BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(26)04

AND

STUART TOWERS (01-12964)

DETERMINATION OF A SUBSTANTIVE HEARING
13-17 JULY 2026

Committee Members:	Louise Fox (Chair) Lisa Hill (Lay) Ben Summerskill (Lay) Gemma O'Rourke (Optometrist) Louise Gow (Optometrist)
Legal adviser:	Hala Helmi
GOC Presenting Officer:	Sam Thomas of Counsel
Registrant present/represented:	Present and represented
Registrant representative:	Bo-Eun Jung of Counsel Gareth Martin (Olliers)
Hearings Officer:	Terence Yates
Facts found proved:	2(a), 3(a), (b) & (d), 4(a), (b) & (c), 5(a), (b) &(c) and 6.
Facts not found proved:	1(a), 1(b), 2(b), 2(c), 3(c), 4(d) & 4(e)
Misconduct:	Found
Impairment:	Not impaired
Waning:	No warning given

ALLEGATION

The Council alleges that you, Mr Stuart Towers (01-12964), a registered Optometrist:

1. *On 9 October 2021, you did not conduct an appropriate assessment of Patients A's eyes in that you;*
   - *(a) Failed to detect signs of a choroidal naevus temporal to the macula of the right eye; and/or*
   - *(b) Failed to assess whether the choroidal naevus temporal to the macula of the right eye was benign or malignant;*
2. *On 9 October 2021, you did not communicate effectively with Patient A in that you;*
   - *(a) Did not take a clear and accurate family history of glaucoma;*
   - *(b) Failed to advise Patient A that she had a choroidal naevus temporal to the macula of the right eye; and/or*
   - *(c) Failed to advise Patient A whether the choroidal naevus temporal to the macula of the right eye was benign or malignant;*
3. *On 9 October 2021, you did not maintain an adequate patient record in that you;*
   - *(a) Did not record a clear and accurate family history of glaucoma;*
   - *(b) Failed to record that Patient A had a choroidal naevus temporal to the macula of the right eye; and/or*
   - *(c) Failed to record whether the choroidal naevus was benign or malignant;*
   - *(d) Failed to record advice given to Patient A regarding a finding of a choroidal naevus temporal to the macula of the right eye; and/or*
4. *On 2 September 2023, you did not communicate effectively with Patient A in that you;*
   - *(a) Did not take a clear and accurate family history of glaucoma;*
   - *(b) Failed to advise Patient A that she had High Intraocular Pressures which were outside the range of normality; and/or*
   - *(c) Failed to advise Patient A of the risks associated with High Intraocular Pressures;*
   - *(d) Failed to advise Patient A that she had a choroidal naevus temporal to the macula of the right eye; and/or*
   - *(e) Failed to advise Patient A whether the choroidal naevus was benign or malignant;*
5. *On 2 September 2023, you did not maintain an adequate patient record in that you;*
   - *(a) Did not record a clear and accurate family history of glaucoma; and/or*
   - *(b) Failed to record advice given to Patient A regarding High Intraocular Pressures in her eyes;*

(c) Failed to record advice given to Patient A regarding a finding of a choroidal naevus temporal to the macula of the right eye;

6. On 2 September 2023, you did not refer Patient A to the hospital eye service for an emergency referral due to High Intraocular Pressures in Patient A's eyes;

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

DETERMINATION

Preliminary Matters

Declaration by the Chair

1. At the outset of the hearing, the Chair made a declaration, which had already been notified to the parties prior to the hearing in writing, to the effect that she had previously had a social connection with the expert witness, in that they had attended university together. The Chair also disclosed that there was a social connection [redacted].
2. Both parties had previously confirmed prior to the hearing that they took no issue with this disclosure, and this was confirmed in the hearing again.

Joint questions asked by the parties of Patient A prior to commencement of the hearing

3. The parties put agreed questions in writing to Patient A, through the GOC acting as a medium, prior to her giving her evidence. Patient A replied by email, and the questions and Patient A's answers were provided to the Committee prior to the commencement of the hearing.

Admissions in relation to the particulars of the allegation

4. The Registrant admitted the following factual particulars:

    Particular 2(a)
    Particular 3(a), (b), and (d).
    Particular 4(a), (b) and (c).
    Particular 5(a), (b) and (c).
    Particular 6.

5. The Committee therefore found these Particulars proved by way of the Registrant's admissions.

Background to the allegations

6. The Registrant is an Optometrist who first became registered in 1986. At the material time he ran a Vision Express practice in [redacted], at which he also undertook work as an optometrist. The Allegation faced by the Registrant arise out of two separate patient appointments with Patient A, which took place on 9 October 2021 and 2 September 2023 at the [redacted] practice. A referral to the General Optical Council (GOC), dated 4 February 2025, was made by Patient A highlighting a number of concerns which she had with the Registrant's care and treatment of her. The GOC undertook an investigation and commissioned an independent expert report from Dr Anna Kwartz, who produced an expert report dated 16 June 2025 as well as an addendum report dated 8 February 2026.

Decision on Facts

7. The GOC called Patient A to give live evidence.
8. Both parties agreed that the expert witness, Dr Kwartz, was not required to give live evidence, with the Registrant accepting the contents of her report and addendum report without challenge.
9. The GOC also relied on a bundle of documents which included Patient A's witness statement, Patient A's optical records, her hospital records and the two reports from the expert.
10. The Registrant gave live evidence under affirmation.
11. The Registrant also relied on his own bundle of documents which comprised of his witness statement, CV, CPD record and character references.
12. The Committee heard submissions on facts from Mr Thomas, on behalf of the GOC, and Ms Jung, on behalf of the Registrant. The Committee read the skeleton argument of Mr Thomas dated 11 July 2026, as well as the Amended Admissions Schedule submitted on behalf of the Registrant. The Registrant submitted fundal images from Patient A which showed the choroidal naevus in her right eye, information about CPD undertaken by the Registrant on MOLES and a paginated journal paper on MOLES.
13. The Committee accepted the advice of the Legal Adviser who advised that the Registrant should be taken to be a person of good character, and that he is entitled that his good character be taken into account by the Committee when considering his credibility and his propensity to act as alleged.
14. The Committee was aware that the burden of proof remains entirely on the GOC throughout, and that the standard of proof is the civil standard of the balance of probabilities.

Application to amend the Allegation

15. Following the close of the Registrant's case, Mr Thomas applied to amend Particulars 1(b), 2(c), 3(c) and 4(e), relying upon written submissions. The amendment sought was the same in respect of each of those Particulars, namely that instead of the word "malignant" in each of those Particulars there should be substituted the words:

    "whether there were any sinister signs or characteristics that were suggestive of malignancy".

16. Mr Thomas made the application on the basis that these amendments were consistent with the way the GOC had put its case when opening it at the start of the hearing and that there was no change of substance. The GOC's case was that there was no duty on the Registrant to diagnose whether a choroidal naevus was benign or malignant, but rather, as stated in the addendum report of Dr Kwartz, (the evidence of whom was agreed between the parties) there was a duty to "assess" whether a naevus was benign or malignant, and in particular, when considering malignancy whether there were "*any sinister signs or characteristics that were suggestive of malignancy"*. This informed the GOC's case that the duty upon the reasonable and competent optometrist was not to make a final

diagnosis or conclusion in relation to a naevus but to assess whether there were indicators towards malignancy which might require a specialist referral. The amendments sought were to give clarity and to reflect the way that the GOC's case had been put from the start.

17. Ms Jung, on behalf of the Registrant, opposed the application. Ms Jung submitted that the amendments sought would change the substantive nature of the allegations, altering the nature of the case, at a point in time when the Registrant's ability to give evidence and question GOC witnesses had ceased. Ms Jung pointed to the history of the allegations in question including that they had already been amended previously following the involvement of the Case Examiners, with the reason having previously been given that they reflected the opinion of Dr Kwartz. The GOC now sought the amendments again on the basis that they reflected the opinion of Dr Kwartz. The amendments sought would lower the bar that the GOC would have to meet to prove the allegations in question, and the case would be different to that which the Registrant had prepared to meet. It was the GOC's responsibility to ensure that the Allegation was properly drafted, and it was now too late to seek amendment.

18. The Committee accepted the advice of the Legal Adviser who referred to Rule 40(2) of the General Optical Council (Fitness to Practise) Rules 2013 (the 2013 Rules), which states that the Committee has the discretion to amend an allegation where the amendment can be made without injustice.

19. The Committee considered the application and took into account the GOC's position that it was not for the Registrant to diagnose whether a choroidal naevus was benign or malignant, rather it was for the Registrant to assess it to effectively decide if it needed a referral to a medical specialist who could make a diagnosis. The Committee took the view that on a fair and straightforward reading of the relevant Allegation as they currently stood, they did rely on a form of words which suggested a duty to come to a decision as to whether the choroidal naevus was either benign or malignant, rather than merely make an assessment as to whether there were characteristics of concern which required a referral. As such, the Committee concluded that the amendments sought would change the nature of what was alleged, lowering the bar.

20. The Committee took into account that the application was being made after all the evidence had been heard, and both parties had closed their case. The Committee concluded that the substance of the allegations would be altered at this late stage, and that it would cause prejudice to the Registrant to allow the amendments after the Registrant had concluded the presentation of his case without prior notice of the application.

21. In the circumstances, the Committee concluded that the application should be refused, on the basis that the degree of prejudice to the Registrant was such that it would cause injustice.

Application to withdraw Registrant's admission

22. Following the Committee's decision on the GOC's application to amend some of the allegations, Ms Jung applied to withdraw the Registrant's admission to Particular 3(c) on the basis that it had been made in error, and that the Registrant

did not accept it for the same reasons which he was disputing the other allegations which had been the subject of the application to amend.

23. Mr Thomas was neutral in respect of the application.

24. The Committee accepted the advice of the Legal Adviser, and concluded that it would be fair to allow the Registrant to withdraw his admission to Particular 3(c) on the basis that he had made the admission in error.

Particular 1(a)

25. Patient A's evidence was that in 2021 she attended the Registrant 's practice in [redacted] for a routine eye test. She remembered that was when she had her first scan of the back of her eyes. Although she could not recall the specific tests that were done, she recalled being shown images and a video of the scan, although could not remember this being on a big screen and remembered it being on a monitor on the Registrant's desk. Patient A did not clarify if this was at the 2021 appointment or the 2023 appointment or both.

26. Patient A remembered being told at the 2021 appointment that she could not get contact lenses because one of her eyes is "shaped like a rugby ball". She did not remember when asked in cross-examination if the Registrant had told her there was a "freckle" on her eye. She accepted he could have said it, but she might not remember if it had not been presented as a concern by the Registrant. This was because she tended to remember only matters of concern which had been pointed out to her rather than matters which were said to be of no concern.

27. Patient A's notes do not record a choroidal naevus temporal to the macula of the right eye.

28. Dr Kwartz stated in her addendum report that a reasonably competent optometrist should have detected the choroidal naevus in Patient A's right eye from the ophthalmoscopic examination and from the fundus photograph, and that a failure to detect the choroidal naevus would fall far below the standard of a reasonably competent optometrist.

29. The Registrant told the Committee that he had no memory of Patient A or either of the consultations in 2021 or 2023.

30. The Registrant's evidence was that the [redacted] practice was one of the first practices to receive an OCT (optical coherence tomography) scanner which provides a 3D scan of the retinal and optic disc. This went beyond the 2D images of photographs. The Registrant stated that he wanted all patients to benefit from the OCT imaging and so no extra charge was incurred for the first five years of installation. He stated that he had a strong belief in patient involvement in the eye examination and the OCT provided an opportunity to view and discuss images on the screen. He had also, of his own volition, purchased a 50-inch monitor which was hung on the wall of his consulting room so that he could show his patients images and scans of their eyes and involve them in discussions about their eyes.

31. The Registrant's evidence was that a full OCT scan was conducted on 9 October 2021. He explained that, as was his usual practice, the Registrant would have been shown the retinal images on the 50-inch monitor, and he would have viewed them with the patient. The Registrant's evidence was that the choroidal naevus

was clearly visible on the 2021 fundus photographs of the patient's right eye (and indeed on the images from 2018, 2023 and 2024). He could not see how he could have missed the naevus at the 2021 appointment, particularly when it was displayed at large scale on the 50-inch monitor. His evidence was that he would have seen in it his examination using the slit lamp and Volk lens. His evidence was that he would also have viewed the patient's current images simultaneously with images from previous appointments. This would have provided him with an ideal opportunity to compare the appearance of the choroidal naevus over a period of time. He stated that he would have done all of this with Patient A, including mentioning to her that she had a "freckle" which is how he referred to obviously benign choroidal naevi with patients, using common language.

32. The Committee first considered whether there was a duty to detect the choroidal naevus. Considering the evidence of Dr Kwartz, the Committee was satisfied that there was such a duty. Dr Kwartz in her addendum report stated that:

"1.2.1 The most significant risk of the failure to detect a pigmented lesion on a patient's fundus is that there is a failure to identify a choroidal melanoma, which has sight- and life-threatening implications.

1.2.2. Monitoring of fundus lesions is indicated to rule out growth and the presence/ development of malignant features. Therefore, baseline characteristics should be recorded to determine if there is any subsequent growth."

33. The duty clearly arose from the fact that a choroidal naevus needs to be detected so as to be able to assess whether there needs to be a referral to specialist for diagnosis. In addition, monitoring of fundus lesions is important to be able to detect if there is any subsequent growth and which may indicate therefore the presence of malignancy.

34. The Committee took into account the Registrant's evidence of the routine he had when conducting patient appointments, the "robotic" manner in which he undertook the necessary tasks, and assessments which were repeated as a matter of habitual routine throughout his lengthy career approaching 40 years. The Registrant gave his evidence in this regard in a detailed manner, explaining how he had a particular way of dealing with appointments, viewing images with patients, explaining matters to patients and dealing with matters in those appointments in a particular order.

35. In addition, the Registrant gave evidence about how he utilised the older "ABCDE" scoring, and gave examples of how he had previously referred choroidal naevus having considered that they demonstrated signs of malignancy. The Committee accepted from his evidence that he knew from experience what to look for. In his evidence, he stated that he saw the choroidal naevus, assessed it, but did not record it.

36. The Committee also took into account that included in Patient A's records, were fundus photos of both eyes of Patient A's, and an OCT scan. The Registrant explained to the Committee the choroidal naevus was clearly visible on the photograph of the right eye and the Committee was able to view this.

37. The Committee also took into account, as made clear by Dr Kwartz in her addendum report that there was nothing concerning about the appearance of the naevus suggestive of malignancy. The Committee considered that in such circumstances it was unlikely that the Registrant would have spent much time speaking about it to Patient A.

38. The Committee considered that the Registrant's routine was thorough and ingrained. Consequently, it is more likely than not that he would have noted the choroidal naevus. There were a number of opportunities for him to detect it, from the photos, both those from 2021 and 2018 and from the examination. The Committee also noted that Patient A accepted that she was shown photos on a screen and that she recognised the fundus photos.

39. Taking into account the evidence set out above, the fact that Patient A did not remember the choroidal naevus being mentioned to her was not sufficient to evidence the fact that the Registrant did not detect it. Nor was the fact that the Registrant did not make reference to it in Patient A's notes. The Committee also considered what may be termed as the failure of the Registrant's routine in other respects as admitted by him, such as his failure to advise Patient A's high inter-ocular pressures. However, the Committee decided this was not sufficient to be satisfied that the Registrant failed to detect the signs of the choroidal naevus.

40. In all the circumstances, the Committee decided that the GOC had not discharged the burden of proof.

41. **The Committee therefore found Particular 1a not proved.**

Particular 1(b)

42. Patient A's notes do not record an assessment of whether the choroidal naevus temporal to the macula of the right eye was benign or malignant.

43. Dr Kwartz in her addendum report stated that:

"1.2.1 The most significant risk of the failure to detect a pigmented lesion on a patient's fundus is that there is a failure to identify a choroidal melanoma, which has sight- and life-threatening implications.

1.2.2. Monitoring of fundus lesions is indicated to rule out growth and the presence/ development of malignant features. Therefore, baseline characteristics should be recorded to determine if there is any subsequent growth."

44. The Registrant's evidence was that as a matter of routine, he would have assessed whether the naevus had any concerning features. Had there been any cause for concern, particularly any features that indicated that it may be malignant or required further investigation, then an onward referral would have been made, something he had done many times during his career. Any images of lesions or areas of concern would have been transferred digitally onto the Acuitas system as well as being sent off with the referral.

45. The Registrant did not accept that he was required to assess whether the naevus was benign or malignant because he considered that such diagnosis required specialist assessment falling outside of his remit and expertise. If he considered

the naevus merited further investigation, he would refer to the Hospital Eye Service ("HES") for a definitive assessment.

46. The Committee considered that in the ordinary and natural meaning of the wording in Particular 1b in alleging that there was duty to assess whether choroidal naevus was benign or malignant, there was a reference to a decision to be made that the choroidal naevus was either benign or malignant. It appeared to the Committee that the allegation referred to a clear decision about whether or not it was malignant. There was no reference to a duty to assess if it had any concerning features which could indicate that it may be malignant and therefore required a referral. On that basis, it was clear to the Committee that the particular did not correctly set out the duty of an optometrist, and that the way it was drafted did not accord with the GOC's clear case based on the opinion of Dr Kwartz, with which the Registrant agreed.

47. **The Committee therefore found Particular 1b not proved.**

Particular 2(b)

48. Patient A's evidence was that she did not remember the choroidal naevus being mentioned to her by the Registrant. Patient A stated that she did not remember the Registrant telling her there was a "freckle" on her eye, but she accepted he could have said it and she did not remember, if it was not presented as a concern by the Registrant, as she tended only to remember the matters of concern.

49. Patient A's notes do not document that the Registrant advised Patient A that she had a choroidal naevus at all.

50. Dr Kwartz in her report (p. 99 8.8.3 and 8.5.2) expressed the opinion that if the Registrant did not explain to Patient A about the naevus, then he fell far below the expected standards of a reasonably competent optometrist.

51. The Registrant's evidence was that although he did not record his discussion with Patient A, he was confident that a full OCT discussion would have taken place, during which he would have advised Patient A that she had a choroidal naevus in her right eye. His evidence was that he would not have used terms like "choroidal naevus" or "temporal to the macula" but would have used terms such as "freckle" or "freckle-like feature" to indicate that it was not of concern. He did not use the words "benign" or "malignant" with patients unless it was clinically necessary, as he considered that such terms usually gave rise to fear and anxiety. He would more likely have explained to Patient A that her naevus (freckle) did not appear to have any worrying features. He would also have advised the patient to continue attending regular eye examinations involving OCT to monitor the "freckle".

52. The Committee first considered whether the Registrant had a duty to advise Patient A that she had a choroidal naevus and concluded that this was clear, according to the agreed eviendce of Dr Kwartz.

53. The Committee took into account the evidence it considered in respect of Particular 1a, including the detail of his evidence of how the Registrant routinely looked at images, communicated to patients about them and displayed them for patients. In addition, the Registrant in his evidence told the Committee that he would put previous images of fundus photos from the last appointment as well as those taken at the current appointment side by side on his 50-inch screen and

explain what he saw to the patients. The size of the screen meant that images would have been magnified for patients. Patient A accepted she had seen the photos although did not distinguish at which appointment this was or if it was at both.

54. The Committee took into account all of the evidence set out above including the Registrant's habitual and methodical method of practice, the fundus photos, the importance the Registrant placed on communication with patients and involving them in looking at images. The Committee was not satisfied that the GOC had discharged its burden of proof.

55. **The Committee therefore found Particular 2b not proved.**

Particular 2(c)

56. Patient A's notes do not document that the Registrant advised Patient A whether the choroidal naevus was benign or malignant.

57. Dr Kwartz in her addendum report stated that:

"1.2.1 The most significant risk of the failure to detect a pigmented lesion on a patient's fundus is that there is a failure to identify a choroidal melanoma, which has sight- and life-threatening implications.

1.2.2. Monitoring of fundus lesions is indicated to rule out growth and the presence/ development of malignant features. Therefore, baseline characteristics should be recorded to determine if there is any subsequent growth."

58. The Registrant's evidence was that as a matter of routine, he would have assessed whether the naevus had any concerning features. Had there been any cause for concern, particularly any features that indicated that it may be malignant or required further investigation, then an onward referral would have been made, something he had done many times during his career. Any lesions or areas of concern would have been screen shot and transferred digitally onto the Acuitas system as well as being sent off with the referral.

59. The Registrant did not accept that he was required to assess (and therefore advise a patient) whether the naevus was benign or malignant because he considered that such diagnoses required specialist assessment falling outside of his remit and expertise. If he considered the naevus merited further investigation, he would refer to the HES for a definitive assessment. Consequently, he did not accept that he had a duty to advise a patient whether the choroidal naevus was "benign or malignant" according to the Allegation.

60. The Committee considered that looking at the ordinary and natural meaning of the wording in Particular 2c in alleging that there was duty to advise Patient A whether choroidal naevus was benign or malignant, there was a refence to a decision to be made that the choroidal naevus was either benign or malignant. It appeared to the Committee that the allegation involved making a clear, decision about whether or not it was malignant. There was no reference to the lower bar advocated by the GOC, namely to a duty that to advise Patient A that it had concerning features

which could indicate that it may be malignant and therefore required a referral). On that basis, it was clear there was no such duty as set out in the particular.

61. **The Committee therefore found Particular 2c not proved.**

Particular 3c

62. In relation to Particular 3c, the Committee referred to the evidence and reasoning in respect of the Particulars 1b and 2c.

63. The Registrant did not accept that he had a duty to record whether the choroidal naevus was benign or malignant for the same reasons that he did not accept the duty to assess whether it was benign or malignant or that he had a duty to advise Patient A whether it was benign or malignant.

64. The Committee considered its findings and reasoning in respect of Particulars 1b and 2c. Once again, the Committee decided that on examining the ordinary and natural meaning of the wording in Particular 3c in alleging that there was a duty to record whether the choroidal naevus was benign or malignant, there was a reference to a decision to be made that the choroidal naevus was either benign or malignant. There was no reference to the lower duty to assess if it had any concerning features which could indicate that it may be malignant and therefore required a referral. On that basis, it was clear there was no such duty, as was the GOC's clear position based on the opinion of Dr Kwartz.

65. For the same reasons as in Particulars 1b and 2c the Committee decided that the GOC had not discharged its burden of proof.

66. **The Committee therefore found Particular 3c not proved.**

Particular 4 (d)

67. Patient A's evidence was that in 2023 she saw the Registrant for a routine eye test, and that he told her that she had dry eyes and that she could purchase over the counter treatment. Her evidence was that the Registrant also informed her that she had the early start of a cataract in one eye but that he did not inform her of anything else. Patient A said she recalled being shown the images of her eyes but did not recall if it was during the 2021 appointment or the 2023 appointment or both. In her evidence, Patient A stated that she did not remember the Registrant telling her there was a "freckle" on her eye, but she accepted he could have said it and she did not remember, if it was not presented as of concern by the Registrant.

68. Patient A's notes do not document that the Registrant advised Patient A that she had a choroidal naevus. However, in Patient A's records for the examination on 2 September 2023, the Registrant has noted the words "naevus peripheral" in the right eye.

69. Dr Kwartz in her report (p. 99 8.8.3 and 8.5.2) expressed the opinion that if the Registrant did not explain to Patient A about the naevus, then he fell far below the expected standards of a reasonably competent optometrist.

70. The Registrant's evidence was that although he did not record his discussion with Patient A, he was confident that he would have discussed it with her. His evidence

was that he did record a "naevus peripheral" on this occasion and would not have noted this without discussing it with the patient. He also referred to the fact that in Patient A's notes on 2 September 2023, he had recorded a Fuchs dystrophy being discussed which related to a change to the back surface of the cornea. His evidence was that this can only be viewed using a slit lamp microscope under high magnification. This was recorded along with lens changes (early cataract). He would not normally note "discussed" unless the patient had been unsettled or inquisitive about something. Given that he had discussed what he referred to as very subtle changes with the patient's lens, he was confident that a conversation would have taken place with the patient regarding the naevus. His evidence was that he would not have used terms like "choroidal naevus" or "temporal to the macula" but would have used terms such as "freckle" or "freckle-like feature" to indicate that it was not of concern. The Committee accepted from his evidence that such a reference would have been briefly made.

71. The Committee first considered whether the Registrant had a duty to advise Patient A that she had a choroidal naevus, and was clear from the evidence of Dr Kwartz that he did.

72. It was clear from the reference to the choroidal naevus in Patient A's records for the 2 September 2023 that the Registrant had detected it and noted it. The Committee found the Registrant's evidence reliable and credible regarding his habitual routine in showing patients images of their eyes and explaining his findings. Patient A said she could not remember whether the Registrant had mentioned the naevus as a freckle or freckle-like, but noted she tended to remember better issues of concern rather than non-concerning matters. On the basis of all of the evidence considered, the Committee was not satisfied on the balance of probabilities that he did not advise Patient A of the choroidal naevus.

73. **The Committee therefore found Particular 4d not proved.**

Particular 4(e)

74. The committee referred to the evidence and its reasoning in relation to Particular 2c which is drafted in the same terms.

75. Dr Kwartz in her addendum report stated that:

"1.2.1 The most significant risk of the failure to detect a pigmented lesion on a patient's fundus is that there is a failure to identify a choroidal melanoma, which has sight- and life-threatening implications.

1.2.2. Monitoring of fundus lesions is indicated to rule out growth and the presence/ development of malignant features. Therefore, baseline characteristics should be recorded to determine if there is any subsequent growth."

76. The Registrant's evidence was that as a matter of routine, he would have assessed whether the naevus had any concerning features. Had there been any cause for concern, particularly any features that indicated that it may be malignant or required further investigation, then an onward referral would have been made, something he had done many times during his career. Any lesions or areas of

concern would have been screen shot and transferred digitally onto the Acuitas system as well as being sent off with the referral.

77. The Registrant did not accept that he was required to assess (and therefore advise a patient) whether the naevus was benign or malignant because he considered that such diagnoses required specialist assessment falling outside of his remit and expertise. If he considered the naevus merited further investigation, he would refer to the HES for a definitive assessment. Consequently, he did not accept that he had a duty to advise a patient whether the choroidal naevus was "benign or malignant" according to the Allegation.

78. The Committee considered that looking at the ordinary and natural meaning of the wording in Particular 4d in alleging that there was duty to advise Patient A whether choroidal naevus was benign or malignant, there was a reference to a decision to be made that the choroidal naevus was either benign or malignant. It appeared to the Committee that the allegation involved making a clear, decision about whether or not it was malignant. There was no reference to the lower bar advocated by the GOC, namely to a duty that to advise Patient A that it had concerning features which could indicate that it may be malignant and therefore required a referral. On that basis, it was clear there was no such duty as set out in the particular.

79. **The Committee therefore found Particular 4e not proved.**

Decision on Misconduct

80. The Committee heard submissions from Mr Thomas, who also relied on his written submissions. Mr Thomas submitted that the facts found proved were sufficiently serious to constitute misconduct. Mr Thomas submitted that the Registrant himself in his evidence had admitted the seriousness of failing to identify the high intraocular pressures and to make an emergency referral accordingly. Mr Thomas referred to a number of authorities in his submissions.

81. Ms Jung reminded the Committee that it should examine the seriousness of what has been found proved, but also that context was important. Ms Jung submitted that the failings relating to the intraocular pressures were in a different category than the other factual findings which were less serious and did not fall far below the standards expected. However, Ms Jung submitted that a failure to detect the high intraocular pressures was not necessarily misconduct, and the Committee should take a rounded view. Ms Jung took the Committee through a number of authorities.

82. The Committee accepted the advice of the Legal Adviser who referred to *Roylance v GMC* (No. 2) [2000] 1 AC 311, and the general legal principles governing the decision on misconduct. The Legal Adviser advised that while Dr Kwartz had expressed opinions on what failings had fallen far below the standards, this was a judgment ultimately for the Committee itself. The Committee took into account all of the evidence, and its findings thus far, as well as the sections on Misconduct in the GOC's Hearings and Indicative Sanctions Guidance.

83. The Committee was aware that misconduct is a matter for its own independent judgment.

84. The Committee considered the Standards of Practice, to which the Registrant was subject, and was of the view that by his failures and omissions, the Registrant breached the Standards applicable at the time as set out below. The Committee was aware that breaches of such Standards in themselves do not necessarily mean that the Registrant's actions constituted misconduct.

Standards of Practice for Optometrists and Dispensing Opticians (2016)

7. Conduct appropriate assessments, examinations, treatments and referrals

7.1 Conduct an adequate assessment for the purposes of the optical consultation, including where necessary any relevant medical, family and social history of the patient. This may include current symptoms, personal beliefs or cultural factors.

7.2 Provide or arrange any further examinations, advice, investigations or treatment if required for your patient. This should be done in a timescale that does not compromise patient safety and care.

8 Maintain adequate patient records

8.1 Maintain clear, legible and contemporaneous patient records which are accessible for all those involved in the patient's care.

Particular 2a

85. The Committee took into account the omission in taking the family history of glaucoma on 9 October 2021. The significance of noting it would have been that it would have triggered a one year recall for a subsequent appointment, rather than the standard two years, which Patient A was given. In addition, if the Registrant had noted the family history of glaucoma, it should have made him more aware of the need to pay particular attention to the intraocular pressures at the time. The Committee also took into account that the family history of glaucoma was noted in Patient A's 2018 records and the Registrant admitted in his evidence that he should have looked at the earlier records which was not something that he routinely did at the time, rather than relying on questioning of patients on the day of their appointment.

86. Dr Kwartz stated in her report that a reasonably competent optometrist would not check every piece of information at an appointment with what had been documented in the patient records at previous examinations. In addition, Dr Kwartz highlighted that it is not possible to ascertain if Patient A had mentioned a family history of glaucoma, and if a patient does not do so, Dr Kwartz did not consider that a reasonably competent optometrist needed to explicitly state that in the records.

87. The Committee was mindful that there was no evidence before it about what Patient A had said in the appointment about her family history of glaucoma. In addition, while the Committee considered that it would have been important to check the previous records, the Committee took into account Dr Kwartz's opinion as above on the lack of seriousness of failing to do so.

88. In light of the lack of details of the conversation, and taking into account Dr Kwartz's opinion, the Committee concluded that the omission in Particular 2a was poor practice but did not fall sufficiently below the Standards and was not so serious as to constitute misconduct.

Particular 3a

89. The Committee has already decided that not taking a clear and accurate family history of glaucoma on 9 October 2021 did not constitute misconduct for the reasons set out above.

90. The Committee recognised that without obtaining a clear and accurate family history the Registrant was not in a position to record it. For the same reasons found with Particular 2a the Committee determined that it was poor practice but in these circumstances did not fall sufficiently below the Standards and was not so serious as to constitute misconduct.

Particular 3b

91. While there was a fundal photo which displayed the choroidal naevus, the failure to record its existence in the patient records meant that there was no note for subsequent professionals to read, which was important for continuity of care for Patient A. As made clear by Dr Kwartz in her addendum report, monitoring of a choroidal naevus is important to rule out growth and the development of malignant features, particularly because of the potential for "sight and life-threatening implications".

92. However, in this case the choroidal naevus was benign, and also, as stated by Dr Kwartz, it was obviously benign from the photos. While it was still important to make a record in Patient A's notes, the Committee concluded that the existence of the photo, which was part of Patient A's records, and its obvious benign nature, meant that, in the Committee's decision, the failure in Particular 3b did not fall sufficiently below the standards and was not so serious as to constitute misconduct.

Particular 3d

93. The Committee considered that in failing to record the advice given to Patient A on 9 October 2021, subsequent professionals would be unable to read that advice had been given, and what that advice had been, even if it had been brief. However, in this case the choroidal naevus was benign, and the advice would have been that it was normal. The Committee considered that while there was a duty to record the advice, the fact that advice was not recorded did not put Patient A at risk.

94. In the circumstances, the failure in Particular 3d did not fall sufficiently below the standards and was not so serious as to constitute misconduct.

Particular 4a

95. The Committee considered the omission in taking the family history of glaucoma on 2 September 2023. The Committee considered whether there was any difference in seriousness between this omission in 2023 and the same omission in 2021. It concluded that there was no difference for the same reasons for its decision regarding Particular 2a. Consequently, the Committee concluded that the omission in Particular 4a did not fall sufficiently below the standards and was not so serious as to constitute misconduct.

Particular 4b

96. As stated by Dr Kwartz in her addendum report, Patient A's intraocular pressures were "very raised" and "there was a risk of serious harm to the patient". Dr Kwartz's opinion was that the interocular pressures in both eyes were high, and as a result of the pressure recorded in the left eye "there is a very high chance of the patient developing glaucomatous optic neuropathy and also a risk of retinal vascular occlusion". In other words, Patient A may have suffered loss of vision as a result.
97. In his evidence, the Registrant himself accepted clearly that the failure to identify the high intraocular pressures was a matter of great seriousness. He stated that pressures at the level in question could have damaged the eyes, and that failing to identify them was "the worst" level of seriousness.
98. The Registrant was unable to give a specific reason as to why he did not notice, and therefore advise, Patient A of the high intraocular pressures, conceding that he missed them. However, his failure deprived Patient A of crucial knowledge of a potentially sight-threatening condition.
99. The Committee considered that the failure to advise Patient A of her high intraocular pressures was so serious and fell so far below the standards of care expected, that it constituted misconduct.

Particular 4c

100. As stated by Dr Kwartz in her addendum report, Patient A's intraocular pressures were "very raised" and "there was a risk of serious harm to the patient". Dr Kwartz's opinion was that the interocular pressures in both eyes were high, and as a result of the pressure recorded in the left eye "there is a very high chance of the patient developing glaucomatous optic neuropathy and also a risk of retinal vascular occlusion". In other words, Patient A may have suffered loss of vision as a result.
101. The Registrant's failure to notice the high interocular pressures meant that he failed to advise Patient A of the risks associated with them. This was a serious failure in his duty towards Patient, and deprived Patient A of crucial knowledge of a potentially sight-threatening condition and any potential steps she could take to mitigate them.
102. The Committee considered that the failure to advise Patient A of the risks associated with high intraocular pressures was so serious and fell so far below the standards of care expected, that it constituted misconduct.

Particular 5a

103. The Committee has already decided that not taking a clear and accurate family history of glaucoma on 2 September 2023 did not constitute misconduct.

104. The Committee took account of the omission in not recording the family history of glaucoma on 2 September 2023. The significance of noting it would have been that it would have triggered a one-year recall for a subsequent appointment, rather than the standard two years, which Patient A was given. In addition, if the Registrant had noted the family history of glaucoma, it should have made him more aware of noting the intraocular pressures on that date. The Committee also took into account that the family history of glaucoma was noted in the 2018 records for Patient A, and the Registrant admitted in his evidence that he should have looked at the earlier records which was not something that he routinely did at the time, rather relying on questioning of patients on the day of the appointment.

105. Dr Kwartz stated in her report she would not consider that a reasonably competent optometrist would check every piece of information with what had been documented in the patient records at previous examinations. In addition, Dr Kwartz highlighted that it is not possible to ascertain if Patient A mentioned a family history of glaucoma, and if a patient does not do so Dr Kwartz did not consider that a reasonably competent optometrist needed to explicitly state that in the records.

106. The Committee was mindful that there was no evidence before it about what Patient A had said in the appointment about her family history of glaucoma. In addition, while the committee considered that it would have been important to check the previous records, the Committee took into account Dr Kwartz's opinion on the lack of seriousness of failing to do so.

107. In light of the lack of details of the conversation, and taking into account Dr Kwartz's opinion, the Committee concluded that the omission in Particular 5a did not fall sufficiently below the Standards and was not so serious as to constitute misconduct.

Particular 5b

108. The Committee took into account its decisions on misconduct in relation to Particulars 4b and 4c.

109. The evidence was clear that not having identified the high intraocular pressures, he did not mention them to Patient A.

110. The Committee was not persuaded that the Registrant could be found culpable for failing to record advice which he had not given, particularly because he was not aware of the issue.

111. As such, the Committee did not consider that the failure in this particular met the threshold of misconduct.

Particular 5c

112. As found by the Committee at the fact-finding stage, the Registrant had on 2 September 2023 recorded the existence of the choroidal naevus and also advised Patient A of it.

113. The Committee considered that in failing to record the advice given to Patient A, subsequent professionals would be unable to read that advice had been given, and what that advice had been, even if it had been brief. However, in this case the choroidal naevus was benign, and the advice would have been that it was normal. The Committee considered that while the advice should have been recorded as a matter of the Registrant's duty, the omission did not put Patient A at risk at that time.

114. In the circumstances, the failure in Particular 5c did not fall sufficiently below the Standards and was not so serious as to constitute misconduct.

Particular 6

115. Dr Kwartz's opinion in her addendum report was that in failing to make a referral for Patient A's "very raised" intraocular pressures, the Registrant fell far below the required standard as there was a risk of serious harm to the patient and a significant departure from the expected standard.

116. The Registrant himself in his evidence expressed how serious this failing was and acknowledged the serious risk to Patient A which could have resulted in loss of vision. He stated that it was an emergency situation which should have led him to call the HES straightway and get Patient A seen that day.

117. The failure to refer Patient A to the HES prevented Patient A from receiving crucial oversight and care in an emergency situation. As the Registrant had explained to the Committee in his evidence, optometrists were the frontline of the NHS. The Registrant's failure prevented Patient A receiving emergency oversight and care when she needed it.

118. The Committee concluded that the failure in Particular 6 to refer Patient A to the HES on an emergency basis fell so far below the standards expected as to constitute misconduct.

Conclusion

119. The Committee found misconduct in respect of the factual findings in Particulars 4b, 4c and 6.

Decision on Impairment

120. The Committee heard submissions from Mr Thomas, who also relied on written submissions. Mr Thomas referred to a number of authorities including the case of *GOC v Clarke* [2018] EWCA Civ 1463. Mr Thomas submitted that it was a significant concern that the Registrant was unable to explain why the misconduct, in particular the failure to identify the high intraocular pressures, occurred. As such, Mr Thomas invited the Committee to consider whether, as a result of this, there could be sufficient confidence in the Registrant's standard of practice and

that there is no impairment of it. Mr Thomas stated that the position of the GOC was that there was nothing in the case which would merit a finding of impairment on the basis of the wider public interest because, for example, there was no issue of lack of probity or dishonesty.

121. Ms Jung submitted that the Registrant's fitness to practise was not impaired, either on the basis of the need to protect the public or in the wider public interest. Ms Jung referred to a number of authorities including *GOC v Clarke*.

122. The Committee accepted the advice of the Legal Adviser who referred to *CHRE v (1) NMC (2) Grant* [2011] EWHC 927. *GOC v Clarke* [2018] EWCA Civ 1463. The Committee was aware that impairment is a matter for its own independent judgment and that both public protection and the wider public interest should be considered. The Committee took into account all of the evidence, and its findings thus far, as well as the sections on Impairment in the GOC Hearings and Indicative Sanctions Guidance.

123. The Committee considered the case of *Grant* which set out questions from the Fifth Shipman Report to be asked by it when considering impairment. In considering these questions the Committee concluded that the Registrant had in the past put Patient A at unwarranted risk of harm in failing to detect Patient A's high intraocular pressures which led him to fail to advise her of them and their risks and to make the required emergency referral to the HES. The Committee also concluded, when considering the remaining questions from the Fifth Shipman Report, that the Registrant had in the past, by reason of his misconduct, brought the profession into disrepute. He had also breached fundamental tenets of the profession which placed upon him an obligation not to put patients at risk of harm and that he should arrange for timely referrals to a specialist in such a way that he did not jeopardise patient safety.

124. The Committee then considered whether he was liable to act in these ways in the future.

125. The Committee was of the view that the Registrant was sincere, open and honest in giving his evidence. In both his written and oral evidence, he expressed empathy towards Patient A. He also expressed his apologies to Patient A, not only in his written statement but also through Ms Jung who expressed his apology to Patient A directly. In his written statement, the Registrant stated:

"Throughout my career, I was fully committed to the safe and effective care for all those that I had the privilege to call my patients. I remain proud of the career that I had, and of the care that I sought to provide to my patients over many years. For that reason, I was horrified and deeply distressed to learn of the current allegations now before the Committee.

…

Since becoming aware of the allegations, I have reflected carefully and extensively on my practice and on the matters which the Committee will be considering and have tried to engage with the process as openly, transparently and constructively as possible.

As indicated by the attached Schedule of Admissions, I admit several of the factual allegations. I also accept many of the criticisms made by the GOC's

expert. In particular, I accept that in 2023 I failed to act on, and advise Patient A, in relation to her significantly elevated IOPs. Those readings required urgent specialist attention, and I accept that I should have made a referral.

I would like place on record my sincere and unreserved apologies to Patient A. I am truly sorry that I failed to act in her best interests in relation to the obvious risks indicated by her raised IOPs, and for the stress and anxiety this whole situation will no doubt have caused her and those closest to her. My standard of care of Patient A has been a source of deep personal regret and something which I have played over time and again in my head."

126. The Committee took the view that the Registrant was open and honest in his evidence in that he stated that he could not explain why he missed the intraocular pressures. This may be seen as a logical consequence of the Registrant being unable to remember Patient A at all, and he did not seek to excuse his failures or blame them on extraneous circumstances The Committee considered that there was no evidence that the Registrant did not know what to do in relation to high intraocular pressures, but on 2 September 2023 he made a grave error of judgment by failing to look at the readings on pressures, which resulted in the breaches set out in the misconduct found.

127. The Committee took into account the Registrant's admissions at the start of the hearing, including to the most serious allegations relating to the intraocular pressures, his oral evidence, and the manner in which he engaged with the hearing. The Registrant has been retired for some time, and told the Committee that he had no intention of returning to practise, but, as he explained to the Committee, he wished to engage with and attend these proceedings as part of his desire to contribute to and uphold the regulatory process.

128. The Committee took into account that while it was not the subject of an allegation, the Registrant accepted that the way he wrote some of Patient A's records was unclear in his language and was not acceptable. He was also candid in accepting that he did not routinely look at previous patient records when in an appointment, and stated that he should have done so. The Committee was mindful that the Registrant made this concession despite Dr Kwartz expressing the opinion did she not consider this it was a serious matter not to do so. Mr Thomas accepted on behalf of the GOC that the Registrant has engaged with humility, and the Committee considered that his engagement was an expression of his professionalism and the value which he placed upon public confidence in the profession, as well as the value which he placed upon the regulatory process.

129. The Registrant's remorse, shame and feelings of upset at himself for his failures was clear to the Committee. It was also clear that the regulatory process has been a salutary lesson for the Registrant.

130. The Committee considered the Registrant's reflections on the misconduct and his reflections on why and how the misconduct would not happen again. He has undertaken further targeted CPD including on record-keeping, glaucoma and MOLES, evidence of which was before the Committee.

131. The Committee found the Registrant to have demonstrated a high level of insight. He demonstrated to the Committee that he has learnt from his failures. In light of all of the evidence before it, the Committee was satisfied that the Registrant has sufficient insight into his misconduct. Taking into account the training undertaken,

whilst he has been retired, and the fact that remediation can take the form of reflection, understanding and insight, the Committee could not conceive of any further practical steps he could have taken while he was retired and not in practice, to demonstrate practical remediation. In the circumstances, the Committee was satisfied that he has shown not only sufficient insight but also sufficient remediation.

132. The Committee took into account that the misconduct related to a single patient, in a single appointment, albeit there was more than one instance of misconduct, which was serious. The Committee also took into account the Registrant's otherwise unblemished lengthy career. Having considered the evidence before it, the Committee was satisfied that there is a very low risk of repetition of the failures in question in the future. As such, the Committee was satisfied that the Registrant is not liable in the future to put a patient at unwarranted risk of harm, to bring his profession into disrepute, or to breach fundamental tenets of the profession, and that the risk of repetition of his failures is low.

133. The Committee then considered the wider public interest, namely the need to maintain public confidence in the profession and to uphold proper standards of conduct and behaviour.

134. The Committee took into account that the Registrant has been open and honest in his evidence, and that he has engaged with, and made admissions during, the regulatory process. The Registrant has shown sufficient insight and remediation, and is considered by the Committee to present a very low risk of repetition.

135. On the basis of the matters set out above, the Committee was of the view that a reasonable and well-informed member of the public, aware of all the evidence before the Committee, and all the circumstances of the case as set out above, would not be concerned to discover that the Registrant's current fitness to practise was found to be unimpaired. In terms of the public interest, while he did bring the profession into disrepute and breach fundamental tenets in the past, the Committee concluded that his engagement with the regulatory process, and the evidence of insight and remediation has addressed the public interest concerns in this case. After careful consideration, taking into account all the reasons set out above, the Committee was of the view that the need to maintain public confidence in the profession and to uphold proper standards would not be undermined if a finding of impairment were not made in the particular circumstances of this case.

136. The Committee therefore determined that the Registrant's current fitness to practise as an optometrist is not impaired on either public protection or public interest grounds.

Declaration

137. The Committee makes a formal declaration that the Registrant's fitness to practise is not impaired

Warning

138. The Committee gave the parties the opportunity to read the determination on misconduct and impairment, and to return to the hearing for Mr Thomas to confirm

whether or not he had an application for the Committee to impose a warning in this case. When the parties returned, Mr Thomas referred extensively to paragraphs in the Committee's decision on impairment and stated that on the basis of the Committee's reasoning, it would be disproportionate for there to be a warning in this case. Ms Jung did not seek to address the Committee on this point.

139. The Legal Adviser referred the Committee to Rule 46 (16) and (17) of the 2013 Rules.

140. The Committee was aware of the relevant paragraphs in the Hearings and Indicative Sanctions Guidance, and concluded that this was not a case where a warning would be required on the basis of the reasoning in the Committee's impairment decision.

Chair of the Committee: Louise Fox

Signature  **Date: 17 July 2026**

Registrant: Stuart Towers

Signature *present and received via email* **Date: 17 July 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.
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.