BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(25)01

AND

DENTON BARCROFT (01-10825)

DETERMINATION OF A SUBSTANTIVE HEARING
21 – 29 July 2025

Committee Members:	Adrian Smith (Chair/Lay) Mark McLaren (Lay) Victoria Smith (Lay) Gaynor Kirk (Optometrist) Alexander Howard (Optometrist)
Legal adviser:	Alice Moller
GOC Presenting Officer:	Holly Huxtable
Registrant present/represented:	Present, represented
Registrant representative:	Rebecca Vanstone
Hearings Officer:	Latanya Gordon
Facts found proved:	Particulars 1, 2 and 3 of the Allegation were admitted and found proved
Facts not found proved:	Particulars 4 and 5 of the Allegation were not found proved
Misconduct:	Misconduct found
Impairment:	Fitness to Practise found to be Impaired
Sanction:	Four-month Suspension Order, with Review
Immediate order:	Immediate Order of Suspension.

Notification to Registrant

Counsel for the General Optical Council (the Council) Holly Huxtable said that relevant documents were provided to the Registrant in accordance with Section 23A of the Opticians Act and Rule 61 of the Fitness to Practise Rules (the Rules) 2013.

Application to amend Allegation

1. On the first day of the hearing, Ms Huxtable made an application to amend the Allegation as originally notified to the Registrant under Rule 28 of the Rules.
2. The Council's aim was to render the Allegation more accurate, taking account of documents relied on and the opinions of its expert witness. As the Council no longer considered sub-particular 1(e) i of the Allegation to be amenable to proof, Ms Huxtable requested deletion of that sub-particular. Ms Huxtable asked the Committee to agree other proposed amendments to reflect the expert report.
3. Ms Huxtable submitted that the proposed amendments were uncontentious and may be made without injustice.
4. Counsel for the Registrant, Ms Vanstone, did not object to the Council's application to amend the Allegation and did not dispute the reasons given for doing so.
5. The Legal Adviser said that the Committee should consider each amendment separately. It should consider whether the Allegation could be amended without injustice to the Registrant or to the Council, representing the public interest.
6. The Committee should take account of Rule 46(20) of the Rules:

   '46(20) Where it appears to the Fitness to Practise Committee at any time during the hearing, either upon the application of a party or of its own volition, that—

   (a) the particulars of the allegation or the grounds upon which it is based and which have been notified under rule 28, should be amended; and

   (b) the amendment can be made without injustice, it may, after hearing the parties and consulting with the legal adviser, amend those particulars...'
7. The Committee considered this legal advice and its discretion under Rule 46 to make amendments at any stage of the hearing, provided that no injustice would be caused. The Committee wanted to be fair to the Registrant and the Council.
8. The Committee took account of Ms Vanstone's lack of objection to any change proposed and the Council's aim to ensure that the Allegation reflected the expert report. The Committee considered that it was in the interests of justice for allegations to be clear and readily understood. The Committee accepted that the proposed amendments more accurately reflected the evidence.
9. The Committee accepted that removal of particulars not considered amenable to proof was in the Registrant's interests, and those of the Council. This would allow attention and resources to be focused on those particulars considered to have a realistic prospect of being found proved.
10. The Committee allowed the Council's application to amend the Allegation. The Allegation, as amended, is set out below.

DETERMINATION

Admissions to specific particulars of the Allegation

11. On the first day of the hearing, the Registrant admitted the following Particulars of the Allegation as amended, through his representative Ms Vanstone:

- Particulars 1 and 2
- Particular 3

12. The Committee heard legal advice and submissions from counsel in relation to Particular 3 being an alternative to Particular 4. It accepted that the Council could prove Particular 3 or Particular 4, but not both.

13. Taking account of this point, the Chair announced that Particulars 1 and 2 (only) had been found proved by the Committee. Ms Huxtable said that the Council would present evidence in relation to Particular 4. It was common ground that, if Particular 4 was not found proved, the Committee should find Particular 3 proved on the basis of the Registrant's admission.

14. The Committee proceeded to hear evidence and submissions in relation to the 'outstanding' particulars of the Allegation that remained in dispute:

- Particular 4
- Particular 5

Background

15. The Registrant practised as an Optometrist from 1981 to 2023. At all relevant times in 2022 the Registrant was practising at [redacted].

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

17. Patient A had first attended the Practice on 23 May 2022 as she required new glasses and vision in her left eye was blurred. The Registrant conducted a sight test and provided new glasses and eye drops to Patient A.

18. In an expert report dated 5 December 2024, Dr Kwartz considered Patient A's records for the relevant time and provided an opinion as to various acts and omissions by the Registrant. The report of Dr Kwartz was unchallenged by the Registrant, who made admissions after considering the expert's opinion.

Allegation (as amended)

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

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

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

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

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

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

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

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

ii. *Patient A complaining of reduced vision;*

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

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

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

The duration of the symptom(s);

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

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

2. *On 30 May 2022 you attended to Patient A, and you:*

(a) *Failed to identify and/or record signs of proliferative diabetic retinopathy;*

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

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

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

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

i. *Patient A indicating that she was type 1 diabetic;*

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

iii. *Patient A complaining of reduced vision.*

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

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

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

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

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

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

(a) *Failed to identify and/or record signs of proliferative diabetic retinopathy;*

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

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

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

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

i. *Patient A indicating that she was type 1 diabetic;*

ii. *Patient A complaining of reduced vision;*

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

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

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

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

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

4. *Alternatively, to allegation 3) above, if Patient A did* ***not*** *attend the practice on 8 June 2022, you:*

(a) *failed to advise Patient A that she should seek an opinion by another optometrist and/or the Hospital Eye Service when she told you about her visual symptoms and you were unable to offer Patient A an in-person examination;*

(b) *failed to accurately record what service you provided to Patient A, namely recording an in-person visit when you only spoke to Patient A on telephone.*

5. *Your actions at 4b) above were:*

(a) *misleading; and/or*

(b) *dishonest as you knowingly produced a false record.*

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

DETERMINATION

Key issue in dispute

19. The Committee identified the key issue in dispute as being whether Patient A had attended the Practice in person, or not, on 8 June 2022. To establish the facts alleged at Particular 4, the Council would have to prove that Patient A had ***not*** attended the Practice on this date, because the stem of Particular 4 says, '*if Patient A did not attend the practice on 8 June…*'

20. In his oral and written evidence, the Registrant said that he had seen Patient A in person on 8 June 2022. Patient A disputed this, on the basis that she was '*out of the country*' in England and had not physically attended the Practice in Scotland at any point on 8 June 2022.

21. On this vital point, Patient A and the Registrant gave conflicting accounts of their recollections of 8 June 2022. The Committee had to resolve this disputed issue by analysing the consistency (or otherwise) of each account of events, both internally and in relation to written documents. Neither the Registrant nor the Council relied on evidence from another person as to Patient A's attendance (or otherwise) at the Practice on 8 June 2022.

22. The Committee had to resolve a direct conflict between two live witnesses, Patient A and the Registrant, both of whom had provided written accounts. To do this, it had to analyse successive accounts of events, in the context of clinical records, from each witness.

Account of Patient A

23. On 14 November 2022, Patient A sent a Notice of Complaint to the Practice. In relation to 8 June 2022, Patient A said:

24. '*I was working a night shift and my sight went extremely blurry on both eyes. It was so blurry that I couldn't see one foot in front of me… I could only see shadows. I was very worried so I called Mr Barcroft. I appreciated him taking my call as he was on holiday…*'

25. In a signed witness statement dated 6 November 2023, Patient A said:

'On 8 June 2022 I was driving, and my eyesight was extremely bad, I had stop driving and pulled into a service station after 20 minutes. I phones [redacted], and the reception told me that Mr Barcroft would get back to me on the following Wednesday as I couldn't get an appointment with him.

He phoned me and my reaction was that I was very concerned, I told him that he needed to tell me if there was an issue as my vision in my left eye was much worse and now the vision in my right eye was getting worse. He continued to tell me that there was no problem, and that he would leave a prescription at the opticians for me to pick up. I had to call my husband and brother to come and pick me up as I couldn't drive.'

26. Patient A gave evidence to the Committee and answered all questions. Patient A confirmed that she did not attend the Practice in person on 8 June 2022.

Evidence of the Registrant

27. In his unsigned witness statement provided to the Committee on the first day of the hearing, the Registrant said, in relation to events on 8 June 2022:

'Patient A did not have an appointment scheduled for this day but attended the practice as she had run out of drops… I distinctly remember she came to the practice as I was about to leave for holiday. I checked over the eyes and, as there had been no change and the DRS appointment was imminent, I took no further steps other than to provide Patient A with a further prescription for drops… I made my handwritten note at the time she was in the practice.'

28. The Registrant gave evidence to the Committee and answered all questions. He confirmed that Patient A attended the Practice, in person, on 8 June 2022.

Clinical records – 8 June 2022

29. Patient A's records dated 8 June 2022 from the Practice say: '*Has run out of eye drops. Eyes have gone rather sorer again – had more or less settled up to a few days ago, very photophobic again esp[ecially] LE (left eye)…*'

30. A table headed 'Retinoscopy' has figures recorded for both eyes. Visual acuity in right eye was noted as 6/6- and left eye as 6/12-. A section headed Ocular Examination (Slitlamp) is also completed, as is Ophthalmoscopy.

31. A note at the foot of the page says: '*ran out of drops >> letter for more drops and night time lubricant. Has appt (appointment) for DRS in a few days time = check 1 week.*'

32. The Committee recognised that the accuracy and veracity of the Registrant's clinical records are themselves in dispute. Notes indicating that Patient A attended the Practice in person had potential to support or to undermine the account of the Registrant, as well as that of Patient A, in relation to events on 8 June 2022.

33. If the Committee were to find that Patient A did not attend the Practice, the clinical records would support the Council's allegation of dishonesty at Particular 5. However, the clinical record for 8 June 2022 would confirm the Registrant's account of examining Patient A at the Practice, if the Committee considered it to have been made in good faith at the time.

Disputed Facts at Particulars 4 and 5

34. The Committee considered all evidence adduced by the Council and the Registrant, including clinical records from the Practice, NHS [redacted] and an expert report from Dr Anna Kwartz dated 5 December 2024, statements from Patient A (with exhibits) and the Registrant.

35. The Committee took account of this evidence, as well as written and oral submissions received from the Council and the Registrant, in the context of legal advice.

Submissions on behalf of the Council

36. Ms Huxtable submitted that Patient A has consistently said the only contact with the Registrant on 8 June 2022 was over the telephone. On affirmation, Patient A was adamant that she did not see the Registrant in person on 8 June 2022.

37. Despite '*a degree of confusion'* about some issues, including chronology, Ms Huxtable said that a degree of inconsistency may be expected given the lapse of time between these events and Patient A's complaint and statements. Patient A had been going through a very difficult time with the deterioration of her eyesight.

38. Ms Huxtable asked the Committee to accept independent evidence supporting Patient A's account in relation to events on 8 June 2022, including bank records of transactions in Liverpool on 7 June 2022. Patient A said she was still in England on 8 June 2022 after staying in Liverpool overnight on 7- 8 June 2022.

39. On behalf of the Council, Ms Huxtable suggested that '*the findings of the Eye Screening examination on 9 June 2022 are so markedly different to the Registrant's findings on 8 June 2022, not least the significant and unlikely deterioration in visual acuity within a day, that the only reasonable conclusion is that the Registrant did not or could not have seen and examined Patient A on that date'*. In addition, Ms Huxtable submitted that this '*corroborative evidence'* suggests that Patient A is neither mistaken nor confused about events on 8 June 2022 and lends itself to the conclusion that the Registrant neither saw nor examined Patient A in person.

Submissions of behalf of the Registrant

40. Ms Vanstone highlighted inconsistencies in evidence from Patient A and argued that she was '*plainly confused about dates*'. Ms Vanstone submitted that Patient A was not focused on the particular dates of each appointment, as she had accepted in cross-examination. Ms Vanstone added that an '*otherwise honest witness can be mistaken about the necessary detail*'.

41. In relation to evidence adduced by the Council, Ms Vanstone submitted that Patient A had given evidence in relation to her husband and father-in-law, but the Council had *'chosen not to obtain any evidence from either the patient's husband or her father-in-law in support of these matters, despite knowing from the start of the investigation that there was a significant factual dispute about the patient's attendance on 08 June. It has chosen not to obtain details of who collected the prescription on that day, nor from the friend that the patient says she was with in Liverpool*.'

42. In the context of his admissions to Particulars 1, 2 and 3 of the Allegation, the Committee was invited to accept the Registrant's reluctance to admit disputed particulars as reflective of the true position on Particulars 4 and 5.

Legal Advice – summary

43. The Legal Adviser said that the Committee is required to determine whether any of the disputed facts at Particulars 4 and 5 have been proved. The burden of proof is on the Council, so the Registrant does not need to disprove anything. The standard of proof is the civil standard, or balance of probabilities.

44. The Committee should consider the entirety of oral evidence heard, in the context of documentary evidence. The Committee should analyse the evidence fairly and impartially, taking account of any gaps or apparent contradictions.

45. Although it does not provide a defence, previous good character is an important factor capable of assisting the Registrant in two ways: in relation to credibility as well as propensity. This good character direction is slightly modified by the fact that the Registrant has admitted Particulars 1, 2 and 3.

46. The Committee must reach a conclusion on each paragraph separately, but it is entitled, in determining whether each outstanding particular is proved, to have regard to relevant evidence in relation to any other paragraph. It may consider the evidence as a whole. The Committee must be satisfied that each element of an allegation has been made out before finding a specific allegation proved.

47. It will only be necessary to consider Particular 5 if Particular 4 is found proved. The Committee must first ascertain the Registrant's actual, genuine beliefs as a matter of evidence and then ask itself whether, given those beliefs, his conduct was objectively honest or dishonest: *Ivey* [2017] UKSC 67.

48. There was no comment on the legal advice after it had been given in open session. The Committee was given a full written version and accepted it.

Factual findings in relation to Particulars 4 and 5

49. The Committee did not consider Patient A to be a consistent or reliable witness in relation to the dates of appointments and events on or around 8 June 2022. Neither reps implied that Patient A was deliberately giving a misleading account of events. However, the Committee was aware that an honest witness can be mistaken about dates and other important details.

50. There were discrepancies between Patient A's initial complaint letter dated 14 November 2022 and her first witness statement, which implied that her eyes went blurry while driving. The complaint letter said that both eyes went '*extremely blurry*' on the nightshift at work on 8 June 2022. However, the witness statement said: '*On 8 June 2022 I was driving, and my eyesight was extremely bad, I had stop driving and pulled into a service station after 20 minutes*.'

51. In oral evidence Patient A was asked if she noticed her eyesight was bad on 8 June 2022 when driving. Patient A initially said that she was driving and that her '*vision got much worse in both eyes*.' However, later in cross-examination Patient A said that she did not feel safe to drive on the morning of 8 June 2022 and '*did not get into the car except to load it'*.

52. Patient A acknowledged in cross-examination that she was confused about dates, explaining that she was losing her eyesight at the time. Patient A accepted that dates were not her main focus, as her eyes were her primary concern. Patient A added: '*My recollection might not be clear as I was going through hell'.*

53. Patient A appeared to be confused about whether she attended the Practice on 27 May 2022, confusing that appointment (missed) with another appointment three days later (attended) on 30 May 2022.

54. The Committee found that Patient A did not give a clear or consistent account in relation to travel to Liverpool or Manchester, or from where she was collected.

55. In contrast, the Registrant gave a clear, plausible and consistent account of events. He did not contradict himself in his account of Patient A coming into the Practice on 8 June 2022. His account was supported by clinical records indicating a physical examination, however inadequate, of Patient A.

56. When asked why he was sure that Patient A attended the Practice on 8 June 2022, he said that it was his last day (of work) before his holiday, that he was due to stop work about 1pm so as to be free to go to his other practice that afternoon.

57. In cross-examination, the Registrant confirmed that he saw Patient A in person on 8 June 2022, adding: '*I don't do telephone consultations and wouldn't have done that'*. The Registrant said he was '*100% certain'* that Patient A came into the Practice'.

58. The Registrant told the Committee that he could remember exactly where he stood and that Patient A had run out of eye-drops, also that on examination Patient A's eyes were very dry, but that her vision was reasonable in the right eye, bad in the left eye and that he wrote a prescription for eye drops.

59. The Committee also took account of the Registrant's previously unblemished regulatory record and his otherwise good character, both in relation to the veracity of his account of events and as to his propensity to act as alleged.

60. The Committee was aware that a consistent witness may give a dishonest account, and an inconsistent witness may be telling the truth, to the best of their ability. However, the Committee found the numerous inconsistencies in Patient A's account to undermine the likelihood of it being accurate, especially as to events on 8 June 2022. In contrast the clear evidence of the Registrant, consistent across time and under cross-examination, provided a plausible account of his actions (and omissions) on 8 June 2022.

61. His denials in relation to Particulars 4 and 5 were more compelling in the context of admissions to a long list of failings at Particulars 1, 2 and 3. In evidence, he said: '*I've admitted most of the Allegation but I cannot accept thi*s,' when it was put to him that he had fabricated his clinical note after speaking to Patient A on the telephone on 8 June 2022.

62. Where there was a difference between the respective accounts of Patient A and the Registrant, the Committee preferred the evidence of the Registrant, as it more closely accorded with contemporaneous records than that of Patient A, and it was internally consistent, whereas Patient A's evidence was unclear and had several discrepancies.

63. It was strongly argued by the Council that the clinical records were inaccurate and that the Registrant had dishonestly sought to indicate that Patient A had attended the Practice when she had not. However, the Committee did not accept the argument that the deterioration in recorded vision from 8 June 2022 to 9 June 2022 demonstrated that the record on 8 June 2022 was false.

64. The Registrant's evidence that vitreous haemorrhages can appear quickly was not challenged in cross-examination or submissions and was not commented on by the expert. The Committee found that Patient A's vision may have deteriorated rapidly.

65. The Council did not adduce evidence from its expert Dr Kwartz to support the proposition that the record of 9 June 2022 proved, on a balance of probabilities,

that the Registrant could not have made the observations recorded on 8 June 2022.

66. The Committee was aware that clinicians record symptoms reported by patients, who may not be consistent in describing their condition, which may fluctuate. There may also be an element of subjectivity, or differences in approach, when optometrists are recording their observations.

67. The expert evidence does not support the argument that Patient A's presentation on 9 June at the DRS appointment, would have been the same as her presentation on 08 June. Dr Kwartz' report says: '*The only examination for which there is independently verifiable evidence of the status of Patient A's eyes is 23 May 2022'.*

68. The Committee accepted Ms Vanstone's submission that the expert did not consider the subsequent results of the 9 June 2022 DRS appointment to provide evidence about Patient A's presentation on 8 June 2022. Dr Kwartz was provided with Patient A's records from NHS [redacted] when instructed by the Council, so would have been aware of the DRS results.

69. In its analysis of evidence, the Committee did not consider evidence of bank card transactions to be directly relevant, or probative of any issue in dispute. The fact that Patient A used a bank card in Liverpool on 7 June 2022 does not assist with her whereabouts the following day. It is not difficult to travel from Liverpool or Manchester to Edinburgh in a few hours, by road or otherwise. The Committee had no evidence to demonstrate that Patient A was in England all day or could not have attended the Practice on 8 June 2022.

Conclusions on Facts

Findings in relation to outstanding facts in dispute at Particulars 4 and 5

70. The Committee found that the Council had not discharged the burden on it to prove that it was more likely than not that Patient A had not attended the Practice on 8 June 2022. Particular 4 cannot be proved unless the Council is able to demonstrate that Patient A did not attend the Practice on 8 June 2022.

71. Therefore, the Committee determined that Particular 4 was not proved.

72. Particular 5 is not amenable to proof unless Particular 4b is found proved. As Particular 4b is not proved, Particular 5 cannot be proved.

73. Therefore, the Committee determined that Particular 5 was not proved.

Misconduct – Impairment

74. At an earlier stage, the Chair had invited Counsel to address the Committee in relation to impairment at the same time as making submissions on misconduct. There was no objection to this approach by Ms Huxtable or Ms Vanstone.

Submissions on behalf of the Council

75. Ms Huxtable said that, in determining misconduct, the Committee should have regard to the Council's *Standards of Practice for Optometrists and Dispensing*

Opticians (Standards) effective from April 2016. Ms Huxtable submitted that the Registrant's conduct in 2022 had breached Standards 1, 2, 7, 8, and 17.

76. Further, Ms Huxtable submitted that the Registrant's fitness to practise is currently impaired by reason of misconduct, because his actions and omissions had put Patient A at risk of harm, brought the profession into disrepute and breached its fundamental tenets. Ms Huxtable argued that there must be a risk of repetition, should the Registrant return to practice, as he has not remediated deficiencies in his practice sufficiently to minimise future risk.

77. In conclusion, Ms Huxtable submitted that a finding of impairment is required to protect the public, as well as in the wider public interest, adding that, if no finding of current impairment were made, public confidence in optometrists would be undermined.

Submissions on behalf of the Registrant

78. On behalf of the Registrant, Ms Vanstone accepted that the Committee may reasonably conclude that his admitted actions and omissions amounted to misconduct. However, Ms Vanstone submitted that: '*Three instances of deficient record-keeping do not amount to misconduct, but the Registrant accepts (serious) misconduct',* in relation to his clinical failings at Particulars 1, 2 and 3 of the Allegation. Ms Vanstone reminded the Committee that not every breach of a standard amounts to misconduct.

79. Ms Vanstone said that the Registrant's position was '*neutral on the question of impairment*'. His witness statement made it clear that the Registrant was very sorry about his errors in relation to Patient A. However, these related to one patient in an otherwise unblemished 40-year career. His Practice had now ceased trading, with the premises '*handed over'*.

80. In his witness statement, the Registrant said that he had retired and stopped practising in late 2023 and had no intention of returning to practice. Ms Vanstone said that the fact he had not worked for some time explains why the Registrant had not remediated in the way he would have done if still in practice as an optometrist.

81. After he found out what had happened to Patient A, but prior to her written complaint in November 2022, the Registrant undertook CPD on diabetic retinopathy in June 2022. Ms Vanstone submitted that this '*enabled him to recognise dry eyes as a symptom of diabetic retinopathy'*, indicating that he had benefitted from CPD.

82. In addition, Ms Vanstone submitted that the Registrant has the insight to appreciate that he should have referred Patient A to Hospital, instead of leaving it to the diabetes clinic / DRS.

83. Ms Vanstone said that, before his retirement, the Registrant completed general CPD '*far in excess*' of that required by the Council, as well as complying with the mandatory training required for optometrists registered in Scotland.

84. Due to no longer being in practice, Ms Vanstone submitted that the Registrant is unable to provide the Committee with audits of record-keeping. Also, he has lost access to CPD with the College of Optometrists since retirement. Therefore, he

cannot demonstrate the level of remediation he would otherwise have been able to provide.

85. The Committee was asked to take account of the Registrant's early admissions, cooperation with regulatory proceedings and apology (in his statement) for the impact of his failings on Patient A. Ms Vanstone submitted that the Committee should take account of the context of these events, as well as the fact that there is a spectrum of misconduct.

Legal Advice

86. The Legal Adviser provided guidance as to the approach the Committee should adopt. The Committee has made findings of fact, so must next consider misconduct, and then, if misconduct is found, go on to consider impairment of current fitness to practise. Not every case of misconduct results in a finding of impairment: *Cohen v GMC [2008] EWHC 581*.

87. The word misconduct connotes a serious breach indicating that fitness to practise may be impaired. It is important to set the matters complained of in the context of the Registrant's whole practice: *Calhaem v GMC [2007] EWHC 2606*. Misconduct was described as a wrongful or inadequate mode of performance of professional duty in *Mallon v GMC [2007] CSIH 17*.

88. In *Remedy UK v GMC [2010] EWHC 1245* the High Court said that misconduct is of two principal kinds. First, misconduct in the exercise of professional practice. Second, morally culpable or otherwise disgraceful conduct, outside or within practice. Conduct falls into the second category if it attracts some kind of opprobrium – that may be sufficient to bring the profession into disrepute.

89. The Committee need not go on to consider the issue of impairment, if it were to determine that the facts found proved did not amount to serious misconduct. Misconduct that the Committee might otherwise consider to be serious may be held not to be in the special circumstances: *Campbell v GMC [2005] 2 All ER 970*.

90. The Court of Appeal said in *Schodlok v GMC [2015] EWCA Civ 769*

'*If the Panel decides that the facts do not amount to serious misconduct that would automatically mean that the doctor's fitness to practise is not impaired. However, if the Panel decide that the facts do amount to serious misconduct it has to decide whether that misconduct has the consequence that the doctor's fitness to practise is impaired … A finding of misconduct should not inevitably lead to a finding of impairment of fitness to practise.*'

91. The Legal Adviser reminded the Committee that, at the impairment stage, there is no burden or standard of proof. It is a question of judgement for the Committee. Impairment may be based on historical matters or a continuing state of affairs, but it is to be decided at the time of the hearing. To do this the Committee must look forward, taking account of any reparation, changes in behaviour, conduct or attitude since the relevant time.

92. In determining impairment, the Committee must consider whether or not the Registrant's misconduct indicates any future risk of harm, breach of a fundamental tenet of his profession, bringing optometrists into disrepute or dishonesty: *Grant [2011] EWHC 927*.

93. The need to maintain public confidence in optometrists, or declare standards of behaviour, may mean that a clinician's fitness to practise is impaired by reason of misconduct. This is because the public simply would not have confidence in him, or in the profession's standards, if the Committee regarded this sort of misconduct as leaving fitness to practise unimpaired. A finding of impairment may be necessary (even without risk) to reaffirm to optometrists, and the wider public, the standard of conduct expected: *Yeong v GMC [2009] EWHC 1923*.

94. There was no comment on the Legal Advice, which the Committee accepted.

Analysis and conclusion of the Committee

95. The Committee took account of all evidence adduced, including Dr Kwartz' uncontested expert report, submissions by both counsel, legal advice and guidance. This included the Council's *Standards* 2016.

96. The Committee proceeded on the basis that the facts admitted at Particulars 1, 2 and 3 had occurred as described in the Allegation (as amended on 21 July 2025) which itself reflected the conclusions of Dr Kwartz' expert report. The Committee recognised that everything found proved was admitted by the Registrant on the first day of the hearing.

97. In view of the gravity of her condition and consequent importance of Patient A's clinical records, the Committee did not accept Ms Vanstone's contention that deficiencies in the Registrant's record-keeping did not, alone, amount to (serious) misconduct.

98. The Committee took account of Dr Kwartz' opinion, as well as records from the specialist diabetic clinic / DRS. Dr Kwartz said:

'*There are two schools of thought regarding pupil dilation. One is that, as proliferative changes at the disc had been identified and an urgent referral was indicated, pupil dilation was not absolutely essential, as the optometrist had sufficient information on which to base an urgent referral*.'

99. In view of this, the Committee excluded sub-particulars 1(c) 2(c) and 3(c) from its findings of misconduct.

100. The Committee did not consider that failing to perform and/or record a dilated fundus examination of Patient A's eyes, despite this being clinically indicated, amounted to (serious) misconduct. Although the Registrant did not follow best practice, by failing to dilate, the facts in sub-particulars 1(c) 2(c) and 3(c) were not considered to amount to misconduct, in themselves.

101. The Committee then considered misconduct in relation to the remaining admitted failings. The Committee took account of the context of relevant events, including the fact that the Registrant's last day of work before his holiday was on 8 June 2022.

102. The Committee found that Patient A was placed at risk of harm due to the Registrant's deficient acts and omissions on more than one occasion:

- *Failure to identify and/or record the new vessels at Patient A's optic discs suggesting signs of proliferative diabetic retinopathy;*
- *Failure to make an urgent referral to the Hospital Eye Service, despite this being clinically indicated;*

- *Failure to provide and/or record advice to Patient A about the significance of her diabetic retinopathy so she could make an informed choice;*
- *Failure to accurately document Patient A's visual symptoms by not recording complaints of blurriness and/or reduced vision;*
- *Failure to make and/or record further enquiries as to the onset, nature and duration of Patient A's visual symptoms;*
- *Failure to establish and/or record the level of control of Patient A's diabetes;*
- *Failure to provide and/or record advice to Patient A to avoid contact lens wear until her corneal staining had healed.*

103. Many of these failings were identified by Dr Kwartz as falling '*far below*' the standards expected of a registered optometrist. Most of them occurred on three separate dates, compounding their seriousness.

104. The Committee considered that failing to make an urgent referral, in the context of not conducting and/or recording an adequate history, symptoms and examinations was very serious.

Standards 2016

105. The Committee took account of the preamble to the 2016 *Standards,* which applied at all relevant times in 2022:

'As an optometrist you must make the care of your patients your first and overriding concern: the care, well-being of and safety of patients must always be your first concern. This is at the heart of being a health care professional.'

106. The Committee found that the Registrant's conduct had breached relevant parts of Standards 1, 5, 6, 7 and 17 of the 2016 *Standards* identified below:

'1. Listen to patients and ensure they are at the heart of the decisions made about their care

1.3 Assist patients in exercising their rights and making informed decisions about their care. Respect the choices they make.

5. Keep your knowledge and skills up to date

5.1 Be competent in all aspects of your work, including clinical practice, supervision, teaching, research and management roles, and do not perform any roles in which you are not competent.

5.3 Be aware of current good practice, taking into account relevant developments in clinical research and practice, including digital technologies, to inform the care you provide.

6. Recognise, and work within, your limits of competence

6.2 Be able to identify when you need to refer a patient in the interests of the patient's health and safety and make appropriate referrals.

7. Conduct appropriate assessments, examinations, treatments and referrals

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

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

17. Do not damage the reputation of your profession through your conduct

17.1 Ensure your conduct, whether or not connected to your professional practice, does not damage public confidence in you or your profession.'

107. The Registrant's failings occurred in the exercise of his clinical practice and may properly be described as a wrongful or inadequate mode of performance of professional duty. The Committee found that, except for his failure to dilate at sub-particulars 1(c) 2(c) and 3(c), his behaviour as set out at Particulars 1, 2 and 3 amounted to misconduct which was serious.

108. The Committee concluded that the facts admitted by the Registrant and found proved amounted to misconduct, at Particular 1(a)(b)(d)(e)(f)(g)(h), Particular 2(a)(b)(d)(e)(f)(g) and Particular 3(a)(b)(d)(e)(f)(g).

109. Having found misconduct, the Committee then went on to consider whether the Registrant's fitness to practise is (currently) impaired by reason of misconduct. It accepted the advice of the Legal Adviser and took account of all evidence and submissions presented by the Council and the Registrant.

110. The Committee was not provided with evidence of any other concerns in relation to the Registrant's 40-year career as an optometrist. However, the Committee accepted that his failings on three occasions in 2022 had a significant impact on Patient A and could undermine public confidence in optometrists.

111. The Committee took account of Patient A's evidence that the Registrant's failings had had an adverse impact on her eyesight and may have compounded Patient A's anxiety at what was already a very difficult time, with the need for vitrectomy and other medical procedures.

112. Patient A's witness statement said:

'*My vision in my right eye is now back to normal, my left eye is not… my vision is now a lot better but my left eye is still causing problems.'*

113. The Committee also took account of the Registrant's evidence. In a written statement he said:

'*My last day of practice was 16 December 2023… I have since retired and have no intention of returning to practice. I was always proud to have conducted careful and thorough examinations of my patients and made timely referrals. Patient A was an exception in a career of over 40 years and one for which I am very sorry…*

I should have made a referral on an urgent basis and now deeply regret not doing so. I incorrectly focused on the fact that Patient A was due to be seen by the DRS and that this was likely to lead to a quicker referral lead time and thought at the time this would be the quickest and best course of action. I now accept it was not,

and I should have explained the possible referral options to Patient A and allowed her to make an informed decision. I also accept I did not record the time of the IOP reading, this is something I would usually make a note of. I also accept that the record is not clear the reading was an average.'

114. The Registrant acknowledged the seriousness of this case to the Committee and accepted that his actions amounted to misconduct.

115. '*This has affected me very deeply in last three years, nothing like this has happened before...*'

116. The Committee considered that the Registrant had demonstrated some insight into his failings, expressed remorse for the impact of his conduct on Patient A and acted early to improve his awareness of signs and symptoms of diabetic retinopathy. He had undertaken, and learned from, relevant CPD as soon as he realised that deficiencies in his practice may have led to avoidable harm. To his credit, this preceded a formal complaint from Patient A.

117. However, the Registrant continued to practise as an optometrist until late 2023 without further professional development. Although the Committee was aware that his retirement was imminent, it considered that the Registrant had not done as much as he could have to remediate. Improvements in practice may be associated with minimisation of future risk, in the (albeit unlikely) event that the Registrant were to return to work as an optometrist.

118. As the Registrant's remediation has been only partial (for understandable reasons) the Committee identified an ongoing risk of repetition, taking account of his inability to keep up-to-date since retiring from practice.

119. The Committee viewed the Registrant's misconduct as remediable, but was unable to conclude that it had, in fact, been remediated. Despite his retirement, the Committee could not be satisfied that there was little risk of repetition, if the Registrant were to resume his professional practice.

120. Taking account of the factors in *Grant*, the Committee found that the Registrant had put Patient A at unwarranted risk of harm, had brought the profession into disrepute and had breached important Standards and fundamental tenets of his profession. In 2022, he had not ensured that his conduct in relation to Patient A did not damage public confidence in him or his profession; he had put a patient at risk of harm and thus undermined trust in his profession.

121. Moreover, the Committee identified an ongoing risk of repetition should the Registrant change his mind and go back to work as an optometrist, however sincere his current intention not to do so.

Conclusions on Impairment

122. In all the circumstances, the Committee concluded that a finding of impairment is required to protect the public and in the wider public interest, including to uphold standards and maintain confidence in the profession.

123. The Committee determined that the Registrant's fitness to practise is impaired by reason of misconduct.

Sanction

124. Having determined that the Registrant's fitness to practise is currently impaired by reason of misconduct, the Committee went on to consider whether it was impaired to a degree which required action to be taken in relation to his registration.

Submissions on behalf of the Council

125. On behalf of the Council, Ms Huxtable submitted that the appropriate and proportionate sanction was a Suspension Order for 9-12 months, slightly adapting her written Skeleton argument to reflect the findings of the Committee.

126. The Committee was reminded that the sanctions available are set out in section 13F (3)(a) – (c) and section H of the Opticians Act. Ms Huxtable added that, when deciding on sanction, the Committee should be aware that '*orders made by the tribunal are not primarily punitive:' Bolton v Law Society* [1994] 1 WLR 512. But, the primary concern of the Committee should be public protection, with the impact of any sanction on the Registrant being a secondary consideration: *PSA v NMC* [2015] EWHC 1887.

127. The Committee must take account of its decision on misconduct/impairment, in the context of the Council's *Hearings and Indicative Sanctions Guidance* (ISG) 21.1 to 23.39 and balance all relevant issues in a proportionate manner.

128. Ms Huxtable submitted that this matter is too serious for the Committee to take no further action or to impose a fine on the Registrant, adding that conditions would be inappropriate and unworkable as the Registrant has retired from practice.

129. Ms Huxtable submitted that the '*Registrant has not yet sufficiently remediated; he has not kept up-to-date with current practice or maintained his skill set, as he has been retired for 18 months'*. The Committee should take account of the need to protect the public as well as the wider public interest.

130. When asked, Ms Huxtable declined to identify specific aggravating or mitigating factors. However, she acknowledged that the Registrant has shown remorse, as well as '*a level of insight'*.

131. Nevertheless, although he had engaged with his regulator, demonstrated some insight and made admissions to all particulars found proved, Ms Huxtable submitted that suspension is the only sanction which is sufficient to protect the public and wider public interest. In conclusion, Ms Huxtable said that the Council views suspension for 9-12 months as the appropriate and proportionate sanction.

Submissions on behalf of the Registrant

132. Ms Vanstone said that Ms Huxtable's original Skeleton argument was drafted to reflect the Council's position in relation to dishonesty, which was not found proved by the Committee. Thus, factors relating to dishonesty at paragraph 14.3 of the ISG do not apply.

133. Ms Vanstone submitted that the Registrant's attitude to his past behaviour, full admissions, good character and previous clear regulatory record in the context of

a long career are all to his credit. The Committee should also take account of its findings at the Impairment stage that:

'*the Registrant had demonstrated some insight into his failings, expressed remorse for the impact of his conduct on Patient A and acted early to improve his awareness of signs and symptoms of diabetic retinopathy'*.

134. The Committee finds itself in the '*unenviable position'* of having to consider the available options for a retired optometrist, but it must not impose any sanction more restrictive than the minimum required to satisfy the regulatory objectives.

135. Although the Registrant appreciates that conditions of practice may no longer seem workable, Ms Vanstone submitted that conditions of practice need not be restricted to those currently in practice.

136. In this case, Ms Vanstone said that the Committee was aware that the Registrant's performance in certain areas fell short of what was required, so conditions may properly be identified by the Committee to protect the public.

137. If the Committee were to conclude that conditions are not a feasible response, Ms Vanstone submitted that a short Suspension Order would be the next option to consider. However, this would not necessarily address the issue of public protection, so the Committee may ultimately deem conditions more appropriate.

138. Furthermore, if the Committee were to impose a Suspension Order, Ms Vanstone submitted that 9-12 months (suggested by the Council) would be disproportionate, taking account of the fact that dishonesty was not proved. The allegations which were found proved, on admission, relate to three appointments for one patient.

139. It is common ground that erasure is not required. Ms Huxtable did not address the Committee on this most serious sanction.

140. In conclusion, Ms Vanstone submitted that conditions of practice or a short Suspension Order would suffice to address relevant concerns.

Legal Advice

141. The Legal Adviser said that, at the Sanction stage of proceedings, there is no burden or standard of proof and the decision on sanction is a matter for the Committee's judgement alone.

142. *Raschid v GMC* [2007] 1 WLR 1915 indicates that the Committee is mainly concerned with the reputation of the profession, despite the fact that sanctions may have a punitive effect. *Bijl v GMC [2001]* UKPC 42 said that a Committee should not be obliged to erase an otherwise competent and useful healthcare professional who presents no danger to the public, in order to satisfy public demand for blame or punishment.

143. The ISG is intended to be flexible and is not comprehensive in describing all circumstances. Although a Committee need not adhere to the ISG, it should have proper regard to it: *Bramhall [2021]* EWHC 2109.

144. Mitigation can affect the type of sanction, as well as the length of a relevant order. In *Wisniewska v NMC* [2016] EWHC 2672 it was said that, where there are only two options for sanction, it is critical that the available mitigation is applied when

evaluating the proportionality of each alternative. Mitigation can reduce the length of an order of suspension.

145. In deciding what sanction, if any, to impose the Committee should consider the available options starting with the least restrictive. It should also take account of the principle of proportionality and the need to weigh the interests of the public against those of the Registrant.

146. The Committee should consider evidence of apology, remorse, insight and remediation, including the Registrant's witness statement and CPD. Account should be taken of submissions from both counsel.

The Committee's Decision on Sanction

147. The Committee accepted this advice and took account of the *ISG* which confirms that sanctions are to be considered in ascending order of restrictiveness. The Committee accepted that the purpose of a sanction was not to be punitive, but to protect members of the public; also that the wider public interest includes declaring and upholding professional standards and maintaining public confidence in both the profession and the regulatory process.

148. In reaching a decision on sanction, the Committee took account of all evidence and submissions from counsel, in light of principles in the *ISG* and relevant law.

149. The Committee took account of its decisions at earlier stages of this hearing in its deliberations on sanction. The Committee considered and balanced the aggravating and mitigating factors identified in this case.

Aggravating and Mitigating Factors

150. The Committee considered paragraph 14.3 of the *ISG* and identified the following aggravating factor:

- Patient A was placed at risk of harm due to the Registrant's misconduct on three occasions, particularly by his failure to make an urgent referral.

151. This aggravating factor was identified as serious.

152. The Committee considered paragraph 14.2 of the *ISG* and identified the following mitigating factors:

- The Registrant made early admissions to all particulars found proved and did not dispute that his behaviour amounted to misconduct.
- His misconduct affected one patient in the context of a long career.
- The Registrant has demonstrated some insight:
    - He provided a written apology to Patient A.
    - The Registrant quickly recognised some (or all) of his failings.
    - He accepted that he should have behaved differently and undertook some relevant CPD in June 2022.
    - He identified a reason for his failure to make the requisite referral.
    - The Registrant expressed remorse in his written and oral evidence, in the context of fully engaging with these proceedings.

153. The Committee gave equal weight to these mitigating factors and took account of the fact that the Registrant had no previous regulatory findings.

154. After weighing the aggravating and mitigating factors discussed above, the Committee considered each option / sanction in ascending order of severity, starting with the least restrictive outcome.

No further action

155. The Committee considered whether to conclude the case by taking no further action. Taking no action after a finding of impaired fitness to practise is appropriate only in exceptional circumstances. The Committee determined that there are no exceptional circumstances that would justify taking no action. To take no action would not be proportionate or in the public interest, given the seriousness of the Registrant's misconduct.

156. No further action would not protect patients, uphold standards or maintain public confidence in the profession. The Committee found that a sanction was required.

Financial penalty

157. A financial penalty was not deemed relevant to this case as the Allegation did not relate to financial issues. Both Counsel acknowledged this.

Conditional Order

158. The Committee next considered whether to impose conditions of practice for up to three years on the Registrant.

159. The Committee took account of paragraph 21.25 of the *ISG*:

21.25 Conditional registration may be appropriate when most, or all, of the following factors are apparent (this list is not exhaustive):

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

g. It is possible to formulate appropriate and practical conditions to impose on registration and make provision as to how conditions will be monitored.

160. In the Committee's view the clinical failings of the Registrant did not indicate fundamental attitudinal problems. However, he has retired, so cannot feasibly be subject to workable conditions or monitored. The Committee was not presented with any proposed conditions by Counsel, or given evidence that the Registrant would comply with any specific conditions of practice.

161. In any event, the Committee concluded that imposing a Conditional Order on the Registrant would not be sufficient to protect any future patients, uphold standards or maintain public confidence in the profession of optometry, taking account of the seriousness of the misconduct and limited remediation.

Suspension Order

162. The Committee next considered whether to suspend the Registrant from practice for up to twelve months. Suspension can have a deterrent effect, and it would send a signal to the Registrant, the profession, and the public as to the standards expected of registered optometrists.

163. Suspension may be appropriate where there is an acknowledgement of fault and the Committee is satisfied that the misconduct is unlikely to be repeated. It would protect the public during the suspension (if the Registrant were to return to work) and give the Registrant time to develop further insight and/or to remediate, before

any review. The Committee was aware that the Registrant had retired, and also that he could return to practice if he were to change his mind about retirement.

164. The Committee took account of relevant criteria in paragraph 21.29 of the *ISG*:

21.29*This sanction [Suspension] 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. …

165. The Registrant's misconduct breached important professional standards. These allegations stemmed from the Registrant's serious failings in relation to Patient A in June 2022. However, the Committee did not consider the Registrant's behaviour to be fundamentally incompatible with being a registered professional.

166. The Committee identified a serious instance of misconduct where a sanction less than suspension would not be sufficient to protect the public and wider public interest. However, there was no evidence of harmful deep-seated personality or attitudinal problems and no evidence of repetition since June 2022. The Committee considered that the Registrant has some insight and does not pose a significant risk, in all the circumstances, of repeating his misconduct.

167. The criteria for a suspension order, set out in the *ISG*, indicate that this would be adequate to deal with the concerns raised by these proceedings.

168. The Registrant's admissions to each particular found proved demonstrated openness and some insight. The Committee sought to adopt a proportionate approach, balancing mitigating with aggravating factors.

Erasure

169. In considering erasure, the Committee took account of the *ISG*. The Committee did not consider the Registrant's behaviour to be so serious that it is fundamentally incompatible with continued registration. The Council did not submit that erasure was necessary.

170. The Committee did not consider that a sanction of erasure was required to protect patients, maintain public confidence in the profession of optometry, or to uphold professional standards. Such an outcome would be disproportionate.

Conclusion

171. The Committee determined that a Suspension Order for four months, with a Review, shortly before its expiry, would be sufficient to protect any future patients, uphold standards and maintain public confidence in optometrists.

172. The purpose of the Review hearing would be to enable the Registrant to reassure the Review Committee that he is fit to resume practice (unrestricted or with conditions). The Registrant may consider providing the following information at such a hearing:

- Confirmation of his intention not to return to practice as an optometrist.

- Any further reflections on catalysts for his misconduct and/or potential consequences.
- Evidence of any further professional development.

173. The Committee therefore determined to suspend the Registrant's name from the register of optometrists for four months, with a Review.

Decision on the Council's Application for an Immediate Order

174. Having determined to suspend the Registrant's name from the register of optometrists, the Committee considered if his registration should be subject to an immediate order, in accordance with section 13I of the Opticians Act 1989 and paragraph 23 of the ISG.

Submissions

175. Ms Huxtable applied for an immediate order of suspension due to the Council's concerns about the Registrant's lack of remediation.

176. On behalf of the Registrant, Ms Vanstone opposed the application. Ms Vanstone submitted that an immediate order was not necessary. There was no interim order in this case.

177. Ms Vanstone said that there is no prospect of the Registrant returning to work as he has sold his former practice. Therefore, she submitted that there would be no risk if the Committee declined to impose an immediate order.

Legal Advice

178. The Committee may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the Registrant; the standard is necessity. An immediate order might be particularly appropriate in cases where the Registrant poses an identifiable risk to patient safety.

179. Immediate action may also be taken to protect public confidence in the profession. In relation to the wider public interest, the bar is high, very close to necessity.

Decision of the Committee

180. The Committee took account of relevant paragraphs of the *ISG*. In particular, it considered paragraph 23:

> '*23.3 If the Committee has made a direction for suspension or erasure, it should consider whether there are reasons for ordering immediate suspension. Before doing so, the Committee must be satisfied that to do so is necessary for the protection of members of the public, otherwise in the public interest or in the best interests of the Registrant.*
>
> *23.4 If the Committee thinks there may be grounds for immediate conditions or suspension, it must inform the Registrant of these concerns and invite representations on this issue from both the Presenting Officer and the Registrant's*

representative. The Committee must then decide whether to impose an Immediate Order and give reasons.

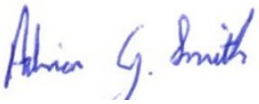
23.5 The Committee must always make clear in its determination that it has considered whether to make an Immediate Order and explain the factors considered, even if it decides that an Immediate Order is not necessary.'

181. The Committee, having heard and accepted the advice of the Legal Adviser, decided to impose an immediate order. In view of its findings that there was an ongoing risk to the public, the Committee considered that such an order was necessary to protect the public and otherwise in the wider public interest.

182. The direction to suspend the Registrant's name from the register of optometrists will take effect 28 days from when notice is deemed to have been served on him, unless he lodges an appeal in the interim. A notice explaining his right of appeal will be sent to him. If the Registrant lodges an appeal, the immediate order of suspension will remain in place until such time as the outcome of any appeal is determined.

183. That concludes this case.

Chair of the Committee: Adrian Smith

Signature  **Date:** 29 July 2025

Registrant: Denton Barcroft

Signature: Present via Microsoft Teams **Date:** 29 July 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.