BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(21)30

AND

ROB LAMONT (01-21557)

DETERMINATION OF A SUBSTANTIVE HEARING
11-13 JULY 2022

Committee Members:	Mr Graham White (Chair) Dr Jackie Alexander (Lay) Ms Danielle Ellis (Optometrist) Ms Denise Connor (Optometrist) Ms Victoria Smith (Lay)
Legal adviser:	Mr Paul Moulder
GOC Presenting Officer:	Ms Tope Adeyemi
Registrant present/represented:	Yes and represented
Registrant representative:	Mr David Claxton
Hearings Officer:	Mr Terence Yates
Facts found proved:	(1) to (6) inclusive proved by admission
Facts not found proved:	None
Misconduct:	Found
Impairment:	Not impaired
Warning:	3 years

Proof of service

1. The Registrant attended the hearing and was represented. No issue was taken with service of proceedings.

Proceedings

2. The hearing was conducted in accordance with The General Optical Council (Fitness to Practise) Rules Order of Council 2013 (SI 2013 No. 2537) ("the Rules").

ALLEGATION

That being a registered optometrist, the fitness to practise of Mr Rob Lamont is impaired by reason of misconduct, in that:

1) You failed to detect glaucoma on Patient A on the following dates:

    a. 30 August 2016; and/or
    b. 26 May 2018; and/or
    c. On or around 6 July 2019;

2) You failed to appropriately refer Patient A despite the appearance of the optic nerve heads suggesting the presence of glaucoma on the following dates:

    a. 30 August 2016; and/or
    b. 26 May 2018; and/or
    c. On or around 6 July 2019;

3) You failed to provide acceptable recommendations and management in light of Patient A's presenting symptoms following the examinations on:

    a. 30 August 2016; and/or
    b. 26 May 2018; and/or
    c. On or around 6 July 2019;

4) On 30 August 2016 you failed to maintain adequate patient records in that you did not record:

    a. Details of the fundus examination and findings; and/or
    b. appearance of the optic nerve; and/or
    c. appearance of blood vessels; and/or
    d. appearance of the macula; and/or
    e. measure of intraocular pressures; and/or
    f. Near Visual Acuity; and/or
    g. Details of lens changes; and/or
    h. Assessment of Visual fields; and/or

i. Details of advice and/or management.

5) On 26 May 2018 you failed to maintain adequate patient records in that you did not record:

a. Details of lens changes; and/or
b. The appearance on the optic nerve head; and/or
c. Appearance of the blood vessels; and/or
d. Appearance of the macula; and/or
e. Near Visual Acuity; and/or
f. Measure of intraocular pressures; and/or
g. Visual field assessment being performed; and/or
h. Details of advice and/or management.

6) On or around 6 July 2019 you failed to maintain adequate patient records in that you did not record:

a. Details of lens changes; and/or
b. Central Serous Retinopathy; and/or
c. Details of the fundus examination and findings; and/or
d. appearance of the optic nerve; and/or
e. appearance of blood vessels; and/or
f. appearance of macula; and/or
g. Tests conducted to assess ocular alignment; and/or
h. Measure of intraocular pressures; and/or
i. Near Visual Acuity; and/or
j. Visual field assessment being performed.

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

DETERMINATION

Admissions in relation to the particulars of the allegation

3. The Registrant admitted the factual particulars (1) to (6) (including the sub-particulars) of the allegation at the start of the hearing.

Background to the allegations

4. Ms Adeyemi told the Committee that the Registrant had been registered as an optometrist since 2005. She said that there were six factual allegations arising from his conduct. The Registrant had been working as a sole practitioner. The allegations arose from a referral in 2019 from Patient A.

5. Patient A had been a longstanding patient of the Registrant. He had consulted the Registrant in August 2016, complaining of a slight blurring in the sight of his right eye. He was examined by the Registrant and reassured that there was no need for immediate treatment. In May 2018, the vision in his right eye having deteriorated, Patient A attended the Registrant's practice again, but was again told there was no need for immediate treatment. In July 2019, Patient A was concerned that his vision in his right eye had further deteriorated and attended the Registrant's practice once more. On this occasion, the Registrant suggested that Patient A had Central Serous Retinopathy ("CSR") and referred him to Moorfields Eye Hospital ("Moorfields") via his GP, to confirm the diagnosis.

6. On attendance at Moorfields, a consultant ophthalmologist diagnosed Patient A with 'advanced glaucoma' of the right eye. On 04 March 2020, Patient A underwent a trabeculectomy of the right eye. Patient A states that he has suffered irreversible sight loss in that eye, as a result of the glaucoma and he will also, in time, need an operation on his left eye.

Findings in relation to the facts

7. At the commencement of the hearing, the Registrant admitted the facts of the allegation, numbered (1) to (6) in full. In accordance with paragraph 46(6) the Chair of the Committee announced the facts as having been proved.

Findings in relation to misconduct and impairment

8. The facts having been found by admission, the parties agreed that the Committee should next consider submissions on misconduct and impairment together.
9. The Committee was aware of its power to regulate its own proceedings, pursuant to Rule 46. The Committee considered that it was fair and appropriate to deal with these stages of the proceedings together.
10. The Committee heard submissions on behalf of the Council and the Registrant. It has accepted the advice of the Legal Adviser.

11. Ms Adeyemi opened the facts of the case to the Committee. She submitted that all the charges amounted to misconduct. She submitted that the case was of the utmost seriousness, since the Registrant had failed to recognise the possibility of glaucoma over several years. There was no evidence that he had detected it. He had not carried out the right tests, nor recorded the outcome of the tests that he had carried out.

12. Ms Adeyemi referred the Committee to the expert report of Person 1 26 October 2020. She referred the Committee to the opinion of Person 1 that the Registrant had made no record of Patient A's general health, occupation, nor previous family history. He had not recorded tests which he had undertaken, nor of his assessment of Patient A. He had not recorded intra-ocular pressures, nor his advice or management. She submitted that the expert report stated that, based on the records it was not reasonable for the Registrant to have missed the possibility of glaucoma in July 2019.

13. Ms Adeyemi submitted that Person 1 commented on the seriousness of the case in her reports.

14. Ms Adeyemi acknowledged that the Council had noted that the Registrant had expressed his regret about the situation of Patient A. He had invested at significant cost in his practice, obtaining new machinery. She submitted that, whilst the steps he had taken were very positive, there remained deficiencies in his insight. Ms Adeyemi submitted that it was an important step to understand what had gone wrong but that the Registrant had provided limited details of his understanding. Therefore, she said, the Committee could not be sure how he would recognise in the future that he needed to upgrade his equipment.

15. Ms Adeyemi referred to the Registrant's reflections on his improvements whilst subject to interim conditions of practice. She said that the Registrant had stated that he accepted that he had missed changes in Patient A's cup to disc ratios. Ms Adeyemi submitted that the Registrant's shortcomings were more extensive, embracing a failure to record a family history and a failure to assess visual fields. Ms Adeyemi submitted that the Registrant had not explored why he had failed to carry out the correct tests. On further questioning of the Registrant, Ms Adeyemi submitted that the Registrant still displayed a deficiency in understanding the 'root cause'.

16. Ms Adeyemi submitted that the Registrant had demonstrated insufficient understanding of the negative effect of his failings on Patient A, his family and the wider profession. Ms Adeyemi submitted that, not having sufficient insight, the Committee could not be satisfied that he would not repeat his past failings.

17. Ms Adeyemi also referred to the wider public interest and submitted that a finding of impairment was required in order to maintain public confidence and uphold standards.

18. Mr Claxton made submissions on behalf of the Registrant. The Committee had been provided with a Registrant's bundle of documents. This included the Registrant's witness statement, his reflections statement, details of the Registrant's Continuing Education and Training ("CET") and a reference from a fellow optometrist.

19. Mr Claxton told the Committee that the Registrant did not resist the Committee finding that there was misconduct in the case, but he challenged a finding of impairment. He submitted that the central issue for the Committee was whether the Registrant presented an ongoing risk to the public. He said that the matter of insight was one of the analytical tools which could be used, but it should not be elevated to the level of a test. Someone who was more insightful was less likely to repeat failings, but it was not the case that a person who lacked some insight would necessarily repeat misconduct.

20. Mr Claxton submitted that it was relevant that the Registrant had qualified as an optometrist in 1986. By the time of the events, he had been in practice for 30 years, without any adverse findings in relation to fitness to practise. He submitted that these events should be placed in the context of that history.

21. In addition, Mr Claxton submitted, there had been no further regulatory concerns since the events. He told the Committee that the Registrant had initially been subject to an interim suspension order, which was quashed by the High Court, and then interim conditions of practice including supervision. The interim order had then lapsed and not been further pursued by the Council. As a result, the Registrant had been in unrestricted practice since, for almost a year.

22. On the matter of a risk of repetition, Mr Claxton submitted that the fact that there was misdiagnosis in relation to one patient, but no equivalent failures alleged in relation to others, was highly relevant.

23. Mr Claxton submitted that nothing detracted from the seriousness of the consequences for Patient A. However, he said, the Registrant had taken the intra-ocular pressures ("IOPs") on one occasion. The IOPs were a principal indicator of glaucoma. Therefore, the Registrant had had some basis in clinical practice, to indicate the lack of presence of glaucoma. He had diagnosed CSR; it was not as if he had been presented with key factors and ignored them. However, Mr Claxton said that the expert evidence was not contested.

24. On the matter of insight, Mr Claxton submitted that there were a number of factors. First, the Registrant had made early admissions; those who contested allegations were less likely to have insight. Second, the Registrant provided a statement addressing the gravamen of his failings. Mr Claxton submitted that this was a focussed document dealing with the principal failings. Third, the Registrant had detailed significant changes in his practice: the extension of consultation times by 50%; the alteration of his records to incorporate a 'checklist'; the very substantial investment in technology. Fourthly, Mr Claxton submitted, there was the Registrant's CET, a period of supervised practice and the personal reference, which spoke highly of the Registrant.

25. Mr Claxton submitted that the measures spoke volumes about the Registrant's attitude, his learning and his change of approach. These matters, he submitted, tended to indicate against the risk of repetition.

26. Mr Claxton submitted that the Registrant's past misconduct was remediable and there was no real risk of repetition. He submitted that this was not a case where the wider public interest required a finding of impairment. He submitted that this was a 'clinical' case rather than a more serious case of misconduct. The primary consideration, he said, was the expectation of the public to be protected from risk, thereby upholding standards for the profession. Mr Claxton submitted that it was appropriate to take an objective view of the gravity of the Registrant's failings.

27. The Committee asked for and was provided with a copy of the Registrant's supervisor's report on his interim condition. This stated the supervisor's view that his management of suspect glaucoma is appropriate. The supervisor also commented positively on the Registrant's progress in improving his record-keeping, referring to his most recent records as a "*significant improvement*", as well as changes to his practice, his equipment and his use of it, "*and particularly a more methodical investigation of signs which may indicate glaucoma".*

28. The Registrant provided a witness statement for the Committee. He stated that he now had a pachymeter which measured corneal thickness and assisted in ensuring more

accurate pressures were taken. He had also invested in new visual fields equipment and upgraded the machines that were available two years ago.

29. The Registrant also stated that the patient records which he now uses are a significant improvement on those in use at the time of the events. He now used a system which relied on both digital images and handwritten notes, the combination of which forced him to examine all the images with great care, thus improving assessment. He stated that he should have reviewed the comparison between the 2016, 2018 and 2019 images, which would have allowed assessment of cumulative changes. He has now extended appointment times from 30 to 45 minutes and reviews previous scans before each new one.

30. In his reflections, the Registrant stated that he thought that the failure with Patient A was an isolated case but he had made many changes; he described his new ways of practising in detail.

31. The Registrant gave evidence to the Committee, in order to respond to its questions. He told the Committee that he had measured Patient A's IOPs in some of the consultations. He had relied on information which he had obtained from the previous consultations.

32. The Registrant said that he admitted failings. He said that missing the field test was 'basic' and a major oversight. He said that he had relied on the digital image and had not written things down because he relied on the image. He accepted that it was a failure not to do IOPs in the 2019 appointment.

33. The Registrant said that he did routinely ask patients about family history. He now made specific record entries in this regard. He recalled that Patient A had previously consistently told him that there was no relevant family history.

34. The Registrant said that he now ensured that he had more time in a consultation to make greater comparison of the information. He had been engaging in CET courses both for glaucoma and his general education. He attended meetings with other optometrists at a local hospital, in order to discuss cases.

35. The Registrant expressed his regret over the position of Patient A. He said that he had known and liked Patient A and had known about his retirement plans. He felt dreadful about the situation. He said that, in the 2018 examination, the IOPs had still appeared 'normal'. He had recorded family history simply as '-' to indicate 'normal'. His new record cards now prompt him with specific questions to ask on glaucoma and diabetes.

36. The Registrant confirmed that he had altered his criteria for carrying out IOPs in patients in the future. He said that he recognised that the public, learning of the events, would be concerned about a situation where something had been missed. He said that the public could be reassured by the steps that he had taken in response to events, the regulation process and the oversight by the regulator.

37. The Committee heard and accepted the advice of the Legal Adviser. He advised the Committee that it should first determine whether the facts found proved amounted to misconduct, as a statutory ground. It had then to determine whether any misconduct found demonstrated that the Registrant's fitness to practise is currently impaired. Both matters were for the Committee's judgement, not involving a burden of proof. The concessions on misconduct could be taken into account, but the matter was for the Committee to determine.

38. The Legal Adviser advised the Committee that, to amount to misconduct, as a statutory ground, it had to consider that there had been serious professional misconduct. This had

been variously described by the courts, using such terms as 'deplorable' conduct, but the seriousness was for the Committee to decide. The standards of the profession and the expert report were relevant to its consideration.

39. As for impairment, the Legal Adviser advised the Committee that it should consider both whether the past misconduct was 'remediable', whether it had been remedied and whether it was 'highly unlikely' to be repeated. He advised the Committee that, alongside those issues, impairment may be found where the public interest demands it. This might occur where there had been a breach of a fundamental tenet which went to the heart of the relationship between the professional and the patient, so that a finding was necessary in the interests of maintaining public confidence in the profession.

40. The Committee first considered whether the admitted facts amounted to misconduct, which was serious professional misconduct. It took into account the evidence bundles from both parties, including the expert reports, the supervisor's report and the oral testimony from the Registrant himself. It also considered the oral submissions of the Council and on behalf of the Registrant.

41. The Committee noted that there was no issue taken by the Registrant with the evidence in the expert report of Person 1. Person 1 had stated in her report, on the global issue of the failings, that *"This misdiagnosis is exceptional and has had an impact on patient safety for it has led to irreversible damage to Patient A's sight with prospective further deterioration in the future and possible blDindness in the right eye".*

42. The Committee noted that, with regard to the standards, and the eye examination in July 2019, Person 1 was of the opinion that the Registrant's practice had *'fallen both below and far below the standard of a reasonably competent optometrist'.* Person 1 stated that this was because of a failure to perform and record findings of an external and internal examination of the eye, such as CSR, appearance of the optic nerve, blood vessels and macula. There had also been a failure to measure the IOPs and failure to assess visual fields in a patient "at risk" of glaucoma. There had also been a failure to appropriately refer a patient whose optic nerve head findings are suggestive of glaucoma.

43. When Person 1 had been asked whether glaucoma had been present at the time of each appointment, she stated that, in August 2016, *"the optic nerve head appearance in both eyes is suspicious and suggestive of glaucoma".* In relation to the May 2018 appointment, she stated that IOPs were noted to be *"on the upper end of normal range"* and there was no record of visual field assessment being performed. Person 1 stated that *"Patient A's symptoms could be suggestive of glaucoma and would require further investigation".*

44. In relation to the July 2019 appointment, Person 1 stated that *"Patient A has a positive history of glaucoma as noted by the consultant ophthalmologist though this is not noted in the optometric record for this visit".* She stated that based on this, Patient A was in a higher than average risk group for primary open angle glaucoma. She went on *"Based on the fundus images obtained on this date, a reasonably competent optometrist would have been able to identify the highly suspicious appearance of optic nerve head that is suggestive of glaucoma…."."* Based on the records provided, Person 1 said that it was not reasonable for the Registrant to have missed the presence of glaucoma in August 2016, it was not possible to comment for May 2018, but it was not a reasonable omission, based on the records for July 2019. She gave her opinion that the Registrant had not completed a full assessment of Patient A on each of the appointments in 2016, 2018 and 2019.

45. In her addendum report, dated 29 June 2021, Person 1 gave her opinion that, in relation to each of the appointments, there were elements in which the Registrant had fallen far below the standard of a reasonably competent optometrist.

46. The Committee noted that there was no dispute with regard to the content of Person 1 report. It bore in mind that, to amount to misconduct, it had to be satisfied that the conduct amounted to serious professional misconduct.

47. The Committee accepted the expert evidence of Person 1. It noted that the Registrant had admitted the failure to detect glaucoma on three dates, and that Person 1 had opined that there had been suggestions of the same. In the case of each appointment, Person 1 opinion was that the failure to refer Patient A fell 'seriously below' the standard, as did the failure to perform and record a proper external and internal examination of the eye.

48. The Committee considered that the following professional standards from the Code of Conduct were engaged:

    - *Standard 5: Keep your knowledge and skills up to date*
    - *Standard 5.3: Be aware of current good practice, taking into account relevant developments in clinical research, and apply this to the care you provide.*
    - *Standard 6.2: Be able to identify when you need to refer a patient in the interests of the patient's health and safety, and make appropriate referrals.*
    - *Standard 7.1: Conduct an adequate assessment for the purposes of the optical consultation, including where necessary any relevant medical, family and social history of the patient. This may include current symptoms, personal beliefs or cultural factors.*
    - *Standard 7. 2: Provide or arrange any further examinations, advice, investigations or treatment if required for your patient. This should be done in a timescale that does not compromise patient safety and care.*
    - *Standard 8.1: Maintain clear, legible and contemporaneous patient records which are accessible for all those involved in the patient's care.*
    - *Standard 17: Do not damage the reputation of your profession through your conduct.*
    - *Standard 17.1: Ensure your conduct, whether or not connected to your professional practice, does not damage public confidence in you or your profession.*

49. The Committee considered that there were repeated failures over the period of 3 years, in relation to a serious and developing eye condition in Patient A's right eye. The Committee found that these were significant departures from what had been expected of the Registrant in the circumstances. The failures in addition had allowed a position where Patient A's eyesight had been seriously harmed.

50. The Committee concluded that, in respect of each of the particulars (1) to (6) inclusive of the allegation, the Registrant's conduct amounted to serious professional misconduct which had occurred in the course of the Registrant's clinical practice.

51. The Committee found that the admitted facts amount to misconduct.

Findings regarding impairment

52. The Committee next considered whether, based on its findings of misconduct, this demonstrated that the Registrant's fitness to practise is currently impaired. It took into account the submissions from the Council and on behalf of the Registrant, together with all the evidence provided, both oral and documentary.

53. The Committee first looked at the risk that the Registrant might repeat his past misconduct. It considered that the clinical failings in this case were potentially remediable, although there had been serious consequences for Patient A.

54. The Committee heard directly from the Registrant and heard him expand on his insight and explain further the remediation which he had undertaken to improve his practice. It found him to be a genuine and credible witness and accepted his evidence. The Committee noted the Registrant's expressions of regret towards Patient A and believe that they were genuinely given and heartfelt. It accepted that the Registrant realised the severity of the outcome for Patient A which had arisen due to his errors.

55. The Committee took into account the extensive investment that the Registrant has undertaken in his practice, both financially and in altering his attitude and approach. He has updated the practice equipment and importantly has instituted back-up procedures and proformas which, the Committee accepted, should support an improvement in practice and recording, and which reduces the risk of repetition.

56. The Committee felt that it had been very useful for it to have heard directly from the Registrant, on his reaction to the events and the steps he had taken to improve his practice. It also took into account the positive personal reference provided by another optometrist who has known the Registrant for a number of years and has also been a patient of the Registrant's.

57. The Committee accepted the submission that the Registrant's failings, albeit serious, had to be placed in the context of a long career in the profession and that it had been informed of no other regulatory concerns or findings having been made against him. In addition, the Registrant had been practising both subject to supervision under conditions of practice and later without restriction for a considerable period, again without consequence.

58. The Committee considered that there was no evidence of any attitudinal issues on the part of the Registrant. It appeared that, due to the weaknesses in his procedures for testing and recording his consultations with Patient A, he had seriously erred in failing to select appropriate tests and not recording data, which had led him to fail to advert to the developing condition.

59. The Committee did consider that the Registrant had developed sufficient insight. He has reflected upon the misconduct, expressed regret and taken steps to update his procedures appropriately. For a period, his practice has been subject to supervision. The Committee did not accept the submission that his inability to explain with precision how he had fallen into error demonstrated a fatal lack of insight, or presented a real risk of repetition.

60. The Committee also noted that the Registrant has maintained his CET requirements including peer review events at a local hospital with other optometrists and being part of a post-cataract scheme which has improved his relationship with a local hospital.

61. The Committee considered that there had been a series of serious failings with serious consequences for Patient A. However, it considered that the Registrant has appropriately reflected on his past misconduct and has taken sufficient steps to remedy the past misconduct and to put in place measures to minimise the risk of recurrence. The Committee concluded that it was highly unlikely that he would repeat these mistakes again.

62. The Committee took into account that, despite attempts at remediation, there are cases where the failings are so serious, in terms of a breach of 'fundamental tenets' of the profession that the public would demand a finding of impairment. As the Committee had been advised, in the case of *CHRE v NMC & Grant [2011] EWHC 927 (Admin)* the Court had referred to the judgment in *Yeong v GMC [2009] 1923 (Admin)* that in such a case, steps to remediate misconduct may be of less relevance. However, the Committee noted from the judgment in *Yeong* as cited in *Grant* the court specifically drew a distinction between that case and 'clinical' cases.

63. The Committee considered that, in judging the issue of the wider public interest, in terms of public confidence and/or professional standards in this case, it was still relevant for the Committee to take into account the steps that the Registrant has taken to try to ensure that there will be no repetition of the past misconduct.

64. The Committee bore in mind its conclusions on the matter of remediation and the risk of repetition. The Committee took the view that the Registrant's failings approached but fell short of the threshold for current impairment. The Committee concluded that in the Registrant's case the maintenance of public confidence and or professional standards did not require a finding of current impairment.

65. The Committee found that the fitness of the Registrant to practise as an optometrist is not impaired.

Declaration

66. The Committee makes a formal declaration that the Registrant's fitness to practise is not impaired because it has determined that the past misconduct is highly unlikely to be repeated. Further, a finding of impairment in the wider public interest is not required in all the circumstances.

Warning

67. The Committee heard submissions from Ms Adeyemi on behalf of the Council and from Mr Claxton on behalf of the Registrant. It accepted the advice of the Legal Adviser.

68. Ms Adeyemi submitted that the Committee had noted that the Registrant had a previously good history, had shown appropriate remorse, had engaged in the regulatory process and had made improvements to his practice at significant cost.

69. Ms Adeyemi submitted that the Committee had also found conduct which approached, but fell short, of the threshold for current impairment. It had found that there had been numerous breaches of the Standards of Practice. Ms Adeyemi submitted that a Warning is considered necessary in the public interest.

70. Mr Claxton did not make submissions but confirmed that he did not seek to dissuade the Committee from issuing a Warning.

71. The Legal Adviser advised the Committee that it had power pursuant to section 13F(5) of the Opticians Act 1989 to issue a Warning. It should be guided by the Council's Hearings and Indicative Sanctions Guidance ("ISG") and provide reasons for either issuing or not issuing a Warning. The Committee should specify the expiry of any Warning, with reasons.

72. The Committee considered the factors set out in the ISG. It noted that there had been appropriate expressions of regret by the Registrant. He had a long previous good history. He had taken appropriate rehabilitative steps and had provided an appropriate reference. The clinical failings in the allegation had related to a single patient.

73. The Committee also considered, however, that there had been serious breaches of several of the Standards of Practice, real harm had resulted to Patient A and the misconduct had approached the threshold for current impairment. In all the circumstances, the Committee decided that it was necessary to issue the Registrant a Warning as to his future conduct.

74. The Committee decided that the Warning should be kept on the Register for a period of 3 years, so expiring on 12 July 2025. It considers that this period is to mark the seriousness of the concerns and allow time for the Council to be satisfied that there is no repetition of any misconduct.

75. The Committee settled the wording of the Warning as follows:

"Mr Lamont

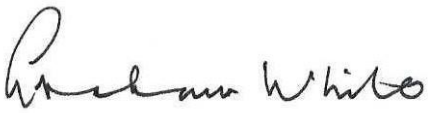
The Committee found that you had, on a number of occasions, failed to detect the possibility of glaucoma in your patient, failed to make appropriate referrals, or provide appropriate treatment and advice. It also found deficiencies in your record-keeping.

The Committee found that these matters amounted to misconduct. The matters found proved amounted to serious breaches of the Standards of Practice for Optometrists and Dispensing Opticians("Standards of Practice"). However, as a result of the significant remediation that you had put in place, the Committee decided that your fitness to practise is not currently impaired. The Committee concluded that your misconduct approached but fell short of the threshold for current impairment. However, the concerns were sufficiently serious that any repetition is likely to result in a finding of impairment and as a result the Committee feels that it is necessary to issue you with this formal Warning.

The Committee warns you that the misconduct found proved did not meet the standards required of a professional optometrist. The required standards are set out in the Standards of Practice and associated guidance issued by the General Optical Council. The misconduct found proved caused serious harm to a member of the public and had the potential to affect public confidence in the profession; it brings the profession into disrepute and must not be repeated. Any further matters brought to the attention of the regulator may result in a more serious outcome.

This Warning will expire on 12 July 2025."

Chair of the Committee: Graham White

Signature  **Date: 13 July 2022**

Registrant: Rob Lamont

Signature present via video **Date: 13 July 2022**

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 10 Old Bailey, London, EC4M 7NG or, by telephone, on 020 7580 3898.