BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(23)38

AND

KARTIK BHARADIA (01-26443)

DETERMINATION OF A SUBSTANTIVE HEARING
20-30 January 2025

Committee Members:	Hermione McEwen (Chair/Lay) John Vaughan (Lay) Diane Roskilly (Lay) Amit Jinabhai (Optometrist) Sanna Nasrullah (Optometrist)
Legal adviser:	Megan Ashworth
GOC Presenting Officer:	Genevieve Woods
Registrant present/represented:	Yes and represented
Registrant representative:	Richard Mumford
Hearings Officer:	Latanya Gordon
Facts found proved:	4.a, 4.b and 5.a proved by admission. 2.a to the extent of failure to record only; and 3.a and 3.b to the extent of failure to record only
Facts not found proved:	None
Misconduct:	Found in respect of particular 5.a
Impairment:	Not currently impaired

ALLEGATION

(as amended, showing withdrawn particulars struck through and other amendments in bold)

The Council alleges that you, Mr Kartik Bharadia (01-26443), a registered optometrist:

~~*1) Between 25 May 2020 and 7 June 2020, you failed to act on instruction from a statutory authority requiring measures to be implemented to safeguard the welfare of patients and staff in that you permitted and/or facilitated the carrying out of non-urgent and/or non-essential in-person patient consultations with some or all of the patients listed in Schedule A, contrary to Government and associated guidance that was in force at that time, following the Health Protection (Coronavirus, Restrictions (England) Regulations 2020*~~

2) Between around 25 May 2020 and 7 June 2020, in relation to some or all patients in Schedule B, you failed to adequately manage these patients, in that you:

a. Failed to perform and/or record the findings of any cover test ~~of~~ or any other binocular vision test;

3) Between around 25 May 2020 and 7 June 2020, in relation to ~~some or all patients in Schedule C~~ ***Patient 33****, you failed to adequately manage ~~these~~* ***this*** *patient~~s~~, in that you:*

a. Failed to perform and/or record the findings of any cover test or any other binocular vision test

b. Failed to perform and/or record pupil reflex testing;

4) On or around 30 May 2020, you attended to Patient 107 and you failed to adequately manage this patient in that you:

a. Failed to perform a visual fields test, despite this being clinically indicated; and/or

b. Failed to make a referral to Patient 107's General Practitioner ("GP") for further investigation;

5) On or around 3 June 2020, you attended to Patient 84, and you:

a. Failed to complete a full examination in that you failed to perform a dilated examination of Patient 84's eyes;

~~*6) Between around 25 May 2020 and 7 June 2020, you failed to maintain*~~

~~*adequate patient records, in that you:*~~

~~*a. Failed to record adequately or at all your internal examination findings for some or all of the patients in Schedule D.*~~

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

Schedule B
Patient 18
Patient 40
Patient 60
Patient 76
Patient 107

~~***Schedule C***~~
~~*Patient 27*~~
~~*Patient 33*~~

~~***Schedule D***~~
~~*Patient 1*~~
~~*Patient 3*~~
~~*Patient 10*~~
~~*Patient 13*~~
~~*Patient 19*~~
~~*Patient 20*~~
~~*Patient 21*~~
~~*Patient 22*~~
~~*Patient 23*~~
~~*Patient 24*~~
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~~*Patient 52*~~
~~*Patient 53*~~
~~*Patient 56*~~
~~*Patient 60*~~
~~*Patient 61*~~
~~*Patient 62*~~
~~*Patient 65*~~

~~*Patient 72*~~
~~*Patient 75*~~
~~*Patient 79*~~
~~*Patient 92*~~
~~*Patient 96*~~
~~*Patient 98*~~

DETERMINATION

Application to amend the Allegation

1. At the outset of the hearing, the General Optical Council (GOC) applied to amend the Allegation to discontinue particulars 1 and 6.a in their entirety and particulars 3.a and 3.b as they related to Patient 27.

2. In relation to particular 1, Ms Woods, on behalf of the GOC explained that the position of the GOC was that particular 1 should not proceed because there were insufficient prospects of success and its pursuance was not in the public interest. She applied to amend the Allegation by deletion. She explained that particular 1 related to alleged conduct on the part of the Registrant during the Covid-19 pandemic and the relevant guidance applicable at the time which the Registrant was alleged to have breached. Ms Woods explained that the guidance was drafted in language which was advisory rather than mandatory, making recommendations. Ms Woods further explained that the GOC did not submit that there was a realistic prospect of the facts amounting to misconduct or leading to impaired fitness to practise, in any event.

3. In relation to particulars 3 (in relation to Patient 27) and 6, Ms Woods explained that the application to amend was made in light of the joint expert report, dated 8 January 2025. The opinions of the experts in that report were that for particular 3, stereopsis was measured for Patient 27 and for particular 6 (record keeping), there was no departure from the required standards.

4. Ms Woods drew the Committee's attention to Rule 46(20) of the GOC (Fitness to Practise) Rules Order of Council 2013 (the Rules) which covered the making of amendments, provided they could be made "without injustice". Ms Woods submitted that it was not in the interests of justice to pursue particulars 1, 3(in relation to Patient 27) and 6 and that no injustice would be caused if the Committee allowed the proposed amendments.

5. Mr Mumford, on behalf of the Registrant, supported the application.

6. The Committee heard and accepted the advice of the Legal Adviser. She advised the Committee of its power to amend an Allegation under Rule 46(20), provided any amendments could be made without injustice. She also advised the Committee that in respect of those particulars which the GOC wished to withdraw, this was akin to offering no evidence, so the Committee should satisfy itself under *PSA v NMC and X [2018] EWHC 70 (Admin)*, that it was appropriate to allow the particulars to be withdrawn.

7. The Committee considered that the amendments could be made without injustice. In relation to particular 1, it noted that the Covid-19 guidance had been advisory as opposed to mandatory. In light of this, the Committee did not consider that there was a realistic prospect of finding particular 1 proved.

8. In relation to particulars 3.a and 3.b and 6.a, the Committee took account of the joint expert report, dated 8 January 2025. It noted that the experts' respective opinions had developed, such that the joint opinion withdrew the criticism which had been levelled at the Registrant in respect of these particulars.

9. The Committee agreed to the GOC's application to discontinue particulars 1, 3.a and 3.b (in respect of Patient 27) and 6.a, and was satisfied that this would cause no injustice. In light of the deletion of Patient 27 from particular 3.a and 3.b, this meant that it now related to one patient (Patient 33) and so the Committee decided to amend particular 3.a and 3.b to delete Schedule C and add Patient 33 to the body of particular 3 itself.

Admissions in relation to the particulars of the Allegation

10. Following the amendments, Mr Mumford, on behalf of the Registrant was invited to indicate whether there were any admissions to the factual particulars. Mr Mumford informed the Committee that the Registrant admitted particulars 4 and 5 of the Allegation. Accordingly, the Committee found these particulars proved under Rule 46(6).

11. In respect of particulars 2.a and 3.a and 3.b, the Registrant admitted that he failed to record the findings of the relevant tests, but he denied that he failed to perform them. The Committee noted these admissions.

Application to admit late evidence

12. Mr Mumford, during the course of the Registrant's evidence, applied to admit a document of an audit of the Registrant's work, from 2019, into evidence. The audit document consisted of one page and related to six patients. The Registrant had given evidence that he was confident he had performed the relevant tests,

including the cover test, based on his usual practice and that this was confirmed by audits of his records each year. He was cross examined on the basis that there was no evidence of such audits before the Committee.

13. Ms Woods objected to the application. She submitted that it had little or no relevance to the proceedings; that it related to a year before the time period of the Allegation and before the Covid-19 pandemic; and had the potential to derail and delay the hearing.

14. Mr Mumford submitted that it was a document which had previously been provided to the GOC for consideration by the case examiners three years before and the GOC expert, Dr Tromans, had referenced that the case examiners material had been included in the documentation provided to her to prepare her expert report. He submitted that the Registrant had specifically been asked questions about it, and given its brief nature, the GOC were not prejudiced by its admission.

15. The Committee heard and accepted the advice of the Legal Adviser. She advised the Committee of its power under Rule 40(1) to receive evidence, even at a late stage in proceedings, if it considered it fair and relevant to the case before it.

16. The Committee considered that the audit document was relevant and that it would be fair to admit it. The Registrant had described in evidence that regular audits had been conducted on his patient records which identified no issues within his record keeping. This confirmed to him that it was his usual practice to perform the relevant tests during a sight test.The Committee bore in mind that the Registrant had been cross examined on the evidence he had given about being regularly audited and had been questioned on whether there was documentary evidence in support. The Committee considered that at the very least, the audit document tended to corroborate his evidence about this. Furthermore, the Committee noted that although the audit document related to only a few patients and at an earlier time before the Covid-19 pandemic, it was nevertheless potentially capable of supporting the Registrant's assertion that his usual practice was to conduct a cover test.

Background to the Allegation

17. The Registrant is a registered Optometrist. He was first registered with the Council as a student Optometrist on 25 September 2007 and became a fully qualified Optometrist on 18 October 2011.

18. At the relevant time, he was working as an Optometrist at [redacted] Visionplus Limited Specsavers ([redacted])

19. The factual particulars relate to a period between 25 May 2020 and 7 June 2020, which was during the lockdown or "red phase" of the Covid-19 pandemic. During that time, the Registrant carried out sight test appointments with Patient 18, Patient 40, Patient 60, Patient 76, Patient 107 (all subjects of particular 2.a) and Patient 33 (subject of particulars 3.a and 3.b).

20. The College of Optometrists issued guidance in 2018 for "The routine eye examination" (the Guidance), which remained in force at the relevant time. At paragraph A44, the Guidance states:

> *You must conduct an adequate assessment for the purposes of the optical consultation. This should normally include:*
>
> *…*
>
> *c. assessing and recording habitual ocular muscle balance [OMB] and the method used, at least cover test, for distance and near. This should be done with the habitual prescription and/or without the prescription, if appropriate.*

21. In relation to the pandemic, the College of Optometrists issued further guidance for Optometrists entitled "COVID pandemic modified sight test". In relation to OMB, the modified advice for practitioners was to *"Consider if needed if asymptomatic"*.

22. Binocular vision or ocular muscle balance (OMB) testing is an assessment of how well the two eyes work together and these tests can detect misalignment of the eyes such as a strabismus (manifest deviation) or phoria (latent deviation). A cover test is an objective method for determining the presence of, type and magnitude of ocular misalignment and can be performed at both near and distance. Cover testing and fixation disparity testing are useful to determine the causes of symptoms such as diplopia (double vision) and headaches.

23. The GOC instructed an expert, Dr Tromans, to provide her expert opinion in respect of the patient records. The Registrant instructed an expert, Dr Kwartz, to provide her expert opinion in respect of the patient records. Both experts concluded that the presenting symptoms of the six patients, who are the subject of particulars 2.a and 3.a, required a cover test to be performed and that there was no entry within the respective records of a cover test having been performed. Both experts also concluded that the presenting symptoms of Patient 33, who is the subject of particular 3.b, required pupil reflex testing to be performed.

24. It is alleged that the Registrant failed to perform and/or record the results of any cover test or any other binocular vision test and that he failed to perform and/or record pupil reflex testing.

25. It is alleged that the Registrant failed to manage Patient 107 by failing to perform a visual fields test which was clinically indicated and that he failed to refer Patient 107 to his GP for further investigation (particulars 4.a and 4.b).

26. It is further alleged that the Registrant failed to complete a full examination in that he failed to perform a dilated examination of Patient 84's eyes (particular 5.a).

Findings in relation to the facts

27. The Committee had been provided with documents in support of the GOC case. These included witness statements from Patient 18 and Patient 76, an expert report from Dr Tromans, dated 2 December 2024, the relevant patient records of the patients in respect of whom the particulars related.

28. The Committee was also provided with documents in support of the Registrant's case. These included the Registrant's witness statement and exhibits and an expert report from Dr Kwartz, dated 29 November 2024.

29. In addition, the Committee was provided with a joint expert report, dated 8 January 2025, where both experts attempted to narrow the issues and relevant College of Optometrists Guidance for a routine eye examination, both generally and specifically during the Covid-19 pandemic.

30. The Committee heard evidence from both experts and the Registrant gave evidence.

31. The Committee heard and accepted the advice of the Legal Adviser. She advised that the burden of proof was on the GOC and the standard of proof required was the civil standard, namely whether it was more likely than not that the alleged facts occurred. In relation to the particulars alleging a failure, the Legal Adviser advised that this was an allegation that the Registrant did not do whatever was alleged and that he was under a duty or obligation to act in the particular way required, according to the standards of appropriate optometric practice at the relevant time.

32. The Committee considered all of the evidence produced by both parties and the submissions of Mrs Woods on behalf of the GOC and Mr Mumford on behalf of the Registrant.

33. At the outset of the deliberations, the Committee identified a number of general factors relevant to its considerations. It bore in mind that the time frame for the allegations was a two-week period between 25 May and 7 June 2020, which was a time when the country was in lock down due to the Covid-19 pandemic. During this time, the College of Optometrists issued the Covid pandemic modified sight test guidance to Optometrists. In terms of OMB testing, which would ordinarily

include the cover test, the modified guidance invited practitioners to consider if it was needed, if the patient was asymptomatic.

34. In relation to the six patients, the subject of particulars 2 and 3, the Committee bore in mind that, according to both experts, each of these patients presented with symptoms and therefore a cover test was required in each case. Patient 18, Patient 33 and Patient 107 each presented with headaches, according to the patient records. Patient 40, Patient 60 and Patient 76 each presented with double vision (diplopia). Therefore, the Committee was satisfied in each case, the Registrant was under a duty to perform a cover test as part of the modified sight test.

35. The Committee noted that, in each case, the GOC relied on the absence of a recording within the patient records as the evidence on which the Committee could be satisfied that it was more likely than not that the Registrant did not perform a cover test in respect of each patient. The Committee further noted that the Registrant's position was not that he had a positive recollection of performing the cover tests on six patients nearly five years earlier, rather that it was his usual practice to perform a cover test as the first in a series of relevant tests.

36. The Committee had regard to the Registrant's evidence regarding his usual practice. He said that during the period in question, [redacted] was open to the public for urgent and essential eye care only. Requests for appointments were triaged by telephone and face-to-face appointments were only given where deemed clinically necessary. Many staff members were furloughed and the practice was operating during reduced opening hours. During the pandemic, eye examinations (in terms of the time period where the patient and Optometrist were in the same room) were generally of shorter duration. Therefore, he carefully selected the most relevant clinical tests in order to reduce the length of contact time with patients.

37. Prior to the pandemic, it was the Registrant's evidence that it was his usual practice to perform and record binocular vision/OMB testing on every patient attending for a sight test. Specifically, a cover test would be performed on all patients and stereopsis would be done on all children under eight years of age. During the red phase of the pandemic, the Registrant continued with this practice unless the patient was having a refraction undertaken for replacement spectacles and did not have any previous complications or report any new symptoms.

38. Prior to the pandemic, it was the Registrant's evidence that it was his usual practice to conduct pupil reflex testing on every patient along with a motility test, as both involve the use of a pen torch. In accordance with the Covid-19 modified sight test guidance, the Registrant was more selective on when he performed pupil reflex testing and so he conducted such tests on patients complaining with

symptoms such as headaches, nausea and unexplained vision loss, or headaches that might be linked to neurological complications.

39. In respect of particular 2.a, the Committee then considered each patient listed in Schedule B separately.

Particular 2

Between around 25 May 2020 and 7 June 2020, in relation to some or all patients in Schedule B, you failed to adequately manage these patients, in that you:

a. Failed to perform and/or record the findings of any cover test or any other binocular vision test;

Patient 18

40. The Committee finds particular 2.a in relation to Patient 18, proved in respect of the failure to record the findings of any cover test or any binocular vision test only.

41. Patient 18, according to the patient records, was referred by their GP due to headaches which had started some three weeks before. There was no entry within the patient records to the effect that the Registrant had performed a cover test.

42. Patient 18's witness statement confirmed that prior to the appointment with the Registrant on 25 May 2020, they had been experiencing some rather bad headaches and throughout that their vision was being affected as a result. Both of their eyes were blurry and they experienced pain wearing the glasses. Their GP informed them that they first had to contact their opticians to rule out if the cause was their eyes before any further referral could be made.

43. The Committee bore in mind that Patient 18 had attended the appointment with the Registrant for a medical reason, following a referral from their GP. It took account of Patient 18's witness statement, where they had described a series of tests having been performed, although they could not specifically recall whether or not the Registrant had performed any cover or binocular tests due to the lapse of time.

44. The Registrant, having checked the patient records, was able to confirm in his witness statement that he had checked Patient 18's vision, which with spectacle correction was good in both eyes; had assessed the motility, which was full and smooth; and checked the pupils, which had no issues. In his oral evidence, he

said that the patient's presenting symptoms of headaches would have "triggered" him to perform a cover test as a way of identifying any neurological issues.

45. In relation to the cover test, he said:

> *I believe that I would have also carried out a cover test with the same occluder as firstly, my usual practice is to always perform a cover test before other secondary binocular vision testing such as motility; and secondly, the patient had symptoms (i.e. headache) which warranted a cover test.*

46. The Registrant explained that, prior to the pandemic, he would have performed a cover test and recorded his findings immediately on the Muscle Balance Tests (MBT) screen, clicking onto 'proceed' to move to the next screen. He stated during the pandemic, to minimise contact with the patient, he would perform all the tests and then go back and record the information. He now recognised that he did not always go back to the home screen or click back multiple times to complete the information for all the relevant tests performed. In his oral evidence, he also said that he could not think of a time where he would have conducted a motility test without doing a cover test first.

47. Whilst the Committee acknowledged that the Registrant could not recall having performed a cover test, it considered that he was more likely than not to have done so because:

a) The Committee accepted that the Registrant was a competent and experienced Optometrist who knew which tests were required, based on a patient's presenting symptoms;

b) The Registrant's usual practice was to perform the cover test at an early part of the sight test, as each stage would inform the next stage and which secondary tests would be appropriate;

c) The Committee accepted the Registrant's evidence that at the time, he was being selective about which patients he would examine and complete all the relevant tests as he wished to resolve all the issues so that the patient would not have to return during the pandemic;

d) Patient 18 had attended as a result of a GP referral, and the Committee considered it unlikely that he would not thoroughly investigate the case, and perform the appropriate tests to rule out potential causes of the headaches;

e) Patient 18 in their witness statement described a series of tests, indicating to the Committee that the Registrant had conducted a thorough sight test.

48. In all the circumstances, the Committee was not satisfied that the GOC had established that the Registrant had not conducted a cover test in respect of Patient 18. It therefore concluded that particular 2.a in respect of Patient 18 was proved only in relation to a failure to record, as admitted by the Registrant.

Patient 40

49. The Committee finds particular 2.a in relation to Patient 40, proved in respect of the failure to record the findings of any cover test or any binocular vision test only.

50. Patient 40, according to the patient records, attended an appointment with the Registrant on 28 May 2020 and reported longstanding (12 months) horizontal and double vision associated with watching TV.

51. The Registrant, having checked the patient records, was able to confirm in his witness statement that Patient 40 had no double vision with reading and his distant and near vision were okay. He had also measured, with refraction, that the visual acuity was 6/7.5 in the right eye and 6/6 in the left eye. He said that he assessed the fixation disparity and prescribed a prism.

52. In relation to the cover test the Registrant said:

> *I believe that I did a cover test in this case as: (a) it is always the case that I perform a cover test before assessing fixation disparity and; (b) the patient had symptoms (double vision) which warranted a cover test. I accepted. I did not record this. I also believe that I would have assessed ocular motility and checked the pupils because of the patient's symptoms.*

53. Dr Kwartz agreed with Dr Tromans that, based on Patient 40's presenting symptoms of double vision, a cover test should have been performed. Although Dr Kwartz accepted that prism values could be obtained by measuring a patient's glasses rather than performing fixation disparity, she considered that the prism values recorded in the patient records were more likely to have come from measuring fixation disparity. She was of this opinion because the patient records recorded that this appointment was the first time prism had been prescribed for Patient 40.

54. Whilst the Committee acknowledged that the Registrant could not recall specifically having performed a cover test, it considered that he was more likely than not to have done one because:

    a) The Committee accepted that the Registrant was a competent and experienced Optometrist who knew which tests were required, based on a patient's presenting symptoms;

b) The Registrant's usual practice was to perform the cover test at an early part of the sight test, as each stage would inform the next stage and which secondary tests would be appropriate;

c) The Committee accepted the Registrant's evidence that at the time, he was being selective about which patients he would examine and complete all the relevant tests as he wished to resolve all the issues so that the patient would not have to return during the pandemic;

d) The Registrant said that he always performed a cover test before assessing fixation disparity and Dr Kwartz confirmed in her oral evidence that that there was a strong link between a cover test and a fixation disparity test, as both assessed the movement of the eyes, and a fixation disparity test would naturally follow a cover test, it being a secondary test to measure the amount of prism required;

e) Dr Kwartz opined that for the Registrant to have prescribed prism, he was likely to have performed fixation disparity, thus managing the patient's oculomotor problem.

55. In all the circumstances, the Committee was not satisfied that the GOC had established that the Registrant had not conducted a cover test in respect of Patient 40. It therefore concluded that particular 2.a, in respect of Patient 40, was proved only in relation to a failure to record, as admitted by the Registrant.

Patient 60

56. The Committee finds particular 2.a in relation to Patient 60, proved in respect of the failure to record the findings of any cover test or any binocular vision test only.

57. Patient 60, according to the patient records, attended an appointment with the Registrant on 1 June 2020, reporting a one-week history of intermittent double vision, with the last episode being two days earlier.

58. The Registrant, having checked the patient records, confirmed in his witness statement that he had measured Patient 60's visual acuity and with refraction, it was 6/6 in the right eye and 6/6-3 in the left eye. He had assessed the fixation disparity and prescribed a prism.

59. In relation to a cover test, the Registrant said:

> *A cover test would have been done as a matter of course before assessing fixation disparity and in light of the patient's symptoms double vision. I acknowledge that I did not record the test results of the cover test.*

I believe that I would have assessed ocular motility as it would be normal practice for me to do a cover test, ocular motility, and pupils check at the same time.

60. Dr Kwartz agreed with Dr Tromans that, based on Patient 60's presenting symptoms of double vision, binocular vision testing should have been performed. Dr Kwartz further opined that, as for Patient 40, since prism was prescribed, it was apparent to her that fixation disparity had been performed.

61. Whilst the Committee acknowledged that the Registrant could not recall specifically having performed a cover test, it considered that he was more likely than not to have done one for the following reasons:

    a) The Committee accepted that the Registrant was a competent and experienced Optometrist who knew which tests were required, based on a patient's presenting symptoms;

    b) The Registrant's usual practice was to perform the cover test at an early part of the sight test, as each stage would inform the next stage and which secondary tests would be appropriate;

    c) The Committee accepted the Registrant's evidence that at the time, he was being selective about which patients he would examine and complete all the relevant tests as he wished to resolve all the issues so that the patient would not have to return during the pandemic;

    d) The Registrant said that he always performed a cover test before assessing fixation disparity and Dr Kwartz confirmed in her oral evidence that that there was a strong link between a cover test and a fixation disparity test, as both assessed the movement of the eyes, and a fixation disparity test would naturally follow a cover test, it being a secondary test to measure the amount of prism required;

    e) As the Registrant had recorded prism values, the Committee considered that it was more likely than not that he had assessed fixation disparity, having previously performed a cover test.

62. In all the circumstances, the Committee was not satisfied that the GOC had established that the Registrant had not conducted a cover test in respect of Patient 60. It therefore concluded that particular 2.a, in respect of Patient 60, was proved only in relation to a failure to record, as admitted by the Registrant.

Patient 76

63. The Committee finds particular 2.a in relation to Patient 76, proved in respect of the failure to record the findings of any cover test or any binocular vision test only.

64. Patient 76, according to the patient records, attended an appointment with the Registrant on 3 June 2020, complaining that their vision was not comfortable.

65. Patient 76's witness statement confirmed that he had been experiencing problems with double vision and the glasses that he had been prescribed had not resolved the problem. Patient 76 described the consultation as lasting around 20 to 25 minutes and that during the consultation he underwent some assessments and although he was unable to confirm the name of the tests completed, it appeared as if the Registrant was:

> "*going systematically through a list of all tests. It was all very technical and professional…There was nothing during this consultation that was different from any other consultation that I have had with other Optometrists. In fact, I felt that [the Registrant] was very thorough with me and probed me quite a lot during the consultation; I was very impressed with his treatment."*

Patient 76 confirmed that he was provided with new glasses with prism in the lenses which resolved his problems.

66. The Registrant, having checked the patient records was able to confirm that Patient 76 reported that his vision was not comfortable with his current prescription which did not contain prism but had been okay with his previous spectacles. He measured the patient's visual acuity which, with refraction, was 6/6-3 in both eyes.

67. In relation to a cover test, the Registrant said:

> *I assessed the fixation disparity (which would have involved a cover test and ocular motility…) and prescribed a prism.*

68. Whilst the Committee acknowledged that the Registrant could not recall specifically having performed a cover test, it considered that he was more likely than not to have done a cover test for the following reasons:

a) The Committee accepted that the Registrant was a competent and experienced Optometrist who knew which tests were required, based on a patient's presenting symptoms;

b) The Registrant's usual practice was to perform the cover test at an early part of the sight test, as each stage would inform the next stage and which secondary tests would be appropriate;

c) The Committee accepted the Registrant's evidence that at the time, he was being selective about which patients he would examine and complete all the relevant tests as he wished to resolve all the issues so that the patient would not have to return during the pandemic;

d) Patient 76 in their witness statement described consulting at least two previous Optometrists about his visual problems but who had not been able to resolve them and one of them had referred him to the Registrant. He described him as going systematically through a list of tests professionally, the appointment was thorough and resolved his issues;

e) The Registrant said that he always performed a cover test before assessing fixation disparity and Dr Kwartz confirmed in her oral evidence that that there was a strong link between a cover test and a fixation disparity test, as both assessed the movement of the eyes, and a fixation disparity test would naturally follow a cover test, it being a secondary test to measure the amount of prism required;

f) As the Registrant had recorded prism values, the Committee considered that it was more likely than not that he had assessed fixation disparity, having previously performed a cover test.

69. In all the circumstances, the Committee was not satisfied that the GOC had established that the Registrant had not conducted a cover test in respect of Patient 76. It therefore concluded that particular 2.a, in respect of Patient 76, was proved only in relation to a failure to record, as admitted by the Registrant.

Patient 107

70. The Committee finds particular 2.a in relation to Patient 107, proved in respect of the failure to record the findings of any cover test or any binocular vision test only.

71. Patient 107, according to the patient records, attended an appointment on 30 May 2020 with the Registrant, complaining of headaches associated with the sensation of vomiting, which had started three months earlier and which were intermittent and worse at night time.

72. The Registrant, having checked the patient records was able to confirm in his witness statement that Patient 107's distance vision was "okay" with his spectacles but he struggled with near vision on his phone and was prescribed first time near vision spectacles. With refraction, his visual acuity in the distance, was 6/6 in both eyes.

73. In relation to the cover test, the Registrant said:

> *I believe that I would have done a cover test at distance, and near in line with my usual practice, and in light of the symptoms of headaches associated with the sensation of vomiting, but unfortunately, I did not record the results.*

74. The Committee took account of the opinion of both experts to the effect that, given the presenting symptoms, a cover test was required in Patient 107's case.

75. The Committee noted that Dr Kwartz, the defence expert, in her assessment of the patient records, confirmed that there was no information in the record regarding oculomotor testing. She also identified that the Registrant had recorded that the patient had excellent visual acuity in both eyes; ophthalmoscopy was uneventful; the optic disc cup/disc ratios had been recorded and the margins were healthy.

76. Whilst the Committee acknowledged that the Registrant could not recall having performed a cover test, it considered it more likely than not that he had performed one because:

a) The Committee accepted that the Registrant was a competent and experienced Optometrist who knew which tests were required, based on a patient's presenting symptoms;

b) The Registrant's usual practice was to perform the cover test at an early part of the sight test, as each stage would inform the next stage and which secondary tests would be appropriate;

c) The Committee accepted the Registrant's evidence that at the time, he was being selective about which patients he would examine and complete all the relevant tests as he wished to resolve all the issues so that the patient would not have to return during the pandemic;

d) Dr Kwartz, on her review of the patient records concluded that the Registrant had documented the results of a number of tests, indicating to the Committee that he had conducted a thorough eye test. Further, she had opined:

> *To his credit, he did document that Patient 107 was not experiencing diplopia (double vision); if they had acquired a significant binocular vision abnormality, as they had equal and normal vision in both eyes, they would have noticed double vision.*

77. In all the circumstances, the Committee was not satisfied that the GOC had established that the Registrant had not conducted a cover test in respect of

Patient 107. It therefore concluded that particular 2.a, in respect of Patient 107, was proved only in relation to a failure to record, as admitted by the Registrant.

Particular 3

Between around 25 May 2020 and 7 June 2020, in relation to Patient 33, you failed to adequately manage this patient in that you:

a. failed to perform and/or record the findings of any cover test or any other binocular vision test

78. The Committee finds particular 3.a in relation to Patient 33, proved in respect of the failure to record the findings of any cover test or any binocular vision test only.

79. Patient 33, according to Dr Kwartz's interpretation of the patient records, attended an appointment with the Registrant on 27 May 2020, complaining of a two-month history of headaches associated with an ache behind the eyes. She did not experience dizziness or vomiting and was visually asymptomatic. Imaging with OCT was performed and fundus photographs taken.

80. The Registrant, having checked the patient records confirmed in his witness statement that the patient had a history of longstanding headaches dating back to 2008, and that her previous sight test had been in 2016. The Registrant measured Patient 33's visual acuity and, with refraction, it was 6/6 in both eyes. He advised the patient that she required a new prescription for distance vision and recommended full time use. He also advised that if the headaches persisted she should see her GP, which he did enter into the record.

81. Specifically in relation to a cover test, the Registrant stated:

> *I believe that, in view of the patient's symptoms of headaches, I would have performed a cover test in line with my usual practice although I accept that this has not been recorded. I also believe that I checked Patient 33's pupils, even though this is not recorded.*

82. Whilst the Committee acknowledged that the Registrant could not recall having performed a cover test, it considered it more likely than not that he had performed one for the following reasons:

    a) The Committee accepted that the Registrant was a competent and experienced Optometrist who knew which tests were required, based on a patient's presenting symptoms;

    b) The Committee accepted the Registrant's evidence that at the time, he was being selective about which patients he would examine and

complete all the relevant tests as he wished to resolve all the issues so that the patient would not have to return during the pandemic;

c) Patient 33 was presenting with symptoms of longstanding headaches behind the eyes which would have been the trigger for him to do a cover test;

d) The Registrant's usual practice was to perform the cover test at an early part of the sight test, as each stage would inform the next stage and indicate which secondary tests would be appropriate.

83. In all the circumstances, the Committee was not satisfied that the GOC had established that the Registrant had not conducted a cover test in respect of Patient 33. It therefore concluded that particular 3.a was proved only in relation to a failure to record, as admitted by the Registrant.

Particular 3

b. Failed to perform and/or record pupil reflex testing (on Patient 33)

84. The Committee finds particular 3.b in relation to Patient 33, proved in respect of the failure to record pupil reflex testing only.

85. The Committee had regard to the College of Optometrists routine eye examination guidance, which at paragraph A45 states:

> *If you feel it is clinically appropriate, you may:*
>
> *…c. assess pupil reflexes.*

86. The Committee took into account the opinion of both experts, to the effect that pupil reflex testing need only be performed if considered clinically necessary, and that it would be clinically necessary to check pupil responses if a patient was complaining of headaches. Therefore, pupil reflex testing was required in Patient 33's case.

87. Specifically in relation to pupil reflex testing, the Registrant in his witness statement said that he believed that he had also performed pupil reflex testing although he had failed to record it.

88. In relation to pupil testing generally within his usual practice, the Registrant said:

> *Prior to the pandemic, it was my usual practice to conduct pupil reflex testing on every patient along with a motility test, as both involve the use of a pen torch. During the pandemic, the guidance required me to be selective on when I performed pupil testing and therefore pupil testing was intended for patients complaining of symptoms such as headaches,*

nausea and unexplained vision loss or headaches that might be linked to neurological complications.

89. Whilst the Committee acknowledged that the Registrant could not specifically recall having performed a pupil reflex testing, it considered it more likely than not that he had performed such a test for the following reasons:

    a) The Committee accepted that the Registrant was a competent and experienced Optometrist who knew which tests were required, based on a patient's presenting symptoms;

    b) The Committee accepted the Registrant's evidence that at the time, he was being selective about which patients he would examine and complete all the relevant tests as he wished to resolve all the issues so that the patient would not have to return during the pandemic;

    c) Patient 33 was presenting with symptoms of longstanding headaches behind the eyes;

    d) The Registrant's usual practice during the pandemic was to perform pupil reflex testing on patients presenting with symptoms such as headaches.

90. In all the circumstances, the Committee was not satisfied that the GOC had established that the Registrant had not conducted pupil reflex testing in respect of Patient 33. It therefore concluded that particular 3.b was proved only in relation to a failure to record, as admitted by the Registrant.

Findings in relation to misconduct

91. Having announced its decision on the facts, the Committee went on to determine in accordance with Rule 46(12), whether, on the basis of the facts found proved, the alleged ground of impairment, namely misconduct, was established. The Committee understood that if it concluded that it was, then it would go on to determine whether the Registrant's fitness to practise is currently impaired by reason of that misconduct, in accordance with Rule 46(14).

92. Ms Woods submitted that the facts found proved do amount to misconduct and met the threshold for misconduct. In respect of particulars 4 and 5, she submitted that each of these was serious in itself and therefore amounted to misconduct, reminding the Committee that both experts agreed the conduct fell far below the expected standards, because of the risk of serious harm to each patient as a result of the Registrant's failures.

93. In relation to the record keeping failures at particulars 2 and 3, Ms Woods submitted that it was permissible to consider these failures cumulatively and identified that there were numerous admitted failings, which when taken together, amounted to misconduct. She asked the Committee to consider, if the public were to hear that no regulatory action resulted from such repeated failings, whether that would uphold public confidence in the profession.

94. Mr Mumford submitted that the conduct, both individually and collectively, was not sufficiently serious as to amount to misconduct. He submitted that the questions for the Committee in determining whether the conduct amounted to misconduct could be framed, according to the case law, as follows:

    a) Was there negligence "to a high degree"/"of a higher degree of gravity than mere carelessness"?; and

    b) Was such conduct of a seriousness such as to "be regarded as deplorable by fellow practitioners"?

95. Mr Mumford submitted that the record keeping failures (particulars 2 and 3) should not be cumulated with adverse findings relating to clinical decision making (particulars 4 and 5).

96. The Committee heard and accepted the advice of the Legal Adviser. She cited the cases of *Roylance v GMC (No.2) [2000] 1 AC 311,* and *Calhaem v GMC [2007] EWHC 2606 (Admin)* drawing the Committee's attention to the need for a serious departure from the standards required of an Optometrist, for a finding of misconduct. The Legal Adviser also cited the case of *Nandi v GMC [2004] EWHC 2317 (Admin)*, which considered what was meant by the word 'serious' (as referenced in the case of *Roylance),* where it was said:

    'The adjective serious must be given its proper weight and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners. It is of course possible for negligent conduct to amount to serious professional misconduct, but the negligence must be to a high degree.'

97. In relation to cumulation, the Legal Adviser cited the cases of *Schodlock v GMC [2015] EWCA Civ 769* and *Rimmer v GDC [2011] EWHC 348*, and advised that it was permissible to consider a series of mutually reinforcing similar errors together and conclude that they may amount to misconduct.

98. The Committee understood that any findings of misconduct are matters for the independent judgement of the Committee. It had regard to the GOC standards in place at the time, namely the Standards of Practice for Optometrists and Dispensing Opticians. The Committee also had regard to the relevant sections of

the GOC's Hearings and Indicative Sanctions Guidance (November 2021) (Hearings Guidance). The Committee understood that not every breach of the standards would necessarily amount to misconduct.

99. As part of its assessment of whether the facts found proved amounted to misconduct, the Committee first considered the context in which they had arisen. The Committee bore in mind that the period in which these errors had occurred was during lockdown, the "red phase" of the pandemic. This was a time when practitioners' working practices were severely disrupted in order to reduce contact time with patients so as to minimise the risk of transmission of the Covid-19 virus. The College of Optometrists had issued guidance modifying the requirements of a sight test, requiring some previously standard tests only to be performed when clinically necessary, in order to reduce contact time with patients. In the Committee's judgement, it was appropriate to consider the Registrant's failings in that context.

Particular 4

100. In relation to particulars 4.a and 4.b, the Committee considered whether the Registrant's failures were so serious as to amount to misconduct. The Committee noted that assessing visual fields would, ordinarily under the Guidance, have been conducted at a routine sight test, if the practitioner had felt it was clinically appropriate. Under the modified sight test Guidance during the pandemic, the Committee noted that the advice for testing visual fields was modified to:

> *As clinically necessary. Consider omitting if discs and IOP (intra ocular pressures) unchanged since previous visits, and no other relevant signs/symptoms.*

101. The Registrant explained that for the [redacted] practice, visual field testing was in limited use during this period of lockdown due to the increased risk of transmission of the virus and the need to allow 72 hours between each patient's use of the visual fields screening machine.

102. The Registrant accepted that a visual fields test was required given the presenting symptoms of Patient 107 of headaches associated with vomiting and that there should have been a referral to the patient's GP. By way of explanation for his failures, he said that from the slit lamp examination and OCT scan the eyes appeared healthy and he had not believed Patient 107 met the threshold for a written referral at the time. From his entries in the patient records, the Registrant explained that he had interpreted the headaches as being more often at the end of the day and so could be attributed to visual stress made worse by poor lighting at night and the lack of a near vision correction at the time. Consequently, he advised Patient 107 that he needed a new prescription for near vision and advised

the patient to return immediately if he had any problems. The Registrant noted that Patient 107 returned to the store on 6 June 2020 to collect his spectacles and did not report any further problems.

103. The Committee considered the steps that the Registrant had conducted during the sight test. It noted from the records that he had performed a retinal examination using a Volk lens, OCT imaging and had undertaken many of the steps relevant to a routine eye examination. He had also advised the patient to return immediately if there were any problems.

104. The Committee considered the expert evidence. It noted that both experts were of the opinion that the Registrant's failings fell far below the standards expected. Dr Tromans explained that visual field testing is used to detect vision loss caused by damage to the visual pathway, for example, brain tumour, stroke or damage to the optic nerve in diseases such as glaucoma. Her reasoning for concluding the Registrant's failures fell far below the required standard was that there was a risk of serious harm to the patient. Dr Kwartz opined:

> *To his credit, [the Registrant] recorded sufficient information to establish that the patient clearly did not have swollen optic discs (papilloedema), which can be a manifestation of an intra-cranial mass. However, this finding did not negate the requirement for a visual field test…*
>
> *Whilst the risk of Patient 107 having an underlying brain tumour was very low and an apparent ocular cause for the symptoms had been found, I agree with Dr Tromans that in not performing a visual field test, [the Registrant's] standard fell far below the required level. My reasoning is that, albeit the risk was very small, there was a chance of harm to the patient.*

105. The Committee did not disagree with the opinions of the experts that the Registrant's failures fell far below the expected standards. However, the Committee did not consider that this was a case where the Registrant had displayed a high degree of negligence. In the Committee's judgement, the Registrant had followed a reasoned clinical pathway and made a clinical judgement not to perform visual field testing at the time of the pandemic and not to refer, which he accepted with hindsight, had been wrong. The Committee considered that the risk of harm identified by both experts (a very small risk in the opinion of Dr Kwartz) had been further reduced by the advice given to the patient to return immediately if there were any problems, and the Committee could see this advice recorded on the patient records: Advice given "*If prob return immed*".

106. The Committee further noted that there had been no evidence of actual harm to Patient 107, as he had returned to the practice on 6 June 2020, some 7 days after

the appointment, to collect his near vision spectacles and the patient had not reported any issues.

107. In all the circumstances, the Committee was not satisfied that the Registrant's failures in respect of particular 4 had been so serious as to amount to misconduct.

Particular 5

108. In relation to particular 5a, the Committee considered whether the Registrant's failures were so serious as to amount to misconduct. Patient 84's presenting symptoms, as recorded in the patient records were an onset of floaters over the previous two weeks in the right eye, and they were intermittent.

109. The Committee considered the College of Optometrists' Guidance in relation to 'Examining patients who present with flashes and floaters', which states at paragraph A203:

> *If you suspect a retinal break or tear you should, as a minimum:…*
>
> *c. perform a dilated fundal examination, using an indirect viewing technique…*

The Committee also considered the Covid pandemic modified sight test guidance. Under dilation it stated: "*As clinically necessary".*

110. The Registrant accepted that on the basis of a history of a new onset of floaters, dilation should have been carried out. He explained that he had been conflicted about the clinical relevance of dilating, and he had made the decision not to dilate under the pressure of reducing patient contact with himself and others during the pandemic.

111. The Committee considered the expert evidence. It noted that both experts were of the opinion that the Registrant's failings fell far below the standards expected. Dr Tromans explained that a dilated examination was necessary to adequately review the anterior vitreous and to rule out any breaks in the peripheral retina. Her reasoning for concluding the Registrant's failures fell far below the required standard was that there was a risk of serious harm to the patient. Dr Kwartz opined:

> *I agree with [Dr Tromans] in that in not performing pupil dilation, [the Registrant's] actions fell far below those of a reasonably competent optometrist in that he did not perform an appropriate assessment (dilated, fundus examination, and a check for Shafer's sign following pupil dilation) in a patient with symptoms suggestive of retinal detachment. There was, consequently, a risk of harm to the patient in that a peripheral retinal, tear or detachment was not detected.*

112. The Committee agreed with the opinions of both experts that the Registrant's failures fell far below the expected standards. In the Committee's judgement, the patient presented with what might be described as "red flag" symptoms which required further investigation. The Registrant had failed to perform sufficient investigation in order to rule out retinal detachment, the potential consequences of which could be loss of sight for the patient. The Committee was of the view that the Registrant's failure had resulted in a significant risk of serious harm to the patient and the advice to return if there were further problems was insufficient to reduce this risk. The Committee was further of the view that the prevailing concerns about reducing contact time with the patient due to the pandemic, were not a barrier to the Registrant's duty to complete a full examination of Patient 84's eyes, which should have included pupil dilation.

113. In all the circumstances, the Committee concluded that the Registrant's failure was so serious as to amount to misconduct.

Particular 2

114. In relation to particular 2.a, the Committee considered that these were record keeping failures of a similar type, namely a failure to record performing a cover test, which could appropriately be considered together. The Committee had regard to Standard 8 of the GOC Standards. The Committee bore in mind that over a two-week period in the lockdown phase of the pandemic, there were five instances of such a failure.

115. The Committee noted that both experts considered that individually, a single instance of failure to record performing a cover test did not fall far below the required standard, although Dr Tromans considered that the cumulative effect of multiple record keeping failures in respect of multiple patients fell far below the required standards.

116. The Committee considered that for three out of the five patients, those presenting with double vision, the Registrant had recorded a significant amount of clinical information relevant to the sight test.

117. The Committee accepted the Registrant's evidence that his usual method of recording information had been disrupted during that early stage of lockdown. His approach of grouping information after performing relevant tests and then entering the information into the patient records afterwards had resulted in patchy and suboptimal record keeping on his part. However, the Committee did not consider that he was disregarding his responsibilities in respect of record keeping, rather he had not been careful enough to ensure that every relevant element of the sight test was recorded for those five patients.

118. In the circumstances of this case, the Committee did not consider that there was a significant risk of harm to patients in the cover test not being recorded, as the evidence was that this test would be routinely performed for these patients at each appointment. As such, the continuity of information was less significant than might otherwise be the case.

119. In all the circumstances, the Committee was not satisfied that the failures in record keeping in respect of recording the cover test were such that either individually or collectively, they were sufficiently serious as to amount to misconduct.

Particular 3

120. In relation to particular 3.a and 3.b, the Committee considered that these were two areas of record keeping failures in respect of one patient.

121. As for particular 2, the Committee accepted the Registrant's evidence that his usual method of recording information had been disrupted during that early stage of lockdown. His approach of grouping information after performing relevant tests and then entering the information into the patient records afterwards had resulted in patchy and suboptimal record keeping on his part. However, the Committee did not consider that he was disregarding his responsibilities in respect of record keeping, rather he had not been careful enough to ensure that every relevant element of the sight test was recorded for Patient 33.

122. The Committee considered the expert evidence. It noted that Dr Tromans' opinion was that multiple failings in respect of one patient fell far below the required standards. However, Dr Kwartz's opinion was:

> *If [the Registrant's] version of events is accepted, ie he performed the tests, but did not document the results, I consider that his standard fell below the required level, but not far below, as there was no risk of harm to the patient, but there was a disparity between his actions and those of a reasonably competent optometrist.*

123. The Committee preferred the evidence of Dr Kwartz on this point. It was of the view that the context of the pandemic with the disrupted routines for practitioners was relevant, and Dr Tromans did not appear to have factored that into her opinion.

124. In all the circumstances, the Committee was not satisfied that the failures in record keeping in respect of recording the cover test and the pupil reflex testing for Patient 33 were such that either individually or collectively, they were so serious as to amount to misconduct.

Findings regarding impairment

125. Ms Woods referred the Committee to the submissions previously set out in the GOC's skeleton argument, to the effect that the Registrant's fitness to practise is currently impaired by reason of his misconduct.

126. Mr Mumford submitted that the Registrant's fitness to practise is not currently impaired. He drew the Committee's attention to the Registrant's stage 2 bundle which included:

a) The Registrant's stage 2 witness statement, signed and dated 28 January 2025;

b) The transcript (not official) from [redacted] University of the Registrant's postgraduate Medical Retina course, successfully completed on 22 July 2022;

c) The Registrant's reflections of relevant CPD courses undertaken;

d) Audits of patient records for August 2021, September 2021 and October 2021;

e) A peer review audit of 20 randomly selected patient records between January and November 2024, specifically checking whether the clinical findings of cover test, pupils, and external and internal eye examinations were adequately recorded; and

f) Recent references from professional colleagues.

127. The Registrant also gave further oral evidence to the Committee.

128. The Committee heard and accepted the advice of the Legal Adviser. She advised the Committee to keep in mind the critically important public policy issues of: the need to protect patients and the collective need to maintain public confidence in the profession as well as declaring and upholding proper standards of conduct and behaviour. The Committee understood that in relation to impairment, what has to be determined is whether there is impairment of fitness to practise today and looking forward from today.

129. The Committee considered whether the misconduct was capable of remediation. The Committee acknowledged that the Registrant's misconduct had occurred nearly five years ago and related to a clinical failing in respect of one patient during the height of the pandemic. The Committee noted the observations in the Hearings Guidance, paragraph 16.1, which states that *"Certain types of misconduct (for example, cases involving clinical issues) may be more capable of being remedied than others)"*. Given that this was a clinical failing, the Committee was satisfied that the misconduct was capable of being remedied.

130. The Committee went on to consider whether the Registrant's misconduct had, in fact, been remedied. The Committee had regard to the Registrant's admission at the outset of the hearing and the references and testimonials of professional colleagues, which attested to a high level of clinical competence, professionalism and dedication to the profession. The Committee also bore in mind that there was no evidence before it of any further concerns regarding the Registrant's practice since the incident of misconduct in June 2020.

131. The Committee took into account the evidence of extensive relevant education and training which the Registrant had undertaken throughout the period since the misconduct. It was apparent to the Committee that he had consistently undertaken relevant training throughout the whole of that time. In particular it noted the [redacted] University postgraduate course entitled "Medical Retina", successfully completed in July 2022. The Registrant told the Committee that the 20 credits equated to around 250 hours of study and had included specific components relevant to detecting retinal detachment and the importance of dilation for identifying key clinical signs and symptoms.

132. The Registrant had also, since the misconduct, completed a CPD course on clinical decision making in July 2023 and participated in peer review discussions as well as undertaking an online peer review course in March 2024, organised by the College of Optometrists. The Committee noted that he had taken on roles within his employment as a professional facilitator for pre-registration trainees, in particular drawing on his own experiences to help develop and support their learning. In addition, in July 2024, the Registrant was appointed and completed induction as a Stage 1 assessor for the College of Optometrists, a role involving assessing pre-registration trainee competence. Whilst that role was on hold pending the outcome of the GOC proceedings, the Committee considered that the Registrant demonstrated a commitment to the profession as a whole and not just to his own practice.

133. Furthermore, the Committee considered that the Registrant had reflected deeply on all the areas of his practice where concerns had been raised, including the area in which misconduct had been found. It noted his regret at having done a disservice to his patients during the period of the allegations and his determination to learn from his misconduct and strive to continually improve his practice. The Committee considered that the Registrant had achieved a good level of insight, noting that he had not just accepted what had gone wrong, but had analysed why. He acknowledged that the pressure of reducing patient contact time during the pandemic should not have influenced his clinical judgement to the extent that it did and that the patient's health must remain the top priority. The Committee accepted the Registrant's assurance that:

I will, in the future, ensure that I base my clinical decisions solely on the potential risks to the patient's ocular health and not allow external pressures, such as reducing contact time, to affect my clinical decision-making.

134. In light of all of the information before it, in the Committee's judgement, the Registrant had attained a good level of insight into his failing during the pandemic. The GOC proceedings had clearly been a salutary lesson to him, as evidenced by the extensive practical steps he had taken to remedy his misconduct. He had undertaken relevant and regular education and training, and it was evident that he was applying this learning in his professional practice. In all the circumstances, the Committee concluded that the Registrant had remedied his misconduct. As a consequence, the Committee was satisfied that it was highly unlikely that the misconduct would be repeated.

135. The Committee also recognised the importance of considering the public interest. In this regard, the Committee bore in mind the Hearings Guidance at paragraph 16.4 which states:

> *When considering impairment of fitness to practice, the Committee must have regard to public interest considerations. In PSA v NMC (Grant) [2011] EWHC 927, the High Court said that, in deciding whether fitness to practise is impaired, the Committee should ask themselves,*
>
> > *"Not only whether the registrant continued to present a risk to members of the public, but whether the need to uphold proper professional standards and public confidence in the registrant and in the profession would be undermined if a finding of impairment of fitness to practise were not made in the circumstances of this case."*

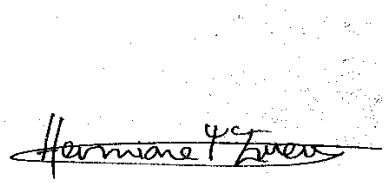
136. The Committee bore in mind that this was a single incident of misconduct which occurred nearly five years ago, during the difficult circumstances of the lockdown phase of the pandemic. Given the Committee's conclusion that the Registrant was highly unlikely to repeat the misconduct, it did not consider that he continued to present a risk to members of the public. In terms of maintaining public confidence and upholding standards, in the Committee's judgement, a fully informed member of the public, appraised of all the circumstances, would not have their confidence in the reputation of the profession undermined if a finding of current impairment were not made in this case. The Committee considered that a fully informed member of the public would understand the challenging circumstances of the pandemic; would recognise that the Registrant had since undertaken sincere and extensive steps to ensure there would be no repetition; and would take account of the highly unlikely risk of repetition.

137. Furthermore, given the Registrant's commitment to the profession in both providing high quality patient care and supporting pre-registration trainees, the Committee considered it was in the public interest to retain such Optometrists in the profession.

138. In all the circumstances, the Committee makes a formal declaration that the Registrant's fitness to practise is not currently impaired on the grounds of public protection or in the public interest.

139.

Chair of the Committee: Hermione McEwen

Signature  **Date: 30 January 2025**

Registrant: Kartik Bharadia

Signature Present via MS Teams **Date: 30 January 2025**

FURTHER INFORMATION
Transcript
A full transcript of the hearing will be made available for purchase in due course.
Appeal
Any appeal against an order of the Committee must be lodged with the relevant court within 28 days of the service of this notification. If no appeal is lodged, the order will take effect at the end of that period. The relevant court is shown at section 23G(4)(a)-(c) of the Opticians Act 1989 (as amended).
Professional Standards Authority
This decision will be reported to the Professional Standards Authority (PSA) under the provisions of section 29 of the NHS Reform and Healthcare Professions Act 2002. PSA may refer this case to the High Court of Justice in England and Wales, the Court of Session in Scotland or the High Court of Justice in Northern Ireland as appropriate if they decide that a decision has been insufficient to protect the public and/or should not have been made, and if they consider that referral is desirable for the protection of the public. Where a registrant can appeal against a decision, the Authority has 40 days beginning with the day which is the last day in which you can appeal. Where a registrant cannot appeal against the outcome of a hearing, the Authority's appeal period is 56 days beginning with the day in which notification of the decision was served on you. PSA will notify you promptly of a decision to refer. A letter will be sent by recorded delivery to your registered address (unless PSA has been notified by the GOC of a change of address). Further information about the PSA can be obtained from its website at www.professionalstandards.org.uk or by telephone on 020 7389 8030.
Effect of orders for suspension or erasure
To practise or carry on business as an optometrist or dispensing optician, to take or use a description which implies registration or entitlement to undertake any activity which the law restricts to a registered person, may amount to a criminal offence once an entry in the register has been suspended or erased.
Contact
If you require any further information, please contact the Council's Hearings Manager at 10 Old Bailey, London, EC4M 7NG or, by telephone, on 020 7580 3898.