BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(24)40

AND

RAVI BHOJWANI (01-18000)

DETERMINATION OF A SUBSTANTIVE REVIEW
31 JULY 2026

Committee Members:	Gerry Wareham (Chair) Audrey McFarlane (Lay) Ian Hanson (Lay) Caroline Clark (Optometrist) Louise Gow (Optometrist)
Legal adviser:	Kelly Thomas
GOC Presenting Officer:	Leonie Hinds
Registrant:	Present and unrepresented
Hearings Officer:	Terence Yates
Outcome:	Erasure order

ALLEGATION (as amended)

The Council alleges that you, Ravi Bhojwani (01-18000), a registered optometrist whilst employed at [redacted] *Eyecare Limited:*

1. *On or around 1 September 2022 you failed to make a referral in respect of suspected glaucoma for Patient B when it was indicated to do due to the appearance of the optic discs.*
2. *On or around 14 August 2022 you failed to*
   a. *assess, adequately or at all, Patient C's maculas in that you did not:*
      i. *undertake an OCT scan; and/or*
      ii. *use an Amsler chart;*
   b. *provide any, or any adequate, lifestyle advice to Patient C;*
   c. *provide any, or any adequate, safety netting advice to Patient C;*
   d. *measure Patient C's visual acuity;*
   e. *record Patient C's visual acuity;*
3. *On or around 29 July 2022 you failed:*
   a. *to identify vascular changes present in Patient D's eyes;*
   b. *to refer Patient D to his General Practitioner for a blood pressure assessment.*
4. *On or around 24 June 2022 you failed to obtain an adequate history in relation to Patient F's diabetes in that you did not establish:*
   a. *how long Patient F had been diagnosed with diabetes;*
   b. *how well it was controlled;*
   c. *whether Patient F was attending diabetic screening appointments.*
5. *On or around 20 May 2022 you failed to:*
   a. *retest Patient I's intra ocular pressures; and/or*
   b. *to make a referral in respect of Patient I's intra ocular pressure results when it was indicated to do so;*
   c. *advise Patient I of the examination findings consistent with age related macula disease;*
   d. *provide any, or any adequate, safety netting advice to Patient I;*
6. *On or around 21 May 2022 you failed to:*
   a. *identify a haemorrhage at Patient K's left optic disc;*
   b. *make a referral in respect of the haemorrhage at Patient K's left optic disc when it was indicated to do so;*

7. *On or around 19 March 2022 you failed to:*
    a. *advise Patient L of the examination findings of vitreo-retinal traction in their right eye;*
    b. *provide any, or any adequate, safety netting advice to Patient L regarding their vitreo – retinal traction;*
    c. *carry out a central visual field test on Patient L;*
    d. *make a referral for suspected glaucoma in respect of the appearance of Patient L's left optic disc;*
8. *On or around 14 January 2022 whilst employed at* [redacted] *Visionplus Limited you:*
    a. *failed to carry out a dilated fundus examination of Patient M;*
    b. *did not check for tobacco dust (Shafer's sign) following pupil dilation;*
    c. *did not give safety- netting advice for symptoms suggestive of retinal detachment;*
    d. *failed to consider and / or record consideration of retinal detachment as a possible cause of Patient M's symptoms.*

And as a result of the matters set out above, your fitness to practise is impaired by reason of misconduct.

DETERMINATION

Preliminary issues

1. One member of the Fitness to Practise Committee, Ms Gow, an Optometrist member, raised a potential conflict. Ms Gow noticed that Professor Bruce Evans had provided clinical guidance for this matter. Ms Gow outlined that she had worked in Professor Evans' private optometry practice for 25 years and considers him as a friend.
2. Ms Hinds on behalf of the General Optical Council (*"the Council"*) raised no objections.
3. The Registrant raised no objections.
4. The Legal Adviser advised the Committee to consider the principles in the case *Suleman* and also those in *Porter v Magill [2002] 2 AC 357*, as to '*whether the fair minded and informed observer, having considered the facts, would conclude that there was a real possibility that the tribunal was biased. And…the appearance of independence and impartiality is just as important as the question of whether these qualities exist in fact. Justice must not only be done but be seen to be done'.* The Legal Adviser also referred to the case of *Locabail (UK) Ltd v Bayfield Properties [2000] IRLR 96* in advising the Committee that the test is objective, i.e. would a

reasonable independent observer, in full possession of the facts, consider that there was a real possibility of bias, arising from the relationship between Ms Gow and Professor Evans.

5. The Committee noted that there were no objections from either party, whilst recognising that the Registrant was unrepresented. It therefore considered of its own motion whether the relationship between Ms Gow and Professor Evans might give rise to an appearance of bias. The Committee took into account that this was a substantive review hearing and that its role was confined to determining impairment and, if necessary, sanction. The factual findings made by the previous Committee, including those relating to Professor Evans' evidence, were binding upon it and were not open to reconsideration. In those circumstances, the Committee was satisfied that a fair-minded and informed observer, in possession of all the relevant facts, would not conclude that there was a real possibility of bias. Accordingly, the Committee was satisfied that there was no proper basis for Ms Gow's recusal and that it was appropriate for her to continue to sit as a member of the Committee for the remainder of the hearing.

Background

6. The Registrant has been a registered Optometrist since April 2000. Between March 2021 and March 2022, he worked at Specsavers in [redacted] ([redacted] Vision Plus Limited) and from March 2022 to September 2022, the Registrant worked at [redacted] Eyecare Limited in [redacted].

7. [redacted] Eyecare identified issues with the Registrant's clinical abilities in obtaining adequate history of patients, performing accurate refractions, performing adequate posterior segment examinations and in the assessment of retinal photographs and Optical Coherence Tomography (OCT) images. There was an internal investigation which identified concerns with Patients B, C, D, F, I, K and L between 19 March 2022 and 1 September 2022. The Registrant's employment was terminated on 28 September 2022, and a referral was made to the Council via a letter dated 4 October 2022.

8. On 17 October 2022, the Council received a second referral raising concerns about an examination carried out on Patient M on 14 January 2022 whilst the Registrant was working at Specsavers in [redacted]. Patient M had reported flashes, floaters and a shadow over his left eye. He said the Registrant advised him that "[his] eyes were fine and [he] had nothing to worry about" and he informed Patient M that his next eye examination was due in two years' time.

9. On 6 June 2022, Patient M experienced a sudden loss of sight in his left eye and attended [redacted] Specsavers. He was advised by the receptionist to attend the hospital where he was diagnosed with macula-off and total retinal detachment in his left eye.

10. At the substantive hearing between 7-16 May 2025, and 20-21 November 2025, the Registrant admitted particulars 1, 2(e), 5, 6, 7(c) and 8 and the Committee found those facts proved.
11. The Committee found that there was no case to answer in relation to particulars 2(b), 4(a) and 4(b).
12. The Committee found particulars 2(a)(i), 2(a)(ii), 2(c) and 2(d) not proved.
13. The Committee found particulars 3(a), 3(b), 4(c), 7(a), 7(b) and 7(d) proved.
14. The substantive Committee found serious misconduct in relation to particulars 1, 5(a), 5(b), 6(a), 6(b), 7(a), 7(b), 7(c), 7(d), 8(a), 8(b), 8(c) and 8(d).
15. At the impairment stage, the substantive Committee determined that a finding of impairment was necessary for public protection and public interest grounds.
16. In relation to public protection, the previous Committee found that, although the Registrant had made some admissions, accepted that his practice was not "up to scratch," and had apologised to Patient M through his Counsel, his insight remained limited. The previous Committee was not satisfied that the misconduct had been remedied: there was no evidence of reflection or developed insight into the misconduct, how to address it, or its impact on the profession and public confidence. Given that the Registrant had not practised since 2022, had undertaken no recent targeted remediation, and remained largely in the same position as when the misconduct occurred, the previous Committee concluded that the risk of repetition on return to practise was high.
17. In relation to public interest, the substantive Committee found that the Registrant's previous misconduct had placed patients at unwarranted risk of harm, caused actual harm to Patient M, brought the profession into disrepute, and breached fundamental tenets of optometric practice, including duties relating to referral, adequate assessment, further examination and investigation, and record keeping. The Committee considered that these limbs of the *CHRE v Grant 2011 EWHC 927* ("*Grant")* test were also engaged with regard to being 'liable in the future to so act,' given the high risk of repetition found.
18. At the sanction stage, the substantive Committee determined that the following aggravating factors were present:
    - The breadth of misconduct, in that there was a range of clinical deficiencies and breaches of the standards involving a number of patients, forming a pattern of repeated failings;
    - In respect of Patient M, there had been actual harm in that they had lost sight in their left eye and therefore there was a high risk of harm to other patients;
    - The Registrant had demonstrated only limited insight and remediation. He had let his CPD requirements lapse, as he had not yet completed any CPD in that current cycle and there remained a high risk of repetition.

19. The previous Committee considered the following to be mitigating factors:

    - The Registrant made admissions to some particulars of the Allegation at the outset of the hearing and in his earlier oral evidence accepted that his practice was 'not up to scratch;'
    - The Registrant, through his Counsel, made a heartfelt apology to Patient M when he gave evidence;
    - The Registrant engaged with the GOC and the regulatory process

20. The previous Committee had determined that a suspension from practice of 9 months was necessary to mark the seriousness of the misconduct.

21. The previous Committee indicated that a Reviewing Committee may be assisted by the following:

    - A detailed reflective statement demonstrating reflections and insight into the impact of the misconduct upon the profession and upon public confidence in the profession;
    - A Personal Development Plan that takes account of the clinical shortcomings identified in this case;
    - Any evidence of further remediation addressing the clinical failings (particularly in areas of glaucoma and other ocular pathology) such as attendance at training or CPD, formal certificates and/or self-directed learning, shadowing or observing specialist clinics.

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Impairment

22. Ms Hinds, on behalf of the Council, submitted that the burden is on the Registrant to demonstrate that his fitness to practise is no longer impaired. The Council submitted that in the absence of evidence addressing meaningful remediation, the public protection and public interest concerns remain and therefore invited the Committee to consider whether the Registrant's fitness to practise remains impaired.

23. The Registrant attended and was not represented. The Registrant did not give evidence but relied on his written submissions as follows: *"I Ravi Bhojwani, do not want to remain on the GOC Optical Register. I did not renew my GOC registration in 2026. I have not been able to find a supervisor. I have not completed my CET requirements. I have found the investigation very stressful and hope that my submission will bring a close to this matter. I do not want to practice as an Optometrist. I intend to attend my hearing however I do not have legal representation."* The Registrant also submitted a document dated 8 December 2025 which confirms his removal from the NHS Performers List. The Registrant submitted

that he does have insight and that is why he has requested to be removed from the Register.

24. The Legal Adviser outlined that the guidance in relation to substantive order review hearings can be found at *paragraphs 22.11-22.15* of the updated (2026) *Hearings and Indicative Sanctions Guidance ("the Guidance").* The case of *Clarke v GOC [2017] EWHC 521 (Admin)* established that a review hearing will be dealt with as a substantive hearing and will commence at the impairment stage.

25. The Legal Adviser outlined that the cases of *Abrahaem v GMC EWHC 183 (Admin)* and *Khan v GPhc [2016] UKSC 64* confirm that in a substantive review hearing, there is a persuasive burden upon a Registrant to demonstrate that they are fit to resume unrestricted practice. The Legal Adviser advised that the Committee should first consider the current fitness of the Registrant to resume practice, judged in light of what they have, or have not, done since the substantive hearing and whether they remain impaired.

26. The Legal Adviser also outlined *Sections 12-13* of the *Guidance* in relation to impairment, and in particular *paragraphs 13.1-13.8*. The Legal Adviser advised the Committee to consider the two separate elements of impairment namely the public component, which concerns the reputation of the profession and upholding professional standards, and the personal component which concerns the risk of repetition and insight displayed on the part of the Registrant as in *Cohen v GMC (2008) EWHC 581*. The Legal Adviser also highlighted the four questions in the *Grant* case. The Legal Adviser drew the Committee's attention in particular to *paragraph 13.5* and the case of *GOC v Clarke (2018) EWCA Civ 1463*, that "*the concept of fitness to practise is whether a practitioner is fit to practise currently, rather than a deliberation of whether there is any likelihood of a return to practice, and thereby any risk in the future."* Finally, the Legal Adviser advised the Committee that at the impairment stage, there is also no burden or standard of proof, but ultimately it is a question of judgement for the Committee alone.

27. In making its findings on current impairment, the Committee had regard to the evidence it had received from both parties, the previous Committee decision, submissions made, the *Guidance*, the Council's Standards of Practice for Optometrists and Dispensing Opticians ("*the Standards")* and the legal advice given by the Legal Adviser. The Committee reminded itself that it was not bound by the findings of the previous Committee on impairment or sanction.

28. The Committee considered the *Guidance* at *paragraphs 13.1-13.8*, the cases of *Clarke* and *Cohen* and the four questions in the *Grant* case, namely:

    a. 'Has [the Registrant] in the past acted and/or is [he] liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or

    b. Has [the Registrant] in the past and/or is [he] liable in the future to bring the medical profession into disrepute; and/or

    c. Has [the Registrant] in the past breached and/or is [he] liable in the future to breach one of the fundamental tenets of the medical profession;

d. has in the past acted dishonestly and/or is liable to act dishonestly in the future.

29. The Committee also considered the GOC's overriding objective, and gave equal consideration to each of its limbs, which are *"To protect, promote and maintain the health, safety and well-being of the public, the protection of the public by promoting and maintaining public confidence in the profession and promoting and maintaining proper professional standards and conduct."*

30. The Committee considered that limbs (a)-(c) of the *Grant* test are all engaged in relation to the Registrant's *past* conduct. The Committee considered that the misconduct put patients at unwarranted risk of harm, especially given that there was actual harm to Patient M and risk of harm to the other patients. The misconduct brought the profession into disrepute by the Registrant not conducting proper examinations and appropriate referrals, which led to harm to Patient M. The Committee also considered that the misconduct breached fundamental tenets of the profession as it breached several of the Council's *Standards*, including *6.2(appropriate referrals), 7.1 (conduct adequate assessments), 7.2 (arrange further examinations and investigations)* and *8 (maintain adequate records).*

31. The Committee then went on to consider the issues in the case of *Cohen* as found at *Paragraph 13.1* of the *Guidance*, as to whether the Registrant's conduct was remediable, whether it had been remedied and whether the conduct is likely to be repeated in future.

32. The Committee had regard to the *Guidance,* which at *paragraph 13.1*, states that: '*Certain types of misconduct (for example, cases involving clinical issues) may be more capable of being remedied than others.'* The Committee was satisfied that given the clinical nature of the misconduct in this case, relating to the detection of glaucoma, detection of vitreoretinal pathology and appropriate referral of patients, this was conduct that was capable of being remedied, providing that the appropriate training and development was undertaken.

33. The Committee considered whether the misconduct had been remedied by the Registrant since it had occurred. The Committee considered the steps that the Registrant had taken to remediate, which it noted were largely limited to the completion of some CPD courses between June 2022 and April 2024. The Committee also noted the Registrant's evidence that not renewing his GOC registration and removing himself from the NHS Performers List was evidence of his insight.

34. The Committee noted that the Registrant had not completed any training or remediation since April 2024. Despite being suspended and without a supervisor, the Registrant would not be prevented from completing CPD or further training but he had actively chosen not to do so. The Registrant has taken part in no clinical practice since 2022. Additionally, the Registrant has also provided evidence of his removal from the NHS Performers List. The Registrant has also not addressed the issues outlined by the previous Committee to demonstrate his insight, including a detailed reflective statement, a Personal Development Plan or any evidence of

further remediation addressing the clinical failings. The Registrant has indicated that he has not completed his CET requirements and does not wish to practice as an Optometrist.

35. The Committee concluded that the Registrant had demonstrated very limited insight. There was no evidence of reflection or developed insight into the misconduct so as to prevent its repetition in future. There was little evidence that the Registrant had reflected on how his misconduct had affected the profession and the public perception of it. The Committee considered this to amount to a persistent lack of insight. In the circumstances, the Committee was not satisfied that the Registrant had remedied the misconduct.

36. The Committee turned to consider the likelihood of repetition. Considering the lack of remediation, the fact that there was now a further length of time without being in practice or furthering his training, and the Registrant's failures to meet the previous Committees' concerns, the Committee considered not just that the Registrant was largely in the same position as when the misconduct occurred, but that there was now an increased risk of repetition. The Committee therefore concluded that the risk of repetition, should the Registrant return to practice, was very high.

37. The Committee returned to the *Grant* questions with reference to the Registrant's *future* risk. The Committee considered that limbs a) to c) of the *Grant* test were engaged both on the Registrant's past conduct in relation to the misconduct found proved and on the basis of being 'liable in the future to so act,' given the very high risk of repetition found. The Registrant has actively chosen not to undertake the remediation identified by the previous Committee, has completed no clinical work since 2022, and has undertaken no CPD or further training since 2024. The Committee considered that the regulatory process has given the Registrant every opportunity to meet those concerns. The Committee concluded that in the future, there was a clear risk of putting patients at unwarranted risk of harm; bringing the profession into disrepute; and breaching one of the fundamental tenets of the profession.

38. The Committee considered whether a finding of impairment was necessary on the basis of the wider public interest in order to uphold proper professional standards and public confidence in the profession. The Committee determined that the misconduct established was serious, particularly so in relation to Patient M, who had lost his sight in his left eye. The Committee considered that the Registrant's misconduct was a significant departure from the standards to be expected of a reasonably competent Optometrist. The Committee was of the view that the public would be concerned and public confidence in the profession would be undermined if a finding of impairment were not made in respect of the Registrant's misconduct.

39. The Committee was also of the view that, given the lack of insight and remediation, and the fact that there have been no efforts made to engage with the concerns of the previous Committee, this raises a heightened risk of repetition due to a longer period of not maintaining clinical practice. The Committee concluded that an informed and fair-minded member of the public, if they were appraised of the facts,

would be very concerned, and public confidence in the profession would consequently be undermined, if a finding of impairment was not made in those circumstances. The Committee determined that it was necessary to make a finding of impairment in this case on public interest grounds, in order to maintain confidence in the profession and in order to uphold proper professional standards.

40. Accordingly, the Committee found that the Registrant's fitness to practise as an Optometrist is currently impaired on both public protection and public interest grounds.

Sanction

41. The Committee went on to consider what would be the appropriate and proportionate sanction, if any, to impose in this case. The Committee received no further evidence at this stage.

42. The Committee heard submissions on behalf of the Council. Ms Hinds highlighted to the Committee the principles that it ought to apply in determining the appropriate sanction in this case, referring the Committee to the *Guidance*. She reminded the Committee that the purpose of any sanction is to protect patients and the wider public interest.

43. The Registrant was offered the opportunity to make submissions and simply referred the Committee to his written documents as outlined above.

44. The Legal Adviser referred to the *Guidance* at *paragraphs 16-21* and *13F - 13H of the Opticians Act 1989* in outlining the sanctions available to the Committee. The Legal Adviser stated that the sanctions guidance is not a 'straitjacket,' but if the Committee were to deviate, they must give reasons. It is not the purpose of sanctions to punish, but the Committee should consider proportionality and balance the interests of the public against those of the Registrant. The Legal Adviser advised that the Committee should, according to *paragraph 20.5* of the *Guidance*, start with the least severe and work in ascending order.

45. When considering sanction, the Committee had regard to all of the evidence and submissions it had heard, its previous findings and the *Guidance*.

46. The Committee firstly considered the aggravating and mitigating factors that were present in this case. In the Committee's view, the aggravating factors are as follows:

    - The breadth of misconduct, in that there was a range of clinical deficiencies and breaches of the standards involving a number of patients, forming a pattern of repeated failings;
    - In respect of Patient M, there had been actual harm in that they had lost sight in their left eye and a high risk of harm to other patients;
    - The Registrant has demonstrated very limited insight and remediation. He has let his CPD requirements lapse, as he has not yet completed any CPD in the current cycle and there remains a high risk of repetition;

- The Registrant has now shown a persistent lack of insight, now having failed to engage with the issues outlined by the previous Committee;
- The Registrant has demonstrated an attitudinal obstacle to remediation. Despite a period of suspension and clear guidance from the previous Committee as to the steps required to address the regulatory concerns, he has not undertaken meaningful remediation, has not maintained his clinical skills through training or CPD, and has not provided evidence of reflection addressing the identified failings.

47. The Committee considered the following to be mitigating factors:
    - The Registrant made admissions to some particulars of the Allegation at the outset of the substantive hearing and had accepted that his practice was 'not up to scratch;'
    - The Registrant, through his Counsel, made a heartfelt apology to Patient M when he gave evidence at the substantive hearing;
    - The Registrant has engaged with the GOC and the regulatory process.
48. The Committee considered the sanctions available to it from the least restrictive to the most restrictive, starting with no further action as per the *Guidance* at *paragraph 20.5*.
49. The Committee considered taking no further action, however, it was of the view that there were no exceptional circumstances to justify taking no action in this case. Furthermore, it was of the view that taking no further action would not protect the public, was not proportionate nor sufficient given the seriousness of the misconduct and would not meet the public interest concerns.
50. The Committee next considered the issue of a financial penalty order. However, it was of the view that such an order was not appropriate, given that this case did not involve financial motivation or gain. Additionally, a financial penalty order would not protect the public nor meet the public interest concerns.
51. The Committee considered the *Guidance* at *paragraph 20.29* in relation to the imposition of a conditional order. The Committee noted that the misconduct was of a type where conditions could be appropriate, as it involved identifiable clinical areas of practice in need of assessment or retraining, which conditions often seek to address. However, it was of the view that conditional registration would not be appropriate, as conditions would not be workable in this case. The Committee noted its earlier findings that there was very limited insight and a further heightened risk of repetition. The Committee concluded that conditional registration would not meet the increased concerns of the Committee, nor would it adequately protect the public or meet the wider public interest. Any conditions imposed would have to be robust and involve direct supervision, and it noted that the Registrant had been unable to find a supervisor and had been unable to work under interim conditions. The

Committee concluded that conditions could not be devised which would be appropriate, proportionate, or workable in this case.

52. The Committee next considered suspension and had regard to *paragraphs 20.33* to *20.35* of the *Guidance*. In particular, the Committee considered the list of factors contained within *paragraph 20.33* that indicate where a suspension may be appropriate, which are as follows:

    a. A serious instance of misconduct where a lesser sanction is not sufficient;

    b. No evidence of harmful deep-seated personality or attitudinal problems;

    c. No evidence of repetition of behaviour since incident;

    d. The Committee is satisfied the registrant has insight and does not pose a significant risk of repeating behaviour;

    e. [not applicable]

53. The Committee considered that some of the factors in *paragraph 20.33* of the *Guidance* were applicable in this case. The misconduct was serious and it had found that a lesser sanction would not be sufficient in the circumstances. However, the Committee had concluded that there was evidence of an attitudinal obstacle to remediation. The Registrant had chosen not to undertake the remedial steps identified by the previous Committee, despite having had a significant period in which to do so. The Committee found the Registrant cooperative and professional in his engagement with the hearing. The Registrant's stated intention to leave the profession may explain his reluctance to remediate, but his persistent failure to address the identified deficiencies demonstrated a lack of commitment to remediating those concerns.

54. Whilst there was no evidence of repetition since the misconduct occurred, the Committee had found that there was an increased risk due to the increased length of time the Registrant had spent out of clinical practice and without any updates to his training. The Committee was not satisfied that the Registrant has insight and concluded that there was a significant risk of repeating behaviour.

55. The Committee therefore considered the *Guidance* factors indicating where erasure may be appropriate, and considered that many of the factors set out in *paragraph 20.40*, did apply to this case:

    a. Serious departure from the relevant professional standards as set out in the Standards of Practice for registrants and the Code of Conduct for business registrants;

    b. Creating or contributing to a risk of harm to individuals (patients or otherwise) either deliberately, recklessly or through incompetence, and particularly where there is a continuing risk of harm to patients;

    c. [not applicable];

    d. [not applicable];

e. [not applicable];

f. [not applicable];

g. [not applicable]

h. Persistent lack of insight into seriousness of actions or consequences.

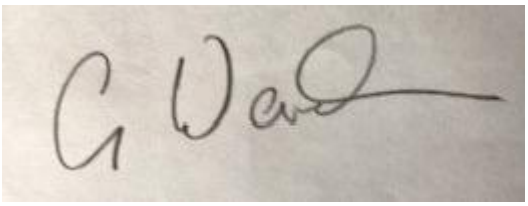
56. The Committee was mindful that erasure is likely to be appropriate when the behaviour is fundamentally incompatible with being a registered professional and where erasure is the only sanction that would protect the public. The Committee considered that the misconduct was serious and created a risk of harm to patients. The Committee found that factor (b) was engaged, as the Registrant had not taken any steps to remedy his clinical failings and therefore there is a continuing risk of harm to patients. Further, factor (h) was engaged because the Registrant had persistently failed to address the concerns identified by the substantive Committee. Despite a period of suspension and clear guidance as to the evidence that would assist a future reviewing Committee, he had not undertaken meaningful remediation, produced a reflective statement, maintained relevant training, or demonstrated how the identified risks to patients would be avoided in future. The Committee considered that this amounted to a persistent lack of insight into the seriousness of the misconduct and its consequences.

57. The Committee recognised that erasure is the most serious sanction available and would only being appropriate where the behaviour was fundamentally incompatible with being on the register and according to *paragraph 20.42* of the *Guidance,* where it is the only means of protecting patients and/or maintaining public confidence in the optical profession. The Committee acknowledged that erasure would have a substantial effect upon any Registrant. However, it noted that the Registrant has stated that he no longer wishes to practise as an Optometrist, has not renewed his registration, and has removed himself from the NHS Performers List. In those circumstances, the Committee concluded that the public protection and public interest considerations significantly outweighed the impact of erasure upon the Registrant.

58. For all of the above reasons, the Committee concluded that erasure was the only appropriate and proportionate sanction.

59. As an immediate order cannot be imposed, the suspension period will continue until 18 September 2026 when the erasure order will take effect.

Chairman of the Committee: Gerry Wareham

Signature  **Date: 31 July 2026**

Registrant: Ravi Bhojwani

Signature *present and received via email* **Date: 31 July 2026**

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

If you require any further information, please contact the Council's Hearings Manager at Level 29, One Canada Square, London, E14 5AA or by telephone, on 020 7580 3898.