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

**GENERAL OPTICAL COUNCIL**

**F(25)37**

**AND**

**ANEEKA RAMZAN (01-33690)**

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**DETERMINATION OF A SUBSTANTIVE HEARING**
**14 MAY – 20 MAY 2026**

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| **Committee Members:** | Adrian Smith (Chair/Lay)<br>Ben Summerskill (Lay)<br>Gerry Wareham (Lay)<br>Danielle Ellis (Optometrist)<br>Kalpana Theophilus (Optometrist) |
| **Legal adviser:** | Aaminah Khan |
| **GOC Presenting Officer:** | Holly Huxtable |
| **Registrant present/represented:** | Yes and represented |
| **Registrant representative:** | Alex Mills [Counsel]<br>Scott Shadbolt [AOP] |
| **Hearings Officer:** | Arjeta Shabani |
| **Facts found proved:** | 1(a), 1 (d) and 2(a) |
| **Facts not found proved:** | 1(b), 1(c) and 2(b) |
| **Misconduct:** | Not found in relation to 1(a)<br>Found in relation to 1(d) and 2(a) |
| **Impairment:** | Not impaired (Warning issued) |
| **Sanction:** | Not applicable |
| **Immediate order:** | Not applicable |

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## ALLEGATION (AS AMENDED)

*The Council alleges that you, Aneeka Ramzan (01-33690), a registered Optometrist, whilst working at Specsavers Opticians, [redacted]:*

1. *On or around 28 May 2024, you conducted a sight test on Patient A and:*

    a. *failed to maintain adequate patient records in that you did not document the details of the member of support staff who carried out the preliminary examinations on Patient A;*

    b. *failed to advise the patient and/or record the advice given that the new spectacles prescription you had issued him with may have been inaccurate due to his current pathology and may need to be changed at a later date;*

    c. *failed to send an urgent referral to the Hospital Eye Service for further investigation of Patient A's suspected BRVO (branch retinal vein occlusion) in his right eye;*

    d. *failed to maintain adequate patient records in that you falsified an entry in Patient A's records to indicate that the hospital had acknowledged receipt of a referral, when they had not, in fact, done so.*

2. *Your conduct as set out above at 1d is:*

    a. *misleading; and/or*

    b. *dishonest in that you knew that the hospital had not confirmed receipt of the referral.*

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

## Preliminary Issues

1. At the outset of the hearing Ms Huxtable, on behalf of the Council, made an application to amend the Allegation under Rule 46(20) of the of the General Optical Council (Fitness to Practise) Rules Order of Council 2013 ("the Rules"). Ms Huxtable explained that the Council was seeking to better particularise the dishonesty aspect of the Allegation, by adding that it was alleged that the Registrant "*knew that the hospital had not confirmed receipt of the referral*". In relation to the remainder of the proposed amendments,

Ms Huxtable stated that these were to tidy up the Allegation and make it more concise and easier to read.

2. Ms Huxtable submitted that these proposed amendments did not materially change the substance of the Allegation and there was no prejudice to the Registrant. Ms Huxtable stated that the Registrant had been given sufficient notice of the application to amend and the application was not opposed, which was confirmed by Mr Mills, the Registrant's representative.

3. The Committee was advised by the Legal Adviser that it had the power to amend the Allegation under Rule 46(20), either upon the application of a party, or on its own volition, at any stage of the hearing, if the amendment can be made without injustice.

4. The Committee was satisfied that the Council's proposed amendments to the wording of the Allegation made what the Council was alleging against the Registrant clearer. Additionally, it was satisfied that the amendments could be made without causing injustice or prejudice to the Registrant and it noted that the application was unopposed. Accordingly, the Committee granted the Council's application to amend the Allegation.

## DETERMINATION

### Admissions in relation to the particulars of the Allegation

5. The Registrant made no admissions to the Allegation. Mr Mills explained that the Registrant could admit some parts of the Allegation but these admissions would be on a particular basis. As these would be qualified admissions, which were not accepted by the Council, it was considered appropriate by the parties and the Committee that these were treated as denials.

### Background to the allegations

6. The Registrant is an Optometrist who first registered as a student in 2016, then an Optometrist in July 2021. On 28 May 2024, the Registrant was working as a locum Optometrist at Specsavers, [redacted] ("the Practice"). This was the one and only occasion that the Registrant worked at the Practice.

7. One of the patients examined by the Registrant that day was Patient A. During that eye examination, the Registrant identified that Patient A had a branch retinal vein occlusion (BRVO), which required an urgent referral to the Hospital Eye Service (HES). The Registrant prepared a referral letter and told Patient A that he would be contacted shortly by the hospital about an appointment. Whilst at the Practice, Patient A was also provided with a prescription by the Registrant and he purchased glasses.

8. Patient A did not receive an appointment from the hospital and he chased the referral with the Practice at the end of August, when it was found that the referral had not been sent to the HES after Patient A's appointment with the Registrant in May 2024. Patient A was concerned about the delay in the referral and was also unhappy with his new prescription, as he felt that his vision was blurry and that it had deteriorated since his appointment with Patient A.

9. Following the discovery that the referral had not been sent, Patient A was then given an urgent appointment by the HES. When he was seen by the HES in early September 2024, he was informed that he had a BRVO with macula oedema in his right eye, which was subsequently treated with a series of injections into his eye.

10. On 17 October 2024, the Council received a referral from Patient A, which stated that:

"*On May 28th, 2024, I visited Specsavers [redacted] for an eye test regarding concerns with my right eye vision. The Optician identified an issue and scheduled an urgent follow-up with the hospital. Despite receiving a new prescription and glasses, my vision deteriorated from the time of my appointment. As I patiently waiting for my appointment I contacted the branch on 29th of August, 2024, I discovered the hospital had not acted on the appointment request. Specsavers at first blamed the hospital for not contacting me but after some investigation they attributed the oversight to a Locum, who failed to forward my details to the hospital. Not only had the Locum not arranged my appointment, the branch told me when there's a visual impairment/occlusion in someone's eye you should never change their prescription*".

11. The Ophthalmic Director of the Practice, Mr A, provided the Council with a witness statement regarding his involvement in relation to Patient A's complaint to the Practice. Mr A's evidence is that he had made enquiries regarding the referral and found that the original referral letter prepared by the Registrant had been scanned into the Practice's DIPS (digital imaging processing system) in mid-June 2024. However, it appeared that this had not been sent to the HES and the Council's case is that there is no evidence to suggest that the Registrant made a referral in respect of Patient A.

12. The Council allege that there has been a failure, by the Registrant, to refer Patient A to the Hospital Eye Service for a suspected BRVO and that a false entry was made by the Registrant in Patient A's records indicating that a referral had been received and acknowledged by the hospital, when that was not the case.

13. The Council obtained an expert opinion from Dr Anna Kwartz, a registered Optometrist. In her report dated 19 June 2025, Dr Kwartz made the following findings:

i) There is no evidence that Patient A was referred to the HES. The omission fell far below that of a reasonably competent optometrist.

ii) In certain pathologies, including such as that which Patient A presented with, a new prescription should be issued with caution. One reason is that there could potentially be an inaccuracy of the refraction due to the patient's

pathology. In this situation, the Optometrist should have a conversation with their patient regarding their findings and warn them that the result could potentially be inaccurate.

iii) Details of the member of staff who undertook the preliminary examinations (the pre-screening tests, such as OCT) should have been documented on the patient record and the Registrant had not done so.

**The hearing**

14. The Council relied upon the evidence of Patient A, Mr A, Ophthalmic Director of the Practice, Ms A, Store Manager, and Dr Anna Kwartz, expert witness. Ms A's evidence was not challenged by the Registrant and therefore, she was not required to attend for cross-examination. The remaining witnesses attended the hearing and were questioned by the parties' representatives and the Committee.

15. The Committee had before them the Council's bundle of documentary evidence, which included witness statements and exhibits of the Council's witnesses, Dr Kwartz's expert report, Specsavers' patient records for Patient A, hospital and GP records and Specsavers audit logs showing access and entries made to the Specsavers' Socrates system.

16. The Committee also received bundles of evidence from the Registrant, including her witness statements, a copy of the referral letter she prepared for Patient A, and a remediation bundle including testimonials. During the course of the witness evidence the Committee also received further documents in the form of WhatsApp messages that were exchanged between the Registrant and Ms A and Mr A.

17. The Registrant gave evidence, confirming and expanding upon the contents of her witness statements and was questioned by her representative, Mr Mills, Ms Huxtable, on behalf of the Council and the Committee.

18. The Registrant's evidence, in summary, was that this was the first and only day that she worked at the Practice and she did not know the identity of the pre-screeners, as she had not been introduced to them, nor were their details recorded on any paper that she was given. She identified that Patient A had a BRVO and she went to speak to a resident Optometrist working at the Practice regarding the local referral process and she also rang the HES and spoke to a triage nurse. She was unable to email the urgent referral because as a locum, she did not have access to an NHS email account, which was required. The Registrant states that the other Optometrist told her to print the referral letter and give it to a member of staff to send for her, which she did.

19. The Registrant explained in her evidence that whilst she was making enquiries regarding the referral, Patient A was waiting in the waiting area and had been looking at glasses. When she informed Patient A that an urgent referral was being made and that was all that needed to be done today, she recalled Patient A asking about new glasses because his were broken. The Registrant stated that she considered it appropriate to issue a

new prescription, despite the BRVO, because Patient A required new glasses and would need them for driving.

20. The Registrant stated in her evidence that she had made an urgent referral to the HES for Patient A because she had handed the letter to a member of staff in accordance with practice procedure. In relation to the alleged falsified entry in Patient A's records (regarding the hospital having acknowledged receipt of the referral), the Registrant stated that she added this entry later in the day when she was completing Patient A's records (having seen other patients in between) and that she was "*working on autopilot*". She also stated that she had assumed that the hospital would have received the referral. She accepted that the text she had entered about the referral was not accurate and was misleading, but she did not intentionally set out to deceive in any way.

21. The Committee heard closing submissions from both parties. In relation to Allegation 1(a), Ms Huxtable highlighted that the evidence from Mr A was that the Practice had no definitive way of identifying from store records who had carried out the preliminary assessments of the patient. Further, Ms Huxtable submitted that the clear evidence of Dr Kwartz was that irrespective of local practices, there was a personal duty upon the Optometrist set by the Council's 2016 Standards for Optometrists and Dispensing Opticians (at paragraphs 8.2.7 and 9.7) to record this information.

22. Ms Huxtable stated that whilst Dr Kwartz did concede that if it was recorded elsewhere by the store this may meet the standard, the evidence was that it is not recorded by the Practice. Further, Dr Kwartz's view that the suggestion, that pre-screening may be the same person who booked the patient in, was moving very far away from what was expected in the Standards. Ms Huxtable invited the Committee to find that on the balance of probabilities this failure had been established.

23. In relation to Allegation 1(b), Ms Huxtable referred the Committee to the evidence of Dr Kwartz, which she summarised as being that if Patient A's account is accepted (which was that he did not require new glasses) then there is a failure, on the basis that a new prescription should not have been provided where it may be inaccurate due to the patient's pathology. Ms Huxtable submitted therefore that the key issue for the Committee was whether Patient A required replacement glasses and invited the Committee to find this part of the Allegation proved on the basis of the evidence of Patient A, which was clear and emphatic that he did not need new glasses.

24. Turning to Allegation 1(c), Ms Huxtable accepted that the Registrant had printed a referral letter, as this was later found and scanned onto the Practice's DIPS system. Ms Huxtable acknowledged that if the Committee found that the Registrant had followed the usual process for the referral then there would be no failure. Ms Huxtable reminded the Committee of Mr A's evidence that he had made enquiries within the Practice, about what had happened to the letter and no individual recalled receiving the letter. She submitted that if the referral letter had been given to a member of staff it would have been actioned. Whilst the Registrant in evidence was now certain that she had given it to a member of staff, Ms Huxtable stated that

this was now two years post incident, but when the Registrant had spoken to Mr A only two months after the date in question she had no memory of events. Ms Huxtable submitted that the WhatsApp messages that the Committee had been provided with did not support that the Registrant could recall events earlier as she was not putting forward an affirmative account.

25. In relation to Allegation 1(d), Ms Huxtable submitted that the Registrant's entry in the records, regarding the hospital having acknowledged receipt of the referral, was clearly false. She highlighted that the Registrant had accepted in her evidence that she did not receive an acknowledgement from the hospital and that as a matter of fact, that statement was false. Ms Huxtable submitted that in finding this part of the Allegation proved did not necessarily mean of itself that the Registrant had been dishonest, as that was separately alleged in Allegation 2. Ms Huxtable acknowledged that a statement can be false without necessarily being dishonest.

26. In relation to Allegation 2, Ms Huxtable referred the Committee to the case law on dishonesty and the test in the case of *Ivey v Genting Casinos (UK) Ltd* [2017] UKSC 67. Ms Huxtable invited the Committee to consider the issue of dishonesty in the following way, applying the test in *Ivey*,

    i) Consider whether the act or omission said to be dishonest is proven on the balance of probabilities;
    ii) Consider, on the balance of probabilities, what the Registrant's actual state of knowledge or genuine belief as to the facts was;
    iii) Consider whether the Registrant's actions were dishonest by the standards of ordinary honest people.

27. Ms Huxtable stated that whilst the Registrant's account about her state of mind was that she was on autopilot, with no intention to deceive, the text that the Registrant entered was free-typed and not pre-populated. It was a full sentence and stated very clearly that the hospital 'has responded', which suggests that there had been dialogue between the Registrant and the hospital regarding the receipt of the referral. Ms Huxtable submitted that the Council's case is that the Registrant must have typed this consciously, not on autopilot and that the statement goes further than making a mere assumption. Ms Huxtable submitted that the Registrant's account was implausible and that applying the test in *Ivey* carefully, this would be considered to be dishonest conduct.

28. The Committee received closing submissions from Mr Mills. Mr Mills reminded the Committee of the burden and standard of proof. He also submitted that the good character of the Registrant can be taken into account at the fact stage, particularly when considering dishonesty, as relevant to propensity and credibility. Mr Mills stated that when dealing with events from some time ago, contemporaneous records were of real importance. He submitted that Patient A was obviously a patient that the Registrant had spent a lot of time and attention on that day. The Registrant had correctly identified the BRVO and that an urgent referral was required, speaking to another Optometrist for advice, as well as speaking to the HES.

29. Mr Mills addressed the Committee on the Allegation, taking each part in turn. In relation to 1(a), he stated that there had been a change in the standards in 2016 and Dr Kwartz's interpretation had not '*caught on across the board'*. Further, the Practice had no expectation of Optometrists to record this information and nor had any other Specsavers stores that the Registrant had worked in. There was also a practical difficulty in the Registrant finding out that information when it was the first and only day she had worked in the Practice and she did not know the identity of the pre-screeners. She would have had to leave the room after every patient to ask. Mr Mills submitted that regardless of Dr Kwartz's view, it was a matter for the Committee as to what the standard required. He reminded the Committee that Mr A's evidence was that it was '*more than likely*' that the person who booked the patient in (which was recorded on the Practice's system), was also the person who did the pre-screening and it was a matter for the Committee as to whether that was sufficient to meet the requirement. Otherwise, it would be making the Registrant liable for the state of affairs of the Practice.

30. In relation to 1(b), Mr Mills submitted that he understood the way that the Council had put their case, which was that this all turned upon whether Patient A's glasses were broken or not, based upon the expert evidence of Dr Kwartz. Mr Mills stated that it was for the Council to prove their version of events rather than for the Registrant to prove hers, given the burden of proof is on the Council. He stated that it was notable that the Registrant was not challenged by the Council, when she gave evidence, about her account on this issue. Furthermore, the Registrant's account was supported by the documentary records from that day, where she had made an entry regarding Patient A requiring new glasses. Mr Mills submitted that this was not comparable to someone who amends records after events. It was written on the same day, soon after the Registrant saw Patient A and suggested that if that was not true, there would be no reason for her to write it. Mr Mills submitted that there was no apparent motive for the Registrant to write that entry in the records, if not true.

31. Mr Mills submitted that the Registrant had given clear and detailed evidence on events. Patient A had first been asked about whether his glasses were broken in June 2025 when he was called at work, about to go into a meeting. He also had a lot going on at that time, including the eye treatment that he was undergoing. Mr Mills stated that it was clear that Patient A was not happy with the approach of Specsavers and it was not an ideal situation to be trying to find out his recollection of what had happened over a year earlier.

32. Mr Mills highlighted that in Patient A's detailed accounts he had not said anything about it being odd or unusual that he was given a new prescription and glasses because he did not need them. His complaint had focused upon the effectiveness of the prescription that he was given. It was also clear that his recollection of timing was different, as he thought he had contacted the Practice soon after the appointment, when in fact it was three months later in August. Mr Mills submitted that the Committee did not need to choose

between the evidence of Patient A and the Registrant, as there was a range of possibilities in between, such as misremembering, but should instead focus upon the burden of proof. Mr Mills invited the Committee to conclude that there was insufficient evidence to find the allegation proved on the balance of probabilities.

33. Mr Mills turned to Allegation 1(c), which he submitted had been simplified in light of the evidence heard. Mr A had given evidence that the process was for referral letters to be printed and either put in the basket or handed to a member of staff to send. Dr Kwartz's opinion was that if the usual process had been followed, there was no failing. The Registrant's evidence was that is what she did.

34. Mr Mills submitted that there was a total absence of evidence as to what happened to the referral letter between the day of the examination, until it was found on 16 June 2024. Mr Mills submitted that it was most likely that the Registrant gave it to a member of staff and something went wrong with the transmission of it and that all evidence points in favour of the Registrant's version of events. Mr Mills stated that the Committee may think that Mr A's evidence on this issue was somewhat partial and that he had closed his eyes to other possibilities. In his witness statement, Mr A had not mentioned the WhatsApp messages with the Registrant. Mr Mills submitted that this was a significant weakness of his evidence, which affected his reliability.

35. In relation to the hearsay evidence referred to in Mr A's statement (the results of speaking to staff members), Mr Mills invited the Committee to treat this evidence with caution. Staff members were asked about the referral letter three months after the date in question and Mr Mills suggested that they may not recall the detail of a routine event months later. It was also not known what they were told about it when they were asked. Mr Mills submitted that it was not safe to put any weight on this hearsay evidence at all.

36. Mr Mills submitted that the WhatsApp messages sent by the Registrant show a credible response and that at that time there was a degree of confusion over what had happened to the referral letter. Mr Mills submitted that there was nothing wrong with the Registrant's view of what happened solidifying over time; it could not be said that the Registrant's account was a recent invention. Mr Mills submitted that the Registrant's account had not been undermined and it was likely that she had handed the referral letter over to someone but there was then a failure to follow the proper process.

37. In relation to 1(d), Mr Mills submitted that the word 'falsify' does add an extra element to what is alleged, as it has connotations of an intention to deceive, and was not the same as 'false' or 'inaccurate'. Mr Mills stated that the case had been put to the Registrant in cross-examination that the statement was false, but the Committee may think that to falsify a record is not quite the

same as a record being false. He invited the Committee to consider the allegation as it had been drafted and to look at the patient record entry, only one part of which was inaccurate. The Registrant did speak to the hospital and was told to refer urgently. She inserted the whole of this text in one go and it was only the middle section that was inaccurate and the subject of the Allegation. Mr Mills submitted that there was not enough evidence to support an allegation that the Registrant entered this text with an intention to deceive.

38. Mr Mills acknowledged that if the Committee interpreted the Allegation in the manner that the Council contended for, then 'misleading' (Allegation 2(a)) would be found proved. In relation to Allegation 2(b), the Registrant had assumed that the referral would be received, she did not know that they had not confirmed receipt, which was an important distinction.

39. Mr Mills stated that applying the test in *Ivey*, the Registrant's knowledge and belief was that she had assumed that the letter would be sent and received. Mr Mills submitted that if the Committee found that she knew the hospital had not confirmed receipt, this did not necessarily equate to dishonesty, as not all false statements are dishonest. He referred the Committee to two cases on the issue of a knowingly false statement not amounting to dishonesty, *GMC v Raychaudhuri* [2018] EWCA Civ 2027 and *Maxfield Martin v SRA* [2022] EWHC 307 (Admin). Mr Mills invited the Committee to find that applying the test in *Ivey*, the Registrant's actions were not dishonest; she acted in good faith and was not seeking to deceive anyone. Nor was there any benefit to the Registrant in being dishonest. Mr Mills submitted that the public may think it was the wrong thing to do, to enter an incorrect statement, but would not consider it dishonest.

40. The Committee raised with the parties whether the alleged failure in Allegation 1(b) was regarding whether the Registrant ought to have issued a new prescription or was in relation to a failure to give advice following the issue of a new prescription. Ms Huxtable responded that the Council considered that the position was clearly set out in the expert report of Dr Kwartz and the Council did not seek to go behind that expert evidence. Mr Mills submitted that the Council had put its case on this allegation on the basis of Dr Kwartz's opinion that if the Registrant's account was accepted, there was no failing. She did not go on to say that notwithstanding the broken glasses issue, this would be a failing. Mr Mills stated that to find it proved there would need to be evidence of an existence of a duty, which had not been established.

41. Additionally, Ms Huxtable highlighted that in relation to the meaning of 'falsify' and whether it implied an intention to deceive, the Committee could make an amendment to the Allegation of its own accord, under Rule 46(20), if it considered that a different word would be more appropriate.

42. 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 the disputed facts, on the balance of probabilities. The Committee was advised it is required to make decisions based on the whole evidence, deciding what evidence to accept, what to reject and what weight to attach to evidence, assessing all of the evidence that has been presented, both witness evidence, documentary evidence and the hearsay evidence it had admitted. Reasonable inferences can be drawn from the evidence, but the Committee should not speculate about evidence or witnesses it has not heard from. The Committee was advised that where the Allegation alleges a 'failure to' the Committee needed to first be satisfied that the Registrant was under a duty to so act, before going on to consider whether they failed to so act.

43. In relation to dishonesty, the Committee was advised that the test is set out in *Ivey v Genting Casinos* [2017] UKSC 67 (SC). The test in Ivey has 2 separate stages; firstly the Committee should ascertain, subjectively, the actual state of the Registrant's knowledge or belief as to the facts. Secondly, the Committee should decide whether the conduct was honest or dishonest by applying the objective standards of ordinary decent people. The reasonableness or otherwise of the belief is a matter of evidence going to whether or not the Registrant genuinely held the belief, but there is not an additional requirement that the belief must be reasonable.

44. The Legal Adviser advised that where a Registrant puts forward other explanations for the conduct that is alleged to be dishonest the Committee ought to consider whether there are other reasonable explanations for the conduct. There is often no direct evidence of dishonesty, but the Committee can draw inferences about the Registrant's state of mind from the evidence. However, this must be the most likely inference to draw in the circumstances.

45. In relation to the Registrant's character, the Legal Adviser reminded the Committee that she had no fitness to practise history. Good character could be relevant to both the Registrant's credibility and propensity. However, the weight to be attached to such evidence is a matter for the Committee. In relation to amending the wording of the Allegation, the Legal Adviser agreed that there was a power to do so at any stage of the hearing, under Rule 46(20), if it can be made without injustice, but the parties should be allowed an opportunity to make representations before doing so.

**The Committee's findings in relation to the facts**

46. The Committee considered each part of the Allegation separately and in turn. It had regard to all of the evidence before it, including the documentary evidence, the witness evidence, the expert evidence of Dr Kwartz and the parties' submissions.

47. The Committee also had regard to the Registrant's good character and was mindful that this was relevant in two ways, in relation to propensity (the

likelihood that the Registrant has acted in the way alleged) and credibility (whether the Registrant has given a truthful account).

***1. On or around 28 May 2024, you conducted a sight test on Patient A and:***

***a. failed to maintain adequate patient records in that you did not document the details of the member of support staff who carried out the preliminary examinations on Patient A;***

48. The Committee firstly considered whether there was a requirement or duty for the Registrant to have documented the details of the member of the support staff who carried out the preliminary examinations on Patient A. It considered the expert evidence of Dr Kwartz on this issue, which was that if preliminary examinations were carried out by a member of support staff, such as an optical assistant, their details were required to be documented on the patient record, as per the Council's 2016 Standards for Optometrists and Dispensing Opticians (at paragraphs 8.2.7 and 9.7). Paragraph 9.7 states that an Optometrist should "*Ensure that details of those being supervised or performing delegated activities are recorded on the patient record*."

49. The Committee noted that Dr Kwartz had conceded that this may be complied with if the Practice recorded this information elsewhere than the patient record and the staff member could be identified if required. However, the evidence of Mr A was that the store did not record this information at the time and although it was more than likely the same person who booked in the customer (which was recorded), this was not always the case and was not definitive. When given the scenario in this case, Dr Kwartz was of the opinion that it was a long way from what was expected in the Standards.

50. The Committee acknowledged that the Registrant had difficulty in complying with this Standard given that she was a locum, who had only worked in the Practice for one day and was not familiar with the processes at the Practice. Additionally, she had not been introduced to the staff members in question and did not know the information she needed to record unless she went and made enquiries about it. Furthermore, the Registrant was not told she was required to record this information by the Practice nor at any other store that she had worked at.

51. The Committee considered that there was an onus upon the Practice to ensure that adequate processes were in place to allow for such information to be accessible to the Registrant and to be recorded. However, notwithstanding that, the Committee was mindful that the Standards had been in place for some time and placed a personal responsibility upon individual Optometrists to record this information, regardless of the practices

of the store in question. The Committee accepted the evidence of Dr Kwartz on this issue and concluded that there was a requirement for the Registrant, as the Optometrist, to have recorded this information and it had not been recorded in relation to Patient A's preliminary examinations, therefore the Registrant had not complied with her duty in this regard.

52. Accordingly, the Committee found particular 1(a) of the Allegation to be proved on the balance of probabilities, as a matter of fact.

***b. failed to advise the patient and/or record the advice given that the new spectacles prescription you had issued him with may have been inaccurate due to his current pathology and may need to be changed at a later date;***

53. The Committee considered the submissions of the parties on this issue, which had focused upon the question of whether Patient A's glasses were broken or not and required replacement. The evidence of Dr Kwartz, which the Council did not seek to go behind, was that if the Registrant's account was accepted, then there was no failure.

54. On the issue of whether Patient A required a prescription and new glasses, the Committee noted that Patient A was clear in his evidence that he made the appointment because he had an issue with his vision and had denied that his glasses were broken or required replacement.

55. The Registrant's account was that she initially was not going to issue Patient A with a new prescription, because of his pathology and the referral being made to the HES, but whilst waiting in the store he looked at glasses and then told her that he needed a new pair. She had made an entry in the patient record regarding Patient A's glasses being broken. The Committee considered that it was unlikely that the Registrant would make this entry if it was not the case. The Committee considered that the Registrant's account was reliable as it was supported by the contemporaneous note she had made in the patient record regarding the glasses being broken. It was also consistent with her overall account of the day and the audit log.

56. The Committee was of the view that Patient A's recollection was not as reliable, as he only raised the issue regarding his glasses some months later, when he was telephoned about his complaint. The Committee also noted that Patient A's main concern was about his referral not being processed and how his complaint had been handled by Specsavers, rather than being given the prescription.

57. The Committee was mindful that the Council bears the burden of proving the allegation on a balance of probabilities and it was not satisfied in the circumstances that it had discharged the burden of proving that Patient A

should not have been given a new prescription. Accordingly, the Committee concurred with the opinion of Dr Kwartz, that there would be no failing in these circumstances.

58. The Committee noted that the wording of Particular 1(b) relates to failing to advise Patient A, following the prescription being issued, that it may be inaccurate and need to be changed. However, the focus of the evidence had not been on this specific issue. Where this issue was referred to in the report of Dr Kwartz, it was framed as this advice 'should' be given, rather than 'must'. The Committee therefore considered that no duty had been established for an alleged failure in this regard to be established.

59. Accordingly, the Committee found 1(b) of the Allegation not proved.

***c. failed to send an urgent referral to the Hospital Eye Service for further investigation of Patient A's suspected BRVO (branch retinal vein occlusion) in his right eye;***

60. The Committee firstly considered whether there was a duty upon the Registrant, having detected a suspected BRVO in Patient A's right eye, to send an urgent referral to the HES. The Committee was satisfied on the evidence of Dr Kwartz, that there was such a duty given the potential seriousness of the issue and potential risk of harm to the patient if such a referral was not made. Dr Kwartz in her evidence was asked whether there would be a failing by a locum Optometrist if they had followed the local process for making a referral and Dr Kwartz was of the view that there would not be.

61. The Committee then considered whether the Registrant failed in this case to send the urgent referral to the HES. The Committee noted that the Registrant was unable to personally send the urgent referral herself, as she did not have access to the required NHS email account to do so. Having spoken to the HES and the other Optometrist working in the Practice, the Registrant's evidence was that she followed their advice of printing the referral letter and handing it to a member of staff to send on her behalf.

62. The Committee considered that the Registrant had given credible and reliable evidence on this issue. Having correctly identified that an urgent referral was required, producing a referral letter on the day, printing and initialling it and seeking advice regarding the process, the Committee was satisfied that it was likely that the Registrant handed the referral letter to a member of staff to send it on her behalf. It was the Council's case that the Registrant may have simply left the letter somewhere in the Practice. The Practice subsequently found the Registrant's referral letter, which had been scanned into the DIPS system, on 16 June 2024. The audit did not indicate that the Socrates system had been accessed to check if the referral had

been sent. It was not clear what had happened to the letter between the day of the appointment and it being found on the Practice system, however the Committee did not consider that it was likely that the Registrant had just printed the letter and left it in her examination room.

63. The Committee was satisfied, based upon the evidence of the Registrant, that she did hand it to a member of staff and therefore she had followed the usual process and the advice that she had been given. Having done so, the Committee did not consider that there was any failing on the part of the Registrant for the referral letter not having then been sent to the HES, which was the view of Dr Kwartz. The Committee considered that it would be reasonable for the Registrant to expect, having handed it to a member of staff, that it would be sent by them.

64. The Committee considered the hearsay evidence that was contained within the first witness statement of Mr A (relating to speaking to staff members in August 2024 and none of them having any recollection of being handed a referral letter to send). The Committee considered what weight to attach to this evidence, bearing in mind that none of the staff members had provided witness statements nor given evidence in these proceedings. The Committee considered the case law that it had been referred to on hearsay and the parties' submissions on this issue.

65. The Committee noted that the staff members were unidentified, it was not clear how they had been asked about their recollection and their accounts were not documented, for example in witness statements. Additionally, the Committee considered that it was unlikely that staff members would have a clear recollection of being asked to send a referral letter, which was a routine matter, three months earlier. It may also be the case that, if the sending of the referral letter had been overlooked by a staff member, that they would have a reason to deny having any recollection. For these reasons, the Committee was not satisfied that this hearsay evidence was sufficiently reliable and placed no weight upon it.

66. The Committee, having accepted the evidence of the Registrant and the view of Dr Kwartz, found that there was no failing by the Registrant in the referral letter not being sent to the HES. Accordingly, the Committee found particular 1(c) not proved.

***d. failed to maintain adequate patient records in that you falsified an entry in Patient A's records to indicate that the hospital had acknowledged receipt of a referral, when they had not, in fact, done so.***

67. The Committee firstly considered the parties' respective submissions on the meaning of the word '*falsified*'. The Council's position was that this word was not intended to include or require any finding of dishonesty, as that was separately set out in the Allegation in paragraph 2. Whereas, Mr Mills' contention is that the dictionary definition of '*to falsify'* includes '*in order to*

*deceive people'*. The Committee was mindful that it had the power to amend the Allegation at any stage of the hearing, of its own volition, if it considered it could do so without injustice and after hearing representations of the parties.

68. The Committee considered that there can be different interpretations of the word 'falsified', which could vary depending upon the context. However, in this case, the Committee was satisfied that it was appropriate to take a narrow interpretation, as suggested by the Council, as merely creating a false entry, rather than finding that it implies any intent to deceive, given that this is alleged separately in paragraph 2 of the Allegation. The Committee considered that this narrower interpretation would be the more common interpretation of an ordinary member of the public. In addition, the Committee was not satisfied that a person had to intend to deceive in order to falsify a record, as falsifying a record could also be done recklessly.

69. Accordingly, the Committee's findings on this part of the Allegation are limited to the factual issue of whether the Registrant made a false entry in Patient A's records to indicate that the hospital had acknowledged receipt of the records, when they had not, in fact, done so. Having formed this view, the Committee did not consider that it was necessary to make any amendment to the wording of the Allegation.

70. On that basis, the Committee was satisfied that the facts alleged in this part of the Allegation had been established. The Registrant, in her evidence, had accepted that she had recorded a false entry in Patient A's records and that when she wrote the statement, the hospital had not acknowledged receipt of the referral. She had also accepted that her entry was inaccurate and misleading, and that she had written it on "*autopilot*". On a narrow reading of the Allegation (without making any findings regarding intent), the Committee was satisfied on the balance of probabilities that the Registrant had falsified the relevant entry in the record.

71. The Committee was of the view, that having made a false statement in the patient record of Patient A, it follows that the Registrant failed to maintain adequate patient records, as they were not accurate in respect of the fact that the hospital had not acknowledged receipt of the referral. The Committee therefore found particular 1(d) of the Allegation proved.

***2. Your conduct as set out above at 1d is:***

***a. misleading; and/or***

72. The Committee firstly considered whether the Registrant's conduct as set out in 1(d) was misleading. It considered that misleading does not need to be intentional and is a matter of fact. The Registrant had accepted in her

evidence that the entry that she had made regarding the hospital having acknowledged receipt of the referral was misleading.

73. Additionally, the Committee considered that it would be misleading to another practitioner who later read that entry. It also noted that the Practice had initially understood that the referral had been received by the hospital when in started to investigate Patient A's complaint in August 2024 and it caused some confusion regarding whether the referral had been received.

74. Accordingly, the Committee was satisfied that the Registrant's conduct, as set out in 1(d) was clearly misleading and found this particular of the Allegation proved.

***2. Your conduct as set out above at 1d is:***

***b. dishonest in that you knew that the hospital had not confirmed receipt of the referral.***

75. The Committee next considered whether the Registrant's conduct as set out in 1(d) was dishonest, in that she knew that the hospital had not confirmed receipt of the referral.

76. The Committee applied the test for dishonesty set out in *Ivey v Genting Casinos* [2017] UKSC 67 (SC) and firstly the Committee considered, subjectively, the actual state of the Registrant's knowledge or belief as to the facts.

77. The Committee carefully considered the evidence given by the Registrant, including her account as set out in her witness statement and the oral evidence that she gave during the hearing. The Committee took the view that the Registrant's account, that she was working on "*autopilot*" and on the assumption that the referral would be actioned and acknowledged by the HES, was plausible and credible. She had spoken to the HES, prepared and printed the referral letter and had followed the process for sending the referral by giving it to a member of staff to send. The Committee also noted that the false entry was a single phrase contained within the overall entry made at 14:57 in the patient record.

78. The Committee considered it reasonable in the circumstances for the Registrant to assume that the referral would be actioned, sent and acknowledged by the HES in due course. The Committee accepted the evidence of the Registrant that at the time of making the false statement in the record, she expected that the HES would be acknowledging receipt of the referral, because she had done what was expected of her. The Committee also accepted that sometimes record keeping actions are done

on autopilot, for example, the typing of standard phrases. The Committee considered that it was significant that there was no obligation upon the Registrant to have recorded this statement and there was no motive for making the false statement at the time; for example, it was not covering up a mistake.

79. The Committee also had regard to the fact that the Registrant is of good character by not having prior fitness to practise history and also in respect of the positive testimonials that had been provided. Having regard to all of the above, the Committee was satisfied that the Registrant's explanation for her actions, that they were anticipatory and made mindless of proper care and consideration, rather than with intent to deceive, was the most likely one in the circumstances.

80. The Committee went on to consider whether the Registrant's actions were dishonest by the standards of ordinary honest people. The Committee took the view that, having accepted the Registrant's account of her knowledge and belief, that she was acting on autopilot and making an assumption that the referral was being sent and would be received, an ordinary honest member of the public would not consider that her actions were dishonest.

81. The Committee considered that an ordinary honest member of the public would likely consider it to be poor clinical practice and a reckless statement for the Registrant to make in the patient record, due to the risk that the anticipated acknowledgement from the hospital did not materialise, however they would not on balance consider this to be dishonest. In making this assessment, the Committee was mindful that recklessness was not sufficient to amount to dishonesty and also of the caselaw of *GMC v Raychaudhuri* [2018] EWCA Civ 2027 and *Maxfield Martin v SRA* [2022] EWHC 307 (Admin) and the principle confirmed in these cases that the mere making of a statement, knowing that it was false, is not automatically or necessarily dishonest. The Committee considered that these cases were fact-specific but that the principle arising from them also applied to the facts of this case.

82. The Committee considered it significant that there was nothing for the Registrant to gain in making the false statement; it was not information that she was obliged to record and not the case that she was covering anything up, as the issue with the referral not being sent only became known some months later. The Committee also bore in mind the Registrant's good character. The Committee considered that a reasonable ordinary honest member of the public, being aware of the facts of this case, would not consider that making a reckless false statement, whilst working on autopilot and assuming that an event would occur, to be dishonest.

83. Having regard to all of the above, the Committee was not satisfied on a balance of probabilities that the Registrant's conduct was dishonest applying

the test in *Ivey*. Therefore, particular 2(b) of the Allegation is found not proved.

**Misconduct**

84. The Committee proceeded to consider whether the facts found proved at particulars 1(a), 1(d), and 2(a), amount to misconduct.

85. The Committee heard submissions from Ms Huxtable, on behalf of the Council, and from Mr Mills, on behalf of the Registrant. No further evidence was put before the Committee at this stage. Ms Huxtable referred to the Council's skeleton argument and Mr Mills provided the Committee with a written note of his submissions, which he took the Committee through.

86. Ms Huxtable reminded the Committee that there was no strict definition of misconduct and that it was a matter for the Committee's judgment. Ms Huxtable referred the Committee to the case law on misconduct, including the case of *Roylance v General Medical Council (No.2)* [2000] 1 A.C. 311, where, at paragraph 35, Lord Clyde stated:

> "*Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed in the particular circumstances*."

87. Ms Huxtable highlighted the guidance from the cases of *R (Calhaem) v General Medical Council [2007] EWHC 2606 (Admin), Remedy UK Ltd v General Medical Council [2010] EWHC 1245 (Admin) and* of *Nandi v GMC* [2004] EWHC 2317 (Admin), where Collins J held that the conduct must be serious and the adjective "serious" must be given its proper weight. This had been described as conduct that fellow practitioners would find deplorable.

88. Ms Huxtable referred the Committee to the "*Council's Standards of Practice for Optometrists and Dispensing Opticians*", effective from April 2016. Ms Huxtable submitted that the Registrant has departed from the following standards by virtue of her conduct:

- *Standard 8: Maintain adequate patient records*
- *Standard 17: Do not damage the reputation of your profession through your conduct.*

89. Ms Huxtable invited the Committee to find that there had been breaches of these standards, which were serious and amounted to misconduct. Ms Huxtable submitted that the Registrant's actions would be regarded as deplorable. She reminded the Committee of the evidence of Dr Kwartz that the failing was far below the standards expected in respect of particular 1(a) of the Allegation.

90. In relation to 1(d) and 2(a), Ms Huxtable invited the Committee to take into account the evidence of Mr A that when Patient A queried the referral the false entry caused undue delay and confusion between the Practice and the HES over whether the referral had been sent.

91. Mr Mills, on behalf of the Registrant, submitted that Allegation 1(a) should not lead to a finding of misconduct. In relation to 1(d) and 2(a), which he accepted should be considered together, whether these amounted to misconduct was a matter for the Committee to consider.

92. Mr Mills also referred the Committee to the case of *Roylance,* highlighting that the misconduct must be serious and that, with reference to the case of *Calhaem*, 'mere negligence' does not constitute misconduct. Mr Mills referred to the case of *Remedy UK* [2010] EWHC 1245 (Admin) and that record-keeping failings usually fall within the scope of deficient performance rather than misconduct, but in a sufficiently grave case, where the negligence is gross, it could amount to misconduct.

93. Mr Mills acknowledged that Dr Kwartz's opinion could be taken into account on the issue of misconduct, but when reaching a view, the Committee also had to have regard to the relevant law. He reminded the Committee that Dr Kwartz in her evidence had stated that she regards *any* breach of a Standard to be behaviour that is seriously below the level of conduct expected, which he submitted was incompatible with the applicable law. Mr Mills stated that it was not difficult to imagine a scenario where a simple inadvertent record-keeping error would breach the Standards but would amount to negligence of a low degree at most. Mr Mills submitted that Dr Kwartz's view did not necessarily equate to establishing serious professional misconduct.

94. In relation to particular 1(a), Mr Mills accepted that Standards 8.2.7 and 9.7 are applicable. Dr Kwartz had accepted in her oral evidence that there was no risk of harm in relation to this breach but that the failing was far below the expected standard, appearing to be based upon her view that any breach of a Standard falls far below. Mr Mills invited the Committee to find that it should be regarded as falling below the Standard (but not far below) as there was no risk of harm, it was an issue of "staff training and competency", the relevant circumstances of the Registrant being a locum in a store that did not routinely record that information elsewhere (and if it had, there would have been no breach). Additionally, Mr Mills highlighted that Dr Kwartz had described the Registrant's position as "tricky" and the Committee had acknowledged that she had difficulty in complying with this requirement.

95. Mr Mills submitted that the breach of this requirement was a limited one and was not intentional. He stated that it could not be described as negligence of a gross or grave degree given the circumstances.

96. In relation to 1(d) and 2(a), Mr Mills acknowledged that Standard 8 was applicable. He reminded the Committee that it had accepted the Registrant's evidence that the entry in the record was an unintentional error. He submitted that the following factors were significant:

    (a) It was not intentionally misleading or with any intent to deceive. It was "poor clinical practice and a reckless statement", but also reflected an

underlying assumption which it was “reasonable in the circumstances” for the registrant to have made.

(b) The circumstances of the Registrant having correctly identified the need for the urgent referral and the taking of the appropriate steps are also significant.

(c) The confusion caused by the entry was limited to 29 August 2024, and the risk of harm from the particular entry was limited to what occurred: short-term confusion.

(d) The extent of the inaccurate record was limited: it was one part of the information relating to the interaction with the HES. The rest of the patient record has not been criticised.

(e) There was no motive to making a false statement and nothing to gain.

(f) There was no patient harm caused.

(g) The charge relates to a single incident.

97. Mr Mills accepted that accurate and clear patient records were a matter of importance. However, he submitted that care also has to be taken to ensure that the proper distinction between falling below and far below the standard is maintained. Too great a focus on the importance of record keeping away from the context of the erroneous entry in question would result in all record keeping failures amounting to serious professional misconduct. Mr Mills submitted that this case at its highest was a single incident of poor clinical practice in respect of record-keeping which occurred recklessly.

98. The Committee heard and accepted the advice of the Legal Adviser. The Committee was reminded that misconduct was a matter for its own independent judgement and no burden or standard of proof applied at this stage. Further, that the Committee needed to consider whether the conduct was sufficiently serious to amount to professional misconduct.

99. The Legal Adviser stated that this threshold of serious misconduct has been described in the case of *Meadow v GMC* [2006] as being conduct which would be regarded as deplorable by fellow practitioners. However, it does not necessarily require moral turpitude; an elementary and grievous failure can also reach the threshold of serious misconduct, as held in the case of *Preiss v General Dental Council* [2001] 1 WLR 1296. In relation to negligence, the Legal Adviser confirmed that mere negligence does not constitute misconduct, unless grave or particularly serious.

**The Committee’s findings on misconduct**

100. 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.

101. The Committee firstly considered misconduct in relation to particular 1(a) of the Allegation.

102. The Committee considered the 2016 applicable Standards and was of the view that the following applied in this regard:

- Standard 8: Maintain Adequate patient records
- Standard 8.2: As a minimum, record the following information:
- Standard 8.2.7: Details of all those involved in the optical consultation, including name and signature and other identification of the author
- Standard 9.7: Ensure that details of those being supervised or performing delegated activities are recorded on the patient record.

103. The Committee was satisfied that these Standards had been breached by the Registrant, by not recording the information of the staff member who had carried out the preliminary examinations on Patient A in the patient record. Given this, the Committee was satisfied that there had been an omission by the Registrant, which fell below what was expected of a reasonably competent Optometrist in the circumstances.

104. The Committee was mindful that not every falling short of the standards was sufficient to amount to misconduct, as it must be serious. The Committee went on to consider whether the Registrant's failure to record this information on the one occasion found proved in the Allegation was serious.

105. The Committee considered the importance of Registrants following the Standards and recording what information is required to be documented in the patient record. However, the Committee was mindful of the particular circumstances of this case and its earlier findings at the facts stage. Mindful of the evidence of Dr Kwartz, the Committee concluded there was limited risk of harm to the patient in respect of this failure to record. This occurred on the one occasion when the Registrant was working as a locum in a Practice, which itself did not routinely record this information. The Committee considered that this concern was a staff training and practice competency issue. This was a one-off omission, in an environment in which the working practices did not support compliance with the Standard. Whilst the Registrant was personally required to comply with the Standards, this context was relevant to the seriousness of the contravention.

106. The Committee determined that, considering all of the above, whilst the Registrant's failure to record details of the staff member carrying out the preliminary examinations on Patient A was a falling short of what was required, it was not satisfied that it was serious enough conduct in the particular circumstances of this case to meet the threshold of misconduct.

107. Therefore, the Committee found that the conduct found proved in particular 1(a) does not amount to misconduct.

108. The Committee went on to consider the conduct found proved in 1(d) and 2(a) together, given that they are linked.

109. The Committee considered the Standards in relation to this part of the Allegation and was of the view that the following was the most relevant:

- Standard 8: Maintain Adequate patient records

110. The Committee found that it was implicit within this Standard that for a record to be adequate it had to be accurate and capable of being relied upon by fellow practitioners. The Committee was satisfied that falsifying an entry in Patient A's records, which was misleading, fell below this standard.

111. The Committee was again mindful that not every falling short of the standards was sufficient to amount to misconduct, as it must be serious. The Committee went on to consider whether the Registrant's failure to record this information on the one occasion found proved in the Allegation was serious.

112. The Committee had regard to its earlier findings. It had found that the false entry in question was not made with any intention to deceive, rather it was a reckless entry made when the Registrant was acting on '*autopilot*' in her words and assuming that the referral would be actioned. The Committee considered the case law referred to and was mindful that where there was an isolated act or omission, it needed to be particularly serious to amount to misconduct. The Committee also bore in mind the importance of patient records being accurate but that not all record-keeping errors necessarily fall far below the standards expected.

113. The Committee was of the view that, whilst this was an isolated error and the risk of patient harm was limited, it was nonetheless serious and not a mere slip or omission. The Registrant had made a misleading free-text entry in the patient record stating that the HES had acknowledged receipt of a referral, which had not occurred. The Committee concluded, on balance, that the Registrant's conduct was a significant departure from what is required by the Standards in terms of maintaining accurate and reliable patient records, to the extent that it fell seriously below the standards expected of a reasonably competent Optometrist and therefore amounts to misconduct.

114. Accordingly, the Committee found that 1(d) and 2(a), taken together, amount to misconduct.

**Impairment**

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

116. The Committee had before it a remediation bundle provided by the Registrant, which included a reflective statement, CPD statements and certificates, her GOC performance development plan (PDP) and two references. The Committee was also provided with further CPD records from additional courses that the Registrant had undertaken.

117. The Registrant gave further evidence on oath at this stage of the proceedings and was asked questions on her reflective statement, her insight and the remediation she had undertaken. The Registrant stated in evidence that she now understood that assumptions should not be made in clinical practice and that matters should not be recorded in the patient record unless she was sure of them. She stated that she understands the importance of patient records being accurate and that it cannot be assumed that if a referral was sent it would be received.

118. The Registrant outlined changes that she has made to her practice, since the misconduct, to ensure that referrals are sent. These include using the store's NHS email account herself or watching another staff member send the referral email, documenting the name of any staff member who has sent it on her behalf and giving the patient a copy of the referral letter. She acknowledged in her evidence that the problem with inaccurate patient records is that they could cause confusion and delay, as well as being misleading for future practitioners.

119. In answer to questions from Ms Huxtable, the Registrant accepted that her entry regarding the referral letter was misleading. When asked how her conduct impacted the profession, she replied that it could be misleading to other practitioners looking at the record and that the public may also think it was misleading. When asked about how other professionals would view it, she stated that she thought they would consider it a '*slip up of record-keeping*'.

120. After hearing the Registrant's evidence, both parties addressed the Committee on the issue of current impairment, expanding upon their written submissions. Ms Huxtable reminded the Committee that it had to determine impairment as of today. It was a forward-looking exercise and that the purpose of fitness to practise proceedings is not to punish the Registrant for past wrongdoings, but to protect the public from the acts of those who are not fit to practise now and in the future.

121. Ms Huxtable referred the Committee to the test that was formulated by Dame Janet Smith in the report to the Fifth Shipman Inquiry, which was approved in the case of *CHRE v (1) NMC and (2) Grant* [2011] EWHC 927

(Admin), namely that impairment may be found where a Doctor (but applicable to Optometrists) has either in the past, or is liable in future to:

a. put a patient(s) at unwarranted risk of harm, and/or
b. bring the profession into disrepute, and/or
c. breach one of the fundamental tenets of the profession and/or
d. act dishonestly.

122. Ms Huxtable submitted that limbs (a), (b) and (c) of this test are all met in this case. She submitted that the misconduct was a serious failing in Patient A's care, which contributed to undue delay in Patient A being seen by the HES and caused confusion. She submitted that this put Patient A at an unwarranted risk of harm, brought the profession into disrepute and breached fundamental tenets of the profession.

123. Ms Huxtable submitted that insight was an important consideration. She acknowledged that the Registrant has undertaken some remediation and shown a degree of insight and reflection. However, she suggested that the remediation was not yet sufficient to address the concerns in the case. Ms Huxtable invited the Committee to find that the Registrant's fitness to practise was impaired on public protection grounds.

124. Ms Huxtable reminded the Committee of the Registrant's comment in her evidence that this was a '*slip up'*. Mx Huxtable submitted that the misconduct was serious; it concerned making a false entry in a patient record, relating to an urgent referral, which caused confusion and contributed to the delay in Patient A being seen by the HES. It was the Council's position that a finding of impairment was also required in the wider public interest. This was in order to maintain public confidence and uphold standards in the profession, which would be undermined if a finding of impairment was not made.

125. Mr Mills, on behalf of the Registrant, disputed that the false entry in question had caused any undue delay to Patient A's referral. He submitted that there was no evidence of that and the confusion that it may have caused was limited to 29 August 2024. This was when the Practice initially thought that the HES had confirmed receipt of the referral but the position was then clarified and Patient A offered an appointment. Mr Mills described the confusion as a result of the false entry as relatively short lived. He also reminded the Committee that it had found at an earlier stage of the hearing, that there was only a limited risk of patient harm.

126. Mr Mills invited the Committee to find that the Registrant's fitness to practice is not impaired. He submitted that the Registrant does not pose any ongoing risk of harm to patients. Furthermore, the circumstances of the misconduct alone, and particularly when examined in light of the Registrant's insight and the remediation undertaken, do not make a finding of impairment necessary in the public interest.

127. Mr Mills referred the Committee to the test for impairment in the case of *Grant* (as outlined above) and submitted that the only part of the test that

has any potential connection to the facts of this case is (b), 'bring the profession into disrepute'. Mr Mills stated this on the basis that the Registrant's past conduct brought the profession, if not into disrepute, close to it, through "*poor clinical practice*" by recklessly preparing an inaccurate record. Mr Mills stated that it was not accepted that the Registrant would be liable to do so again in future.

128. Mr Mills invited the Committee to not hold the Registrant's denials of charges 1(d) and 2(a) against her in relation to insight, as the facts that had been found proved by the Committee were admitted by the Registrant in her witness statement. The charge was denied because of the way the Allegation had been drafted. Mr Mills referred the Committee to the case of *Sawati v GMC* [2022] EWHC 283 (Admin) and the principles to be applied from that case on this issue of denied charges.

129. Mr Mills reminded the Committee that the Registrant had prepared her reflective statement before the proceedings started and was willing to take responsibility for parts of the Allegation that had not been proven (1(c)), going beyond the evidence of Dr Kwartz regarding what was her responsibility. Mr Mills submitted that this indicates the seriousness with which the Registrant has addressed this case.

130. In relation to the misconduct found (1(d)/2(a)), Mr Mills submitted that the Registrant had candidly recognised in her reflective statement that this was a "*serious error*" and that she had reflected that assumptions are "*unacceptable and misleading*". Mr Mills submitted that the reflective statement demonstrates a clear understanding of the importance of accurate records and the risks arising if that standard is not met.

131. Mr Mills took the Committee through the Registrant's remediation bundle. He highlighted that the CPD undertaken had a connection to the Allegations, including record-keeping, working safely as a locum, learning from complaints and ethics in optics. Additionally, the Registrant's PDP addresses record-keeping. The Registrant had also provided two references that speak highly of her and refer to voluntary optometry work overseas in 2025.

132. Mr Mills submitted that there is evident and genuine remorse in the Registrant's reflective statement and this was relevant to the risk of repetition, which he suggested was low. He stated that the record-keeping error was readily admitted and the gravity of these errors is clearly understood by the Registrant.

133. In relation to the public interest, Mr Mills submitted that this did not require a finding of impairment in this case. The misconduct was not so striking in its seriousness as to militate towards that conclusion. Mr Mills stated that the Committee could also take into account that it has the power,

subject to hearing further representations, to issue a formal warning if it finds that there is no current impairment. Mr Mills highlighted that a further factor that the Committee could consider, if it made no finding of impairment and gave no warning, was that a finding of misconduct is published on the Council's website for a period of three months, which is a public record of those findings.

134. The Committee heard and accepted the advice of the Legal Adviser who stated that the question of impairment was a matter for the Committee's 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.

135. The Legal Adviser reminded the Committee that as well as considering public protection, the Committee also had to have regard to the wider public interest. It should consider not only whether the practitioner continues to present a risk to members of the public in their 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 in the particular circumstances. The Legal Adviser also commended to the Committee the test in *Grant*, which had been referred to by both parties.

136. 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 (including *Sawati v General Medical Council* [2022] EWHC 283 (Admin).

137. The Legal Adviser stated that in relation to a warning, whilst this could be noted by the Committee at this stage, it firstly had to make a decision on current impairment. If no impairment was found then it could invite representations from the parties on whether a warning may be appropriate.

**The Committee's findings on impairment**

138. In making its findings on current impairment, 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.

139. The Committee firstly considered whether the Registrant's conduct was remediable, whether it had been remedied and whether the conduct is likely to be repeated in future.

140. The Committee noted that the misconduct related to a single incident and was a record-keeping error, which it considered is remediable conduct.

141. The Committee considered whether the Registrant's misconduct had been remedied by her since the events took place in May 2024. The Committee considered the steps that the Registrant has taken in order to remediate, which include reflecting, as set out in her reflective statement, the CPD she has undertaken and the production of a PDP. The Committee was of the view that the Registrant had undertaken a sufficient amount of CPD, which was targeted and relevant to the misconduct, including on record-keeping, learning from optical complaints and working safely as a locum.

142. The Committee was of the view that the Registrant had demonstrated that she had reflected and developed insight. She had also shown remorse, understood the impact on Patient A and had made admissions. Whilst the Registrant did not give detailed answers in her oral evidence when questioned by Ms Huxtable, the Committee considered the evidence of her insight and reflection as a whole. It was impressed by her written reflective statement, which gave clear examples of what she had learnt and how she has changed her practice in specific ways, to confirm that referrals have been sent.

143. In relation to the misconduct found, which was on a narrow issue, the Committee considered that the Registrant had taken responsibility for her actions and had undertaken all of the remediation that she reasonably could. Overall, the Committee considered the level of insight and reflection demonstrated by the Registrant, in her written reflective statement and the oral evidence that she gave during this hearing, to be satisfactory.

144. The Committee turned to consider the likelihood of repetition. The Committee noted that it was now approximately two years since the misconduct occurred and there had been no further concerns raised. The Committee had been reassured by the evidence of the Registrant that she has learnt from her misconduct, developed insight and has shown a satisfactory level of remediation, which mitigates the risk of recurrence. The Committee also considered that these proceedings would be a salutary experience for the Registrant, who was at an early stage in her career.

145. Having regard to all of the above, the Committee found that the Registrant's misconduct is unlikely to be repeated and that the risk of repetition was low.

146. The Committee next had regard 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 considered the submission of Ms Huxtable that limbs (a), (b) and (c) of this test are all engaged in this case, namely conduct which puts patient(s) at unwarranted risk of harm, brings the profession into disrepute

and breaches a fundamental tenet of the profession. The Committee also considered the submission of Mr Mills that the closest relevant limb was (b), on a past basis and that none of them applied when looking to the future.

147. The Committee reminded itself that misconduct had only been found in relation to one aspect of the Allegation (1(d)/2(a)), that it had found limited risk of patient harm and this was a single incident, which was unlikely to be repeated. The Committee considered that there was no evidence that the misconduct found had caused actual delay (noting that 1(c) of the Allegation, that the Registrant failed to send the referral, had not been proved). The Committee was of the view that the false entry had caused some confusion when Patient A queried the referral. The Committee agreed that this confusion was short-lived and once the position was clarified, Patient A was offered an appointment by the HES shortly thereafter. The Committee therefore agreed with the submission of Mr Mills that limb (b) of the *Grant* test was met on a past basis. However, it did not consider that any part of the *Grant* test was 'liable to occur in future' given its finding that the conduct is unlikely to be repeated.

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

149. 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.

150. The Committee had regard to the limited extent of the misconduct found, the context in which it occurred, that it was a single record-keeping error, which was unlikely to be repeated, as well as the remediation that had been undertaken by the Registrant. Whilst the Committee had found that the error was sufficiently serious to amount to misconduct, it did not consider that it was so serious that it required a finding of impairment in the public interest. In the particular circumstances of this case, the Committee concluded that the public would understand and public confidence in the profession would not be undermined, if a finding of impairment was not made. The Committee therefore concluded that it was not 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.

151. Accordingly, the Committee found that the Registrant's fitness to practise as an Optometrist is not currently impaired.

**Determination on a warning**

152. As the Committee determined that the Registrant's fitness to practise was not impaired, it considered whether in accordance with section 13F(5) of the Opticians Act 1989, a warning was required. The Committee invited submissions from the parties on the issue of a warning.

153. On behalf of the Council Ms Huxtable submitted that a warning was appropriate in the circumstances of this case. She referred the Committee to the Council's "Hearings and Indicative Sanctions Guidance" ('the Guidance'). She reminded the Committee that it should have regard to the public interest and that a warning can highlight to the wider profession conduct that is not acceptable.

154. Ms Huxtable referred to Paragraph 20.6 of the Guidance and the factors that indicate when a warning may be appropriate. Ms Huxtable submitted that the case squarely fell within 20.6(a). The Registrant had made a false and misleading entry in a patient record and inaccurate records can potentially cause patient harm. Ms Huxtable reminded the Committee of its earlier findings at the misconduct stage, when it had found the conduct to be serious. Ms Huxtable submitted that all of the factors in paragraph 20.6 a)-d) applied and it would be appropriate to formally mark this conduct with a warning.

155. Ms Huxtable acknowledged that several of the mitigating factors in paragraph 20.7 applied, but submitted that these must be weighed against the aggravating factors in the case, including that the false record did mislead and cause confusion within the Practice. In relation to the length of any warning, Ms Huxtable stated that the Council had no strong views and it was a matter for the Committee.

156. On behalf of the Registrant, Mr Mills submitted that, in the circumstances of this case, it was not necessary to issue a warning. He submitted that although warnings do not restrict ability to work, it may be disclosable and have a significant effect on the Registrant.

157. Mr Mills reminded the Committee that a warning did not necessarily follow a finding of no impairment and that many of the factors in 20.5 and 20.6 of the guidance could apply in most cases, therefore do not offer much guidance. Mr Mills submitted that 20.6(b) did not apply, as nothing in the Committee's reasons had indicated that this case came close to a finding of impairment. Mr Mills highlighted the comments that had been made by the Committee in its earlier findings and invited the Committee to find that there was no need to formally record the concerns.

158. Mr Mills referred the Committee to the Guidance, and submitted that many of the factors set out at paragraph 20.7 were in favour of the Registrant.

159. Mr Mills emphasised that if no warning was imposed the Committee's findings on misconduct would be public for three months in any event. He invited the Committee to find that a warning was not necessary and that the public interest is upheld by the fact of proceedings and the public finding of misconduct. If the Committee did decide to impose a warning, Mr Mills submitted that it should be for no longer than six months.

160. The Committee took into account the evidence already adduced, the submissions made and its own findings. The Committee accepted the advice of the Legal Adviser, who referred to the relevant sections of the Guidance. She reminded the Committee to have regard to the public interest and the principle of proportionality, as well as to consider any aggravating and mitigating factors in the case.

161. The Committee had particular regard to the following paragraphs of the Guidance:

> "*20.6 Factors when a finding of no impairment has been made and a warning may be appropriate:*
>
> *a. A clear and specific breach of the Standards of Practice.*
> *b. The particular conduct, behaviour, or performance approaches, but falls short of the threshold for current impairment.*
> *c. Where the concerns are sufficiently serious that, if there were a repetition, they would likely result in a finding of impaired fitness to practise.*
> *d. There is a need to record formally the particular concern(s).*
>
> *20.7 If the Committee are satisfied that the registrant's fitness to practise is not impaired, they can take account of a range of aggravating or mitigating factors to determine whether a warning is appropriate, having regard to the public interest as part of their considerations. These might include:*
>
> *a. Genuine expression of regret/apology;*
> *b. Acting under duress;*
> *c. Previous good history;*
> *d. Appropriate rehabilitative/corrective steps have been taken; and*
> *e. Relevant and appropriate references and testimonials*."

162. The Committee had found that the Registrant had clearly breached Standard 8 of the Council's Standards of Practice, by not maintaining adequate patient records, in that a false misleading statement was recorded in Patient A's patient record.

163. The Committee considered that the Registrant's misconduct did approach, but fell short of a finding of current impairment and if repeated, would likely result in a finding of impaired fitness to practise. The Committee was also satisfied that there was a need to formally record the particular concern. The Committee therefore considered that paragraphs 20.6 a)-d) were all met in this case.

164. The Committee considered the aggravating and mitigating factors in the case. It noted that several of the factors set out in paragraph 20.7 of the Guidance applied, including that the Registrant had genuinely expressed regret, was of previous good history, had developed insight and undertaken appropriate remediation. Further, there had been no repetition and the Committee thought it unlikely that any such conduct would be repeated.

165. However, the Committee bore in mind that a warning can have a deterrent effect and can send a clear signal to both the Registrant and also the profession, that such conduct is not acceptable. The Committee had regard to the public interest and concluded that a warning was necessary in order to remind the Registrant that her conduct had fallen significantly below the standard expected and should not be repeated. The Committee was satisfied that it was necessary to issue a warning in this case to uphold the public interest and maintain standards and confidence in the profession.

166. The Committee therefore determined that, taking into account all of the circumstances, it was appropriate to issue a warning in this case. The Committee was satisfied that a period of six months was an appropriate and proportionate period, which adequately reflected the misconduct in question.

167. The Committee decided that the warning should be worded as follows:

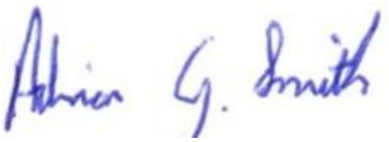
"The Fitness to Practise Committee has concluded that your fitness to practise is not currently impaired. However, the Committee found that your conduct did fall far below the Standards (Standard 8) expected of a Registrant and considers it appropriate and proportionate to issue you with a formal warning for a period of 6 months. This warning will be placed on your registration record and may be taken into account in any future fitness to practise proceedings. While no further action is being taken at this time, the Committee reminds you of the importance of adhering to the Standards set by the General Optical Council and expects no repetition of the conduct in question. This warning will expire on 20 November 2026."

168. The Committee therefore issued a warning which will be recorded against the Registrant's Registration for a fixed period of six months and will expire on 20 November 2026.

**Interim order**

169. There is no interim order to revoke.

**Chair of the Committee: Adrian Smith**

**Signature** …  **Date: 20 May 2026**

**Registrant: Aneeka Ramzan**

**Signature** …received via email……. **Date: 20 May 2026**

| FURTHER INFORMATION |
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| **Transcript** |
| A full transcript of the hearing will be made available for purchase in due course. |
| **Appeal** |
| Any appeal against an order of the Committee must be lodged with the relevant court within 28 days of the service of this notification. If no appeal is lodged, the order will take effect at the end of that period. The relevant court is shown at section 23G(4)(a)-(c) of the Opticians Act 1989 (as amended). |
| **Professional Standards Authority** |
| This decision will be reported to the Professional Standards Authority (PSA) under the provisions of section 29 of the NHS Reform and Healthcare Professions Act 2002. PSA may refer this case to the High Court of Justice in England and Wales, the Court of Session in Scotland or the High Court of Justice in Northern Ireland as appropriate if they decide that a decision has been insufficient to protect the public and/or should not have been made, and if they consider that referral is desirable for the protection of the public.<br><br>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).<br><br>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 Floor 29, One Canada Square, London, E14 5AA or, by telephone, on 020 7580 3898. |