BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(24)36

AND

SIDDIQUE CHOWDHURY (01-42508)

DETERMINATION OF A SUBSTANTIVE HEARING
25 NOVEMBER - 4 DECEMBER 2025

Committee Members:	Mr Clive Powell (Chair/Lay) Mr Mark Richards (Lay) Mr Nigel Pilkington (Lay) Ms Kalpana Theophilus (Optometrist) Ms Caroline Clark (Optometrist)
Legal adviser:	Ms Aaminah Khan
GOC Presenting Officer:	Mr Richard Ive
Registrant present/represented:	Yes and represented
Registrant representative:	Mr Trevor Archer
Hearings Officer:	Ms Natasha Bance
Facts found proved:	Particulars 1(a)(i), (ii), (iii), (v), b) (iii), (iv),(v), (vi), (vii), (viii), 2, 3(a)(ii), 3(b)(ii) and 5 (in respect of the admitted particulars) were found proved by the Registrant's admissions. Particulars 1(b)(i) and (ii), 1(b)(ix), 3(a)(i), 3(a)(iii), 4, 5 (in respect of the particulars which were denied), 6 and 7 were found proved following the facts stage.
Facts not found proved:	Particulars 1(a)(iv), 1(b)(x), 3(b)(i) and 3(b)(iv) which were not proceeded with.
Misconduct:	Found in relation to particulars 1(except 1(b)(ix), 2 and 7
Impairment:	Impaired
Sanction:	Suspension of 2 months – (Without Review)
Immediate order:	Imposed

ALLEGATION

The Council alleges that in relation to you, Siddique Chowdhury (01-42508) a registered Optometrist, whilst employed as a pre-registrant at [redacted] Specsavers Limited:

1) On or around 17 December 2023, you:
   a. Failed to perform an appropriate examination and/or assessment of Patient A's eyes in that you:
      i. Failed to identify signs of diplopia; and/or
      ii. Failed to perform any tests for Patient A's oculomotor status; and/or
      iii. Failed to ask follow-up questions despite Patient A reporting double vision; and/or
      iv. Inappropriately said to Patient A, "Your astigmatism has changed" or words to that effect, despite having insufficient information to advise Patient A that a refractive change had taken place in his right eye; and/or **(particular not proceeded with)**
      v. Failed to appropriately provide Patient A with a signed written prescription, following his test, in accordance with Paragraph 26 of Part IV of the Optician's Act 1989; and/or
   b. Failed to maintain adequate records in that you:
      i. Recorded 'routine check (no symptoms)' despite failing to ask Patient A his reason for visit; and/or
      ii. Recorded 'routine check (no symptoms)' despite Patient A reporting he has noticed a change in his vision; and/or
      iii. Recorded that Patient A said his distance and near vision are good despite Patient A reporting that he has noticed a change in his vision; and/or
      iv. Recorded that Patient A has not reported any flashes, floaters, diplopia, or headaches despite not asking the patient; and/or
      v. Recorded that Patient A has not reported any flashes, floaters, diplopia, or headaches despite the patient reporting his vision as 'double'; and/or
      vi. Recorded near vision and/or near visual acuity despite this not being assessed; and/or
      vii. Recorded performing a cover test and/or ocular motility test and/or pupil assessment despite these not being performed; and/or
      viii. Failed to record Patient A's symptoms of double vision; and/or

ix. Failed to record which supervisor was responsible for the examination; and/or

x. Failed to record who was responsible for the delegated pre-screening activities; and/or **(particular not proceeded with)**

2) On or around 17 December 2023, you made derogatory remarks about Specsavers such as how they overestimate their financial contribution to their trainees and/or that they do not pay their trainees well or words to that effect; and/or

3) On or around 2 February 2024, you:

   a. Did not perform an appropriate and/or adequate examination and/or assessment of Patient B's eyes in that you:

      i. Failed to perform a full sight test [sic] together with a visual fields, test despite Patient B clinically presenting with longstanding frontal headaches; and/or

      ii. Failed to measure Patient B's near point of convergence despite Patient B's presenting symptoms; and/or

   b. Failed to maintain adequate records in that you:

      i. Recorded 'Refracted: unreliable' and failed to record what part of the refraction was unreliable; and/or **(particular not proceeded with)**

      ii. Failed to record the duration of the near vision symptoms and which eye was affected; and/or

      iii. Failed to record which supervisor was responsible for the examination; and/or

      iv. Failed to record who was responsible for the delegated pre-screening activities; and/or **(particular not proceeded with)**

4) On or around 2 February 2024, you left the clinic without appropriate authorisation in circumstances where you had not fully completed a patient consultation and/or there were two further patients scheduled to see you; and/or

5) Your conduct as set out at 1a)i and/or 1a)ii and/or 1a)iii and/or 1a)iv and/or 1a)v and/or 1b)i and/or 1b)ii and/or 1b)iii and/or 1b)iv and/or 1b)v and/or 1b)viii and/or 1b)ix and/or 1b)x and/or 2 and/or 3a)i and/or 3a)ii and/or 3b)i and/or 3b)ii and/or 3b)iii and/or 3b)iv was unprofessional and/or inappropriate; and/or

6) Your conduct as set out at 4) was unprofessional; and/or

7) Your conduct as set out at 1bi and/or 1bii and/or 1biii and/or 1biv and/or 1bv and/or 1b)vi and/or 1b)vii was dishonest in that you recorded information not discussed and/or incorrectly recorded patient responses and/or recorded tests that were not performed; and/or

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

General Optical Council

DETERMINATION

Preliminary Issues

1. Mr Ive, on behalf of the General Optical Council ('the Council') raised two preliminary issues regarding the Council's witnesses. The first related to an application for the witness [Witness B] to give evidence via video link, rather than attend the hearing in person. There was no objection to the application by Mr Archer, on behalf of the Registrant. The Committee granted the application.
2. Mr Ive made a second application, which was for the witness [Witness A] to give evidence behind a screen, so that she would not be able to see the Registrant during her evidence. Witness A had informed the Council's representatives that she wished to give evidence behind a screen because it would be awkward and difficult for her to give evidence in person seeing the Registrant, as they used to work together. Witness A described being anxious and stressed about the prospect of giving evidence and that a screen would make her more comfortable.
3. Mr Archer stated that he had no objection to the application submitting that there was no suggestion that the witness was vulnerable, or that there had been any intimidation by the Registrant. However, it was accepted that a screen would make giving evidence more comfortable for the witness and the application was not opposed on that basis. The Committee, having heard submissions from the parties, was satisfied that the use of a screen, as a special measure, would be appropriate in the circumstances and granted the application.
4. A third preliminary matter related to a declaration made prior to the hearing by Ms Kalpana Theophilus, an Optometrist member of the Committee, of a potential conflict. The declaration related to Ms Theophilus being a part-time senior lecturer at the University of Hertfordshire at the same time that the Registrant was a student there. Ms Theophilus did not recall the Registrant and did not recall having any direct dealings with him, but considered it likely that he was taught by her as part of a large group.
5. Additionally, Ms Theophilus declared that she had recently sat as a Committee member in an unrelated fitness to practise hearing for a locum Optometrist from the [redacted] Specsavers, who had been referred to the Council by the same director Witness A. Ms Theophilus had heard Witness A give witness evidence in that case. Ms Theophilus also declared that she knows both expert witnesses, Dr Anna Kwartz and Professor Bruce Evans, in a professional capacity. They are fellow examiners at the College of Optometrists OSCE circuits, however Ms Theophilus stated that she has never worked on a one to one basis with either expert.
6. The above declarations were provided to the parties in advance of the hearing so that they could consider their positions. Mr Archer confirmed that the Registrant was not making an application that Ms Theophilus ought to recuse herself from hearing this case. However, he requested that the Committee be given advice that it must base its decisions solely on the evidence received in these proceedings and that Committee members must not discuss anything that has taken place in earlier proceedings. The Legal Adviser agreed that this was appropriate advice to

give the Committee in these circumstances and endorsed the advice outlined by Mr Archer.

Admissions in relation to the particulars of the allegation

7. The Registrant admitted particulars 1a)(i), (ii), (iii), (v), 1(b) (iii), (iv), (v), (vi), (vii), (viii), 2, 3(a)(ii), 3(b)(ii) and 5 (in respect of the admitted particulars) of the Allegation, which were found proved by virtue of the Registrant's admissions.

Background to the allegations

8. The Registrant registered as a student Optometrist on 1 October 2019 and registered as a fully qualified Optometrist on 18 July 2024.
9. The Council received a referral regarding the Registrant from [redacted] Specsavers Limited ('the Practice') on 21 February 2024. This referral raised concerns regarding the standard of the Registrant's eye examinations and conduct, which was highlighted in two patient interactions on 17 December 2023 (Patient A) and 2 February 2024 (Patient B).
10. The Registrant's patient interaction with Patient A was a mystery shopper interaction, which was filmed by the mystery shopper by way of covert recording equipment. When the mystery shopper footage was reviewed by the Practice, concerns were raised about discrepancies between the Registrant's completion of the patient record for Patient A and what could be seen from the footage to have occurred in the examination.
11. The Registrant also was seen to have made derogatory remarks during the examination to Patient A about Specsavers, such as how they overestimate their financial contribution to their trainees and that they do not pay their trainees well.
12. In addition, concerns were also raised relating to the Registrant leaving the Practice early on 2 February 2024, without authorisation, when he had not finished his clinic. It is alleged that when the Registrant left, he had not fully completed a patient consultation and there were further patients due to be seen by him.
13. The clinical concerns have been considered by two experts; Dr Anna Kwartz, instructed by the Council and Professor Bruce Evans, instructed by the Registrant. Each expert has provided an expert report and together they have produced a Joint Expert Report.
14. The Council allege that the Registrant's conduct was unprofessional and/or inappropriate. Additionally, where it is alleged that the Registrant recorded information that was not discussed and/or incorrectly recorded patient responses and/or recorded tests that were not performed, it is alleged that this was dishonest.

The hearing

15. The Committee had before it a bundle of documents produced by the Council, which included the referral to the Council, witness statements, the expert reports of both experts and the Joint Expert Report, patient records of Patients A and B, documents from the local Investigation and a transcript of the Mystery Shopper Video on 17 December 2023. The Committee was also provided with a copy of Mystery Shopper footage and CCTV footage showing the Registrant leaving the Practice on 2 February 2024.

16. The Committee also had a Registrant's bundle, which included the Registrant's witness statement and his curriculum vitae ('CV').

17. The witness [Witness A], Ophthalmic Director of the Practice, gave evidence, confirming the contents of her two witness statements dated 26 April 2024 and 16 May 2024. She was questioned by Mr Ive for the Council, Mr Archer on behalf of the Registrant and the Committee.

18. Witness A's evidence, in summary, was that in relation to the events of 2 February 2024, the Registrant left the store without authorisation to do so at 4pm. When asked if he would be allowed to leave the store when there remained patients to be seen, she responded 'no'. Witness A was questioned by Mr Archer regarding the systems in place at the Practice, particularly in relation to the pre-screening tests.

19. Witness A explained that if they needed to identify who had conducted the pre-screening tests this information could be found out from checking who had logged into the system to conduct the tests, the rota and also the 'hub' part of the system, which shows who is using what room. Witness A's evidence was that Optometrists in the Practice did not routinely record the pre-screener's name on the patient records. Witness A did not accept when it was put to her, that the Registrant had come to speak to her at lunchtime about leaving early. She accepted that the locum in the Practice that day had said that the Registrant had asked him to see the Registrant's last two patients of the day. Witness A stated that no-one else knew where the Registrant had gone apart from the locum.

20. The witness [Witness B], Professional Services Consultant for Specsavers Optical Stores, gave evidence, confirming the contents of his witness statement dated 9 April 2024.

21. Witness B's evidence, in summary, was that he was asked to review the Mystery Shopper footage in relation to the Registrant's examination of Patient A on 17 December 2023 and he advised, following this review, that it ought to be brought to the attention of the Council. Witness B explained that this was because the Registrant had recorded performing tests which were not, in fact, carried out and he was concerned that this may possibly be dishonest record keeping.

22. The Council's expert witness Dr Kwartz gave evidence, expanding upon the evidence set out in her expert report dated 15 September 2024, amended on 26 October 2025 (to rectify a typographical error). Dr Kwartz was questioned by Mr Ive for the Council, Mr Archer on behalf of the Registrant and the Committee.

23. During her evidence Dr Kwartz was asked why she had referred to the standards for qualified Optometrists in her report and she explained that she had considered

these to be appropriate because the Registrant was conducting sight tests and acting as a qualified Optometrist in the two sight tests that she had considered. During questioning by Mr Archer, Dr Kwartz accepted that whilst the Registrant was still a student, it would be the pre-registration standards that were applicable and that she had applied the incorrect standards.

24. When the hearing resumed the following day to conclude Dr Kwartz's evidence, the Committee Chair raised that the Committee would need to understand the standards that the Registrant had been expected to meet as a pre-registration Optometrist and that a copy of those standards, as applicable at the material time, were required.

25. The parties obtained a copy of the Council's 'Standards for Optical Students' effective from April 2016, which was placed before the Committee. Dr Kwartz was allowed further time before continuing her evidence to review the student standards and consider if her opinions needed to be revised in light of them. Dr Kwartz produced a further document setting out the relevant standards for students that applied to this case. She confirmed following her review of the student standards that her opinions had not changed.

26. During Dr Kwartz's evidence she referred to guidance from the College of Optometrists to students, which is available from the College of Optometrists website under 'Stage One downloads' with the title 'Patient Confidentiality, anonymity and supervision requirements.' The slides from this video stated that for patient records to be used as evidence, students must record in their logbook and on the patient record, the name of the person supervising them when the patient was examined. A copy of the slides from this video was provided to the Committee.

Submission of no case to answer

27. Following the close of the Council's case, Mr Archer, on behalf of the Registrant, made a submission that there was no case to answer in respect of the particulars 1(b)(ii), 1(b)(x) and 3(b)(iv) of the Allegation.

28. Mr Archer stated that he was making the submission of no case on both limbs (a) and (b) of Rule 46(8), namely that there had not been sufficient evidence adduced upon which the disputed facts could be found proved and that the facts, even if proved, could not find support a finding of impairment. Mr Archer referred the Committee to the case of *Galbraith* (1981) 73 Cr.App.R. 124 (CA), which he summarised as follows:

> *a. If there is no evidence that the allegation is proved and that it could support a finding of impairment, the committee must dismiss the allegation.*
> *b. If there is some evidence, but it is tenuous, weak, vague, or inconsistent, the committee must consider whether, taken at its highest, the allegation could be found proved and that it could support a finding of impairment. If the answer is no, the allegation must be dismissed.*

29. Mr Archer submitted that not every falling short of acceptable practice amounts to professional misconduct of a gravity that crosses the threshold at which a registrant's fitness to practise may be subject to scrutiny. Falling short of the expected standard only crosses that threshold if it can properly be described as "serious" (*Roylance v General Medical Council* [2000] 1 AC 311). Mr Archer further submitted that not every mistake amounts to serious professional misconduct and that negligent mistakes will only constitute misconduct if the negligence is to a "*high degree*".

30. Mr Archer referred the Committee to the Hearings and Indicative Sanctions Guidance, at paragraph 15.8, which states that whilst it is possible to find misconduct based on a single act or omission, such conduct would need to be particularly serious in order to qualify.

31. In relation to particular 1(b)(ii), Mr Archer submitted that this part of the allegation criticises the Registrant for recording "routine check (no symptoms)" despite Patient A reporting symptoms, focusing upon what was recorded. Mr Archer submitted that the particular does not allege that there was a failure to record symptoms of double vision. Mr Archer submitted that given that the Registrant did go on to record symptoms in the same box on the patient record, it was clear that the Registrant had accidentally clicked on the wrong button.

32. Furthermore, Mr Archer submitted that whilst the Committee may find that clicking on a wrong button was a failing, it cannot reasonably be found to be a serious failing and that falling short is not on its own enough. He invited the Committee to find that this part of the allegation cannot support a finding of impairment.

33. In relation to particulars 1(b)(x) and 3(b)(iv), which both relate to failing to record who was responsible for the delegated pre-screening activities, Mr Archer submitted that as the Registrant was a pre-registration student Optometrist at the material time, he was subject to the Council's Standards for Optical Students, not the Council's Standards of Practice for Optometrists and Dispensing Opticians. Mr Archer submitted that nothing in the Standards for Optical Students required the Registrant to record the name of the person who conducted pre-screening delegated activities on the patient record.

34. Mr Archer reminded the Committee of the evidence of Dr Kwartz on this issue, which was that it would be adequate for the name of the person to be recorded in a place where staff could access it to establish specifically who carried out the pre-screening. Additionally, the Practice Director, Witness A, in her live evidence explained that the name of the person who carried out the pre-screening was recorded in several places, including: the store rota, the computer logging system, and a 'hub'. Witness A's evidence was that no optometrist at the practice routinely recorded on the individual patient record the name of the person who conducted the pre-screening.

35. In the circumstances, Mr Archer submitted that this allegation could not properly be said to amount to a failure of the Standards of a reasonably competent student Optometrist, nor would it fall so far below that it could justify a finding of impairment.

36. After consideration of the application, Mr Ive, on behalf of the Council, submitted that the Council's position was that there was a case to answer in respect of

particular 1(b)(ii) but the Council conceded that there was not a case to answer in respect of particulars 1(b)(x) and 3(b)(iv), which the Council did not intend to proceed further with.

37. In relation to particular 1(b)(ii), Mr Ive submitted that there was sufficient evidence upon which the Committee could find this proved and there was evidence to support a finding of impairment in respect of it. Mr Ive invited the Committee to refuse the application and allow this particular to proceed to hear the defence evidence in respect of it.

38. Mr Ive submitted that the patient record was not a true and accurate reflection of what occurred in the examination and that a reader of the patient record would assume that the patient had no symptoms, as it stated so. Mr Ive stated that even if there had been a mistake by the Registrant in clicking the wrong pre-populated text button, the Registrant had not gone on to record an accurate summary of Patient A's symptoms, as he did not include anything regarding the reported double vision.

39. In relation to Dr Kwartz's evidence, Mr Ive submitted that it could be seen from her CV that she has worked in high street practice as well as in hospital settings and that she was referring to all of her experience when she gave evidence. In relation to the suggestion that the Registrant may have clicked the wrong button as a mistake, Mr Ive submitted that it was still a serious failing as it does not provide a true reflection of what Patient A reported and that the full picture was only known from the mystery shopper video. Mr Ive submitted that others should be able to rely upon the accuracy of the patient record.

40. The Committee heard and accepted the advice of the Legal Adviser on the submission of no case to answer. The Legal Adviser referred the Committee to Rule 46(8) of the General Optical Council (Fitness to Practise) Rules Order of Council 2013, which states that:

> "*Before opening the registrant's case, the registrant may make submissions as to—*
>
> *(a)whether sufficient evidence has been adduced upon which the disputed facts could be found proved;*
>
> *(b)whether the facts, whether they are disputed or proved, could support a finding of impairment."*

41. The Legal Adviser advised that *Galbraith* was the leading case and although it was a criminal case it was well established that the same principles apply to regulatory proceedings. The Legal Adviser agreed with how the test had been outlined by Mr Archer, which is outlined above.

42. Further, the Legal Adviser advised that the Committee was not making findings of fact at this stage (considering whether it could rather than would find matters proved/make a finding of impairment) and should consider the Council's evidence as a whole and not only the strongest parts.

The Committee's decision on the submission of no case

43. The Committee retired in private to consider the submission of no case to answer.

44. In respect of the particulars of the Allegation where the submission of no case application was not opposed by the Council, the Committee noted that this had been conceded by the Council and it was satisfied that there was no case to answer in respect of these particulars of the Allegation (particulars 1(b)(x) and 3(b)(iv)).

45. In respect of the contested application of no case to answer (particular 1(b)(ii)), the Committee considered that this part of the allegation fell within the second category of Galbraith, where there is some evidence of what is alleged. The Committee considered whether, taken at its highest, the allegation could be found proved and that it could support a finding of impairment.

46. Having considered the submissions of the parties, the Committee determined that there was sufficient evidence upon which this particular of the Allegation could be found proved. The Committee considered the patient record of Patient A, which had been completed by the Registrant and he had recorded 'routine check (no symptoms)' despite Patient A reporting that he had noticed a change in his vision. Whilst the Registrant had recorded some of the symptoms reported by the Patient, this was not complete when compared to the presenting symptoms in the mystery shopper video. There was evidence that the entry recorded by the Registrant was inaccurate and incomplete.

47. The Committee further considered that although it had been suggested that recording 'routine check (no symptoms)' may have been a mistake by the Registrant, it did not agree with the submission of Mr Archer that this could not amount to a finding of impairment. The Committee considered that this particular of the Allegation was one aspect of a wider alleged failure to maintain adequate records in respect of Patient A, of which other aspects had been admitted by the Registrant. The Committee was satisfied that on the evidence before it, which included the expert evidence of Dr Kwartz, this particular of the Allegation could be found proved and that it could support a finding of impairment.

48. Accordingly, the submission of no case to answer in respect of particular 1(b)(ii) is not upheld.

49. **The Registrant's case**

50. The Committee proceeded to hear the Registrant's case. Professor Evans gave evidence, expanding upon his expert report dated 1 May 2025. Professor Evans was questioned by Mr Archer on behalf of the Registrant, Mr Ive for the Council and the Committee.

51. When asked if he had any revisions to make to his report, Professor Evans stated that he had also applied the standards that applied to qualified Optometrists and he accepted that the applicable standards were those that applied to pre-registration Optometrists. Professor Evans stated that having reviewed the latter standards, his fundamental opinions were not affected. However, the specific

standards referred to throughout his report were different and he took the Committee through the references to the standards in his report, providing the applicable standard for pre-registration Optometrists.

52. The Registrant gave evidence, expanding upon the evidence in his witness statement. During the course of the Registrant's evidence he made reference to his [redacted]. Mr Archer, on behalf of the Registrant, requested that all such evidence be heard in private and not included in the published determination. Mr Ive had no objection to such matters being heard in private.

53. The Legal Adviser advised the Committee that under Rule 25 it had a discretion to sit in private, if it considered it appropriate to do so, when considering matters such as the [redacted] of the Registrant and this could also apply to the [redacted] and similarly confidential matters. However, sitting in private ought to be proportionate and that no more of the hearing should be in private than is necessary, given that these are ordinarily public hearings.

54. In the circumstances, considering the private nature of the information and having regard to the Council having no objection, the Committee was satisfied that it was appropriate for parts of the hearing, where the Registrant gave evidence regarding his [redacted], for these parts of the hearing to be heard in private.

55. In summary, the Registrant's evidence was that he qualified in July 2024, having undertaken a four year masters programme at University and that at the time of the events in question he was in his fourth year completing his pre-registration stage of his University course. The Registrant explained that whilst completing his pre-registration placement at the Practice he was living far away from home, which he found difficult. He was under financial pressure, as his [redacted] had [redacted] and he had to send money home; his [redacted] was also affected and he was [redacted].

56. The Registrant gave evidence that he accepted that he had not written his supervisor's name on the patient records. He stated that he had not been told to do this by any supervisor and he did not recall having previously seen the video that had been shown in the hearing from the College of Optometrists. The Registrant stated that if he had not recorded this information on the patient record, he had on his log book, which recorded the detail of his patient examinations.

57. In relation to the examination of Patient A, the Registrant accepted that when Patient A had said he was a recruiter, he had joked about whether he could '*get him a job'*, which was a poor attempt at humour. The Registrant stated that at the back of his mind was a conversation he had recently had with a recruiter and accepted that he had spoken too casually, which was not appropriate.

58. The Registrant accepted that he had not adequately investigated Patient A's double vision as he felt that the astigmatism was the most likely cause of his complaint of double vision, but accepted that he should have asked more questions regarding other potential causes.

59. In relation to the incorrect entries in the records, the Registrant's evidence was that he was distracted by the conversation with Patient A and he unconsciously did not check the boxes properly, as he was acting on "*auto-pilot*". He accepted that his record-keeping was poor and that he had clicked buttons in error, or forgotten to delete pre-populated text, but denied that he had acted dishonestly.

60. In relation to leaving early on 2 February 2024, the Registrant gave evidence that there was an informal practice of Optometrists helping each other to allow those that had to travel a long distance to leave early. On the day in question, the Registrant stated that he had told Witness A, his supervisor on that day, in her room, that he needed to leave early to travel to [redacted] and that he had arranged for a locum to see his last two patients. She had not responded and he took that as authorisation. He then arranged for the locum Optometrist to see his last two patients of the day.

61. The Committee heard closing submissions from both parties. Mr Ive reminded the Committee of the burden and standard of proof applicable in these proceedings. Mr Ive took the Committee through each individual particular and made submissions on why the Council had discharged the burden of proof in relation to each.

62. In relation to particular 1(b)(i), Mr Ive submitted that the Registrant had accepted that he had recorded '*routine check (no symptoms)*' and it is clear from the video and transcript that he had not asked about the reason for Patient A's visit. Mr Ive referred to the evidence of Dr Kwartz, which was that there were multiple reasons why patients attend a clinic, not just because their vision had changed. Mr Ive reminded the Committee that Dr Kwartz made it very clear in her oral evidence that she was commenting on this case with a background of experiences as a 'community high street Optometrist', not a hospital Optometrist. Mr Ive submitted that even Professor Evans had acknowledged that the Registrant had not asked a specific question about whether this was a routine check.

63. In relation to particular 1(b)(ii), Mr Ive submitted that the Registrant had accepted that he had recorded *'routine check (no symptoms)'* and that the Committee must consider if Patient A had reported a change in their vision. Mr Ive stated that Patient A had reported that everything was '*a little bit more doubled*' and that at night, lights appeared streakier, so had clearly reported a change in his vision.

64. In relation to particulars relating to an alleged failure to record which supervisor was responsible for the examination, Mr Ive submitted that the Registrant did not record this information. Mr Ive referred to the evidence of Dr Kwartz and the guidance from the College of Optometrists, which has been issued to trainees. Mr Ive stated that the word 'must' was a mandatory requirement and the Registrant must have been aware of this guidance. In any event, Mr Ive submitted that the Registrant was also bound by Standard 7.2.7 of the 2016 Standards for Optical Students, which explicitly states that the information recorded should '*include details of your supervisor'.*

65. In relation to Patient B and the particular 3(a)(i), Mr Ive stated that it was accepted by the Registrant as a matter of fact, that he did not perform a visual fields test. Mr Ive submitted that the real reason that this test was not completed is because the Registrant was rushing to leave the clinic before getting a train to [redacted]. This undermines the clinical reason that has been proffered by the Registrant. Mr Ive stated that the Registrant left the clinic at 4:01pm. This was four minutes before Patient B was due to be seen and there is no evidence that Patient B was in a rush and could not stay to have the tests completed.

66. In relation to particular 4, Mr Ive submitted that it was clear from the CCTV footage that the Registrant left the clinic early at 4.01pm and that the next issue to consider was whether he left without appropriate authorisation. Mr Ive reminded the Committee of the evidence of Witness A and that she had not authorised the Registrant to leave early. Mr Ive submitted that there was also a significant amount of evidence in support of the point that the Registrant left without having fully completed a patient consultation and that there were two further patients scheduled to see him.

67. In relation to particular 5, Mr Ive submitted that in relation to each part of this allegation which remained in dispute the conduct of the Registrant was unprofessional and inappropriate. In relation to particular 6, Mr Ive submitted that it was unprofessional for the Registrant to leave early without authorisation.

68. Turning to dishonesty, Mr Ive submitted that it was dishonest for the Registrant to record information that was never actually discussed, for example, that it was a routine visit and also to record tests that were not performed. Mr Ive submitted that the concerns about dishonesty were shared by Dr Kwartz, Witness A and Witness B, who had brought the concerns to the attention of the Council.

69. Mr Ive submitted that in relation to each allegation, the Council had clearly discharged the burden of proof. In relation to each allegation, he stated that there is a considerable amount of evidence, written, oral and documentary, in support of the Council's case. Mr Ive submitted that the Council's case is credible and compelling and he invited the Committee to find that all of the allegations that have not been admitted are proved on the balance of probabilities.

70. Archer submitted that in relation to the allegations regarding an alleged failure to record the supervisors name (1(b)(ix) and 3(b)(iii)), there had been conflicting evidence about what was acceptable practice in this respect. Mr Archer submitted that although the GOC Standards for Optical Students at 7.2.7 state that student registrants must record "*details of your supervisor including name and GOC registration number*" it did not actually specify whether the information must be recorded in the individual patient record card, or simply somewhere that is "*accessible for all those involved in the patient's care*".

71. Mr Archer highlighted the various parts of the evidence that dealt with the issue of recording the supervisor's details, including the evidence of Dr Kwartz, which was that she often sees just the initials recorded, which is acceptable in her view. Mr Archer referred to the evidence of Professor Evans, which was there were difficulties in adopting a literal approach to the GOC Standards of Practice and that they should be approached with common sense. Mr Archer submitted that there was no difficulty in establishing the relevant supervisor, as this was recorded on the rota (accessible by others involved in the patient's care) and by the Registrant in his logbook. Furthermore, Mr Archer submitted that the wording of the Allegation was important as it did not allege that the Registrant failed to record his supervisor's name in the patient record but simply that he "*failed to record which supervisor was responsible for the examination*", which he did not fail to do.

72. In relation to particulars 1(b)(i) and (ii), Mr Archer submitted that it was obvious that the Registrant had clicked the wrong button by mistake, which could be seen from the fact that he had recorded symptoms in the same box. Mr Archer

submitted that it would have been obvious to another Optometrist reading the record that this was simply a mistake.

73. In relation to the allegation that the Registrant failed to ask Patient A about the reason for their visit, Mr Archer submitted that there was some debate about what was an appropriate question to ask at the start of the eye test and he referred the Committee to Professor Evans' evidence and the research that had been undertaken about this. Mr Archer submitted that the question now used by Professor Evans ("*have you noticed any change in your eyes or vision?*") was very similar to the question that the Registrant asked in asking "*do you feel like your vision's changed?*". Mr Archer submitted that it could not be reasonably said that there had been a failure by the Registrant to ask Patient A his reason for visit and that if that was a failure then Professor Evans was also failing on a regular basis to ask his patients the reason for their visit.

74. In relation to particular 1(b)(ii), Mr Archer highlighted that there is a separate allegation at 1(b)(viii) which specifically addresses the failure to record the double vision, which had been admitted. Therefore, this particular must refer to something else. Mr Archer submitted that it criticises the Registrant for selecting the wrong option, but ignored that he had recorded information that made it obvious that this was a mistake. Mr Archer submitted that everyone makes mistakes, with reference to Professor Evans' evidence regarding the research he was involved in. Mr Archer stated the Registrant must be judged by the standards of a student Optometrist and that the next Optometrist would appreciate this was a mistake and not place any reliance upon the assertion that the patient had no symptoms.

75. In relation to particular 3(a)(i), Mr Archer submitted that the key word was 'failed' and that this was only a failure if it was something no other student Optometrist would do. Mr Archer reminded the Committee that Dr Kwartz had agreed that if a pre-registration student requires assistance from a more experienced Optometrist, they should seek that assistance. She agreed that sometimes, even fully qualified Optometrist might seek assistance or a second opinion from a more experienced colleague. Mr Archer referred to the Standards of Optical Students 2016, which at Standard 6.7 [sic] states, "*Where it is not possible or in the patient's best interests to complete the episode of care on the same day, a transfer of care to another optometrist should be made*."

76. Mr Archer referred to the opinion of Professor Evans, who had considered it reasonable for the Registrant to arrange an appointment with his supervisor three days later. Mr Archer submitted that the test was not completed on the day because the Registrant reasonably wanted his supervisor's assistance to complete the test and that is not a failing. He stated that is precisely what he ought to have done in those circumstances.

77. Turning to particular 4, Mr Archer submitted that there were a number of hearsay statements from members of staff in the bundle that he would have liked to have questioned, for example about informal arrangements at the store and he has not had the opportunity to. Mr Archer submitted that regarding the allegation that the Registrant left patients unattended, this simply did not happen. Rather, he arranged for another Optometrist in the store to see those patients and there was no evidence that patients were left unattended or were unable to be seen by an Optometrist that day.

78. In relation to dishonesty, Mr Archer invited the Committee to have regard to the Registrant's good character. Mr Archer submitted that it was obvious from the contradictory information that the Registrant had recorded regarding symptoms that he was not trying to deceive anybody.

79. Mr Archer reminded the Committee of the Registrant's evidence, which was that he went into autopilot mode and pre-populated parts of the record with the information that would usually be appropriate for a patient of this age. Those are words that he had become used to typing and he could type them quickly. They probably would have been appropriate in this case, so he prepopulated the record and then he turned his attention to communicating with his patient. Mr Archer submitted that the Registrant became distracted by the conversation that he became engaged in and when he came back to edit the entries he had typed, he missed parts that needed to be amended.

80. Mr Archer referred to the fact that the Registrant was still studying, managing academic deadlines, sitting exams and undergoing assessments and that when working under pressure people are more likely to make mistakes, but this is not dishonest.

81. Mr Ive responded further solely on the issue of hearsay. Mr Ive submitted that in relation to the witnesses who had give hearsay evidence in the form of informal statement, it had never been the Council's proposal to call these witnesses as it would not be proportionate or pragmatic to do so. Mr Ive submitted that their evidence was limited to discrete points and that Witness A had already given evidence on the events of 2 February 2024.

82. Mr Ive referred the Committee to the caselaw on hearsay evidence, which included the cases of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin), *Suddock v NMC* [2015] EWHC 3612 and *Ogundele v NMC* 2013 EWHC 2748 (Admin). Mr Ive invited the Committee to consider that the hearsay evidence is very limited, there was other factual evidence available, and that calling these further witnesses would not be proportionate. Furthermore, Mr Ive submitted that the absence of the witnesses could be reflected in the weight to be attached to their evidence.

83. The Committee heard and accepted advice from the Legal Adviser at the end of the facts stage, which included advice that the burden of proof throughout lies on the Council to prove, on the balance of probabilities, each of the facts alleged in the Allegation. In relation to those particulars of the Allegation that refer to an alleged failure upon the Registrant, the Committee were advised that they should firstly consider whether a duty or obligation exists upon the Registrant to act in that manner, before going on to consider if the failure is established.

84. The Legal Adviser gave the Committee advice relating to the assessment of credibility (including not to rely solely on demeanour), the use of screens (that this should affect the assessment of her evidence or be held against the Registrant) and the factors to consider when assessing the weight to attach to hearsay evidence. In relation to dishonesty, the Legal Adviser outlined the test for dishonesty in the case of *Ivey v Genting Casinos* [2017] UKSC 67 (SC), which is that the Committee should firstly ascertain subjectively, the actual state of the Registrant's knowledge or belief to the facts and then decide whether their

conduct was dishonest or not by applying the objective standards of ordinary decent people.

85. The Committee were further advised that the Registrant had no fitness to practise history and it was appropriate to give a good character direction. The Committee was reminded that good character by itself is not a defence. However, the Committee can take into account good character at the facts stage, which can be relevant in relation to credibility (that it should take this into account when deciding whether it believes the Registrant's evidence) and propensity (the likelihood that the Registrant acted as alleged).

Findings in relation to the facts

86. The Committee considered all of the evidence in this case, including the documentary evidence, the live witness evidence, including that from the Registrant and the expert evidence. The Committee also considered the submissions from the parties and the Legal Advice received. When it comes to the term "reasonably competent Student Optometrist" the Committee considered that the correct benchmark is student Optometrists who are working in compliance with the GOC Standards as any other approach would risk undermining public confidence in the standards and the regulator.

87. The Committee considered each of the disputed particulars of the Allegation in turn.

Particular 1(b)(i)

88. This particular relates to the allegation that the Registrant failed to maintain adequate records, in that he recorded '*routine check (no symptoms)*' despite failing to ask Patient A his reason for visit.

89. The Committee firstly considered the Registrant's duty to maintain adequate records and whether this required the Registrant to have asked Patient A about, and to have recorded, a reason for his visit. The Committee considered the 2016 Standards of Practice for Students, which at Standard 7.2.3 sets out, that as a minimum, they should record the reason for the consultation and any presenting condition. The Committee also considered the Stage 2 competencies, which are set out in the report of Dr Kwartz. In particular they considered Standard 1.1.2, which relates to eliciting information from patients. The Committee was therefore satisfied that the Registrant was under a duty to enquire with the patient about the reason for the visit.

90. The Committee noted that the Registrant accepts that he recorded '*routine check (no symptoms)*'. In relation to whether the Registrant had asked Patient A about the reason for the visit, it was clear in the Committee's view, from the transcript and mystery shopper footage, that he had not adequately asked Patient A this specific question.

91. The Committee acknowledged that the Registrant had ascertained some information that related to the symptoms that Patient A was experiencing and that his vision had worsened. However, he did not ask a direct question about the

reason for the visit nor had he specifically asked Patient A whether it was a routine check that he was attending for.

92. The Committee noted that Professor Evans' opinion was that the Registrant had asked a reasonable opening question to Patient A. However, the Committee noted that Professor Evans had also acknowledged that the Registrant had not asked specifically Patient A what the reason for Patient A's visit was. Additionally, the Committee accepted the evidence of Dr Kwartz that patients can attend appointments for a multitude of reasons, which an open question such as what is the reason for visit would more likely elicit.

93. The Committee considered that what was alleged in this particular, namely that the Registrant had recorded '*routine check (no symptoms)*' despite failing to ask Patient A his reason for visit, had been established to the required standard of the balance of probabilities.

94. The Committee therefore found Particular 1(b)(i) proved.

Particular 1(b)(ii)

95. This particular relates to the allegation that the Registrant failed to maintain adequate records, in that he recorded '*routine check (no symptoms)*' despite Patient A reporting that he had noticed a change in his vision.

96. The Committee was satisfied that there was an obligation upon the Registrant to have made full and clear entries in the patient record, containing all relevant information, which includes recording relevant symptoms reported by the patient. This included the GOC Stage 2 Competency 2.2.4 to contain all relevant patient details. The Committee was further satisfied that the Registrant had recorded '*routine check (no symptoms)*' and that Patient A had reported a change in his vision which was not recorded, was clear from the mystery shopper footage and transcript.

97. The Committee considered the Registrant's evidence on this issue, which was that he clicked on this pre-populated text box, which referred to no symptoms by mistake, as he was distracted by being in conversation with Patient A and further that he had a habit of pre-populating records then amending them. However, the Committee did not consider that this was a defence to what was alleged as a matter of fact.

98. Where the experts disagreed on this issue, the Committee preferred the evidence of Dr Kwartz. The Committee considered that both experts were experienced expert witnesses, however Dr Kwartz had significant experience of assessing student records as a College Assessor. The Committee had regard to Professor Evans' view that a subsequent Optometrist would be likely to conclude that symptoms were reported. However, the Committee noted that not all of the symptoms had been reported by the Registrant and Professor Evans had accepted that another Optometrist would not know that the patient had reported double vision. The Committee agreed with the view of Dr Kwartz that the record completed by the Registrant provided conflicting information to the reader who would not necessarily know which version of events to accept.

99. The Committee therefore found Particular 1(b)(ii) proved.

Particular 1(b)(ix)

100. This particular relates to the allegation that the Registrant failed to maintain adequate records, in that he failed to record which supervisor was responsible for the examination.

101. The Committee first considered whether the Registrant was under a duty to record which supervisor was responsible for the examination.

102. The Committee noted the guidance given by the College of Optometrists to students, which the Registrant's evidence was he had not seen previously. However, the Committee considered that the key evidence that assisted the Committee on this issue was the 2016 Council's Standards for Students, which states clearly at Standard 7.2.7 that students should record:

> "*Details of all those involved in the optical consultation, including name and signature or other identification of the author. This includes details of your supervisor including name and GOC registration number.*"

103. The Committee considered that what was required under this Standard was clear and related to the domain of maintaining patient records. Accordingly, the Committee was satisfied that this standard required that the supervisor information be recorded on the patient record.

104. The Committee considered the submissions on behalf of the Registrant, that it was not specified where the supervisor's details have to be recorded and whether this is on the patient record or can be elsewhere that is accessible, for example, practice systems. However, the Committee did not accept that a registrant recording the supervisor's information in a logbook or other practice system would be sufficient to comply with what the standard required, as the standard, when read as a whole was referring to patient records. The Committee also noted that it had no physical evidence before it that Patient A's consultation had ever been recorded in his trainee logbook along with a supervisor's name.

105. The Committee noted that it could be seen from the record of Patient A that the supervisor's details had not been recorded by the Registrant. The Committee was satisfied that this was a failing because the Registrant was required to have done so and there was nothing on the patient record that would identify the Registrant's supervisor.

106. The Committee therefore found Particular 1(b)(ix) proved.

Particular 3(a)(i)

107. This particular relates to the allegation that on 2 February 2024, the Registrant did not perform an appropriate and/or adequate examination and/or assessment of Patient B's eyes in that the Registrant failed to perform a full sight test, including visual fields, despite Patient B clinically presenting with longstanding frontal headaches.

108. The Committee firstly considered whether the Registrant was under a duty to complete tests on the same day, or whether it was reasonable for him to refer the

patient to his primary supervisor for a follow-up appointment on the following Monday.

109. The Committee had regard to Standard 5.2 of the 2016 Standards for Students, which states that students should recognise and work within their limits of competence and be able to identify when you need to refer to a tutor or supervisor for further advice and guidance.

110. The Committee considered that the Registrant had completed a significant part of the eye test for Patient B and that he had difficulties in completing the refraction. The Committee acknowledged that the Registrant had identified that he needed to seek support from his supervisor regarding this patient.

111. The Committee considered the differing views of the experts on this issue. Dr Kwartz was of the view that the Registrant ought to have completed a full eye test, although she acknowledged that it was acceptable to delay the visual fields test by a few days if necessary. Professor Evans was of the view that the Registrant's actions in arranging for Patient B to return were reasonable and there was no urgency to investigate the longstanding headaches.

112. The Committee took the view that it was appropriate for the Registrant to seek support from his supervisor on the day regarding Patient B on how to complete the refraction, as other tests could have been considered. However, the supervisor for the Registrant on the day was Witness A, who was on the premises and as his supervisor that day she retained overall responsibility for this patient. The Committee noted that under the GOC Standard of Practice number 9, the Registrant had a duty to work collaboratively with his supervisor in the best interests of the patient.

113. The Committee took the view that the Registrant ought to (noting that the Practice was open until 5.30pm) have sought support from Witness A, rather than require the patient to return for a follow-up appointment days later with his principal supervisor. However, the Registrant did not seek to discuss the patient with Witness A and in the circumstances the Committee considered that it was not reasonable for the Registrant to have postponed the completion of the appointment. The Committee concluded that the Registrant had not performed an appropriate or adequate sight test or assessment of Patient B in the circumstances.

114. The Committee therefore found Particular 3(a)(i) proved.

Particular 3(b)(iii)

115. This particular relates to the allegation that the Registrant failed to maintain adequate records in relation to Patient B, in that he failed to record which supervisor was responsible for the examination. It was clear from Patient B's patient record that this information had not been recorded by the Registrant.

116. The Committee found Particular 3(b)(iii) proved with the same reasoning as applied to Particular 1(b)(ix).

Particular 4

117. This particular relates to the allegation that on or around 2 February 2024, the Registrant left the clinic without appropriate authorisation in circumstances where he had not fully completed a patient consultation and/or there were two further patients scheduled to see the Registrant.

118. The Committee considered the evidence of Witness A and of the Registrant on the issue of whether the Registrant had left the clinic without appropriate authorisation. The Committee considered the evidence of Witness A to be credible and reliable evidence. The Committee further noted that Witness A had also sent out a contemporaneous account in an email shortly after events occurred.

119. The Committee considered that the Registrant's account on this issue of having authorisation, namely that he asked Witness A at around lunchtime that day and she did not answer him, which he took as consent, to be implausible. The Committee did not consider it likely that Witness A would not have responded, having heard and accepted the evidence of Witness A and in any event, it was not credible that the Registrant could take silence as appropriate authorisation.

120. The Committee further noted that the Registrant had accepted that he did not have explicit authorisation and had accepted that he had left the Practice without authorisation when he was asked about this matter in the workplace investigation meeting. The Committee found that on the evidence before it, the only person who knew about the Registrant leaving was the locum Optometrist and none of the other staff were aware that the Registrant was leaving.

121. The Committee considered the Registrant's evidence that he had made arrangements with the locum to see his last two patients. However, as a matter of fact, the Committee was satisfied on the evidence that the Registrant had left the clinic without appropriate authorisation when he had not fully completed Patient B's consultation and also when there were two further patients scheduled to see the Registrant.

122. The Committee therefore found Particular 4 proved.

Particular 5 (as it relates to the denied particulars 1(b)(i) and (ii), 1(b)(ix), 3(a)(i) and 3(b)(iii))

123. This particular relates to the allegation that the Registrant's conduct in these denied particulars was unprofessional and/or inappropriate.

124. The Committee considered that in relation to each individual particular that remained in dispute, the conduct that was alleged to have occurred and which the Committee had found proved, was unprofessional and inappropriate.

125. The Committee therefore found Particular 5 proved.

126. Particular 6

127. This particular relates to the allegation that the Registrant's conduct, as set out in particular 4 (leaving the clinic early without appropriate authorisation) was unprofessional.

128. The Committee considered that by the Registrant leaving the clinic early without appropriate authorisation, this was unprofessional conduct, as he was contracted to work until 5.30pm and it was unprofessional to leave before the scheduled time without securing express authorisation to do so, from an appropriate person authorised to give that permission to leave early.

129. The Committee therefore found Particular 6 proved.

Particular 7

130. This particular relates to the allegation that the Registrant's conduct in relation to 1(b)(i) and/or 1(b)(ii) and/or 1(b)(iii) and/or 1(b)(iv) and/or 1(b)(v) and/or 1(b)(vi) and/or 1(b)(vii) was dishonest, in that he recorded information not discussed and/or incorrectly recorded patient responses and/or recorded tests that were not performed. The Committee was mindful of, and applied, the test for dishonesty in the case of *Ivey v Genting*.

131. The Committee considered this allegation in respect of each particular that was alleged to be dishonest. The Committee noted that some of those particulars related to the Registrant making entries that tests had been performed and recording the results of those tests, when they had not been performed. In other respects, the particulars are alleged to have been dishonest for the Registrant recording matters, for example, responses, to questions that were not asked of the Patient.

132. The Committee had regard to the Registrant's hitherto good character when considering his evidence. The Committee carefully considered the Registrant's evidence as to his state of mind and his account that when he was completing parts of the record he was on "*auto-pilot*" or not consciously recording the information in question. Furthermore, that several of his entries were mistakes or errors in writing standard text and then deleting it appropriately. Essentially, the Registrant's account is that the false entries are due to lack of attention or careless record keeping.

133. The Committee considered that in all of the particulars in respect of which dishonesty is alleged, the Registrant recorded false information. In numerous respects the patient record does not accord with the mystery shopper footage, thereby producing a false record of that examination, misrepresenting what occurred and misleading a subsequent Optometrist.

134. The Committee considered that the Registrant's evidence that this conduct was due to recordkeeping errors or lack of focus was not plausible or credible, particularly in respect of the positive acts that he took to record some of the information (for example to input test results in numerical figures, such as N5). The Committee considered that the Registrant must have known he was inputting such information and that when he was doing so that it was not correct. The Committee was therefore satisfied that the Registrant had knowingly inputted false information into the patient record and that this would be considered to be dishonest by the standards of ordinary decent people.

135. In respect of all aspects of the dishonesty alleged in Particular 7, the Committee was satisfied on the balance of probabilities that the conduct was dishonest.

136. The Committee therefore found Particular 7 proved.

Misconduct

137. The Committee next considered whether the fitness to practise of the Registrant was currently impaired, as a result of the misconduct found. No further evidence was adduced at this stage.

138. Mr Ive outlined the Council's position on misconduct, which was that all of the particulars found proved amounted to misconduct. In relation to the clinical parts of the Allegation, Mr Ive submitted that the expert evidence of Dr Kwartz ought to be preferred to the expert evidence of Professor Evans.

139. Mr Ive reminded the Committee that there is no burden or standard of proof and whether the facts found proved amounts to misconduct is a matter for the judgement of the Committee.

140. Mr Ive referred the Committee to the Hearings and Indicative Sanctions Guidance and the case law on misconduct, including the cases of *Roylance v General Medical Council* [2000] 1 AC 311*, R (on the application of Vali) v General Optical Council [2011] EWHC 310 (Admin), Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *R (Calhaem) v General Medical Council* [2007] EWHC 2606 (Admin) and *Remedy UK Ltd v General Medical Council* [2010] EWHC 1245 (Admin).

141. Mr Ive submitted that there is no definition of misconduct and it is a word of general effect and that it is to be judged by the standards of a reasonably competent student Optometrist in this case. Mr Ive submitted that dishonesty is particularly serious and reminded the Committee that it had found all of the allegations of dishonesty proven.

142. Mr Ive submitted that mere negligence of itself was insufficient to amount to misconduct unless it was sufficiently grave. Mr Ive submitted that the line had been crossed in this case of the Registrant being more than merely negligent.

143. Mr Ive submitted that fellow practitioners would find the Registrant's conduct, of recording tests that had not been performed, to be deplorable. It was conduct that brings the profession into disrepute and dishonesty is conduct that would ne regarded as dishonourable or disgraceful.

144. Mr Ive reminded the Committee that the conduct of the Registrant spans two dates, involving two patients and there were 17 clinical failings where the Registrant's conduct fell far below the standards to be expected. Mr Ive submitted that the Registrant's conduct exposed patients to an unnecessary risk of harm. Mr Ive invited the Committee to find that the clinical failings were serious, falling far below the standards reasonably required.

145. Mr Ive submitted that if the Committee find that the facts found proved amounts to negligent acts or omissions – and that those acts or omissions were serious – the Committee should find misconduct, particularly given the fact that there were multiple acts and omissions on the Registrant's part.

146. Mr Ive highlighted the evidence of Dr Kwartz and her definitions of conduct that fell 'below' the standards expected and 'far below' the standards expected. Mr Ive

submitted that there was a considerable disagreement between the experts on these standards, as set out in their reports and oral evidence. Mr Ive stated that Professor Evans had referred to his experience of what other high street Optometrists often failed to do. Mr Ive submitted that this should not allow the standard to be brought down and that all Optometrists should strive to comply with the standards expected of them.

147. Mr Ive invited the Committee to prefer the evidence of Dr Kwartz, who does have experience of high street practice and over 30 years of experience as an Optometrist. Mr Ive reminded the Committee of its findings at the fact stage regarding the significant experience of Dr Kwartz in assessing student records as a College Assessor. Mr Ive invited the Committee to accept the opinions of Dr Kwartz, as set out in her report, joint expert report and oral evidence.

148. Mr Ive took the Committee through each individual particular of the Allegation, which had been found proved, referring to the evidence of Dr Kwartz and submitting that in relation to each there had been a significant departure from the standard of a reasonably competent student Optometrist.

149. In relation to particular 2, making derogatory remarks about Specsavers, Mr Ive referred the Committee to the opinion of Dr Kwartz that such a conversation with a patient was '*totally inappropriate and unprofessional*.' Mr Ive submitted that fellow practitioners would regard the Registrant's derogatory remarks as deplorable.

150. In relation to particular 4, which related to the Registrant leaving the clinic early without appropriate authorisation, Mr Ive submitted that this clearly amounted to misconduct in circumstances where he had not completed the patient consultation and still had two patients to see. Mr Ive submitted that fellow practitioners would find this conduct to be deplorable. In relation to particulars 5 and 6, Mr Ive submitted that the Registrant's conduct was a serious falling short and fell far short of professionalism. In relation to particular 7. Mr Ive submitted that dishonesty was serious and fellow practitioners would find it deplorable.

151. Mr Ive addressed the Committee on the 2016 Council's Standards for Optical Students and submitted that the Registrant's conduct had breached the following standards:

- Standard 5.2 (be able to identify when to refer to a tutor or supervisor)
- Standard 6.1 (conduct an adequate assessment)
- Standard 6.5 (provide effective patient care and treatments)
- Standard 6.7 (when in doubt consult with your tutor or supervisor for advice)
- Standard 7.1 (maintain clear, legible patient records)
- Standard 7.2.3 (minimum information to be recorded – reason for consultation)
- Standard 7.2.7 (minimum information to be recorded – supervisor name)
- Standard 9.1 (work collaboratively with peers)
- Standard 12.5 (refrain from making unnecessary or disparaging comments about your training provider)
- Standard 14.1 (maintain proper professional boundaries)

- Standard 15.1 (act with honesty and integrity)
- Standard 16.3 (comply with the law and all requirements of the GOC)

152. Mr Archer in his submissions on misconduct submitted that when considering whether each part of the Allegation amounts to misconduct, the Committee ought to focus upon seriousness.

153. Mr Archer submitted that misconduct must be serious to qualify and therefore it must fall seriously below the expected standard before the Registrant's fitness to practise may be subject to scrutiny. Mr Archer stated that mistakes are part of ordinary life and are how we learn, but not every mistake warrants disciplinary action by the regulator.

154. Mr Archer submitted that 'negligence' would only constitute misconduct if it is to a 'high degree' and negligent acts and omissions will only amount to misconduct if they are particularly serious, referring the Committee to the cases of *Roylance v General Medical Council* [2000] 1 AC 311 and *R (Calhaem) v GMC [2007]* EWHC 2606 (Admin) at §39. Further, that an isolated lapse is less likely to be misconduct.

155. Mr Archer submitted that the Committee should not aggregate a number of lesser omissions to make a serious omission, with reference to the case of *Schodlok v GMC* [2015] EWCA Civ 769.

156. When considering the seriousness of any failings, Mr Archer invited the Committee to have regard to the early stage of the Registrant's career, the Registrant's personal circumstances, that this was an isolated lapse (not repeated errors over multiple patients), and that no harm was caused. Furthermore, Mr Archer submitted that the Committee ought to consider the expert view of Professor Evans very carefully, as he was an expert with very considerable experience.

157. Mr Archer stated that it was accepted that dishonesty will almost always amount to misconduct. However, with respect to the clinical aspects of the allegation, in light of Professor Evans' evidence and the other aspects outlined, he submitted that those aspects of the allegation do not fall seriously below the expected standards so as to justifying serious professional misconduct.

158. Mr Archer acknowledged that the allegation that relates to telling Patient B about the fact that Specsavers does not pay its trainees well was unprofessional and if the Registrant was saying that to every patient, perhaps it would be possible to argue that amounts to a fitness to practise issue. However, Mr Archer submitted that is not what happened and the Registrant made the comment to one patient who happened to be a recruiter and that sort of conversation would not happen in an ordinary patient interaction.

159. The Committee heard and accepted the advice of the Legal Adviser, who reminded the Committee 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. The Legal Adviser advised the Committee to consider each part of the Allegation in relation to misconduct and if some were not sufficiently serious to amount to misconduct then they ought not to proceed further.

The Committee's Findings in relation to misconduct

160. In making its findings on misconduct, the Committee had regard to the evidence it had received to date, the submissions made by the parties, and the legal advice given by the Legal Adviser.

161. The Committee considered the Council's Standards for Student Optometrists and considered that the standards referred to by the Council (as set out at paragraph 149 above) applied in this case, albeit was of the view that Standard 16.3 was less directly relevant that the others. The Committee was satisfied that the Standards referred to had been breached by the Registrant's conduct.

162. The Committee was mindful that not every falling below the standards expected was sufficient to amount to misconduct, and went on to consider whether the conduct fell far below the standards expected, or in other words was sufficiently serious, so as to amount to misconduct.

163. The Committee considered the issue of misconduct in relation to the range of conduct covered by the Allegation, considering each particular of the Allegation in turn.

Particular 1

164. The Committee considered the parts of particular 1, relating to Patient A, which had been found proved. The Committee considered the views of both expert witnesses, Dr Kwartz and Professor Evans on the clinical failings, who differed in their opinions as to whether these failings fell below or far below. Generally, where there was a difference in opinion between the experts, the Committee preferred the evidence of Dr Kwartz. The Committee considered that Dr Kwartz had significant experience of assessing student records and whilst Professor Evans had been involved in research, that did not include student Optometrists.

165. The Committee considered the individual parts of particular 1 and considered that in respect of all of the clinical failures they all were departures from the expected standards that fell far below, and therefore were serious, apart from in relation to particular 1(b)(ix), that the Registrant failed to record which supervisor was responsible for the examination. The Committee considered that whilst this was a requirement of the 2016 Student Standards, not recording this information would not be considered deplorable by fellow practitioners and in the circumstances, the Committee took the view that this on its own was not sufficiently serious to amount to misconduct.

166. However, in relation to the remainder of the clinical failings in particular 1, the Committee accepted the opinion of Dr Kwartz that these were significant departures from the standard of a reasonably competent student Optometrist and in relation to several there was also a risk of harm to the patient or patient management could be impacted, for example, with 1(a)(i) there was a risk of harm if the underlying cause of diplopia was not established. The Committee therefore found the remainder of the clinical failings in particular 1 were serious and amounted to misconduct.

Particular 2

167. The Committee considered that the Registrant's conduct of making derogatory remarks about Specsavers to Patient A, such as how they overestimate their financial contribution to their trainees and that they do not pay their trainees well, was a significant breach of Standard 12.5. Having watched the mystery shopper footage of this conversation between the Registrant and Patient A, the Committee considered that the Registrant's conduct was shocking, as the Registrant made completely inappropriate and unprofessional remarks to a patient, which also crossed the boundary between the Optometrist and Patient (Standard 14.1).

168. The Committee was satisfied that this conduct would be regarded as deplorable by fellow practitioners and was serious, amounting to misconduct.

Particular 3

169. The Committee considered the parts of particular 3, relating to Patient A, which had been found proved. The Committee considered the views of both expert witnesses, Dr Kwartz and Professor Evans on the clinical failings, who differed in their opinions as to whether these failings fell below or far below.

170. The Committee also had regard to its findings that it had made at the facts stage in relation to this particular. The Committee had considered that the Registrant had acted appropriately in seeking support from a supervisor, given that he was having difficulty completing the refraction on Patient B. The Committee considered that in doing so he had complied in that respect with the Standards (5.2 and 6.7). The Committee noted that the Registrant also gave the patient appropriate advice in the appointment.

171. Furthermore, the Committee had found this particular proved on the basis that it considered that the Registrant ought to have spoken to his supervisor on that day, Witness A, given that she had responsibility for that patient.

172. However, the Committee bore in mind that clinically there was no risk of harm to Patient B in a follow-up appointment being made for the following Monday with the Registrant's principal supervisor, as there was no urgency given the longstanding headaches. At most this may have been inconvenient for Patient B. Additionally, a visual fields test was not considered necessary by the Optometrist at that follow-up appointment.

173. In the circumstances, the Committee considered that whilst it had found that the Registrant's conduct in relation to Patient B was unprofessional and inappropriate and there were clinical failures in respect of the management of Patient B, it did not consider that these were sufficiently serious as to amount to misconduct. It did not consider that this would be considered to be deplorable conduct. In relation to particular 3(b)(iii), regarding a failure to record the supervisor's name, the Committee did not consider that this amounted to misconduct for the same reasons as for particular 1(b)(ix).

Particular 4

174. The Committee went on to consider particular 4, which concerns the Registrant leaving the clinic early without appropriate authorisation, when he had not fully completed a patient consultation and there were two further patients scheduled to see the Registrant. When considering seriousness, the Committee had regard to

the fact that the Registrant had made arrangements for a follow-up appointment for Patient B and there was no urgency or risk of harm in this regard.

175. In relation to the two patients scheduled, the Registrant had made arrangements for the locum Optometrist to examine those patients and there was no evidence that they had not been able to have their appointments. Whilst the Registrant had not obtained appropriate authorisation to leave early, there was no evidence of any impact upon the patients concerned.

176. The Committee concluded that the Registrant's conduct in respect of this particular was unprofessional but was of the view that it was more of a workplace conduct issue than a fitness to practise concern and accordingly, did not consider that it amounted to misconduct.

Particular 5

177. This particular related to the Registrant's conduct, where it had been found proved, being unprofessional and inappropriate. In relation to where this particular was linked to particular 1, the Committee considered that this was essentially part and parcel of the misconduct set out in particular 1. In relation to where this particular was linked to particular 3, the Committee considered that it fell away, as it had found that the particular 3 conduct did not amount to misconduct.

Particular 6

178. The Committee considered that this particular fell away, as it had found the underlying conduct at particular 4 did not amount to misconduct.

Particular 7

179. This particular related to dishonesty. The Committee had regard to its earlier findings that it had found that the Registrant had deliberately recorded information that had not been discussed with Patient A and had falsely recorded in the patient record tests (including recording results) that had not been performed. The Committee was satisfied that this conduct would be considered deplorable by fellow practitioners and was clearly sufficiently serious to amount to misconduct.

180. In relation to particulars 1 (apart from 1(b)(ix)), 2 and 7 of the Allegation, the Committee was satisfied that the Registrant's misconduct fell far below the standards of what was proper in the circumstances, which was serious and was therefore misconduct.

Impairment

181. The Committee next considered whether the fitness to practise of the Registrant was currently impaired, as a result of the misconduct found.

182. The Committee received a bundle of further material on behalf of the Registrant, which contained material relevant to remediation and the impairment stage, including a detailed reflective statement, testimonials and CPD documentation. The Registrant did not give oral evidence on the issue of impairment.

183. Mr Ive, in his submissions on impairment, referred the Committee to the Council's Hearings and Indicative Sanctions Guidance ('the Guidance') on how to approach impairment, including that the Committee should consider whether the conduct

which led to the allegation is remediable, whether it has been remedied and whether it is likely to be repeated.

184. Mr Ive outlined the case law on impairment, including the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin). Mr Ive submitted that the Committee should consider not only whether the Registrant continues to present a risk to members of the public in his current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made.

185. Mr Ive referred the Committee to the test for impairment approved in the case of *Grant*, which is as follows:

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

186. Mr Ive submitted that the answer to all of the questions in the *Grant* test was 'yes'. Mr Ive submitted that the severity of the Registrant's dishonesty – in recording having performed tests that he had not, in fact, performed – is so serious that the Committee must consider whether the Registrant is simply not fit to practise without restrictions, or at all.

187. Mr Ive stated that the attitude of the practitioner was a matter that could be taken into account either in his favour or against him (with reference to *Nicholas-Pillai v General Medical Council* [2009] EWHC 1048 (Admin)). He reminded the Committee that the Registrant had passed the clinical allegations off as mistakes and this should be held against him.

188. In relation to whether the misconduct was easily remediable, Mr Ive submitted that in relation to the dishonesty, it is very difficult to remediate and it also has not been remedied. Mr Ive stated that dishonesty is particularly serious as it may undermine confidence in the profession. Mr Ive submitted that the Registrant's conduct in recorded tests that had not been performed clearly undermines the trust that the public and the profession have in optometry, regardless of whether this leads to

patient harm. Mr Ive invited the Committee to find that the Registrant's dishonesty was right at the top of the scale of dishonest conduct.

189. Mr Ive stated that the Registrant suffering from stress and burnout was not an explanation for the dishonesty occurring and if it had not been for the mystery shopper video it would not have been uncovered. Mr Ive submitted that there was a risk of repetition.

190. In relation to insight, Mr Ive submitted that further questions about the Registrant's honesty and integrity arise from his impairment bundle. Mr Ive referred to comments made in a testimonial which stated that the Registrant '*accepts complete responsibility for his dishonesty'*, which Mr Ive submitted was at odds with the Registrant denying all allegations of dishonesty.

191. Mr Ive submitted that the Council's position was that the Registrant was currently impaired and further, that the conduct was so serious that if a finding of impairment were not made, this would undermine both public confidence in the profession and in the regulatory process. Mr Ive submitted that a finding of impairment is required in this case to protect the public and also was required in the public interest to declare and uphold proper standards of behaviour and maintain public confidence in the profession.

192. Mr Archer, when making submissions on impairment, referred the Committee to the case of *Zygmunt v General Medical Council* [2008] EWHC 2643, where Mr Justice Mitting said:

> "*A practitioner who acknowledges his deficiencies and takes prompt action to remedy them may no longer be any less fit to practise than colleagues with an unblemished record.*"

193. Mr Archer highlighted that the misconduct in this case took place approximately two years ago and reminded the Committee that when considering whether the Registrant was currently impaired, it must look forward, not back.

194. Mr Archer submitted that the Committee should not have any regard to the fact that the Registrant put the Council to proof on parts of the allegation, with reference to the case of *Towuaghantse v GMC* [2021] EWHC 681 (Admin).

195. Mr Archer invited the Committee to consider that the Registrant is a young man, who was just [redacted] of age at the time of the misconduct, still developing and learning. He submitted that the Registrant had the capacity to change. Additionally, the Registrant is the first in his family to enter a profession, so had to learn himself what a professional role involves.

196. Mr Archer submitted that the Registrant had limited experience of real-world practice at the time of the misconduct and was only a pre-registration student. Mr Archer invited the Committee to also take into account the shock of these proceedings on the Registrant, submitting that he was extremely ashamed and remorseful for his conduct.

197. Mr Archer stated that the Registrant was [redacted] shortly and wished to be a good role model, cannot risk his livelihood being taken away and was willing to do whatever it takes to make sure that does not happen.

198. Mr Archer highlighted the extensive further training that the Registrant had undertaken, including on binocular vision as he had recognised that this was an area of weakness. Mr Archer submitted that the Registrant had undertaken extensive reflection, as set out in his further statement. Mr Archer highlighted the positive character references and compliance reports, which show that the Registrant is able to practice to a very high standard.

199. Mr Archer submitted that in the circumstances, there was no current impairment in terms of future risk. However, he acknowledged that in respect of the dishonesty the Committee would need to consider whether a finding of impairment was nevertheless necessary on public interest grounds to maintain public confidence. However, Mr Archer submitted that the dishonesty in this case was towards the lower end of the scale, it was an isolated incident, the Registrant's relative youth is a relevant factor, and no harm was caused to any patient. In those circumstances, Mr Archer submitted that a finding of impairment is not absolutely necessary on public interest grounds.

200. 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 considerations set out in the case of *Cohen v GMC* [2008] EWHC 581(Admin), namely whether the conduct is remediable, whether it has been remedied, and whether it is likely to be repeated. The Legal Adviser also highlighted the four limbs in the Grant case.

201. In relation to insight, the Committee was advised that the fact a Registrant has contested proceedings does not automatically lead to a lack of insight, as Registrants are properly and fairly entitled to defend themselves. There have been a number of cases which have emphasised that a panel should carefully consider whether it is fair and appropriate to use a rejected defence when considering lack of insight.

202. The Legal Adviser referred the Committee to the case of *GMC v Armstrong* [2021] EWHC 1658 (Admin), which sets out that dishonesty can arise in a variety of circumstances and in a range of seriousness and that Committees must have proper regard to the nature and extent of the dishonesty and engage with the weight of the public interest factors tending towards a finding of impairment. This case also sets out that, in cases of dishonesty, the impact on public confidence in the profession is not diminished by a low risk of repetition and that the Committee must consider the weight that it puts on personal mitigation as this may have a more limited role in cases of dishonesty. It also sets out that it is a rare or unusual case where dishonesty does not lead to a finding of impairment.

The Committee's findings on impairment

203. In making its findings on current impairment, the Committee had regard to the evidence it had received to date, including the Registrant's further documentary evidence produced at this stage, the submissions made by the parties, and the legal advice given by the Legal Adviser.

204. The Committee considered the factors in the Cohen case, namely whether the Registrant's conduct was remediable, whether it had been remedied and whether the conduct is likely to be repeated in future.

205. The Committee noted that the misconduct was wide ranging in nature, including record-keeping and clinical concerns, which whilst serious may be easily remedied. The misconduct also included dishonesty, which was more difficult to remediate.

206. The Committee considered whether the Registrant's misconduct had been remedied by him. The Committee found that the Registrant has taken steps in order to remediate, which include reflecting, as set out in his detailed and comprehensive reflective statement. The Committee considered that the Registrant had completed relevant CPD, including on probity and ethics, a well as on clinical areas. The Committee was impressed by the Registrant's supervision reports, which showed that the Registrant's practice had evolved and improved since the events in question.

207. The Committee considered that the Registrant had reflected and developed insight, giving examples in his reflective statement of how he had changed his practice, for example, by not recording entries on the patient record whilst talking to the patient and ensuring that he checked entries made. The Committee was impressed by the Registrant's reflection that he felt that by working under supervision, as required by an interim order of conditions, that he had the benefit of repeating his pre-registration training.

208. The Committee noted that dishonesty is difficult to remediate and the Committee considered that the Registrant had undertaken all of the remediation that he reasonably could. Overall, the Committee considered the level of insight demonstrated by the Registrant, in his written reflective statement to be good.

209. The Committee turned to consider the likelihood of repetition. The Committee had regard to the references from the Registrant's work colleagues, which were positive. The Committee noted that it was now almost two years since the misconduct occurred and there had been no repetition or further concerns raised. The Committee had been reassured by the reflections of the Registrant that show he has learnt from his conduct, developed insight and has shown a good level of remediation, which mitigates the risk of repetition. In addition, the Committee considered that the Registrant was now working in a supportive practice, with a mentor.

210. In all of the circumstances, the Committee determined that the Registrant had demonstrated that he was a different practitioner to when he committed the misconduct and it was satisfied that it is unlikely to be repeated.

211. Having regard to all of the above, and the fact that there were no current patient safety concerns in this case and the adequate remediation, the Committee determined that the Registrant's fitness to practise was not impaired on public protection grounds.

212. The Committee next had regard to public interest considerations and to the case of *CHRE v (1) NMC and (2) Grant* [2011] EWHC 927 (admin), particularly the test that was formulated by Dame Janet Smith in the report to the Fifth Shipman Inquiry. The Committee agreed with the submission of Mr Ive that limbs (a), (b),

(c) and (d) of this test were all engaged in this case, namely conduct that put patients at risk at harm, brought the profession into disrepute, breached fundamental tenets of the profession and was dishonest. The Committee considered that these limbs of the test were engaged on the Registrant's past conduct in relation to the misconduct found proved. It did not consider that the test was met on the basis of being '*liable in future'* to so act, given its finding that there was a very low risk of repetition.

213. The Committee considered whether a finding of impairment was necessary on the basis of the wider public interest in order to uphold proper professional standards and public confidence in the profession.

214. The Committee considered the extent and seriousness of the Registrant's dishonesty. Whilst the conduct was dishonest in seven respects relating to the patient record of Patient A (as set out in particular 7), the Committee noted that it was limited in scope to one patient interaction, on one date and there was a degree of overlap in the 7 instances of dishonesty. Nonetheless, it was unacceptable and serious conduct, by the Registrant creating a false patient record, which would be misleading to subsequent Optometrists.

215. The Committee was of the view that despite the remediation that had been undertaken by the Registrant, given the seriousness of the conduct (particularly in relation to the dishonesty and making deplorable comments to a patient about his training provider) the public would be concerned and public confidence in the profession would be undermined, if a finding of impairment was not made. The Committee determined that it was necessary to make a finding of impairment in this case in order to maintain confidence in the profession and in order to uphold proper professional standards.

216. Accordingly, the Committee found that the Registrant's fitness to practise as an Optometrist is currently impaired on public interest grounds.

Sanction

217. The Committee went on to consider what would be the appropriate and proportionate sanction, if any, to impose in this case. It heard oral submissions from Mr Ive on behalf of the Council and Mr Archer on behalf of the Registrant. No further evidence was placed before the Committee at this stage of the hearing.

218. Mr Ive reminded the Committee that the central aim of a sanction is to protect the public. When deciding the appropriate sanction Mr Ive invited the Committee to have regard to the principle of proportionality and the Council's Hearings and Indicative Sanctions Guidance and he outlined the various sanction options available to the Committee. Mr Ive stated that in this case the Council were seeking a suspension of 12 months.

219. Turning to aggravating and mitigating factors, Mr Ive suggested that it was a mitigating factor that the Registrant had expressed remorse and shown insight.

220. Mr Ive submitted that it was an aggravating factor that the Committee had found that the Registrant's account was not credible. Further, it was an aggravating factor in the Guidance that this case concerned dishonesty, which was particularly serious as it may undermine public confidence in the profession. Mr Ive stated

that in this case whilst there was only one patient, there were seven instances of dishonesty relating to separate tests and all were found proven as dishonesty. Mr Ive submitted that by the Registrant recording tests that had not been performed, was at the upper end of the scale of dishonesty.

221. Mr Ive submitted that a further aggravating factor was that there had been a breach of trust, specifically in respect of the Registrant's colleagues who need to be able to rely upon the integrity of the patient record.

222. Mr Ive referred to paragraph 22.4 in the Sanctions Guidance, which states that there is no blanket rule that erasure is the appropriate sanction for dishonesty and he outlined the case law on dishonesty, as referred to in the Guidance.

223. Mr Ive submitted that given that seven allegations of dishonesty have been found proven, very limited weight should be attached to the [redacted] and workplace related issues that the Registrant has described. He submitted that these issues do not explain away the fact the Registrant was recording tests and assessments that he had not, in fact, performed.

224. Mr Ive stated that the Council's position was that the appropriate sanction in this case would be a period of suspension. He submitted that all lesser sanctions would be inappropriate given the seriousness of the misconduct. In relation to conditions, Mr Ive submitted these would not maintain confidence in the profession. Mr Ive submitted that the seriousness of this case did require the Registrant's temporary removal from the register.

225. Mr Ive referred the Committee to the list of factors in paragraph 21.29, which indicate when a period of suspension may be appropriate, which he submitted applied.

226. In relation to the length of suspension that ought to be imposed, Mr Ive submitted that a period of 12 months would be appropriate, proportionate and protect the public interest in this case.

227. Mr Ive emphasised that the Council did not consider that erasure would be appropriate in this case, as the misconduct was not fundamentally incompatible with the Registrant's continued registration.

228. Mr Archer reminded the Committee that the purpose of imposing a sanction was not meant to be punitive. He referred back to the Committee's findings at the impairment stage and that there was no risk to the public in light of the remediation and that impairment had been found on public interest grounds only.

229. Mr Archer stated that the Registrant was currently working in [redacted] but would be moving back to [redacted] for when [redacted] in February 2026.

230. Mr Archer acknowledged that suspension was the likely outcome for the Registrant, however he did not agree with the Council's position on the length of suspension, which was at the very top end of the range. Mr Archer submitted that a 12 month suspension was not justified or proportionate and he invited the Committee to impose the minimum period of suspension necessary to meet the public interest.

231. Mr Archer invited the Committee to consider that this was a one-off instance of dishonesty, when the Registrant was working under significant pressure. The

Registrant has fully remediated, there was no harm to patients and the Registrant has been under a lengthy period of interim conditions, including being under direct supervision, which has helped him to develop insight.

232. Mr Archer submitted that one or two months would be a sufficient period of suspension to meet the public interest.

233. In relation to whether a review hearing was required, Mr Archer submitted that this was not necessary given that the Registrant had remediated and the finding of impairment in this case was solely on public interest grounds. He stated that the public interest would be met by the substantive order and there would be no useful purpose to a review hearing.

234. Mr Archer additionally addressed the Committee on the issue of an immediate order. Mr Archer stated that the Registrant wanted to complete any suspension order as soon as possible. He submitted that it was now clear from the Court of Appeal decision in *GDC v Aga* [2025] EWCA Civ 68 that if an immediate order were to be made, this would be additional to the substantive order and in practical terms they would be added together. Mr Archer invited the Committee to bear this in mind when determining the length of suspension.

235. On the issue of an immediate order, Mr Ive on behalf of the Council, outlined the statutory grounds and invited the Committee to make an immediate order, submitting that it appeared to be accepted by the Registrant that one ought to be made.

The Committee's findings on sanction

236. The Committee heard and accepted the advice of the Legal Adviser regarding the approach to follow when considering sanction. When considering the most appropriate sanction, if any, to impose in this case, the Committee had regard to all of the evidence and submissions it had heard and the Sanctions Guidance. The Committee also had regard to its previous findings.

237. The Committee considered the aggravating and mitigating factors. In the Committee's view, the particular aggravating factors in this case are as follows:

a. the misconduct was dishonesty relating to clinical records;
b. the Registrant's conduct breached the trust of his patient and colleagues.

238. The Committee considered that the following mitigating factors were present:

a. It was one occasion of dishonesty involving one patient consultation;
b. there was no evidence of actual harm or impact to the patient;
c. the Registrant has apologised and shown remorse;
d. the Registrant was a student Optometrist at the outset of his career;
e. the positive testimonials from fellow professionals;
f. at the time of the misconduct the Registrant was working in a pressurised environment; and

g. the Registrant has shown that he has developed insight and taken steps to remediate, including engagement working under supervision and has shown a commitment to improving his practice.

239. The Committee took the view that this was a single occasion of dishonesty in relation to a number of overlapping elements and it would not characterise it as seven separate findings of dishonesty.

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

241. The Committee considered taking no further action as set out in paragraphs 21.3 to 21.8 of the HISG. The Committee noted that exceptional circumstances would be required and none were present in this case. Additionally, taking no action would be insufficient to address the public interest concerns in this case.

242. The Committee considered the imposition of a financial penalty order. The Committee considered that this sanction would not reflect the seriousness of the misconduct and appropriately mark the breach of standards expected of an Optometrist in these circumstances.

243. The Committee next considered conditions. The Committee was of the view that conditional registration would not be practicable due to the nature of the misconduct. The dishonesty allegations did not involve identifiable clinical areas of practice in need of assessment or retraining, which conditions often seek to address. Whilst part of the Allegation related to clinical failings, the Committee considered that the Registrant had addressed these issues and they were unlikely to be repeated. In addition, the Committee was of the view that conditions would not sufficiently mark the serious nature of the Registrant's misconduct or address the public interest concerns identified. The Committee therefore concluded that conditions could not be devised which would be appropriate, proportionate, workable or measurable in this case.

244. The Committee next considered suspension and had regard to paragraphs 21.29 to 21.31 of the Guidance. In particular, the Committee considered the list of factors contained within paragraph 21.29, that indicate that a suspension may be appropriate, which are as follows:

Suspension (maximum 12 months)

21.29 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.

245. The Committee was of the view that all of the factors listed in paragraph 21.29 were applicable, apart from factor e), which was not relevant in this case. In relation to factor a), this was a serious matter, where a lesser sanction was not sufficient, as set out above.

246. In relation to b), the Committee did not find that there was evidence of harmful deep-seated personality or attitudinal problems and took account of the Registrant's positive testimonials.

247. In relation to c), there was no evidence of repetition of the behaviour in the two years since the misconduct.

248. In relation to d), the Committee had earlier found that the Registrant has developed insight and the risk of repetition was low. The Committee was therefore satisfied that factors indicating that suspension may be appropriate were established in this case.

249. The Committee balanced the mitigating and aggravating factors in the case and considered the principle of proportionality. The Committee was of the view that a suspension order was an appropriate and proportionate sanction to address the public interest concerns that it had identified. It considered that a suspension order would adequately mark the seriousness of the Registrant's conduct, maintain confidence in the profession and declare and uphold proper standards of professional conduct and behaviour.

250. The Committee, having found that suspension would be an appropriate and proportionate sanction, was not required to go on to consider erasure. However, in any event, the Committee considered that the conduct was not fundamentally incompatible with continued registration. The Committee was of the view that erasure was not the only order that would satisfy public interest concerns and it would be disproportionate and unnecessarily punitive in this case, in light of the mitigating factors.

251. The Committee gave consideration to the appropriate length of the order of suspension. It determined that, having balanced the mitigating and aggravating factors against the public interest, it would be proportionate and appropriate to suspend the Registrant for a period of 2 months. When considering the appropriate length of order, the Committee had regard to the mitigation, the testimonials, and the impact upon the Registrant. The Committee also took into account the Registrant's status as a student Optometrist at the time of these events, the stage he had now reached in his career and the public interest in not removing him from practice which would not allow him to maintain and develop his clinical skills.

252. In the circumstances, the Committee was of the view that 2 months was an appropriate and proportionate period of suspension to sufficiently mark the seriousness of the Registrant's misconduct and to address the public interest concerns it had identified.

253. The Committee considered whether to direct that a review hearing should take place before the end of the period of suspension. The Committee noted that at paragraph 21.32 of the Guidance, it states that a review should normally be

directed before an order of suspension is lifted, because the Committee will need to be reassured that the registrant is fit to resume unrestricted practice. However, the Committee bore in mind that it had found that the Registrant had developed insight, had remediated and the misconduct was unlikely to be repeated. Additionally, the finding of impairment was on public interest grounds only. In the circumstances, the Committee was not satisfied that it was necessary or appropriate to direct a review hearing before the order of suspension expired.

254. The Committee therefore imposed a suspension order for a period of 2 months, without a review hearing.

Immediate Order

255. The Committee went on to consider whether to impose an immediate order of suspension and considered the representations from the parties on this issue.

256. 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 was met, which is that it is necessary for the protection of members of the public, otherwise in the public interest or in the best interests of the Registrant. The Committee was referred to the relevant section in the Guidance on making an immediate order.

257. The Committee did not consider that an immediate order was necessary to protect the public. However, given the seriousness of the misconduct and the fact that the Committee had imposed a period of suspension in order to meet the public interest, it was satisfied that imposing an immediate order was otherwise in the public interest.

258. Accordingly, the Committee determined to impose an immediate order of suspension to cover the period before the substantive order takes effect.

Revocation of interim order

259. The interim order of conditions is hereby revoked.

Chair of the Committee: Clive Powell

Signature  **Date:** 4 December 2025

Registrant: Siddique Chowdhury

Signature *Present remotely and received via email* **Date:** 4 December 2025

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