BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(25)35

AND

ABBIE MCBAIN (01-23326)

DETERMINATION OF A SUBSTANTIVE HEARING
6-10 & 17 JULY 2026

Committee Members:	Andy Brennan (Chair/Lay) Nigel Pilkington (Lay) Ian Hanson (Lay) Annabelle Magee (Optometrist) Sarvat Fida (Optometrist)
Legal adviser:	Kelly Thomas
GOC Presenting Officer:	Holly Huxtable
Registrant present/represented:	Yes and represented
Registrant representative:	James Halliday (Counsel) Chloe Jeram (AOP)
Hearings Officer:	Arjeta Shabani (6-10 July) Natasha Bance (17 July)
Facts found proved:	1aii, 1bii, 2ai, 2aii, 2bi, 2bii, 2ci, 3a, 3bi, 3bii, 3ci and 3cii
Facts not found proved:	1ai, 1bi, 1ci, 2cii and 2ciii
Misconduct:	Found for 1bii, 2ai, 2aii, 2bi, 2bii, 2ci, 3bi, 3bii, 3ci and 3cii
Impairment:	Not impaired (Warning for 2 years)

ORIGINAL ALLEGATION

The Council alleges that you, Abbie McBain 01-23326, a registered optometrist, whilst working at Vision Express, [redacted]:

1. *On or around 4 March 2021, you conducted a sight test on Patient A, a minor, and:*

   a) *You failed to maintain adequate patient records in that you:*
      i. *Recorded inconsistent information regarding Patient A's visual symptoms;*
      ii. *Did not record Patient A's near oculomotor status;*

   b) *You failed to carry out an adequate examination of Patient A in that you:*
      i. *Did not identify the optic disc swelling in Patient A's right eye;*
      ii. *Did not detect signs of an intracranial space-occupying lesion in Patient A;*

   c) *You failed to refer Patient A to the Hospital Eye Service for further investigation, despite this being clinically indicated, in that:*
      i. *There was swelling of the nasal aspect of the optic disc margin of Patient A's right eye;*
      ii. *There was significantly reduced acuity in Patient A's right eye but no apparent amblyogenic factor;*

2. *On or around 7 May 2022 you conducted a sight test on Patient A, a minor, and:*

   a) *You failed to maintain adequate patient records in that you:*
      i. *Did not adequately record Patient A's symptoms of the headaches, such as the onset, location, frequency and duration;*
      ii. *Did not to record Patient A's near oculomotor status;*

   b) *You failed to carry out an adequate sight test on Patient A in that you:*
      i. *Did not identify the optic disc swelling in Patient A's right eye;*
      ii. *Did not detect signs of an intracranial space-occupying lesion in Patient A;*

   c) *You failed to refer Patient A to the Hospital Eye Service for further investigation, despite this being clinically indicated, in that:*
      i. *Patient A reported a new symptom of headaches;*
      ii. *There was increased swelling of the nasal aspect of the optic disc margin of Patient A's right eye;*

iii. There was reduced acuity in Patient A's right eye but no apparent amblyogenic factor;

3. On or around 14 February 2023 you conducted a sight test on Patient A, a minor, and:

a) You failed to maintain adequate patient records in that:

i. You failed to record Patient A's near oculomotor status;

b) You failed to carry out an adequate sight test on Patient A in that you:

i. Did not identify the optic disc swelling in Patient A's right eye;

ii. Did not detect signs of an intracranial space-occupying lesion in Patient A;

c) You failed to refer Patient A to the Hospital Eye Service for further investigation, despite this being clinically indicated, in that:

i. There was increased swelling of the nasal aspect of the optic disc margin of Patient A's right eye;

ii. There was reduced acuity in Patient A's right eye but no apparent amblyogenic factor

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

PRELIMINARY APPLICATIONS

Application to amend allegation/withdraw particulars

1. Ms Huxtable, on behalf of the Council, made an application under *Rule 46(20)* of the *General Optical Council (Fitness to Practise) Rules 2013 ("the Rules")* to amend the allegations.

2. The first proposed amendment related to the allegation that the Registrant failed to maintain adequate records in that she failed to *record* Patient A's near oculomotor status across all three examination dates. The Council sought to add that the Registrant failed to *assess* Patient A's near oculomotor status across all three examination dates. This amendment reflects the expert opinion of Dr Anna Kwartz, registered Optometrist, in her report dated 23 July 2025, and accords with the allegation as it was referred by the Case Examiners.

3. The Council further sought to withdraw particular 1bii, 2bii and 3bii, notably "*Failed to detect signs of an intracranial space-occupying lesion in Patient A".* This failure is not expressly raised by Dr Anna Kwartz. The expert's analysis, in the main, is that the Registrant failed to identify the optic disc swelling in Patient A's right eye across all three examinations.

4. The proposed amended allegations were sent to the Registrant on 18 March 2026. In essence, Ms Huxtable submitted that the proposed amendments better particularise the allegation and reflect the findings of the expert.

5. Finally, in light of the joint expert report of Dr Kwartz and Professor Bruce Evans dated 21 and 24 May 2026 respectively, the Council sought to remove the word *"increased"* from allegation 3cii. Ms Huxtable stated that the proposed amendments were made after the joint expert report was received and is made to narrow the issues in the case.

6. Mr Halliday, on behalf of the Registrant, raised no objections to the proposed amendments except of that in relation to allegation 3cii. Mr Halliday submitted that the Council allegation had consistently referred to "increased swelling" from the case examiner stage onwards and that, in the absence of evidence of increased swelling, the amendment amounted to unfairly "moving the goalposts" to preserve an allegation that would otherwise fail.

7. The Committee received and accepted advice from the Legal Adviser who outlined *Rule 46(20)* of the *Rules.*

8. In relation to all of the proposed amendments except that at allegation 3cii, the Committee noted that there were no objections from the Registrant. The Committee considered the prejudice to the Registrant and balanced this against the overarching objective of protection of the public. The Committee decided that all of the allegations, including that at 3cii should be amended, as the proposed allegations better reflected the evidence and caused no prejudice to the Registrant.

AMENDED ALLEGATION

The Council alleges that you, Abbie McBain 01-23326, a registered optometrist, whilst working at Vision Express, [redacted]:

1. On or around 4 March 2021, you conducted a sight test on Patient A, a minor, and:

a) You failed to maintain adequate patient records in that you:
- *i. Recorded inconsistent information regarding Patient A's visual symptoms;*
- *ii. Failed to record Patient A's near oculomotor status;*

b) You failed to carry out an adequate examination in that you:
- *i. Failed to identify the optic disc swelling in Patient A's right eye;*
- *ii. Failed to assess Patient A's near oculomotor status;*

c) You failed to refer Patient A to the Hospital Eye Service for further investigation, despite this being clinically indicated, in that:

i. There was swelling of the nasal aspect of the optic disc margin of Patient A's right eye;

2. On or around 7 May 2022 you conducted a sight test on Patient A, a minor, and:

a) You failed to maintain adequate patient records in that you:

i. Failed to adequately record Patient A's symptoms of the headaches, such as the onset, location, frequency and duration;

ii. Failed to record Patient A's near oculomotor status;

b) You failed to carry out an adequate examination in that you:

i. Failed to identify the optic disc swelling in Patient A's right eye;

ii. Failed to assess Patient A's near oculomotor status;

c) You failed to refer Patient A to the Hospital Eye Service for further investigation, despite this being clinically indicated, in that:

i. There was a significant reduction in Patient A's right eye visual acuity but no apparent amblyogenic factor;

ii. Patient A reported a new symptom of headaches;

iii. There was increased swelling of the nasal aspect of the optic disc margin of Patient A's right eye;

3) On or around 14 February 2023 you conducted a sight test on Patient A, a minor, and:

a) You failed to maintain adequate patient records in that you failed to record Patient A's near oculomotor status;

b) You failed to carry out an adequate examination in that you:

i. Failed to identify the optic disc swelling in Patient A's right eye;

ii. Failed to assess Patient A's near oculomotor status;

c) You failed to refer Patient A to the Hospital Eye Service for further investigation, despite this being clinically indicated, in that:

i. There was a significant reduction in Patient A's right eye visual acuity but no apparent amblyogenic factor;

ii. There was swelling of the nasal aspect of the optic disc margin of Patient A's right eye;

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

ADMISSIONS

9. The allegations were adopted into the record as above. The Registrant denied all allegations.

BACKGROUND

10. Ms Huxtable opened the case and set out the case law and background.

11. The Registrant is an Optometrist who, at the material time, was employed at [redacted] Vision Express Limited (*"the Practice"*).

12. On 19 February 2024, Patient A attended the Practice for a sight test to investigate the cause of persistent headaches. A locum Optometrist observed blurred disc margins in the left eye nasally, which had not previously been noted, with "scattered missing points" on the left visual field and made an urgent referral to the Hospital Eye Service.

13. On 6 March 2024, Patient A had an MRI scan which revealed a large extra-axial space occupying lesion (brain tumour) causing significant hydrocephalus. She latterly underwent surgery, notably the insertion of a ventriculoperitoneal shunt.

14. Patient A has suffered significant visual impairment and is now registered as visually impaired.

15. Patient A's father initially raised concerns with professional services at Vision Express on 1 August 2024 and then subsequently referred the matter to the Council on 25 July 2025.

16. The Registrant was involved in Patient A's care in the years preceding her urgent referral and had seen her on four separate occasions, notably 28 September 2020, 4 March 2021, 7 May 2022 and 14 February 2023.

17. The Council obtained the expert opinion of Dr Kwartz. In her report dated 23 July 2025, Dr Kwartz considered Patient A's records for the examination on 4 March 2021, 7 May 2022 and 14 February 2023 and broadly concluded that across all three examinations the Registrant:
    - Failed to assess and/or record Patient A's near oculomotor status (1a, 2a and 3a);
    - Failed to identify the optic disc swelling in Patient A's right eye (1b, 2b and 3b);
    - Failed to refer Patient A (1c, 2c and 3c).

SUBMISSIONS AND ADVICE ON FINDINGS OF FACT

18. Dr Kwartz gave evidence and adopted her report dated 23 July 2025 and the joint expert report with Professor Evans dated May 2026.

19. Dr Kwartz's opinion was that the Registrant's care of Patient A fell far below the standard expected of a reasonably competent Optometrist at each of the three examinations. She considered that the Registrant failed to assess and/or record Patient A's near oculomotor status, failed to identify signs of right optic disc

swelling evident from the available clinical information and imaging, and consequently failed to make an appropriate referral despite Patient A's longstanding and unexplained reduction in right-eye visual acuity.

20. In reaching her conclusions, Dr Kwartz emphasised that assessment of Patient A's near oculomotor status was particularly important given her age, educational demands, unexplained reduced vision and documented ocular misalignment. She was also critical of any reliance placed on Patient A's reported history of a "lazy eye" and previous discharge from ophthalmology. Dr Kwartz considered that history to be an unreliable explanation for the markedly reduced visual acuity in circumstances where the clinical records disclosed no obvious amblyogenic factor and where, in her experience as a paediatric optometrist, patient recollection of childhood appointments is often unreliable.

21. Whilst accepting that optic disc swelling can be difficult to detect, particularly in primary care, and that some findings may be missed, Dr Kwartz maintained that a reasonably competent Optometrist would have identified suspicious features. Taking into consideration the totality of the clinical evidence, including the appearance of the optic disc, comparison with previous ocular records, visual acuity findings and ophthalmoscopic examination and reported symptoms. Although her views differed from those of Professor Evans in some respects, she remained of the opinion that each of the failings alleged in particulars 1–3 represented a significant departure from the standards expected of a reasonably competent optometrist and created a risk of serious harm to Patient A.

22. The Committee asked a number of questions of Dr Kwartz.

23. The Registrant gave evidence. In her oral evidence the Registrant adopted her written statement dated 3 April 2026. The Registrant maintained that she performed near cover tests on each of the three occasions when she examined Patient A but did not record the results because her practice at the time was generally to document only abnormal findings or changes from baseline. Whilst she maintained that this reflected common practice, she accepted in hindsight that the absence of a record made it difficult to demonstrate that the tests had been performed, and that her current practice is to record such findings separately and contemporaneously.

24. The Registrant consistently denied that Patient A displayed optic disc swelling at any of the consultations in March 2021, May 2022 or February 2023. She stated that she was highly experienced in binocular indirect ophthalmoscopy (BIO), regarded it as the gold standard for assessing the optic disc, and relied upon her own direct examination rather than a two-dimensional fundus photograph. The Registrant stated that in looking at the fundus images in her consultation room, she would usually only have access to a thumbnail image. In Committee questions, the Registrant stated that if she needed to, she could access larger versions of the images at a different computer. The Registrant

disagreed with Dr Kwartz's interpretation of the photographs and maintained that, on her assessment, the optic nerves appeared healthy on each occasion. The Registrant stated that optic disc swelling is rare but something for which she had a very low threshold for referral because of its potentially serious implications. She said that, had she identified swelling, she would have referred Patient A.

25. The Registrant further maintained that Patient A's reduced visual acuity in the right eye was longstanding and stable. She had accepted the history provided by Patient A that she had a previous diagnosis of amblyopia by the Hospital Eye Service although those appointments were not fulfilled. The Registrant considered it reasonable to rely upon that history. Although the Registrant accepted that the records themselves contained little objective evidence of the underlying cause of the amblyopia, she remained satisfied that the reduced vision was attributable to a longstanding "lazy eye" which had not clinically deteriorated.

26. In relation to the May 2022 consultation, the Registrant accepted that headaches were a new presenting symptom and that she did not record the onset, character, frequency or duration of those headaches. She stated, however, that she had in fact explored the symptoms through discussion and had asked questions aimed at identifying red-flag features, and was satisfied from the responses that the headaches were caused by squinting and eyestrain associated with blurred vision.

27. The Registrant accepted in cross-examination that the relevant professional guidance contemplated recording such information and acknowledged that, viewed retrospectively, her records did not fully reflect the information obtained. The Registrant initially accepted that it was "*possible*" she had not performed the test, although later during re-examination she described that as "*highly unlikely*". She nevertheless maintained that, at the time, she believed her records were adequate and provided sufficient information to a future clinician.

28. Throughout her evidence she accepted that it was now impossible to prove from the records alone that certain tests had been undertaken, but stated that her examination of Patient A was conducted in accordance with her usual clinical routine and that, had she detected optic disc swelling or any other significant pathology, she would have referred Patient A without hesitation.

29. Professor Evans gave evidence and adopted his report dated 24 April 2026 and the joint expert report with Dr Kwartz from May 2026. He agreed that fundus imaging is a valuable and routinely used tool for identifying pathology, but emphasised its limitations as a two-dimensional representation and agreed with Dr Kwartz that concerns about optic disc swelling should be confirmed by BIO, which provides a three-dimensional assessment.

30. On the substantive issues, Professor Evans disagreed with Dr Kwartz's interpretation of the fundus photographs from March 2021 and May 2022. Professor Evans maintained that features relied upon by Dr Kwartz, including a less distinct nasal disc margin and apparent vessel deflection, were either normal anatomical appearances or could not reliably demonstrate swelling from a two-dimensional image. In his opinion, Professor Evans stated that there was no clinically significant difference between the 2020 and 2021 images and therefore there was no photographic evidence of optic disc swelling. He agreed that, had swelling been present, it should have been observable on ophthalmoscopic examination and would have constituted an amber or red flag requiring further investigation.

31. Professor Evans considered it reasonable for the Registrant to attribute Patient A's longstanding reduced visual acuity in the right eye to a reported history of amblyopia because the visual acuity had remained stable over several years and no alternative cause was apparent from the clinical examinations. Whilst accepting that Patient A did not display many of the common clinical factors associated with amblyopia, Professor Evans took the view that an Optometrist is ordinarily entitled to rely upon a patient's reported history of a hospital diagnosis, which is a "higher authority."

32. Professor Evans also maintained that although near cover testing ought to be performed, the absence of recorded near cover test results on each occasion did not amount to a failure of practice, given that baseline oculomotor findings had previously been recorded and there was no evidence of abnormality. In relation to the May 2022 consultation, Professor Evans accepted that the records did not adequately document the onset, character and duration of Patient A's headaches, but considered that the symptoms could reasonably be attributed to squinting and blurred vision associated with refractive error. Under questioning by the Committee, he accepted that optic disc swelling could theoretically have been missed on the three dates in question, but stated that if BIO had been performed and recorded as normal, his conclusion would be that optic disc swelling was not present.

33. In closing, Ms Huxtable submitted that the allegations concerning the near oculomotor assessment were proved on both the evidence and the records. Both experts agreed that near oculomotor testing should have been undertaken at each consultation and that failure to do so would fall below the expected standard. She argued that the Registrant's assertion that she had performed the tests was unreliable, given the passage of time, the number of patients she had seen since 2021, and her concession in cross-examination that it was possible she had not conducted the tests.

34. In relation to record keeping, Ms Huxtable submitted that if the Committee accepted that the tests had been performed, it should nevertheless find a record keeping failure. She relied on Dr Kwartz's evidence that such findings should be recorded, and questioned the rationale advanced by Professor Evans that clinicians could rely on historic baseline findings. She also submitted that the

failure to explore and record the onset, character and duration of Patient A's headaches in May 2022 was further evidence of inadequate record keeping.

35. In relation to the allegations concerning optic disc swelling and referral, Ms Huxtable submitted that the Committee should prefer Dr Kwartz's interpretation of the fundus images. She argued that, notwithstanding the acknowledged limitations of two-dimensional imaging, fundus photographs remain a routine and clinically useful tool for identifying pathology. She submitted that Dr Kwartz identified features consistent with optic disc swelling in the March 2021 and May 2022 images and that those abnormalities should have been recognised by the Registrant. Ms Huxtable further argued that Patient A's markedly reduced visual acuity could not safely be attributed to amblyopia because all parties agreed that the common amblyogenic factors were absent and the Registrant's assessment was based solely on the history provided by a 13-year-old patient rather than objective clinical findings.

36. Ms Huxtable submitted that the combination of poor visual acuity, the fundus appearances, the absence of clinical evidence supporting amblyopia, and, by May 2022, the additional symptom of headaches, were all factors which ought to have prompted referral. Ms Huxtable contended that these features amounted to warning signs. A reasonably competent optometrist should have identified the optic disc swelling and should have referred Patient A on each occasion.

37. Mr Halliday, in closing submissions for the Registrant, submitted that the Committee should approach the allegations bearing in mind the Registrant's good character, her 15-year career without previous regulatory concerns, and the burden of proof resting entirely upon the Council. He argued that the Registrant was a credible witness and that the Committee should not adopt the proposition that, simply because something was not recorded, it did not happen.

38. In relation to the near oculomotor allegations (1a, 2a and 3a), he relied on Professor Evans' evidence that it was acceptable practice within a responsible body of Optometrists not to record unchanged near oculomotor findings where a baseline result already existed. He submitted the Registrant's evidence that she routinely performed the test on every patient should be accepted and there was no persuasive basis for concluding that the assessments had not been carried out. Whilst accepting that the Registrant acknowledged it was possible she had omitted the test, he emphasised that she regarded this as highly unlikely and that it would be inconsistent with her otherwise thorough examinations to omit such a routine assessment.

39. In relation to the optic disc swelling and referral allegations (1b–c, 2b–c and 3b–c), Mr Halliday submitted that the Committee should prefer the evidence of Professor Evans. He argued that the 2020 photograph was poorly centred, making comparison difficult, and that both experts accepted the limitations of two-dimensional fundus photography. He emphasised Professor Evans' opinion that there was no clinically significant difference between the 2020, 2021 and 2022 images, the disc appearances fell within normal limits, and BIO was the

gold standard examination, which the Registrant performed on each occasion and found to be normal. He further submitted that the Registrant was entitled to take into account Patient A's reported history of amblyopia and was not required to second-guess an apparent hospital diagnosis.

40. In his submission, Mr Halliday stated that there was insufficient evidence to establish that optic disc swelling was present on any of the relevant dates and, in the absence of swelling or any other clinically significant finding, there was no duty to refer. He contended that the headaches reported in May 2022 could reasonably have been attributed to eyestrain from squinting to see the board, that the headaches were not shown to be a significant pathological warning sign, and that the allegation that an experienced optometrist repeatedly missed an obvious and serious abnormality was inherently unlikely on the evidence before the Committee.

41. The Legal Adviser advised the Committee that, at the fact-finding stage, the burden of proof rested on the Council to prove each disputed allegation on the balance of probabilities. Each particular allegation had to be considered separately, although the Committee was entitled to evaluate the evidence as a whole. While reasonable inferences could be drawn from the evidence, the Committee was reminded that it must not speculate. It was required to assess all oral and documentary evidence for reliability, accuracy, and credibility, and to provide clear reasons for its findings.

42. In evaluating evidence, the Committee was advised to give most weight to contemporaneous documents and undisputed facts before considering witness demeanour, in accordance with *Dutta v GMC* [2020] EWHC 1974 and *Byrne v GMC* [2021] EWHC 2237 (Admin). It was further advised that credibility should not be assessed solely on demeanour and that credibility may be divided (*Khan v GMC* [2021] EWHC 374 (Admin)).

43. Where expert evidence was disputed, the Committee was required to identify which opinion it preferred and explain why, and not to reject expert evidence without clear and compelling reasons (*Cullen v GMC* [2005] EWHC 353 (Admin); *Rimmer v GDC* [2011] EWHC 3438 (Admin)). The Registrant was of good character. The Legal Adviser advised the Committee that they must take this into account when assessing her credibility as a witness.

FINDINGS ON THE FACTS

44. The Committee accepted the advice of the Legal Adviser, considered all of the oral and written evidence and the submissions of the parties.

45. The Committee first assessed the evidence as per the guidance in the cases of *Dutta, Byrne* and *Khan* in assessing the most independent or contemporaneous account.

46. The Committee noted that the drafting of the allegations does not appear to invite a cumulative assessment of multiple factors, for example the allegations 2c and 3c. There is no use of "and/or" linking any alleged matters, suggesting that each alleged deficiency is intended to stand on its own terms. The Committee has therefore considered each allegation separately and in accordance with its wording.

1ai: On or around 4 March 2021, you conducted a sight test on Patient A, a minor, and you failed to maintain adequate patient records in that you recorded inconsistent information regarding Patient A's visual symptoms

47. The Committee accepted that the disputed entry concerning Patient A's visual symptoms appeared within a grey box in the clinical record. It was common ground between the expert witnesses and the Registrant that this section may have been generated through a cut-and-paste process by an Optical Assistant. As it was accepted that it was not apparent that the Registrant completed this section of the record, the Committee was not satisfied that any inconsistency within it could properly be attributed to the Registrant.

48. The Committee found allegation 1ai was not proved.

1aii: On or around 4 March 2021, you conducted a sight test on Patient A, a minor, and you failed to maintain adequate patient records in that you failed to record Patient A's near oculomotor status

49. The Committee noted that the Registrant accepted that no near oculomotor findings had been recorded. Whilst the Registrant maintained that her practice at the time was not to record normal findings where there had been no change from a previous result, the Committee did not accept that explanation. It considered that recording a normal finding would have been straightforward and that it was less likely that an important and routine examination had been undertaken but omitted from the record than that the test had not been performed at all.

50. For substantially the same reasons as those set out in allegation 1bii, the Committee concluded that the absence of any record reflected the fact that the Registrant did not carry out an assessment of Patient A's near oculomotor status. It followed that the Registrant failed to maintain adequate patient records by failing to record Patient A's near oculomotor status.

51. The Committee therefore found allegation 1aii proved.

1bi: On or around 4 March 2021, you conducted a sight test on Patient A, a minor, and you failed to carry out an adequate examination in that you failed to identify the optic disc swelling in Patient A's right eye

52. The Committee was satisfied that the Registrant examined the optic disc, as her records referred to the optic nerve and her consistent record-keeping over several years indicated that this was her routine practice.

53. The Committee considered the evidence of Dr Kwartz who gave details in relation to the fundus photographs and why she concluded that there was a swelling present at this stage. Professor Evans expressly disagreed and stated that the image showed a normal optic disc appearance. The Committee considered that there remained uncertainty surrounding the presence of swelling on 4 March 2021. The Committee noted the burden on the Council to prove the allegation on the balance of probabilities. The Committee was not satisfied, on balance, that there was swelling in the right eye as of 4 March 2021 and accordingly it was not persuaded that the Registrant failed to identify optic disc swelling in Patient A's right eye.

54. The Committee concluded that the allegation 1bi was not proved.

1bii: On or around 4 March 2021, you conducted a sight test on Patient A, a minor, and you failed to carry out an adequate examination in that you failed to assess Patient A's near oculomotor status

55. The central issue for the Committee was whether the Registrant's evidence was credible in that, despite not recording the results, the Registrant did in fact perform the near oculomotor test on 4 March 2021. The expert evidence could provide only limited assistance on that question because neither expert was present at the consultation and neither could say whether the test had actually been carried out.

56. In considering credibility, the Committee therefore considered the contemporaneous records, the Registrant's evidence, and the surrounding circumstances. The Committee noted that both experts agreed that assessment of near oculomotor status formed part of an adequate examination and should have been undertaken.

57. Firstly, the Committee considered the contemporaneous records. The Committee found the Registrant to be a generally conscientious practitioner who ordinarily maintained adequate records. It noted that she consistently recorded distance cover test findings. The Committee did not accept the Registrant's explanation that a normal near cover test would not have been recorded. It considered that, if the test formed part of the Registrant's routine examination and was regarded as clinically important, it would ordinarily be expected to appear in the record, particularly as other examination findings were documented. The Committee considered that the absence of any clinical record of the test significantly undermined the contention that the test had been carried out.

58. Secondly, the Committee further found that the Registrant's oral evidence, when considered in the context of the evidence as a whole, did not provide a credible explanation to overcome that evidential deficiency or to establish, on the balance of probabilities, that the test had been undertaken. In cross examination, the Registrant initially accepted that it was "*possible*" she had not performed the test. In re-examination, she then described that as "*highly unlikely*". The Committee considered this change in position reduced the reliability of her evidence. Further, given the passage of approximately five years, the Committee found that the Registrant's recollection was based largely on her usual practice rather than any specific memory of the consultation with Patient A.

59. The Committee reminded itself of the Registrant's good character and that the burden of proof rests on the Council. Even taking those factors into account, the Committee found that the absence of any contemporaneous record made it more likely than not that the near oculomotor assessment was not performed.

60. Accordingly, the Committee found allegation 1bii proved.

1ci: On or around 4 March 2021, you conducted a sight test on Patient A, a minor, and you failed to refer Patient A to the Hospital Eye Service for further investigation, despite this being clinically indicated, in that there was swelling of the nasal aspect of the optic disc margin of Patient A's right eye

61. The Committee did not find that Patient A's right optic disc showed swelling of the nasal aspect of the optic disc margin on 4 March 2021 as per allegation 1bi. It therefore follows that there was no clinically indicated referral which was missed.

62. Accordingly, the Committee find allegation 1c not proved.

2ai On or around 7 May 2022 you conducted a sight test on Patient A, a minor, and you failed to maintain adequate patient records in that you failed to adequately record Patient A's symptoms of the headaches, such as the onset, location, frequency and duration

63. It was not in dispute that Patient A reported headaches during the sight test conducted on or around 7 May 2022. The issue for the Committee was whether the Registrant's records adequately documented those symptoms. The clinical records contain no adequate record of the onset, location, frequency or duration of the headaches. The Registrant accepted that she did not record this information and her explanation was that, following discussion with Patient A, she attributed the headaches to eye strain as reported by Patient A.

64. Professor Evans confirmed in cross examination that the Registrant had failed to provide an adequate description of the onset, character or duration, and this minimum level of detail would ordinarily be expected.

65. The Committee noted that in their evidence, both Professor Evans and Dr Kwartz considered the records to be inadequate. The Committee noted *section A51* of the prevailing *College of Optometrists Guidance for Professional Practice (2021)* ("*College Guidance")* which states "*You must conduct an adequate assessment for the purposes of the optical consultation… This should normally include… asking for and accurately recording… description of onset, character and duration of signs and symptoms…"* The Registrant accepted that she did not record, and there was no evidence that the location, onset, frequency and type matters were recorded. In oral evidence the Registrant stated that she had considered these matters, discussed them with the patient, and only recorded the key summary of the discussion with Patient A, in that the headaches were caused by eye strain.

66. In all the circumstances, the Committee is satisfied that the records did not adequately document Patient A's headache symptoms and therefore fell below the required standard.

67. The Committee found allegation 2ai proved.

2aii: On or around 7 May 2022 you conducted a sight test on Patient A, a minor, and you failed to maintain adequate patient records in that you failed to record Patient A's near oculomotor status

68. It was accepted by the Registrant that the records did not contain a record of Patient A's near oculomotor status. In paragraph 46 of her witness statement, the Registrant stated: *"As explained above, I did not record the result but did complete the testing…"* The Committee accepted that no result had been recorded, regardless of whether the assessment had in fact been undertaken.

69. The Committee determined that the notes were inadequate in that there was no contemporaneous evidence that the assessment had been completed or what its outcome had been.

70. In those circumstances, the Committee found allegation 2aii proved.

2bi: On or around 7 May 2022 you conducted a sight test on Patient A, a minor, and you failed to carry out an adequate examination in that you failed to identify the optic disc swelling in Patient A's right eye

71. The Committee noted Professor Evans and Dr Kwartz' disagreement on the issue of whether, when taken in isolation, the retinal image indicated swelling. On balance, the Committee were not satisfied that the image alone was sufficient to conclude that there was swelling at this point. The Committee

accepted Professor Evans' evidence that when viewed in isolation, the retinal image could be regarded by a reasonable body of optometrists as normal.

72. Professor Evans maintained this position in the joint expert report dated May 2026 and made no reference to other contributing factors. However, the Committee noted Dr Kwartz' evidence in her report dated 23 July 2025 at paragraph 8.3.1 and in the joint expert report that *"the Registrant should have considered the body of clinical data with suspicion, given that she was presented with conflicting data of an apparent history of amblyopia in the absence of an amblyogenic stimulus."*

73. The Committee also considered *section A51* of the *Guidance.* The Committee preferred the evidence of Dr Kwartz for this allegation this regard, as it more closely aligned with the *College Guidance* when assessing how the Registrant made her assessment. The Committee decided that it would not be appropriate to consider this allegation by considering the retinal image in isolation.

74. The Committee noted that Patient A was a young patient, had presented with headaches and there was a retinal image which, when considered together with the other clinical features, was capable of giving rise to suspicion. Both experts also agreed in their joint report and in their oral evidence that Patient A did not present with any of the common factors of an amblyopic eye which include high refractive error, unequal refractive error in the two eyes (anisometropia), high astigmatism, squint, childhood cataract and ptosis (droopy eyelid). Taking all of those factors into account, the Committee considered that the Registrant should have widened her assessment to include the image alongside the clinical history and the findings of the examination.

75. The Committee noted the Registrant's case that she had undertaken further examination, including BIO view, and that the optic disc appearance was normal. If so, the Committee would have expected her to identify the abnormality present. The Committee also noted the limited clinical information recorded. There was no adequate documentation of matters such as the headaches, or the basis upon which eye strain was identified as the cause of the symptoms. The absence of contemporaneous records made it more difficult to accept the Registrant's account that further assessment had been carried out and had yielded reassuring findings.

76. The Committee determined that the Registrant did not undertake sufficient investigation in light of Patient A's presentation. In particular, the Registrant proceeded to attribute Patient A's symptoms to eye strain and a change in prescription without adequate records to justify this conclusion, and without evidence of further investigations, which may have assisted in identifying the underlying issue. Taking all of the evidence together, including Patient A's history, the lack of presence of one of the more common factors of amblyopia, the clinical presentation, and the optic disc appearance, the Committee was

satisfied that the Registrant failed to carry out an adequate examination, and in doing so therefore failed to identify the optic disc swelling.

77. The Committee therefore found allegation 2bi proved.

2bii: On or around 7 May 2022 you conducted a sight test on Patient A, a minor, and you failed to assess Patient A's near oculomotor status

78. The Committee considered the allegation on the evidence relating specifically to the consultation on 7 May 2022. The Committee noted the Registrant's position was that she had assessed Patient A's near oculomotor status but had not recorded the result. She maintained that this would ordinarily have formed part of her usual practice. However, there is no contemporaneous record of the assessment having been undertaken.

79. The Committee looked carefully at the "detailed visit information" notes from the consultation on 7 May 2022. The records include information in a grey box which may have been completed by an Optical Assistant and stated *"…is having trouble seeing the white board at school. Gets some headaches with straining her eyes."* The Committee noted a further reference to headaches, which the Registrant accepted she noted, which read *"Feels more blurry looking at board at school, feels squinting to see causes h/a.."* The Committee concluded that Patient A was a young patient who presented with headaches and squinting. The Committee noted the evidence of Dr Kwartz in the joint expert report that headaches were an additional indication for testing near oculomotor status. Again, the Committee noted that Dr Kwartz remained of the view that in those circumstances, assessment of near oculomotor status was an important part of the examination and would have assisted in excluding or identifying possible causes of the symptoms. The Committee also noted that Patient A's prescription was changing, which would have prompted a reasonably competent Optometrist to further investigate binocular vision and ocular alignment.

80. The Committee did not accept the Registrant's explanation that the assessment had been completed. The Committee considered that the absence of any record was particularly significant given the clinical presentation and the relevance of the assessment. It was satisfied, on the balance of probabilities, that the Registrant failed to assess Patient A's near oculomotor status.

81. The Committee found 2bii proved.

2ci: On or around 7 May 2022 you conducted a sight test on Patient A, a minor, and you failed to refer Patient A to the Hospital Eye Service for further investigation, despite this being clinically indicated, in that there was a significant reduction in Patient A's right eye visual acuity but no apparent amblyogenic factor

82. The Committee reminded itself that the drafting of all allegations did not appear to invite a cumulative assessment of multiple factors, for reasons already outlined. The Committee has therefore considered the particulars of the allegations separately and in accordance with its wording.

83. The Committee considered the phrase "*significant reduction."* The allegation does not make clear whether the alleged reduction is to be assessed by reference to a deterioration between examinations on different dates, or by comparison with what would ordinarily be expected in a normal eye. Given that Patient A's right eye visual acuity had already been at a reduced level prior to 7 May 2022, the allegation does not plainly allege a reduction over time. The Committee considered the approach taken by Dr Kwartz, as the Council's expert, in the joint expert report: "*The visual acuity in Patient A's right eye was reduced compared to the left*." Consistent with the approach adopted by Dr Kwartz, the Committee considered the significance of the reduction by reference to the difference between the visual acuity in the right and left eyes. Professor Evans did not address this point.

84. The Committee carefully considered the Registrant's explanation that she believed the reduced vision was attributable to a previously diagnosed "lazy eye" and that Patient A had previously been assessed by the Hospital Eye Service. The Committee accepted that this was a genuinely held view and noted that the case history provided some explanation for the reduced visual acuity.

85. However, the Committee noted that notwithstanding that history, the experts agreed that Patient A presented with a significant disparity in visual acuity between the two eyes without any identifiable amblyogenic factor of the type described in Dr Kwartz' report at paragraph 8.1.3. This included high refractive error, anisometropia, high astigmatism, squint, childhood cataract and ptosis, none of which were identified in Patient A as accounting for the level of reduction observed.

86. The Committee accepted that the Registrant had seen Patient A on various occasions and may have felt assured that the reduced vision was longstanding and unchanged. However, it considered that a young patient presenting with significantly reduced vision in one eye, without an identifiable amblyogenic factor, warranted referral for further investigation. Professor Evans accepted during Committee questions that there was a lower threshold for referral in a teenager or child who has reduced vision in one eye compared with a patient that may have good vision in both eyes. The Committee concluded that the difference in visual acuity between the eyes remained unexplained and that this, of itself, constituted a sufficient clinical basis for referral to the Hospital Eye Service. In those circumstances, the Committee is satisfied that referral was clinically indicated and that the Registrant failed to make that referral.

87. The Committee found allegation 2ci proved.

2cii: On or around 7 May 2022 you conducted a sight test on Patient A, a minor, and you failed to refer Patient A to the Hospital Eye Service for further investigation, despite this being clinically indicated, in that Patient A reported a new symptom of headaches

88. The Committee accepted that Patient A reported headaches at the consultation on 7 May 2022 and considered whether that symptom, viewed in the context of this allegation, made a referral to the Hospital Eye Service clinically indicated. The Committee noted the Registrant's evidence that she considered the headaches to be explained by Patient A's visual difficulties, including the need for a change in prescription and the reported symptoms associated with eye strain.

89. Whilst headaches may be a relevant consideration when determining whether a referral is required, the Committee did not consider that the reporting of headaches alone was sufficient to make referral clinically indicated in the circumstances of this case. The Committee therefore concluded that the Council had not established that the Registrant failed to refer Patient A despite a clinical indication to do so based solely on the presentation of headaches.

90. The Committee therefore found allegation 2cii not proved.

2ciii: On or around 7 May 2022 you conducted a sight test on Patient A, a minor, and you failed to refer Patient A to the Hospital Eye Service for further investigation, despite this being clinically indicated, in that there was increased swelling of the nasal aspect of the optic disc margin of Patient A's right eye

91. The allegation is framed on the basis that there was *"increased swelling"* of the nasal aspect of the optic disc margin of Patient A's right eye. The Committee considered that the use of the word "increased" necessarily requires a comparison with an earlier state of swelling. However, the allegation does not clearly identify the point of comparison, and the Committee found the wording to be ambiguous.

92. The Committee previously found that it was not satisfied that there was optic disc swelling on 4 March 2021 at allegation 1bi. Whilst the Committee has found that it was satisfied that optic disc swelling was present on 7 May 2022 at allegation 2bi, it does not follow that the Committee can be satisfied that there was an *increase* in swelling since 4 March 2021. The Committee considered that it could properly find the presence of swelling on 7 May 2022, but the allegation as drafted requires proof of *increased* swelling.

93. The Committee derived little assistance from the expert evidence on this issue. Dr Kwartz's opinion that there had been an increase in swelling was based upon a comparison with the earlier examination, a comparison which is inconsistent with the Committee's finding that it was not satisfied that swelling was present on 4 March 2021. Conversely, Professor Evans' position was that there was no

swelling initially on 4 March 2021 and therefore no increase. In those circumstances, neither expert's analysis resolved the difficulty created by the wording of the allegation.

94. The Committee also noted that elsewhere in the allegations the word *'increased'* was not used. The Committee considered it inappropriate to read words into the allegation or to reformulate it so as to allege merely the presence of swelling. Applying the allegation as drafted and given the ambiguity in the term '*increased swelling*', the Committee is not satisfied that this particular has been proved.

95. The Committee therefore found allegation 2ciii not proved.

3a: On or around 14 February 2023 you conducted a sight test on Patient A, a minor, and you failed to maintain adequate patient records in that you failed to record Patient A's near oculomotor status

96. The Registrant accepted in her oral evidence that there was no contemporaneous record of Patient A's near oculomotor status on this date. As with the Committee's findings in relation to allegations 1aii and 2aii, the issue is not whether the assessment may have been undertaken, but whether the clinical records adequately documented the examination and its findings.

97. The Committee noted that there was no recorded result for Patient A's near oculomotor status for this date and no documentary evidence from which it could determine what assessment had been undertaken or what the outcome had been. The Committee considered that, where a clinical assessment is relied upon as part of an optometric examination, its findings should be adequately recorded. The absence of any such record rendered the clinical notes incomplete.

98. The Committee was not persuaded that the absence of a record could be cured by the Registrant's retrospective account that the assessment had been performed. Consistent with its reasoning in relation to particulars 1aii and 2aii, the Committee concluded that the failure to record Patient A's near oculomotor status amounted to inadequate record keeping.

99. The Committee found allegation 3a proved.

3bi: On or around 14 February 2023 you conducted a sight test on Patient A, a minor, and you failed to carry out an adequate examination in that you failed to identify the optic disc swelling in Patient A's right eye

100. Consistent with its findings in relation to allegation 2bi, the Committee concluded that the Registrant failed to identify optic disc swelling in Patient A's right eye during the examination on or around 14 February 2023. Although no retinal image was available from this consultation, the Committee considered

the wider clinical evidence, including its finding that optic disc swelling was present on 7 May 2022 and the absence of any evidence that the condition had resolved.

101. The Committee considered that, some nine months after the May 2022 examination, the position had not improved and there was sufficient evidence to conclude that optic disc swelling was likely to be present at the February 2023 consultation. The Committee was not persuaded that the examination undertaken by the Registrant was sufficient to identify the abnormality. As with particular 2bi, the issue was not confined to the interpretation of a single image but required consideration of the examination as a whole and the clinical features that should have prompted further investigation.

102. For substantially the same reasons as those set out in relation to allegation 2bi, the Committee concluded that the Registrant failed to identify optic disc swelling in Patient A's right eye and therefore failed to carry out an adequate examination.

103. The Committee found 3bi proved.

3bii: On or around 14 February 2023 you conducted a sight test on Patient A, a minor, and you failed to carry out an adequate examination in that you failed to assess Patient A's near oculomotor status

104. For substantially the same reasons as those set out in relation to particular 2bii, the Committee concluded that the Registrant failed to assess Patient A's near oculomotor status during the sight test on or around 14 February 2023.

105. The Registrant's position was that the assessment would ordinarily have formed part of her normal practice. However, there is no contemporaneous record of any such assessment having been undertaken and no recorded result from which the Committee could determine either the nature of the examination or its outcome. Given the importance of near oculomotor assessment in a young patient presenting with ongoing visual concerns, the Committee would have expected clear documentation if the assessment had been carried out.

106. The Committee was not persuaded that the absence of a record could be explained solely by an omission in note-taking. Consistent with its findings in relation to earlier consultations, the Committee considered that where there were deficiencies in the Registrant's record keeping, this undermined the reliability of her retrospective assertion that the assessment had been performed. On the balance of probabilities, the Committee was not satisfied that Patient A's near oculomotor status was assessed. Accordingly, the Committee concludes that the Registrant failed to carry out an adequate examination.

107. The Committee found allegation 3bii proved.

3ci: You failed to refer Patient A to the Hospital Eye Service for further investigation, despite this being clinically indicated, in that there was a significant reduction in Patient A's right eye visual acuity but no apparent amblyogenic factor

108. For the reasons set out in allegation 2ci, the Committee considered that this allegation was directed to the significant disparity in visual acuity between Patient A's right and left eyes, rather than to any change in acuity over time. The Committee accepted Dr Kwartz's approach to the interpretation of the allegation and noted that there was no identifiable amblyogenic factor recorded that would adequately explain the level of reduced visual acuity in the right eye.

109. The Committee considered the Registrant's view that the reduced vision was attributable to a longstanding "lazy eye" and acknowledged that this was a genuinely held belief. However, as with the earlier consultation on 7 May 2022, the Committee accepted the evidence that Patient A presented with significantly reduced vision in one eye without an apparent amblyogenic factor of the type identified in the expert evidence. The Committee also considered that Patient A remained a young patient and that Professor Evans had accepted that a lower threshold for referral was appropriate where significant unilateral visual reduction remained unexplained.

110. The Committee noted that there was nothing materially different in the evidence available at this consultation from that considered in relation to allegation 2ci. Consistent with its earlier reasoning, it concluded that referral to the Hospital Eye Service was clinically indicated because Patient A had significantly reduced right-eye visual acuity with no apparent amblyogenic factor. The Registrant did not make such a referral.

111. The Committee therefore found allegation 3ci proved.

3cii: You failed to refer Patient A to the Hospital Eye Service for further investigation, despite this being clinically indicated, in that there was swelling of the nasal aspect of the optic disc margin of Patient A's right eye

112. The Committee is satisfied, on the balance of probabilities, that optic disc swelling was present in Patient A's right eye on 14 February 2023. In reaching that conclusion it relied upon its finding that optic disc swelling was present on 7 May 2022 and the absence of evidence that the condition had resolved in the intervening period.

113. The Committee did not approach the matter solely by reference to fundus photography. The Registrant's evidence was that she had undertaken a BIO examination, which she described as a more accurate means of assessing the optic disc. If that examination was performed as described, the Committee would have expected the Registrant to identify the swelling that was present. However, the Committee found that she did not do so and therefore did not appreciate the need for further investigation.

114. The Committee accepted Dr Kwartz's opinion in the joint expert report that referral was clinically indicated in light of the optic disc appearance. Having found that optic disc swelling was present, the Committee is satisfied that this abnormality required referral to the Hospital Eye Service. The Registrant failed to make that referral because she failed to identify the swelling during her examination. Accordingly, the Committee concludes that referral was clinically indicated.

115. The Committee found allegation 3cii proved.

116. In conclusion, the Committee found allegations 1ai, 1bi, 1ci, 2cii and 2ciii not proved.

117. The Committee found allegations 1aii, 1bii, 2ai, 2aii, 2bi, 2bii, 2ci, 3a, 3bi, 3bii, 3ci and 3cii proved.

SUBMISSIONS AND ADVICE ON MISCONDUCT

118. Ms Huxtable submitted that the Committee should find misconduct when applying established authorities which describe a serious falling short of professional standards, whether arising within clinical practice or through morally culpable, disgraceful conduct bringing the profession into disrepute (*Roylance v General Medical Council (No. 2) [2000] 1 A.C. 311; R (Calhaem) v General Medical Council [2007] EWHC 2606 (Admin); Remedy UK Ltd v General Medical Council [2010] EWHC 1245 (Admin); Nandi v GMC [2004] EWHC 2317 (Admin)*).

119. In determining misconduct, the Committee was invited by the Council to have regard to the *General Optical Council* S*tandards of Practice for optometrists and dispensing opticians ("the Standards"),* effective from April 2016, and whether the Registrant has departed from the following standards by virtue of her conduct:

    a. Standard 7 – conduct appropriate assessments, examinations, treatments and referrals.

    b. Standard 8 – maintain adequate patient records.

    c. Standard 17 - do not damage the reputation of your profession through your conduct.

120. The Council submitted that the Registrant's conduct amounts to misconduct in that her conduct was serious and must be regarded as deplorable by fellow practitioners.

121. Mr Halliday accepted that allegations 2bi, 2ci, 3bi, 3ci and 3cii amounted to misconduct, but submitted that the remaining allegations did not. He argued that the failures relating to the assessment and recording of near oculomotor status, together with the failure adequately to record Patient A's headache symptoms, were errors and departures from expected practice but did not cross the

threshold of sufficiently serious professional misconduct. Mr Halliday submitted that the Registrant was a conscientious practitioner, that Dr Kwartz accepted the absence of near oculomotor testing would not have affected the decision to refer, and that the record-keeping deficiencies, whilst falling below the expected standard, did not create a level of risk or seriousness sufficient to amount to misconduct. In relation to the records relating to headaches, Mr Halliday further submitted that, although the notes may have been inadequate, Dr Kwartz accepted it could be plausible and reasonable not to record every aspect of a symptom history, and therefore the omission did not fall far below professional standards as to justify a finding of misconduct.

122. The Legal Adviser outlined that even where the parties agree that there should be a finding of misconduct as per *Rule 46,* it is still a matter for the Committee to decide. The Legal Adviser outlined the case law and the *Hearings and Indicative Sanctions Guidance ("the Guidance")* at *Paragraphs 15.5-15.9* in relation to misconduct, reminding the Committee of the descriptions of misconduct in the cases of *Roylance* and *R (on the application of Vali) v General Optical Council (2011) EWHC 310 (Admin).* The Committee should consider each of the proven allegations in turn and decide whether each amounted to serious misconduct.

123. Finally, the Legal Adviser stated that misconduct was a matter for the Committee's own independent judgement and no burden or standard of proof applied. The Committee should only move on to the impairment stage if it found serious misconduct.

FINDINGS ON MISCONDUCT

124. The Committee accepted the advice of the Legal Adviser and considered the case law and *Guidance,* as well as the written and oral submissions.

125. The Committee was satisfied that the Registrant's conduct engaged a number of the Council's *Standards*. In particular, the Committee noted *Standards 7, 8 and 17.*

126. While the Committee accepted that not every breach of a standard must amount to a falling far below the required standard, it found Dr Kwartz's evidence on the seriousness of the departures, particularly where there was a risk of harm, to be more persuasive. The Committee compared the experts' evidence in relation to each individual allegation before reaching a conclusion on misconduct.

1aii: On or around 4 March 2021, you conducted a sight test on Patient A, a minor, and you failed to maintain adequate patient records in that you failed to record Patient A's near oculomotor status

127. The Committee considered that regardless of whether the assessment had been undertaken, it was incumbent upon the Registrant to make and maintain an adequate clinical record of the examination. The Committee noted the evidence of Dr Kwartz at paragraph 9.8.1 of her report, that the failure was below the expected standard, although she did not characterise it as a serious departure from accepted practice. The Committee also had regard to *Standard 8*, which requires registrants to maintain adequate patient records.

128. The Committee considered it a matter of concern that a young patient underwent an eye examination and that an important element of the examination was not documented. The absence of a record deprived subsequent practitioners of potentially useful baseline information and undermined the completeness of the clinical record. However, the Committee also took into account that this particular matter represented a failure to record only one aspect of the examination. The distance cover test findings had been recorded and there was no evidence that the omission itself altered the clinical outcome for Patient A on that date.

129. In all the circumstances, the Committee concluded that the Registrant's conduct fell below the standards expected of a reasonably competent Optometrist and therefore amounted to misconduct. However, viewed in isolation, the failing was at the lower end of the spectrum and therefore amounted to non-serious misconduct.

1bii: On or around 4 March 2021, you conducted a sight test on Patient A, a minor, and you failed to carry out an adequate examination in that you failed to assess Patient A's near oculomotor status

130. The Committee had regard to *Standard 7*, which requires Registrants to conduct an adequate assessment for the purposes of the optical consultation. Both Dr Kwartz and Professor Evans agreed that assessment of near oculomotor status formed part of an adequate eye examination and should have been undertaken in this case.

131. The Committee considered that this failing was materially more serious than a record-keeping omission. The issue was not merely that the assessment was not documented; rather, the Committee found that the assessment was not performed at all. The omission concerned an important component of the examination itself and deprived the Registrant of information which should have informed her clinical assessment of Patient A. The Committee considered that the profession and the public are entitled to expect that core elements of an eye examination will be carried out, particularly where the purpose of the test is to identify or exclude clinically relevant conditions.

132. In all the circumstances, the Committee concluded that the failure to assess Patient A's near oculomotor status represented a serious departure from the standards expected of a reasonably competent Optometrist and therefore amounted to serious misconduct.

2ai On or around 7 May 2022 you conducted a sight test on Patient A, a minor, and you failed to maintain adequate patient records in that you failed to adequately record Patient A's symptoms of the headaches, such as the onset, location, frequency and duration

133. The Committee had regard to *Standards 7 and 8*. The inadequate records reflected a corresponding failure properly to explore and document a potentially significant symptom. Headaches formed a material part of Patient A's presentation and were clinically relevant to the assessment and investigation of the underlying cause of the visual difficulties. The Committee considered that a competent practitioner should have sought and recorded sufficient information about those symptoms to inform appropriate clinical decision-making.

134. The Committee was mindful that both experts considered the records to be inadequate and that the omission deprived subsequent practitioners of important information regarding Patient A's presentation. In the circumstances of a young patient presenting with headaches, the failure to obtain and record this information represented a serious departure from the standards expected of a reasonably competent Optometrist. Accordingly, the Committee concluded that the conduct amounted to serious misconduct.

2aii: On or around 7 May 2022 you conducted a sight test on Patient A, a minor, and you failed to maintain adequate patient records in that you failed to record Patient A's near oculomotor status

135. The Committee had regard to *Standards 7 and* 8. The Committee considered that this failing was more serious than the equivalent omission in March 2021 because of Patient A's presentation on this occasion. Patient A reported headaches and symptoms associated with visual strain, matters which both experts agreed increased the clinical importance of assessing near oculomotor status. In those circumstances, the absence of any record of the assessment deprived the clinical notes of information directly relevant to the investigation of Patient A's presenting symptoms.

136. The Committee concluded that the omission undermined the adequacy of the clinical record and the ability to understand what assessment had been undertaken and what conclusions had been reached. Given the nature of Patient A's symptoms and the importance of near oculomotor assessment in that clinical context, the Committee determined that the failure represented a serious departure from the standards expected of a reasonably competent Optometrist, and therefore amounted to serious misconduct.

2bi: On or around 7 May 2022 you conducted a sight test on Patient A, a minor, and you failed to carry out an adequate examination in that you failed to identify the optic disc swelling in Patient A's right eye

137. The Committee had regard to *Standards 7* and *17*.

138. The Committee noted that the identification and assessment of abnormalities of the optic disc are central aspects of an Optometrist's clinical role. As set out in its findings of fact, the Committee concluded that the Registrant failed to recognise optic disc swelling despite the available clinical information, including Patient A's symptoms and presentation. The Committee considered that this represented a significant failure in the examination itself.

139. The Committee also took into account that the Registrant's representative, Mr Halliday, accepted that this particular was capable of amounting to misconduct. The Committee agreed. The failure concerned a fundamental component of the Registrant's professional responsibilities and carried the potential to delay the identification and investigation of a clinically significant condition in a young patient.

140. In all the circumstances, the Committee concluded that the Registrant's conduct represented a serious departure from the standards expected of a reasonably competent Optometrist and therefore amounted to serious misconduct.

2bii: On or around 7 May 2022 you conducted a sight test on Patient A, a minor, and you failed to assess Patient A's near oculomotor status;

141. The Committee had regard to *Standard 7.* The Committee considered this failing to be significant because Patient A was a young patient who presented with headaches, squinting and visual difficulties. Both experts agreed that assessment of near oculomotor status formed part of an adequate examination and Dr Kwartz considered that Patient A's symptoms provided a specific indication for such testing. The omission therefore deprived the Registrant of information which could have assisted in identifying or excluding possible causes of the presenting symptoms.

142. The Committee concluded that the omission was a failure to undertake an important component of the examination itself. In those circumstances, the conduct represented a serious departure from the standards expected of a reasonably competent Optometrist and therefore amounted to serious misconduct.

2ci: On or around 7 May 2022 you conducted a sight test on Patient A, a minor, and you failed to refer Patient A to the Hospital Eye Service for further investigation, despite this being clinically indicated, in that there was a significant reduction in Patient A's right eye visual acuity but no apparent amblyogenic factor

143. The Committee had regard to *Standards 7 and 17*. The Committee was satisfied that this presentation warranted referral to the Hospital Eye Service for further investigation. The Registrant did not make such a referral and instead accepted the position that the reduced vision was attributable to a longstanding "lazy eye" without obtaining specialist assessment.

144. The Committee considered this failing to be particularly serious because it concerned a fundamental clinical judgment affecting a young patient. Referral pathways exist to ensure that potentially significant abnormalities are investigated promptly and appropriately. By failing to refer, the Registrant missed an important opportunity for further specialist assessment of an unexplained visual deficit.

145. The Committee also took into account that the Registrant's representative, Mr Halliday, accepted that this particular was capable of amounting to misconduct. The Committee agreed. The failure to make a clinically indicated referral in these circumstances represented a serious departure from the standards expected of a reasonably competent Optometrist and had the potential to undermine public confidence in the profession. Accordingly, the Committee concluded that the conduct amounted to serious misconduct.

3a: On or around 14 February 2023 you conducted a sight test on Patient A, a minor, and you failed to maintain adequate patient records in that you failed to record Patient A's near oculomotor status

146. The Committee had regard to *Standard 8*.

147. The Committee considered this failing to be comparable to the omission identified in allegation 1aii. Whilst the absence of a record meant that the clinical notes were incomplete and deprived subsequent practitioners of potentially useful information, the Committee took into account that there were no additional presenting symptoms, such as the other symptoms reported in May 2022, which heightened the significance of the omission. The Committee also had regard to Dr Kwartz's evidence at paragraph 9.8.1 of her report, in which she regarded such a failing as falling below the expected standard, but not as a particularly serious departure from accepted practice.

148. The Committee therefore concluded that the Registrant's conduct fell below the standards expected of a reasonably competent Optometrist and amounted to misconduct. However, consistently with its approach to allegation 1aii, the Committee considered that this failing was at the lower end of the spectrum and did not amount to serious misconduct when viewed in isolation.

3bi: On or around 14 February 2023 you conducted a sight test on Patient A, a minor, and you failed to carry out an adequate examination in that you failed to identify the optic disc swelling in Patient A's right eye

149. The Committee had regard to *Standards 7 and 17*. The Committee noted that the Registrant's representative, Mr Halliday, accepted that this particular amounted to misconduct. The Committee agreed. As set out in its findings of fact, the Committee was satisfied that optic disc swelling was present on 7 May 2022 and that there was no evidence that the condition had resolved by February 2023. The Committee therefore concluded that, on the balance of probabilities, optic disc swelling remained present at the consultation on 14 February 2023. The Committee further found that the examination undertaken

by the Registrant was insufficient to identify that abnormality and that the clinical features should have prompted further investigation.

150. The Committee considered this failing to be serious. Identification of optic disc abnormalities forms a fundamental part of an Optometrist's clinical responsibilities. The failure occurred some nine months after the previous consultation, during which the abnormality had also not been identified. The Committee considered that the swelling should have been recognised and investigated further. The omission deprived Patient A of the opportunity for timely specialist assessment and carried the potential for significant consequences in a young patient.

151. In all the circumstances, the Committee concluded that the Registrant's failure to identify optic disc swelling represented a serious departure from the standards expected of a reasonably competent Optometrist, and therefore the conduct amounted to serious misconduct.

3bii: On or around 14 February 2023 you conducted a sight test on Patient A, a minor, and you failed to carry out an adequate examination in that you failed to assess Patient A's near oculomotor status

152. The Committee had regard to *Standard 7*. The Committee considered that this failing was comparable to, and should be treated consistently with, the failing identified in allegation 1bii.

153. Both Dr Kwartz and Professor Evans agreed that assessment of near oculomotor status formed part of an adequate eye examination and should have been undertaken. The omission concerned a core component of the examination itself rather than a deficiency in record keeping. By failing to perform the assessment, the Registrant deprived herself of information which should have informed her clinical evaluation of Patient A.

154. At the date of the first allegation on 4 March 2021, there was a previous near oculomotor result available from 11 February 2020; in later years, the time gap increased. The Committee found that the older the baseline became, the weaker the Registrant's position that the recording made in the past was reliable.

155. The Committee considered that members of the public and the profession are entitled to expect that essential elements of an eye examination will be completed. The failure to assess Patient A's near oculomotor status represented a significant departure from accepted professional standards and undermined the requirement to conduct an adequate assessment.

156. In all the circumstances, the Committee concluded that the Registrant's conduct fell seriously below the standards expected of a reasonably competent Optometrist and therefore amounted to serious misconduct.

3ci: You failed to refer Patient A to the Hospital Eye Service for further investigation, despite this being clinically indicated, in that there was a significant reduction in Patient A's right eye visual acuity but no apparent amblyogenic factor

157. The Committee had regard to *Standards 7 and 17*.

158. As set out in its findings of fact, the Committee concluded that Patient A continued to present with a significant reduction in visual acuity in the right eye when compared with the left eye, without any apparent amblyogenic factor to explain that disparity. The Committee was satisfied that this presentation warranted referral to the Hospital Eye Service for specialist investigation. The Registrant did not make such a referral despite the continuing abnormal findings.

159. The Committee considered this failing to be particularly serious. Referral is a fundamental safeguard within optometric practice, ensuring that patients with potentially significant pathology receive timely specialist assessment and treatment. In this case, the failure occurred against the background of previous missed opportunities to identify and investigate abnormalities in Patient A's right eye. The Committee considered that the unexplained reduction in vision in a young patient demanded further investigation and that a referral should have been made.

160. The Committee also took into account that the Registrant's representative, Mr Halliday, accepted that this particular amounted to misconduct. The Committee agreed. The failure to make a clinically indicated referral represented a serious departure from the standards expected of a reasonably competent Optometrist and had the potential to undermine public confidence in the profession, this amounted to serious misconduct.

3cii: You failed to refer Patient A to the Hospital Eye Service for further investigation, despite this being clinically indicated, in that there was swelling of the nasal aspect of the optic disc margin of Patient A's right eye

161. The Committee had regard to *Standards 7 and 17*. As set out in its findings of fact, the Committee was satisfied that optic disc swelling was present in Patient A's right eye on 14 February 2023. The Committee concluded that this finding, of itself, made referral to the Hospital Eye Service clinically indicated. The Committee noted that the Registrant failed to identify the swelling during her examination and, as a consequence, failed to appreciate the need for referral and further investigation.

162. The Committee considered this failing to be particularly serious. The identification and appropriate referral of patients with optic disc swelling lies at the heart of safe optometric practice. Referral pathways exist to ensure that potentially serious underlying pathology is promptly investigated by specialist services. The Committee noted that Professor Evans agreed that, where optic disc swelling is identified, referral is required. The Committee also took into

account that the Registrant accepted, through her representative, that this allegation was capable of amounting to misconduct.

163. Patient A was deprived of timely specialist assessment despite the presence of a significant clinical abnormality. The conduct represented a serious departure from the standards expected of a reasonably competent Optometrist and had the potential to undermine public confidence in the profession. Accordingly, the Committee concluded that the Registrant's conduct amounted to serious misconduct.

164. In conclusion, the Committee found that the conduct in allegations 1bii, 2ai, 2aii, 2bi, 2bii, 2ci, 3bi, 3bii, 3ci and 3cii amounted to serious departures from the *Standards* expected of a reasonably competent Optometrist and decided that the Registrant's conduct amounted to serious misconduct within the meaning of *section 13D(2)(a)* of the *Act*.

SUBMISSIONS ON IMPAIRMENT

165. Ms Huxtable submitted that the Registrant's fitness to practise is currently impaired. Ms Huxtable outlined the case law in this area, and submitted that the appropriate approach for the Committee when considering impairment might be that which was formulated by Dame Janet Smith in the report to the Fifth Shipman Inquiry:

> *"a. 'Has [the Registrant] in the past acted and/or is [he] liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b. Has [the Registrant] in the past and/or is [he] liable in the future to bring the medical profession into disrepute; and/or*
>
> *c. Has [the Registrant] in the past breached and/or is [he] liable in the future to breach one of the fundamental tenets of the medical profession;*
>
> *d. Has [the Registrant] in the past acted dishonestly and/or is [he] liable to act dishonestly in the future."*

166. The Council submitted that limbs a) to c) of the test are engaged in this case. The allegations, if proved, demonstrate a serious failing in the level of care provided to Patient A, on three separate occasions.

167. Ms Huxtable submitted that the Registrant's conduct relates to the core *Standards* expected of a reasonably competent Optometrist. Ms Huxtable stated that a failure to conduct adequate optic disc assessments or prompt referral to rule out any serious underlying conditions can have serious consequences for patients. In this case, the conduct of the Registrant must have contributed to a serious risk of harm being caused to Patient A and the Registrant's conduct has clearly brought the optical profession into disrepute and breached a fundamental tenet of the profession. Similarly, Ms Huxtable submitted that inaccurate patient records can cause serious harm for patients and be misleading to other

practitioners, who may erroneously conclude that a patient's condition is more or less serious as a result.

168. Ms Huxtable acknowledged the evidence put forward by the Registrant in relation to insight and remediation, and in doing so the Committee should consider the cases of *Cohen v General Medical Council [2008] EWHC 581 (Admin); Kimmance v General Chiropractic Council [2016] EWHC 607 (Admin) and Cheatle v General Medical Council [2009] EWHC 645 (Admin)*. The Council accepted that the Registrant has continued to practice with no suggestion of further misconduct, had completed targeted CPD, provided a statement of insight and positive references. Ms Huxtable submitted that it is a matter for the Committee whether it considers impairment on the grounds of public protection.

169. In any event, Ms Huxtable submitted that the circumstances of this case, in particular serious clinical failings contributing to a serious risk of harm to Patient A, are such that a finding of impairment is required to protect the public and meet the wider public interest, notably to uphold proper professional standards and maintain public confidence in the profession.

170. The Registrant gave evidence on impairment that she has undertaken extensive and sustained remediation since Patient A's care, with patient safety now at the forefront of her practice. She described changes to clinical procedures, including improved image storage, more comprehensive handovers, greater scrutiny of imaging, use of OCT technology, maintaining a higher index of suspicion for unusual presentations, and adopting a significantly lower threshold for referral. The Registrant explained that she now makes extensive use of advice-and-guidance pathways with hospital ophthalmology services and seeks specialist input whenever she is uncertain about optic nerve or optic disc findings. Her learning has focused on the areas identified in the allegations, namely communication, record keeping, optic disc abnormalities, visual field interpretation, examination methods and paediatric assessment.

171. The Registrant also explained that she has discussed the allegations openly with colleagues, invited regular formal and informal audits of her records, and received consistently positive feedback. In relation to children, she emphasised the importance of detailed history-taking, review of previous secondary care involvement, thorough ocular assessment and prompt referral where concerns arise. The Registrant accepted responsibility for maintaining public trust, acknowledged that members of the public would be concerned by the matters found proved, and accepted that her previous assessment of Patient A fell short of the "gold standard" she expected of herself. She maintained that she has developed substantial insight, learned from the case, embedded lasting changes in her practice, and can demonstrate through her subsequent referrals and clinical work that the risk of repetition is very low.

172. During the Committee's questioning of the Registrant on impairment, the issue arose whether Foster Kennedy Syndrome, the eventual diagnosis in Patient A's case, was a rare condition. Mr Halliday indicated that he wished to adduce

further evidence regarding the rarity of the condition. Having considered the application, the Committee declined to admit the proposed evidence pursuant to Rule 40(1). The Committee considered that it would be unfair to the GOC to introduce further evidential material at that stage of the proceedings, and that the proposed evidence was not relevant to the impairment assessment. The Committee determined that its assessment should proceed on the basis of its previous findings of fact and misconduct and did not permit further evidence concerning the rarity of the condition.

173. Mr Halliday submitted that the correct question for the Committee is whether the Registrant is currently impaired and fit to practise without restriction. He argued that the evidence provided by the Registrant demonstrated full remediation, significant insight, and a very low risk of repetition. He relied on her reflective statements, CPD and learning logs, targeted training, audits of her record keeping, discussions with colleagues, and examples of referrals demonstrating changed practice. Mr Halliday submitted that these steps were undertaken over a prolonged period and not merely in response to the proceedings. He further contended that the Registrant has shown deep and ongoing insight into the deficiencies identified in Patient A's care, understands the professional implications of the findings, and has embedded changes to reduce the likelihood of recurrence. The events occurred over three years ago, she has practised unrestricted since then without further concern, and the East of England NHS Trust's Professional Standards Group concluded that all identified risks had been mitigated.

174. On the wider public interest, Mr Halliday argued that a finding of impairment is not automatic in cases involving remediable clinical failings. Relying on authorities including *Cohen, Yeong v General Medical Council [2009] EWHC 1923 (Admin);* ***R (on the application of Meadow) v General Medical Council [2007] QB 462; [2006] EWCA Civ 1390****; General Medical Council v Azzam and Salooja [2008] EWHC 2711 (Admin); General Medical Council v Armstrong [2021] EWHC 1658 (Admin); and Professional Standards Authority for Health and Social Care v General Medical Council and Uppal [2015] EWHC 1304 (Admin),* Mr Halliday submitted that where clinical errors have been fully addressed and the practitioner presents no ongoing risk, the public interest may be satisfied without a finding of current impairment.

175. Mr Halliday pointed to numerous character references from experienced Optometrists and employers which described the incidents as out of character and attesting to the Registrant's competence, professionalism and record keeping. He also relied on the NHS Trust's decision to take no further action. He therefore invited the Committee to conclude that the Registrant's fitness to practise is not currently impaired and, if a formal public interest response is nevertheless considered necessary, that a warning would be available as an alternative to a finding of impairment.

176. The Committee heard and accepted advice from the Legal Adviser who outlined *Paragraphs 16.1* to *16.7* of the *Guidance*. The Legal Adviser advised the Committee to consider the two separate elements of impairment namely the public interest component, which concerns the reputation of the profession and upholding professional standards, and the public protection component which concerns the risk to the public of repetition. She advised the Committee to consider any insight displayed by the Registrant as set out in *Cohen v GMC (2008) EWHC 581*. The Legal Adviser also highlighted the four questions in the *Grant* case. The Legal Adviser further advised the Committee that at the impairment stage, there is no burden or standard of proof, but ultimately it is a question of judgement for the Committee alone.

177. The Legal Adviser set out the *Guidance* in relation to warnings, and advised the Committee to consider the factors set out in *paragraphs 20.6 and 20.7.*

FINDINGS ON IMPAIRMENT

178. The Committee heard and accepted the legal advice, considered the *Guidance* at *paragraphs 16.1* to *16.7*, the *Cohen* case and the four questions in the *Grant* case.

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

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

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

181. The Committee reminded itself of its previous findings on misconduct. The Registrant had failed Patient A on three separate dates. By inadequate record keeping, failing to recognise signs associated with a serious underlying condition, and failing to refer Patient A to the Hospital Eye Service despite this being clinically indicated, the Registrant had fallen below *Standards 7, 8* and *17.* The Registrant's actions had placed Patient A at unwarranted risk of harm and undermined the reputation of the profession amongst members of the public, professional colleagues and patients. The Committee therefore found that the Registrant had, in the past, a) put Patient A at unwarranted risk of harm, b) brought the optical profession into disrepute, and c) breached one of the fundamental tenets of the profession.

182. The Committee then considered the issues in the case of *Cohen* as found at *Paragraph 16.1* of the *Guidance.*

183. Firstly, the Committee considered whether the conduct which led to the allegations is remediable. The Committee was satisfied that the misconduct was capable of remediation, it being clinical in nature. The Committee considered

that in cases of this type, self-directed training, learning, reflection and practice improvements can be completed which deal directly with the clinical concerns. For those reasons, the Committee found that the Registrant's misconduct is remediable.

184. Secondly, the Committee considered whether the conduct has been remedied. The Committee had regard to the Registrant's reflective statements, extensive CPD and learning logs, targeted training, audits of her record keeping, discussions with colleagues and evidence of changed clinical practice through subsequent referrals. The Committee noted that the Registrant's learning had been comprehensive and focused on the matters identified in the allegations, including communication, record keeping, optic disc abnormalities, interpretation of visual fields and methods of examination. The Committee further took account of the *Guidance* at *paragraph 16.6* and in *GMC v Awan* [2020] EWHC 1553 (Admin), recognising that, notwithstanding her previous position, the Registrant had, to her credit, moved significantly from her earlier view and now accepted that her care had not met the standard expected.

185. The Committee also attached weight to the independent evidence supporting the Registrant's remediation. For example, it noted the reference from [redacted], an Optometrist and former practice owner who had worked closely with the Registrant for many years, who stated: *"I am aware of the subject matter of the case that Ms McBain faces. These allegations most certainly do not fit the character of Ms McBain … Through the entirety of our working relationship, Abbie's attention to detail, her clinical skills and record keeping were absolutely first rate. Her patient record cards were clear, concise, complete and detailed. Abbie would always refer when clinically necessary and her association with the Hospital Eye Service only added to her knowledge and experience."*

186. The Committee also had regard to the decision of the East of England NHS Trust Professional Standards Group, which concluded: *"The PSG noted all the information available and agreed to close your case with no further action. The rationale being that the panel agreed that all risks have been mitigated, that you continue to work without any problems and that your employer, patients and patient representatives are more than happy with your work."*

187. Finally, the Committee found the Registrant's own reflections to be persuasive evidence of insight and remediation. It noted her acknowledgement that: *"I recognise that the concerns in this case are framed as misconduct and therefore relate not only to clinical judgement but to the professional standards expected of an optometrist. I understand the seriousness of that characterisation and the potential impact such findings have on public confidence in the profession. I have reflected extensively on the events in question and put into place the enhancements outlined above. With the benefit of hindsight and subsequent review of the case, I understand how earlier escalation might be argued. I recognise that rare or atypical presentations can evolve in ways that are not initially apparent. This case has reinforced for me the importance of maintaining a high index of suspicion, and to the*

consideration of ruling out ocular pathology as a priority at every patient encounter." The Committee also noted her further statement that: *"I fully recognise the seriousness of these allegations. I have reflected deeply with a determination to learn from it to ensure the risk of events repeating themselves is as low as possible."*

188. Taking all of this evidence together, the Committee was satisfied that the Registrant has demonstrated substantial insight and had done everything that could reasonably be expected to address the concerns identified in this case. The Committee found that the concerns in this case had been fully remedied.

189. The Committee considered whether there was a risk of repetition. The Committee found that the Registrant had demonstrated in her oral and written evidence the extensive steps she has taken to demonstrate insight and to prevent any repetition of repeating such clinical failures. The Committee considered that the risk of repetition was low.

190. The Committee then returned to the *Grant* questions with reference to the Registrant's *future* risk.

191. The Committee was satisfied that the Registrant did not present a future risk to patients and was not liable to place patients at an unwarranted risk of harm. The Committee attached significant weight to the extensive remediation undertaken, the absence of any restrictions, conditions or supervision on her practice, the absence of any further concerns since the events in question, her voluntary monitoring and audit of her work, and the conclusion of the NHS Trust Professional Standards Group that all risks had been mitigated. In those circumstances, the Committee considered the risk of repetition to be very low and was not satisfied that the Registrant remained liable in the future to place a patient at unwarranted risk of harm, bring the profession into disrepute or to breach a fundamental tenet of the profession.

192. The Committee next considered whether, notwithstanding its findings in relation to the case of *Grant,* a finding of current impairment was nevertheless required on public interest grounds. It reminded itself that such a finding is not automatic. Applying *Persand v GMC [2013] EWHC 2300 (Admin),* the Committee recognised that impairment based solely on public interest considerations represents a high threshold and requires careful consideration of whether a fully informed and reasonable member of the public would be seriously concerned were no finding of current impairment made. The Committee accepted that the misconduct in this case was serious. It involved a child patient who attended on three occasions and in respect of whom there were failures to recognise and act upon signs later associated with a serious underlying condition. The Committee acknowledged that a member of the public, focusing solely on the outcome and the eventual diagnosis, could understandably be concerned by those facts.

193. However, the Committee considered that a fair-minded and fully informed member of the public would not view the case in isolation from what had

occurred since. Such a person would be aware of the Registrant's extensive remediation, deep insight, targeted training, changes to her clinical practice, the absence of any further concerns over a prolonged period of unrestricted practice, and the conclusion of the NHS Trust Professional Standards Group that all risks had been mitigated. The Committee also took into account that the misconduct was clinical in nature and capable of remediation, and that the Registrant had demonstrated that remediation in practice.

194. Having balanced the seriousness of the misconduct against the compelling evidence of remediation and the absence of any continuing risk, and bearing in mind the high threshold identified in *Persand*, the Committee concluded that this was not a case where a finding of current impairment was required solely in order to maintain public confidence in the profession or uphold proper professional standards. Accordingly, the Committee determined that the public interest component of impairment was not established.

195. The Committee therefore concluded that the Registrant's fitness to practise is not currently impaired on either public protection or public interest grounds.

WARNING

196. Under the Guidance, the Committee considered whether it was appropriate to issue a warning where concerns raised by the case were sufficiently serious to require a formal response, even though they did not reach the threshold for current impairment.

197. The Committee took into account the parties' submissions on warning, the legal advice and the *Guidance*, in particular that of *paragraphs 20.6* and *20.7*:

> *"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. [not relevant]*
> *c. Previous good history;*
> *d. Appropriate rehabilitative/corrective steps have been taken; and*

e. Relevant and appropriate references and testimonials."

198. The Committee had found that the Registrant had clearly breached *Standards 7, 18 and 17*. 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.

199. The Committee considered the aggravating and mitigating factors in the case. It noted that several of the mitigating factors set out in *paragraph 20.7* of the *Guidance* applied, including that the Registrant had demonstrated genuine insight and regret, had an otherwise unblemished professional history, had taken extensive rehabilitative and corrective steps, and had provided impressive and persuasive testimonials from colleagues, employers and the NHS Trust. The Committee found that the Registrant had done everything that could reasonably be expected of her to address the concerns and had provided compelling evidence that the risk of repetition was highly unlikely.

200. The Committee balanced those substantial mitigating factors against the seriousness of the misconduct. The Committee considered 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 concluded that a warning was the appropriate and proportionate outcome in the public interest, as it formally marked the seriousness of the conduct whilst recognising that the Registrant's fitness to practise was not currently impaired.

201. The Committee was satisfied that a period of two years was an appropriate and proportionate period, which adequately reflected the misconduct in question, marked the misconduct and maintained public confidence in the profession.

202. The warning will therefore remain on the Register until 16 July 2028, when it will expire.

203. 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 below the standards expected of a Registrant and considers it appropriate and proportionate to issue you with a formal warning. This warning will be placed on your registration record and may be taken into account in any future fitness to practise proceedings for a period of two*

years with an expiry date of 16 July 2028. 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."

Chair of the Committee: Andy Brennan

Signature  **Date**: 17 July 2026

Registrant: Abbie McBain

Signature Present remotely and received via email **Date:** 17 July 2026

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

Where a registrant can appeal against a decision, the Authority has 40 days beginning with the day which is the last day in which you can appeal. Where a registrant cannot appeal against the outcome of a hearing, the Authority's appeal period is 56 days beginning with the day in which notification of the decision was served on you. PSA will notify you promptly of a decision to refer. A letter will be sent by recorded delivery to your registered address (unless PSA has been notified by the GOC of a change of address). Further information about the PSA can be obtained from its website at www.professionalstandards.org.uk or by telephone on 020 7389 8030.
Contact
If you require any further information, please contact the Council's Hearings Manager at Level 29, One Canada Square, London, E14 5AA or by telephone, on 020 7580 3898.