the allegation is remediable*. The Committee considered that although the Registrant's failings were serious, it would be possible to remediate such clinical failing with appropriate measures such as training or supervision.

34. Secondly, in considering *Cohen*, the Committee considered *whether the conduct has been remedied*. The Committee noted at the substantive hearing that the Registrant had demonstrated some insight into his failings, expressed remorse for the impact of his conduct on Patient A, acted early to improve his awareness of signs and symptoms of diabetic retinopathy and had undertaken, and learned from, relevant CPD.

35. The Committee looked at the three pieces of information which the previous substantive Committee had indicated would be useful for a substantive review hearing:

***a) Confirmation of [the Registrant's] intention not to return to practice as an Optometrist:***

36. The Committee noted here the case of *Clarke* and to some extent noted that the fact of the Registrant's retirement was irrelevant to its current review. However, in considering whether the Registrant had remediated the Committee looked at the question of risk.

**b) *Any further reflections on catalysts for [the Registrant's] misconduct and/or potential consequences:***

37. The Committee noted that the Registrant had recognised the necessity of, and completed targeted CPD training as early as June 2022. This was after the Registrant was made aware of what had happened, but before he was notified that Patient A had made a complaint or that there was an investigation, which was to the Registrant's credit. The Registrant also demonstrated sufficient insight in his reflective statement, stating "*I was aware that Ocular Surface Disease was more prevalent in diabetic patients, but I was unaware that Ocular Surface Disease would be an indicator of advanced diabetic retinopathy*."

**c) *Evidence of any further professional development:***

38. The Committee determined that the specific failings by the Registrant were specifically addressed in the targeted courses he chose to undertake since the substantive hearing. The Registrant had provided evidence of CPD course in August 2024 which included the criteria for referral with reference to the Scottish grading, and again in April 2025 specifically regarding the treatment of diabetic retinopathy which demonstrated the Registrant's own insight into his particular training needs.

39. Thirdly, from *Cohen,* the Committee considered the *risk of repetition*. The Committee determined that the Registrant had provided sufficient evidence to

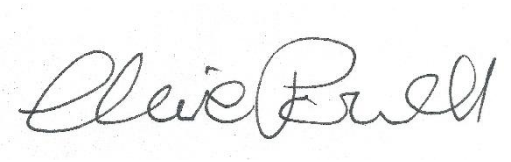
address the three concerns of the previous Committee. The Committee noted that the Registrant had an otherwise unblemished 40 year career. The Committee determined that despite his retirement, the Registrant continues to engage, has completed appropriate CPD training, and has provided reflective evidence. The Committee determined that the misconduct was specific, and regardless of the Registrant's retirement, the Registrant had demonstrated sufficient remediation and reflection to reduce the risk of repetition. The Committee determined that there was a minimal risk of repetition.

40. The Committee returned to the Grant questions with reference to the Registrant's *future* risk. Given its findings, the Committee considered limbs a), b) and c) of the Grant case as to whether the Registrant was in the future likely to put patients at unwarranted risk of harm, bring the profession into disrepute or breach one of the fundamental tenets of the profession. The Committee determined that the Registrant has discharged the persuasive burden upon him to demonstrate that he is fit to resume unrestricted practice and has undertaken remediation sufficient to satisfy the Committee that such conduct will not be repeated in the future. Therefore, the Committee found that the Registrant was not liable in the future to put a patient or patients at unwarranted risk of harm; bring the medical profession into disrepute; or to breach one of the fundamental tenets of the medical profession.

41. The Committee then considered the public interest element. The Committee determined that an informed and fair-minded member of the public, if they were appraised of the facts, would consider that the Registrant's specific misconduct had been sufficiently marked with a four-month suspension. Given the remediation and insight, and the Committee's findings on repetition, the Committee determined that a finding of impairment was no longer necessary to promote and maintain public confidence in the profession and proper professional standards and conduct.

42. The Committee therefore found that neither the personal or the professional elements of impairment were present, and determined that the Registrant had discharged the persuasive burden upon him to demonstrate that he is fit to resume unrestricted practice. Further, the four-month suspension had met the need to demonstrate to the public that the Committee would uphold proper professional standards and public confidence in the profession.

43. The Committee therefore found that the Registrant was not currently impaired. The current period of suspension will expire on 26 December 2025.

**Signature**  . **Date: 17 November 2025**

**Registrant: Denton Barcroft**

**Signature** present and sent decision by email **Date: 17 November 2025**

| **FURTHER INFORMATION** |
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| **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.