BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(24)47,48,49,50

AND

BANSRI RUGHANI (01-23626)
MEERA PATEL (01-32451)
SAPNA BARIYA (D-13202)
MANEEKA KOTHARI (01-35047)

DETERMINATION OF A SUBSTANTIVE HEARING
19-23 JANUARY 2026, 2-4 FEBRUARY 2026
10-12 FEBRUARY 2026
27-29 APRIL 2026, 1 MAY 2026

Committee Members:	Ms Louise Fox (Chair/Lay) Ms Vivienne Geary (Lay) Mr Mark Richards (Lay) Ms Gaynor Kirk (Optometrist) Mr Philip Cross (Dispensing Optician)
Legal adviser:	Ms Aaminah Khan
GOC Presenting Officer:	Mr Christopher Geering
Registrants present/represented:	Ms Bansri Rughani- No and not represented Ms Meera Patel- Yes and represented Ms Sapna Bariya- No and not represented Ms Maneeka Kothari- Yes and represented
Registrants' representatives:	Mr Nicholas Hall (Ms Meera Patel) Mr Richard Mumford (Ms Maneeka Kothari)
Hearings Officers:	Ms Natasha Bance Ms Bernice Yeboah Mr Terence Yates
Facts found proved:	Ms Patel – all by virtue of admissions Ms Kothari – all by virtue of admissions Ms Rughani - Particulars 1 (in its entirety), 2, 3, 4, 5(a) and (b), 6, 7, 8, 9 , 10, 13 and 14 Ms Bariya - Particulars 1 (in its entirety), 2, 3, 4, 5(a) and (b), 6, 7, 8, 9, 10 and 12

Facts not found proved:	Ms Patel - none Ms Kothari – none Ms Rughani - Particulars 5(c), 12 and 15 Ms Bariya - Particulars 5(c) and 11
Misconduct:	Found for all four Registrants as follows: Ms Patel – Particulars 1-4 Ms Kothari – Particulars 1-4 Ms Rughani – Particulars 1-10 Ms Bariya – Particulars 1-10
Impairment:	Ms Patel – Impaired on public interest grounds Ms Kothari – Impaired on public interest grounds Ms Rughani – Impaired on public protection and public interest grounds Ms Bariya – Impaired on public protection and public interest grounds
Sanction:	Ms Patel – Suspension for a period of two months (Without Review) Ms Kothari – Suspension for a period of two months (Without Review) Ms Rughani – Erasure Ms Bariya – Erasure
Immediate order:	Ms Patel – No Ms Kothari – No Ms Rughani – Yes Ms Bariya - Yes

Proof of service

1. Two of the Registrants, Ms Bansri Rughani and Ms Sapna Bariya, did not attend the hearing. The Committee was provided with a service bundle in respect of each absent Registrant, containing recent correspondence with them regarding the hearing. However, Mr Geering, on behalf of the Council, informed the Committee that the Council were not in a position to apply to proceed in the absence of Ms Bansri Rughani because there had not been good service in respect of her. This was due to the Notice of Hearing having been sent to Ms Rughani's email address when she had not given prior consent to receive notices from the Council by email, a procedural step which Mr Geering acknowledged was required under Section 23A of the Opticians Act 1989 ('the Act').
2. Mr Geering indicated that the Council took the view that it would not be appropriate to proceed in the absence of one director and not the other and it was therefore considering making an application to sever the cases of the two employees (Ms Meera Patel and Ms Maneeka Kothari) from the case against the two directors (Ms Bansri Rughani and Ms Sapna Bariya) in order for their cases to proceed.
3. Mr Hall, on behalf of Ms Patel, indicated that such an application, if made, would be opposed by his client. Mr Mumford, on behalf of Ms Kothari, indicated that he required further time to take instructions from his client before he could confirm her position to such an application. The Council therefore invited the Committee to allow the parties time before being in a position to confirm whether such an application would be made and if so, the employee Registrants' responses to it. The Committee agreed to do so.
4. The hearing resumed on day two for an update from the Council. Mr Geering informed the Committee that following further enquiries it was apparent that an earlier Notice of Hearing, which included the current start date of the hearing, had been sent to Ms Bansri Rughani on 26 November 2025 by Royal Mail recorded delivery and had been signed for. In the circumstances, the Council considered that there had in fact been good service and it was in a position to make an application to proceed in absence in respect of both Ms Rughani and Ms Bariya. The Committee was provided with updated service bundles, which contained a wider range of correspondence including the Notice of Hearing from November 2025 and 'signed for' confirmation.
5. The Committee then heard an application from Mr Geering for the matter to proceed in the two director Registrants' absence. First, the Council was required to satisfy the Committee that the documents had been served in accordance with Section 23A of the Act and Rule 61 of the Fitness to Practise Rules 2013 ('the Rules').
6. Mr Geering referred the Committee to the documents in the updated service bundles and submitted that there had been good service in accordance with Rule 61. He explained that an updated Notice had been sent in December 2025 by email when there was an update to the later sitting dates, but that the November 2025 Notice of Hearing was sufficient for the Committee to be satisfied that there had been good service in relation to Ms Rughani. In relation to Ms Bariya, Mr Geering submitted that as she had provided consent to receive Notices from the Council by

email (as shown by an email to that effect in the service bundle) it was clear that there was effective service in respect of her Notice of Hearing.

7. The Legal Adviser provided the Committee with legal advice on the service requirements under Section 23A of the Act and the Rules. The Committee reviewed the further information provided in the updated service bundles, noting that it now had confirmation that a Notice of Hearing in November 2025 was served by post to Ms Rughani's address and signed for by a name which had been recorded as 'Rughani'. In relation to Ms Bariya, the Committee noted that she had provided consent for email service and a Notice of Hearing had been served on her at the email address which she had registered with the Council.

8. In the circumstances, the Committee was satisfied that all reasonable efforts have been made to notify the Registrants of the hearing and that the Notices of Hearing had been properly served in accordance with the Rules.

Proceeding in the absence of the Registrants

9. The Committee then went on to consider whether it would be in the public interest to proceed in the Registrants' absence in accordance with Rule 22.

10. Mr Geering submitted that both director Registrants had voluntarily absented themselves from the hearing and there would not be any purpose served by an adjournment. Mr Geering highlighted that in Ms Rughani's case she had previously been represented by the AOP but they sent an email dated 26 February 2025 in which they stated that they no longer represented her and she had decided to voluntarily absent herself from the proceedings, including the substantive hearing and understood that the case may proceed in her absence. Mr Geering submitted that this was a conscious decision not to engage and, in those circumstances, there would be no purpose in adjourning, as that would not result in her attending a future hearing.

11. Mr Geering submitted that it was in the public interest to proceed with the case in the two director Registrants absence. He submitted that particularly given the age of the Allegations in this case, that it was in the public interest to proceed with them as expeditiously as possible. Regarding Ms Bariya's position, Mr Geering stated that although she had not made an unequivocal statement that she would not be engaging, that could be inferred from the circumstances. He submitted that Ms Bariya was clearly aware of the ongoing case as she had responded to the joinder issue, but not to the many efforts of the Council to contact her.

12. The Committee received advice from the Legal Adviser on proceeding in the Registrants' absence. The Committee accepted the advice of the Legal Adviser, which was that the Committee had a discretion under Rule 22 as to whether to proceed in absence of the Registrant, which should be approached by applying the factors from the case of *R v Jones* [2002] UKHL. The Legal Adviser referred the Committee to the case of *GMC v Adeogba; GMC v Visvardis* [2016] EWCA Civ 162, where the Court of Appeal gave guidance that when deciding whether to proceed

in absence, fairness to the practitioner is a prime consideration but it is not determinative; fairness to the Council and the public interest must be taken into account and a culture of adjournments is to be deprecated and would be contrary to the efficient delivery of regulation.

13. The Committee considered the application in relation to each absent Registrant. In relation to Ms Rughani, the Committee considered that it had been made clear in the AOP's email that she was voluntarily absenting herself from the proceedings. The Committee considered that this had not been made expressly clear by Ms Bariya but agreed that it could be inferred from her lack of engagement to the many attempts of the Council to contact her that she was also voluntarily absenting herself from the proceedings.

14. The Committee took the view that it would not be fair to the employee Registrants nor the witnesses who had been warned to attend this hearing to adjourn the hearing. It was in the public interest to proceed as expeditiously as possible, particularly given the age of the Allegations (dated over five years ago). Additionally, no purpose would be served by adjourning as it was unlikely that the absent Registrants would attend a future hearing. The Committee considered that the Registrants had multiple opportunities to engage with the proceedings and had not done so.

15. The Committee determined that it would be in the public interest for the hearing to proceed in the Registrants' absence.

ALLEGATIONS

(as amended in respect of Bansri Rughani and Sapna Bariya)

ALLEGATION – Ms Bansri Rughani

The Council alleges that in relation to you, Ms Bansri Rughani (01-23626), a registered optometrist, whilst you were a director and practising optometrist at [redacted] *Visionplus Limited* [redacted] *('the Store') around between 25 March 2009 and 30 November 2021:*

1. *On one or more occasions intentionally did the following, and / or encouraged and / or pressurised members of staff to do the following:*
   a. *provide OCT scans which were inappropriate and/or not clinically indicated,*
   b. *charge for OCT scans without advising the patient it was optional,*
   c. *misdiagnose patient(s),*
   d. *recommend eyecare products which were not clinically indicated for:*
      i. *dry eye conditions, and/or*
      ii. *blocked glands,*
   e. *overcharge for certain eye care products,*
   f. *offer an "express service" for collecting glasses,*
   g. *produce receipts which were not itemised and/or did not accurately reflect all the patients' purchases*
   h. *not accurately record the products/services purchased on Specsavers' Socrates system,*
   i. *dispense high index lenses when not clinically indicated and/or without offering the patient an informed choice,*
   j. *not provide patient(s) with a copy of their prescription*
2. *In respect of 1 (e) and (f) you knew you were not permitted to set these prices and/or offer this service,*
3. *In respect of 1 (g) and (h) you intended to disguise from the patient what particular products/services had cost them, and/or to disguise from Specsavers that you were offering an "express service":*
4. *Your actions at 1 a-i, 2 and 3 were dishonest*
5. *On one or more occasions you intentionally did and/or allowed and/or acquiesced in the insertion of the following false information in patient records:*
   a. *email address(es) linked to you as the patient's personal email address, and/or*
   b. *the optician's address as the patient's home address, and/or*

c. *recommendations for products prior to any examination being undertaken*

6. *On one or more occasions you did and/or allowed and/or requested the creation of:*
   a. *false email accounts for the purpose of submitting false patient feedback,*
   b. *false patient feedback which was submitted to the MAZE Customer Service Portal*
7. *Your actions at 5 a-c and 6 a-b, were dishonest*
8. *On one or more occasions, as a director, you allowed and/or acquiesced in staff members working whilst on furlough,*
9. *You knew that employees were not permitted to undertake work for their employer under the terms of the furlough scheme*
10. *Your actions at paragraph 8 and 9 above were dishonest;*
11. *[deleted]*
12. *You allowed or were aware that the visual acuity chart had been inappropriately cut to remove print sizes N5 and N6;*
13. *Between 10 August 2020 and 25 September 2020 you allowed or acquiesced in Registrant C conducting NHS sight tests when not on the NHS England Ophthalmic Performers List;*
14. *On one or more occasions, you signed a GOS1 form(s) declaring you had conducted the sight test when you knew Registrant C had conducted the sight test;*
15. *Your actions at 14 above were dishonest;*

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

ALLEGATION – Ms Sapna Bariya

The Council alleges that in relation to you, Ms Sapna Bariya (D-13202), a registered dispensing optician, whilst you were a director and practising dispensing optician at [redacted] *Visionplus Limited* [redacted] *'the Store' between around 6 January 2009 and 30 November 2021:*

1. *On one or more occasions intentionally did the following, and/or encouraged and/or pressurised members of staff to do the following:*
   a. *provide OCT scans which were inappropriate and / or not clinically indicated,*
   b. *charge for OCT scans without advising the patient it was optional,*
   c. *misdiagnose patient(s),*
   d. *recommend eyecare products which were not clinically indicated for:*

i. *dry eye conditions, and/or*

ii. *blocked glands,*

e. *overcharge for certain eye care products,*

f. *offer an "express service" for collecting glasses,*

g. *produce receipts which were not itemised and/or did not accurately reflect all the patients' purchases*

h. *not accurately record the products/services purchased on Specsavers' Socrates system,*

i. *dispense high index lenses when not clinically indicated and/or without offering the patient an informed choice,*

j. *not provide patient(s) with a copy of their prescription*

2. *In respect of 1 (e) and (f) you knew you were not permitted to set these prices and/or offer this service.*

3. *In respect of 1 (g) and (h) you intended to disguise from the patient what particular products/services had cost them, and/or to disguise from Specsavers that you were offering an "express service":*

4. *Your actions at 1 a-i, 2 and 3 were dishonest*

5. *On one or more occasions you intentionally did and/or allowed and/or acquiesced in the insertion of the following false information in patient records:*

   a. *email address(es) linked to you as the patient's personal email address, and/or*

   b. *the optician's address as the patient's home address, and/or*

   c. *recommendations for products prior to any examination being undertaken*

6. *On one or more occasions you did and/or allowed and/or requested the creation of:*

   a. *false email accounts for the purpose of submitting false patient feedback,*

   b. *false patient feedback which was submitted to the MAZE Customer Service Portal*

7. *Your actions at 5 a-c and 6 a-b, were dishonest*

8. *On one or more occasions, as a director, you allowed and/or acquiesced in staff members working whilst on furlough,*

9. *You knew that employees were not permitted to undertake work for their employer under the terms of the furlough scheme*

10. *Your actions at paragraph 8 and 9 above were dishonest.*

11. *You allowed or were aware that the visual acuity chart had been inappropriately cut to remove print sizes N5 and N6*

12. *Between 10 August 2020 and 25 September 2020 you allowed or acquiesced in Registrant C conducting NHS sight tests when not on the NHS Ophthalmic Performers List;*

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

ALLEGATION - Ms Meera Patel

The Council alleges that in relation to you, Ms Meera Patel (01-32451), a registered optometrist, whilst you were working at [redacted] *Visionplus Limited between around 7 June 2016 and 30 March 2021:*

1. *On one or more occasions, you intentionally misdiagnosed patients with:*
   a. *dry eye conditions; and/or*
   b. *blocked glands;*
2. *Your actions at 1 were dishonest;*
3. *On one or more occasions, you intentionally recommended eyecare products to patients which were not clinically indicated for:*
   a. *dry eye conditions; and/or*
   b. *blocked glands;*
4. *Your actions at 3 were dishonest;*
5. *On one or more occasions, you failed to issue patients with their prescription;*
6. *On one or more occasions, you conducted NHS sight tests when not on the NHS Ophthalmic Performers List;*
7. *In or around December 2020 you failed to adequately assess Patient 1 and/or Patient 2 and/or Patient 3 in that you did not assess binocular function at distance and near;*
8. *On one or more occasions, you failed to follow infection control procedures.*

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

ALLEGATION - Ms Maneeka Kothari (as amended to change 'undertake training' to 'practise')

The Council alleges that in relation to you, Ms Maneeka Kothari (01-35047), a registered optometrist, whilst you were working at [redacted] *Visionplus Limited as a pre-registration optometrist between around 6 August 2019 and 30 March 2021:*

1. *On one or more occasions, you intentionally misdiagnosed patients with:*
   a. *dry eye conditions; and/or*

b. blocked glands;

2. *Your actions at 1 were dishonest;*
3. *On one or more occasions, you intentionally recommended eyecare products to patients which were not clinically indicated for:*
   a. dry eye conditions; and/or
   b. blocked glands;
4. *Your actions at 3 were dishonest;*
5. *You wrote out and issued a prescription to Patient 3 on 11 December 2020 when you were not authorised to do so as a pre-registration Optometrist;*
6. *You failed to ensure you wore appropriate PPE and/or follow infection control procedures;*
7. *You failed to raise the following concerns with your tutor in respect of your supervisor:*
   a. instructing you to misdiagnose patients; and/or
   b. instructing you to recommend products to patients which were not clinically indicated, and/or
   c. instructing you to use Sodium fluorescein as routine on adult patients.

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

DETERMINATION

Preliminary issue – amendment of the Allegations

16. Mr Geering, on behalf of the Council, made an application to amend the wording of the Allegations, from what had been notified to the Registrants under Rule 28. This application was being made in respect of the Allegations against the director Registrants (Ms Bansri Rughani and Ms Sapna Bariya) only.

17. The application to amend had three parts to it:

    i) to remove several words ("and knew or ought to have known that") which had been left in the originally worded particular 3 of Allegation by oversight at the end of the paragraph;

    ii) to amend particular 4 of the Allegation to read that "your actions at 1a-i….were dishonest" rather than the original wording which read "your actions at 1a-h…. were dishonest";

    iii) In respect of Ms Bansri Rughani only, to delete particular 11, which was a discrete allegation regarding the entering of codes into patient records that had been included in respect of one director.

18. Mr Geering submitted that the amendment to particular 3 was unlikely to be controversial, as these words were left in the Allegation due to an oversight and with them included, they did not make sense.

19. In relation to particular 11, Mr Geering explained that it was proposed that this particular of the Allegation against Bansri Rughani should be removed, as it was considered by the Council to be inconsistent to bring this allegation against only one of the directors. However, Mr Geering indicated that the Council were not proposing to add the allegation against the other director, Ms Bariya, as it did not materially add to the Council's case given the other, palpably more serious, allegations that they both faced. Mr Geering submitted that it was the Committee's decision whether to drop part of Allegation, but the Council submitted that it was not in the public interest to proceed with it.

20. In relation to widening the dishonesty allegations in particular 4, Mr Geering stated that this was also a clerical error. It was to include the rider of dishonesty in respect of the dispensing of high index lenses, which as the Allegation stood had not been clearly put as being dishonest. However, Mr Geering submitted that it was clearly part of the Council's case as it had been referred to the Case Examiners, who had decided that it should be included in the Allegations to be referred to the Fitness to Practise Committee.

21. Mr Geering highlighted that both directors were made aware that the Council would be applying to amend the Allegations in this manner as they were sent notice of the application on 7 January 2026. Neither responded and they had two weeks in which to flag any prejudice or objections they may have. Mr Geering submitted that even if the Registrants were participating in the hearing, as the underlying foundation for the Allegation had been included (regarding the dispensing of the high index lenses) adding the dishonesty element would not affect any cross-examination of any witnesses. The key evidence would be the Registrants' own evidence as to their knowledge or belief, which would not be due to be given to the Committee until about 10 February 2026 and therefore they have about a month's notice.

22. In any event, Mr Geering submitted that the Registrants had not produced any evidence to challenge the underlying factual allegation or rebut the Council's case. Mr Geering submitted that in the circumstances there was no unfairness to the Registrants in making the amendments, give the notice they had and there was a public interest in ensuring that the Council's case was fully and properly prosecuted.

23. The Committee was provided with the Case Examiners decisions dated 10 July 2024 in respect of Ms Rughani and Ms Bariya, which had been referred to by Mr Geering during his submissions.

24. The Committee received and accepted the advice of the Legal Adviser who referred the Committee to Rule 46(20), which is in the following terms:

"(20) Where it appears to the Fitness to Practise Committee at any

time during the hearing, either upon the application of a party or of its own volition, that—

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

(b) the amendment can be made without injustice, it may, after hearing the parties and consulting with the legal adviser, amend those particulars or those grounds in appropriate terms."

25. The Legal Adviser advised that the Committee had a discretion under Rule 46(20) to make amendments, at any stage of the hearing, either on an application by a party or of its own motion, if satisfied that the amendment can be made without injustice and that issues of prejudice and fairness had to be considered from all parties' perspectives. Relevant factors to consider included the nature of the amendment sought, whether the Registrant had been given notice of it and had the opportunity to object to it.
26. Mr Hall, on behalf of Ms Patel and Mr Mumford, on behalf of Ms Kothari, did not have any comments to make on the application.
27. The Committee retired to consider the application and carefully considered whether the amendments could be made without injustice. Each of the individual proposed amendments were considered separately and in turn.
28. The Committee noted that the first proposed amendments, to delete unnecessary words in particular 3, would make the particular clearer regarding what was alleged against the Registrants. The Committee was satisfied that these amendments would not result in any injustice, as it was clarifying the allegation and granted the application.
29. In respect of amending the allegation of dishonesty in particular 4, to include (i) - the dispensing of high index lenses when not clinically indicated and/or without offering the patient an informed choice, the Committee considered that this amendment would have the effect of extending the dishonesty allegations, however in the context of the case as a whole, this was a small extension to the dishonesty alleged. The underlying conduct had been included in the Allegations and that was conduct that could be said to be on the face of it dishonest. The Committee accepted that this was not a new allegation and that its omission appeared to be due to oversight.
30. In relation to whether the amendment would cause injustice, the Committee considered the Case Examiners' decisions in respect of the allegations which should proceed to a Fitness to Practice Committee. The Committee noted that this aspect of the case was included in the decisions for both directors, albeit in a different format (as could be seen from the decision letters dated 10 July 2024). Accordingly, the Registrants were on notice, at that stage at least, that this may

form part of the Council's case. The Committee noted that the Registrants did not respond to the Case Examiners decisions.

31. Additionally, the Committee considered that the Registrants had received written notice of the Council's intention to make the applications approximately two weeks prior to the hearing and therefore they both have had sufficient opportunity to raise objections to the application and have not done so. The Committee noted that there was no objection to the application on behalf of either employee Registrant. In the circumstances, the Committee was satisfied that the proposed amendments could be made without unfairness or prejudice to any party and by making this amendment, it allowed the dishonesty allegations to be fully put before the Committee. The Committee accordingly granted the application.

32. In relation to the third aspect of the amendment application, to remove particular 11 from the Allegation in respect of Ms Bansri Rughani, the Committee was not persuaded that the fact that this had not been included against the other director Ms Sapna Bariya, was sufficient reason in and of itself to remove the particular from the Allegation. However, when considering the Allegation in the round, the directors both faced a wide range of dishonesty and other allegations and this discrete concern regarding the use of inappropriate codes on patient records did not in the Committee's view materially add to the overall seriousness of the case. On that basis, the Committee was minded to delete particular 11 of the Allegation against Ms Bansri Rughani. The Committee considered that this did not result in injustice as it removes part of the Allegation from consideration.

33. The Allegations set out above reflects the final version of the Allegations after the applications by the Council to make amendments were granted.

Admissions in relation to the particulars of the allegation

34. Mr Hall, on behalf of Ms Patel, confirmed that his client admitted the entirety of the Allegation against her. Pursuant to Rule 46(6), the Chair announced that the Allegations were accordingly found proved by virtue of the Registrant's admissions.

35. Mr Mumford, on behalf of Ms Kothari, confirmed that his client admitted the entirety of the Allegation against her. Pursuant to Rule 46(6), the Chair announced that the Allegations were accordingly found proved by virtue of the Registrant's admissions.

36. The Committee proceeded to hear evidence in relation to the Allegations against the two director Registrants, Ms Rughani and Ms Bariya, who were formally identified by Mr Geering reading their registration details into the record.

Background to the allegations

37. The four Registrants worked together at [redacted] Visionplus Limited ('the store'), which is part of the Specsavers group. Ms Sapna Bariya (a Dispensing Optician) and Ms Bansi Rughani (an Optometrist) at the material times were directors of the store. Ms Meera Patel (an Optometrist) and Ms Maneeka Kothari (then a pre-registration Optometrist) worked as employees. None have any prior fitness to practise history.

38. Following a complaint in September 2020 Specsavers initiated a local investigation. This was conducted by Mr A. It involved using three "mystery shoppers", who attended the store as customers and the interactions were filmed covertly. It is the Council's case that these mystery shopper interactions exposed a number of improper practices, including patients being told that the cost of the eye test was £35 and not being told that the OCT cost of £10 was optional. Additionally, an 'express service' was offered for lenses to be made, which was not a service offered by the Specsavers Group. This resulted in a fuller investigation into practices at the store being carried out, which in turn led to the matter being referred, and self-referred, to the Council.

39. In essence, the case alleges that Ms Rughani and Ms Bariya, as the store directors, facilitated a number of business practices designed to extract additional income from customers. This included instructing staff to misdiagnose patients, and to push products which were not clinically indicated, in particular for dry eyes and blocked glands. It is also alleged that products were sold at higher than Specsavers' usual prices and that patients were often not provided with copies of their prescription. In respect of Ms Patel and Ms Kothari, the Council acknowledge that they worked as junior employees and followed the directors' instructions. It is alleged that the directors' actions went much further, encouraging or pressurising employees to act in this manner.

40. The Council allege that the store directors did not record purchases accurately on the Socrates system, or issue appropriate receipts in order to disguise their actions. Additionally, it is alleged that the directors did, allowed or requested the creation of faked customer emails and feedback in reviews to improve the store's Key Performance Indicators (KPIs) and to address negative reviews that the store had received. During Covid it is alleged that the store directors required some staff to work in breach of the government's furlough scheme.

41. The Council relies to a significant extent upon the evidence collated from the local investigation. This includes the investigations reports and footage from the mystery shoppers. In addition, staff who worked at the store will be called as witnesses. In addition, the Council has instructed an expert witness, Mr Richard

Booth to provide expert evidence and he has prepared separate reports in respect of each Registrant.

The hearing

42. At the outset of the hearing, the Committee raised a query regarding an interview transcript of Mr B which the director Registrant, Ms Bariya, had referred to in her written response to the Specsavers Investigation Report. In that response, Ms Bariya had raised a concern that comments made by Mr B had not been reflected in Mr A's investigation report and the Chair of the Committee enquired as to whether that document could be made available to the Committee.

43. Mr Geering informed the Committee that Mr B's transcript had not been included in the bundle because that witness was not going to be giving evidence and it would be hearsay evidence, which the Council did not intend to rely upon. However, Mr Geering acknowledged that it was within the Committee's power to ask to see that material as part of its inquisitorial function. Mr Geering proposed that the Committee should be given a copy of the transcript to consider whether it would be fair and relevant to admit it into evidence.

44. The Committee was subsequently provided with the interview transcript of Mr B, as well as a short bundle of correspondence with Mr B, which included documents relating to the Council's attempts to contact and engage with Mr B as a witness.

45. Mr Geering stated that the Council's position was neutral on whether the Committee ought to admit the transcript. Mr Geering highlighted some factors that the Committee may wish to consider from the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin), which included whether the statement was the sole or decisive evidence in relation to the issue, the nature and extent of the hearsay evidence, whether there was any reason for the witness to fabricate the evidence, the seriousness of the allegations and impact of adverse findings and whether there was a good reason for the non-attendance of the witness. Mr Geering acknowledged that there was not a good reason in this case, as the witness had stopped engaging.

46. Mr Geering submitted that the Council had taken reasonable steps to secure the attendance of the witness and another factor to consider was whether the absent Registrants had notice that the evidence may be admitted and they had not. In relation to the nature and extent of the hearsay, Mr Geering accepted that this was not in witness statement form, but the transcript was more formal than other forms of hearsay such as a file note. In relation to fairness, Mr Geering submitted that there was information in the transcript that may assist the Registrants, for example

issues with the printers, but parts may support other aspects of the Allegation, such as the use of the express service.

47. Mr Hall and Mr Mumford both confirmed that they were entirely neutral on the application.

48. The Committee heard and accepted advice from the Legal Adviser on admitting evidence and in particular hearsay evidence. The Legal Adviser referred the Committee to the wide discretion that the Committee had to admit evidence under Rule 40, if the evidence is considered to be fair and relevant to the case before it. The Legal Adviser referred the Committee to the factors to consider regarding the admission of hearsay evidence, as set out in the Hearings and Indicative Sanctions Guidance (paragraph 13.12) and the case of *Thorneycroft v Nursing and Midwifery Council* (2014) EWHC 1566 (Admin). The Legal Adviser advised the Committee to consider the issue of fairness from all perspectives, including that of each Registrant and to consider any prejudice to a party should the evidence either be admitted or not.

49. The Committee considered the material that it had received relating to Mr B It first considered whether this material was relevant to the issues that it had to determine in the case. The Committee found that the interview transcript of Mr B was clearly relevant. It provided information and context to the working practices within the store, which were the subject of the various allegations. The Committee also found the information in the correspondence bundle to be relevant to the efforts that the Council had made to contact Mr B and obtain a witness statement from him. It also showed his lack of engagement, all matters which were relevant to its admissibility as hearsay and what weight to attach, should it be admitted.

50. In relation to whether it was fair to admit this evidence, the Committee noted that parts of the interview transcript may be helpful to the Registrants, whereas other parts may support the Council's case. The Committee considered that it was not sole or decisive evidence and it fits in with other evidence of employees. There did not appear to be any reason why the information provided would be fabricated by this witness. However, as Mr B was not willing to attend to give evidence (and there was no good reason for his non-attendance), the Committee was mindful that it was not possible for his account to be tested. The Committee considered that the Council had taken reasonable steps to try to get Mr B to engage and secure his attendance, albeit they had not contacted him recently.

51. The Committee considered that it was reasonable to infer both of the directors had had the opportunity of reading Mr B's interview transcript, as it is listed in the index of the internal investigation report. However, the Committee considered the factor that the absent Registrants were not aware that this evidence may be admitted for

this hearing. It balanced this against the fact that the Registrant Ms Bansri had expressly referred to it in her written response to the investigation and queried its absence in the report. The Committee considered that had Ms Bansri attended this hearing she may have wished for it to be admitted, given that she appeared to rely upon it in her response.

52. The Committee decided that on balance, it was fair to admit the interview transcript with Mr B and part of the correspondence with him. The Committee noted however that there was information in the correspondence that should be redacted as it related to matters raised which were outside of the Allegations. The Committee considered that it would not be fair to the director Registrants to admit these parts and they were duly redacted and put out of the Committee's minds. The Committee subsequently identified the parts that are to be redacted, and they will form no part of the Committee's consideration.

The Council's case

53. Mr Geering then opened the case for the Council, outlining the background, as summarised above. Mr Geering called Mr A, [redacted] Consultant from Specsavers, who carried out the local investigation, to give evidence. Mr A gave evidence and confirmed the contents of his two witness statements and investigation reports. He was questioned by Mr Geering, on behalf of the Council and the Committee. Mr Hall and Mr Mumford did not have any questions for this witness.

54. The Council arranged for further witnesses from Specsavers to attend to give evidence, namely Mr C ([redacted] Consultant, who assisted with the investigation), Mr D ([redacted] Consultant, who assisted with the investigation) and Ms A (then Head of Specsavers [redacted]). However, neither Mr Geering, Mr Hall nor Mr Mumford had questions for these witnesses. The Committee, having reviewed the written evidence of these witnesses confirmed that it had no questions for them and therefore they were not required to attend to give live evidence to the Committee. Similarly, the Council made Patient 1, a mystery shopper witness, available to attend the hearing for questioning, but no party, nor the Committee required him to attend.

55. The Council had arranged for the following witnesses, who were employees of the Practice; Ms B [redacted], Mr E [redacted], Ms C [redacted], Ms D [redacted], Ms E [redacted] and Mr F [redacted] to attend and give evidence. The Committee confirmed that it would like to hear their oral evidence.

56. The Council had made arrangements for Ms F [redacted] to attend to give evidence on day seven of the hearing. However, Mr Geering provided an update to the Committee that Ms F had been injured in an accident and was unable to attend the hearing to give evidence. She was absent from work and had to attend a medical appointment on the date and time that she had been scheduled to give evidence. Mr Geering referred the Committee to a bundle of medical evidence and correspondence between the Council's representatives and Ms F, in support of an application to admit the written evidence of Ms F as hearsay.

57. Mr Geering submitted that it would be appropriate to admit the witness statement of Ms F as hearsay evidence. He stated that it was open to the Committee to reschedule the witness, although the Council was of the view that it would not be necessary nor proportionate to do so. Mr Geering submitted that Ms F evidence was not the sole nor decisive evidence on any issue and there was limited indication that it was disputed. Furthermore, there was no reason to suspect that it was fabricated. In relation to the seriousness of the charge, Mr Geering submitted that Ms F evidence mostly related to the allegations in relation to the receipts, which whilst serious was only part of the Council's case.

58. Mr Geering submitted that there was a good reason for Ms F's non-attendance. He acknowledged that the medical evidence does not of itself show that she is unable to give evidence remotely, but it did confirm that she had health issues. Mr Geering highlighted that one option was for the witness to provide an update after her medical appointment today to see whether she could attend later in the hearing. Mr Geering submitted that there was no fault on the Council for the witness not attending and the correspondence bundle provided to the Committee showed that they had made efforts to secure her attendance today.

59. In relation to the issue of fairness, Mr Geering submitted that the evidence of Ms F assisted the defence in several respects, for example, in relation to the issues of printing receipts, whether children were sold OCT scans and whether lenses were over sold. Mr Geering submitted that it may be fairer to the defence to admit the evidence as hearsay than to exclude it altogether.

60. Mr Hall, on behalf of Ms Patel, had no submissions to make and was neutral on the Council's application to admit Ms F's evidence as hearsay.

61. Mr Mumford, on behalf of Ms Kothari, submitted that he was in favour of Ms F's evidence being admitted in some form, but was neutral on whether it should be admitted as hearsay evidence or whether the alternative of Ms F potentially attending on a later date should be explored. Either way, Mr Mumford indicated that he would wish to refer to the evidence of Ms F in due course and invited the Committee to admit it into evidence.

62. The Legal Adviser reminded the Committee of the advice given earlier in the hearing on the issue of admitting hearsay evidence, as summarised at paragraph 48 above.

63. The Committee firstly considered the relevance of the evidence of Ms F and found that whilst she was a somewhat peripheral witness, her evidence was relevant to several aspects of the allegations, and it agreed that her evidence was part of the tapestry of evidence in the case. It also was not evidence that was clearly challenged. There was no fault on behalf of the Council in relation to Ms F non-attendance, which was due to an unpredictable and unfortunate accident.

64. The Committee took the view that the evidence of Ms F was not sole nor decisive evidence. There was no reason to suspect that the evidence had been fabricated. The Committee was satisfied that there was a good and cogent reason for Ms F not attending as a witness. Whilst the medical evidence produced was not detailed and did not specify whether her injury prevented her from giving evidence as a witness, it was clear that she had sustained a significant injury from which she was absent from work and still recovering. Additionally, the Committee considered that the accident had only occurred recently and the witness had produced as much medical evidence as was reasonable in the circumstances.

65. In relation to whether it would be fair to admit the evidence, the Committee noted that the evidence was in some respects supportive of the Council's case and in some respects, it was supportive of the Registrants' cases. In particular, whilst Mr Hall, on behalf of Ms Patel, was neutral on the application, Mr Mumford supported the admission of the evidence, as he wished to be able to refer to it. The Committee was of the view that if the evidence was not admitted, this would not be fair to the Registrants.

66. The Committee was satisfied that in the circumstances it was fair and appropriate to admit the evidence as hearsay. The Committee considered that there was a public interest in the Committee admitting relevant evidence, when it was fair to do so and it would be able to assess the appropriate weight to attach to this evidence in due course.

67. The Committee considered the possibility of Ms F providing an update after her medical appointment and/or attending later in the case. However, the Committee noted that it was unlikely that it would have questions for this witness. It considered that it would not be necessary to explore this possibility given that the Committee was satisfied that it would be appropriate to admit the evidence as hearsay. Furthermore, the Committee did not wish to unduly delay the hearing progressing. Accordingly, the Committee decided to admit Ms F's evidence as hearsay.

68. On day 8 of the hearing, Mr Geering, on behalf of the Council, called Mr Richard Booth to give expert witness evidence. Mr Booth had provided a written expert report dated 3 July 2023, and an addendum report dated 27 November 2025, in relation to each Registrant. Mr Booth confirmed the contents of his expert reports and answered questions from the parties and the Committee.

Closing submissions

69. At the conclusion of the Council's case, Mr Geering made closing submissions, in which he invited the Committee to find all the allegations against the director Registrants, Ms Rughani and Ms Bariya, proved.

70. Mr Geering provided the Committee with written closing submissions, which he then took the Committee through. Mr Geering reminded the Committee that the Council must prove each allegation on the balance of probabilities. He submitted that the case against both directors is essentially the same and the evidence makes plain that both were instrumental in running the store.

71. Mr Geering acknowledged that at one stage Ms Rughani was less visible because she was on [redacted] leave. However, he stated there is no evidence that somehow Ms Bariya blindsided her or that unbeknownst to her Ms Bariya changed the way the store operated.

72. Mr Geering submitted that the directors acted together, as they shared profits and shared responsibility for running the premises. Mr Geering outlined that the Council's position is they jointly determined to run the store in such a way as to maximise profits. Mr Geering stated that they hiked prices, invented services, had staff misdiagnose conditions and pressured staff to recommend unnecessary products.

73. Mr Geering took the Committee through each part of the Allegations against the directors and highlighted the relevant evidence, which he submitted established the facts alleged. In relation to particular 1 of the Allegations, he submitted that on each instance where dishonesty was alleged it was cross-admissible against the others and that the Committee ought not to look at each sub-charge in isolation, as they formed part of a wider pattern of both financial dishonesty and ignoring of rules and procedures.

74. In relation to the allegations relating to the provision of OCT scans (particulars 1(a) and (b)), Mr Geering submitted that an OCT scan is not required with every eye test and comes at an additional cost. He emphasised that it was Specsavers policy that it was only recommended for someone aged over 25. Mr Geering submitted that

there was no doubt that there were times that patients were charged for OCT scans when, unbeknownst to them, the cost had been combined with the cost of an eye test.

75. Mr Geering stated that there was evidence that OCT scans were being offered to all patients, irrespective of clinical need, for example children. Mr Geering highlighted to the Committee that it did not need to find that all staff were following these practises, as the allegation states that the directors instructed members of staff, rather than all staff to do this.

76. Mr Geering submitted that the key issue is likely to be whether the practice was on the staff's own initiative or at the direction of the directors. He stated that there was no motive nor benefit for junior staff to do this, whereas there was a clear benefit to the directors, as they share in the profits of the store. Additionally, he reminded the Committee that Ms Bariya had admitted in her local investigation interview that by combining the prices she was deliberately misleading customers.

77. Mr Geering submitted that the overwhelming weight of the evidence supported that the direction to staff came from both directors and that it was a deliberate attempt to obtain more money from customers by providing an unnecessary service and depriving the customer of the option of declining the OCT cost. Mr Geering submitted that this was inherently dishonest conduct.

78. In relation to particulars 1(c) and (d) of the Allegations, Mr Geering submitted that there was clear evidence that patients were misdiagnosed. He reminded the Committee of the expert evidence of Mr Booth regarding the rate of dry eye apparent from the Specsavers audit, which was extremely high. Mr Geering acknowledged that the COVID-19 pandemic may have increased these figures but submitted that it was highly doubtful that it could account for the full extent of the discrepancy. Mr Geering took the Committee through the various witness evidence that it had heard on the pressure to "push" eye care products. Mr Geering stated that the Registrant Ms Kothari had confirmed that she was instructed to misdiagnose ocular surface dryness and oversell eye products. Ms Patel had also described being told to "really push" dry eye products by both directors.

79. Mr Geering submitted that it was not credible that staff were overselling or misdiagnosing on their own initiative and for no obvious motive; it was clear that the people who stood to benefit from this conduct were the directors.

80. In relation to particulars 1(e) and (f), regarding overcharging for certain eye care products and offering an "express service" for collecting glasses, Mr Geering reminded the Committee of the mystery shopper footage, which showed the patient being charged £12 per product, when the Specsavers prices for those three

products were £8.95, £7.49 and £9.95 respectively. Ms Bariya had admitted that the customers had been overcharged when questioned in interview.

81. Mr Geering submitted that it was improper for a director to determine Specsavers prices for products and that the directors' agreement sets out the role of a store director (defined as the day-to-day management of the Store) and it stated that pricing was not part of a director's remit. Mr Geering submitted that this overcharging was not an innocent mistake and was another example of the directors seeking to inflate revenue. It was highly unlikely that the directors thought they were permitted to alter the pricing on their own initiative.

82. Similarly, Mr Geering submitted, that there was clear evidence that the directors had introduced an express service, which was admitted by Ms Bariya in her investigation interview. Mr Geering stated that the issue was whether this was done honestly, as Ms Bariya had claimed in interview that she thought it was something that they could do. Mr Geering submitted that it was highly unlikely that either director thought that this was permitted; if so, Mr Geering asked the Committee to consider why was it not transparently recorded in the Specsavers' Socrates system. Rather, the express service was hidden by being scanned as an accessory, which had also been admitted by Ms Bariya in interview. Mr Geering submitted that there was an overwhelming inference that the directors knew perfectly well that this was not permitted.

83. In relation to particulars 1(g) and (h), which related to the production of non-itemised receipts and not accurately recording products and services on the Socrates system, Mr Geering submitted that there was a lack of transparency, which was entirely consistent with a store that was mis-selling products, inflating prices and misleading customers. Mr Geering referred the Committee to the witness evidence regarding customers not being given printed out receipts. He acknowledged that there had been contradictory evidence regarding the printer but submitted that if that was the issue surely the fault would have been dealt with and it was not confined to a matter of days but appeared to be a consistent practice.

84. Mr Geering submitted that the evidence strongly supports the inference of dishonesty, as customers did not clearly see what they had been charged. The lack of transparency obscured the overcharging, and the "express service" was not a service offered by Specsavers. By misrepresenting this transaction, Mr Geering submitted that it mitigated against the risk this misconduct would be uncovered.

85. In relation to particular 1(i) of the Allegations, dispensing high index lenses when not clinically indicated and/or without offering the patient an informed choice, Mr Geering reminded the Committee of the evidence of Mr A and the analysis of the Specsavers Socrates records which showed that in total 3,763 customers with a

"low prescription" had been dispensed with high index lenses (which were more expensive than standard lenses) within the last two years. Mr Geering submitted that this was a striking number of patients who had received high index lenses providing no real benefit. Mr Geering highlighted the comparative average rates of sales of these lenses in the region and nationally, which were much lower. Mr Geering submitted that the degree of disparity strongly suggests that the high index lenses were being dispensed unnecessarily and the drive for this must have come from the directors, which was supported by the various witness accounts on this issue.

86. Mr Geering reminded the Committee that Ms Bariya's account given in interview was that the Store's location, [redacted] is a very affluent area and that this may explain why customers were more likely to opt for the more expensive lenses. Mr Geering submitted that this could not however, explain the extent of the disparity in the high index sales and there was no benefit to the junior staff in selling these lenses to customers, whereas there was a massive financial benefit to the directors for these lenses to be sold. Mr Geering invited the Committee to find that it was a dishonest act for the directors to instruct staff to dispense lenses to patients which were not clinically indicated.

87. In relation to particular 1(j), which relates to not providing patients with a copy of their prescription, Mr Geering stated that the mystery shopper footage shows that customers were not always given a copy of their prescription, which is a legal requirement. That this practice occurred was also supported by the evidence of Ms C and Ms Patel.

88. Mr Geering turned to particular 5 of the Allegations, which relates to the insertion of false information in patient records, namely false email addresses, home addresses and inserting recommendations for products prior to any examination being undertaken. Mr Geering referred to Mr A' investigation, which identified that 1,400 customers had the store address registered as their home address, 105 customers had Ms Rughani's email address as their email address and 58 had Ms Bariya's email address recorded as their own.

89. Mr Geering stated that these facts were not disputed by Ms Bariya in interview although she had put forward an explanation that recording the store address was due to "*an issue with process*" with online appointments and that they would insert the store address to "*do a customer look up*" and then not change it when they came into store. In relation to the email addresses Ms Bariya had stated that these were her friends and family members. Mr Geering submitted that the directors must have known that inaccurate information was being inserted as both directors' email addresses had been used and that it would be highly unlikely that junior staff would have adopted such a practice without their knowledge.

90. Mr Geering submitted that the suggestion that the customers, in relation to the email addresses, were all friends and family was not a credible explanation and was a dishonest practice, as the medical records would not accurately reflect the contact details of the patient. In relation to the recommendation prior to an examination, Mr Geering highlighted the evidence relating to a "*H & B*" stamp being used, which appeared to be related to dry eye products, and submitted that inserting such a recommendation in the notes prior to the patient being seen was a dishonest act.

91. As regards to particular 6, which relates to the creation of false patient feedback submitted to the Specsavers' MAZE customer service portal, Mr Geering reminded the Committee of the evidence of the witness Ms B, who had admitted creating multiple fake email accounts (around 50), at the instruction of both of the directors. She had denied in her oral evidence that she had done so at the behest of Mr G (which had been suggested by Ms Bariya in her interview). Furthermore, the store inspection had found lists of email addresses with notes as to whether MAZE feedback had been completed or not.

92. Mr Geering submitted that the purpose of this conduct was obvious and that it was plainly a dishonest act of deceit, serving to dilute negative feedback and project a false impression of the store, to the obvious benefit of the directors. He reminded the Committee that Ms Bariya had denied any involvement and had stated that she had uncovered evidence of this herself, however there was no evidence that she took any steps to investigate this conduct, which was not credible.

93. In relation to the furlough allegations (particulars 8 and 9), Mr Geering outlined that it was not permitted for staff to work whilst on furlough and it was not controversial that several staff had been placed on furlough, as could be seen by the documents submitted to HMRC. Mr Geering stated that three staff members who had been placed on furlough worked in the store whilst on furlough, as could be seen from text messages sent from Ms Bariya to two of the staff members (Ms B and Mr G) making arrangements for them to come into work.

94. Mr Geering highlighted that Ms Bariya did not dispute in interview that these two staff members came into store whilst on furlough but stated that they came in for training. Mr Geering submitted that this did not account for the wording of the messages such as "*Need you to work tomorrow*", nor the activity recorded on the computer system under Mr G's login. Further, Ms B had admitted working whilst on furlough and denied being trained, and that Mr G had been glazing. Additionally, the witness Ms D had given evidence that she saw Mr G dispensing.

95. Mr Geering submitted that the explanation given by Ms Bariya lacks all credibility and this was a dishonest fraud. Mr Geering submitted that although arrangements

for the working on furlough had been made by Ms Bariya, there was evidence that Ms Rughani had been present in the store and it was vanishingly unlikely that she was not a party to this breach of furlough, as the directors worked as a team. Mr Geering submitted that to breach furlough was a significant decision which would not have been made unilaterally by one director.

96. In relation to the near visual acuity chart being inappropriately cut to remove print sizes N5 and N6, Mr Geering referred to the evidence of this chart being found in the store.

97. Turning to particular 13, relating to allowing or acquiescing to Registrant C conducting NHS sight tests when not on the NHS England Ophthalmic Performers List ('OPL'), Mr Geering stated that this conduct had been admitted by Ms Patel and this was not permitted. Ms Patel has clearly stated that she did so at the direction of the directors, and the Practice claimed £15,582.28 from NHS England for tests conducted whilst Ms Patel was not on the OPL.

98. In relation to particular 14 of the Allegation against Ms Rughani only, of signing GOS1 forms declaring that she had conducted the sight tests claimed for when she knew that it was Registrant C who had conducted the tests. Mr Geering submitted that the Council's case was that this was an obvious misrepresentation and if that was accepted by the Committee, it would follow that this was dishonest.

99. Mr Geering invited the Committee to find all of the matters alleged against both director Registrants proved.

100. Mr Hall had no submissions to make at the end of the facts stage. Mr Mumford, on behalf of Ms Kothari, made submissions on a discrete factual issue relating to furlough working, which arises in respect of particulars 8-10 of the Allegation against the director Registrants (that the directors allowed and/or acquiesced in staff members working whilst on furlough). Mr Mumford addressed the Committee in relation to the evidence that it had heard from Ms Al D, in which she had stated that Ms Kothari may have also worked during the furlough period.

101. Mr Mumford highlighted that Ms Kothari is not charged with any allegation of working during furlough but that there was a risk of a "taint" against Ms Kothari in relation to this issue, should the Committee make any finding of fact that she had worked during furlough. Mr Mumford made submissions regarding the evidence the Committee had heard on this issue and noted that the Council had not, in closing its case, invited the Committee to make any factual finding that Ms Kothari had worked during furlough. Mr Mumford submitted that he endorsed that approach as it would be unfair to make a factual finding in relation to a matter with which she is not charged and which she denies.

102. Mr Mumford observed that there was clear and uncontradicted evidence of other employees working during furlough, particularly Ms B's evidence, which would be sufficient to establish the relevant allegations against the directors. Mr Mumford invited the Committee to avoid making any factual finding against Ms Kothari on this issue, as he submitted that it would be unnecessary and inappropriate to do so.

Legal advice on the facts stage

103. The Committee heard and accepted advice from the Legal Adviser at the end of the facts stage, which included advice that the burden of proof throughout lies on the Council to prove, on the balance of probabilities, each of the facts alleged in the Allegation. The Legal Adviser advised the Committee that it should consider each part of the Allegation separately and the case against each Registrant separately, albeit relevant findings made in respect of one part of the Allegation can then be applied to other parts of the Allegation if relevant and appropriate to do so.

104. The Legal Adviser gave the Committee advice relating to the assessment of credibility (including not to rely solely on demeanour), expert evidence and the factors to consider when assessing the weight to attach to hearsay evidence. In relation to dishonesty, the Legal Adviser outlined the test for dishonesty in the case of *Ivey v Genting Casinos* [2017] UKSC 67 (SC), which is that the Committee should firstly ascertain subjectively, the actual state of the Registrant's knowledge or belief to the facts and then decide whether their conduct was dishonest or not by applying the objective standards of ordinary decent people.

105. The Committee were further advised that the Registrants have no fitness to practise history, and it was appropriate to give a good character direction. The Committee was reminded that good character by itself is not a defence. However, the Committee can consider good character at the facts stage, which can be relevant in relation to credibility (that it should take this into account when deciding whether it believes the Registrants' evidence) and propensity (the likelihood that the Registrant acted as alleged).

The Committee's findings in relation to the facts

106. The Committee went on to determine whether the allegations against Ms Rughani and Ms Bariya had been proved by the Council on the balance of probabilities. In doing so, the Committee considered all the evidence in this case, including the video and documentary evidence, the live witness evidence, including that from the expert witness and the hearsay evidence. The Committee also considered the submissions from the parties and the Legal Advice received.

107. Throughout its deliberations the Committee had regard to the Registrants' accounts of events, where that was known. The Committee has considered the account given by Ms Bariya in the local investigation meetings, as well as her written response to the investigation, prepared for the disciplinary hearing on 12 October 2021. The Committee noted that Ms Rughani was not interviewed during the local investigation, as she was on [redacted] leave, nor did Ms Rughani provide her own written response to the investigation.

108. In summary, Ms Bariya, in her written response to the investigation, raised concerns regarding the Investigation Report and the fairness of the process followed by Specsavers when carrying out the investigation. She raised concerns that she was being victimised and/or subject to the investigation due to having raised concerns herself against the divisional general manager. Ms Bariya states that the Investigation Report omitted key evidence which supports her position.

109. In relation to the OCT related allegations, Ms Bariya denied that she instructed employees to make false statements in respect of the charges for a sight test and that only a minority of employees had stated in their interviews that they had been advised to say the sight test was £35. Ms Bariya referred to the evidence of Ms F who had stated that she always advised customers that the OCT cost was in addition and optional and she was not aware of customers being told otherwise.

110. Ms Bariya suggested that the credibility of Ms E and Ms Kothari was undermined by them only giving their evidence on this issue after being shown the mystery shopper footage, which showed that they were not following Specsavers or store protocol. Ms Bariya raised a concern that Mr G was negatively influencing staff statements or that staff were discussing their evidence amongst themselves. Additionally, Ms Bariya stated that other Specsavers stores were combining the costs and quoting £35 for a sight test and she considered that she was being treated inconsistently to other stores on this issue.

111. Ms Bariya denied instructing staff to promote OCT scans to customers under 25 and maintained that she advised staff to only complete an OCT on children when a parent asked for it to be done. She stated that this was supported by the evidence of Ms D and Ms F, which had not been taken into account.

112. In relation to the promotion of eye care products, Ms Bariya stated that there had been an increase in customers suffering from dry eye since the pandemic, which could be from wearing face masks and increased computer use. Ms Bariya stated that the units sold were not that much higher than other stores and the difference may be due to those stores not correctly processing the products on the system. Ms Bariya further raised that there was a push by Specsavers to recommend dry

eye drops to all contact lens wearers and that ultimately it was up to the clinician to do adequate tests before diagnosing and prescribing.

113. In relation to the allegation of overcharging customers for dry eye products, Ms Bariya's position is that she had believed that the Recommended Retail Price (RRP) on Scope products was just a recommendation, and she thought she was allowed to change it. She stated that they had increased the prices on Scope products, which were not Specsavers products. She stated that the increased prices were in line with what was charged by other Opticians in the surrounding area and she had identified another branch of Specsavers that was doing the same. Ms Bariya denied that this was dishonest, as all transactions were processed through the till, customers were aware of the price and chose to make the purchase. She acknowledged that this may have been a mistake and a misinterpretation of her agreement with Specsavers but maintained that she never intended to mislead or deceive any customers.

114. In relation to the sale of high index lenses, Ms Bariya stated that as a qualified dispensing optician she did not feel that she had advised the mystery shopper in question incorrectly, as there were benefits in relation to the coating on the 1.6 lenses. Ms Bariya raised that the data shows that not all lenses dispensed at the store were 1.6 and whilst they may sell more high index lenses than average, this was because the store is in an affluent area. Ms Bariya stated that failing to give the mystery shopper customer options was a specific error on her part, as she was working under intense pressure at that time due to the absence of the store manager and this was not indicative of a regular practice at the store. She denied that she had instructed staff to automatically dispense 1.6 lens rather than discussing lens options with customers.

115. In response to allegations regarding the introduction of an express service charge, Ms Bariya explained that this was introduced as it often required a member of staff to leave the shop floor to produce the glasses outside of the routine lab process. She stated that in offering this service she did not realise that she was doing anything wrong, and she denied that customers had been misled, as the standard process could take up to 10 days.

116. In relation to the receipts, Ms Bariya maintained that the till printer was not printing clearly, with a vertical line across the print. A temporary solution implemented was to create a receipt on letter headed paper and email this to the customer. Ms Bariya denied the suggestion in the investigation report that this was deliberate or to conceal anything. In relation to not providing prescriptions, Ms Bariya denied that she knowingly or negligently allowed Optometrists to withhold prescriptions from customers and that a qualified Optometrist should be aware of their legal obligation to do so.

117. In relation to the NHS claims and allowing Ms Patel to carry out sight tests once she became a fully qualified Optometrist, but before being included on the NHS England Performers List, Ms Bariya denied knowingly or negligently allowing this to occur. She stated that this was a clinical matter and was not within her scope of responsibilities or her role as Retail Director. When she was interviewed regarding this issue Ms Bariya stated that she was not aware that it was not permitted for Ms Patel's supervisor, Ms Rughani, to sign the forms after she had qualified but before she had her OPL number.

118. Ms Bariya denied that she was involved in the submission of fabricated MAZE feedback responses by employees, nor in failing to maintain patient records properly by recording the store details instead of patients' email and home addresses. She stated that she did find a book in the office that had emails in and she took picture of this, as she was not sure what the emails were for. Ms Bariya stated that she also found a list with emails and passwords in November 2020 and began to investigate further and she had started to question a staff member about this. However, the investigation had to be put on hold due to staff absence, lockdown and Christmas.

119. Ms Bariya stated that it had been her intention to share her findings regarding the MAZE feedback with Specsavers once she had investigated it further herself. Ms Bariya alleged that this conduct was committed by Mr G, whose likely motivation was to address the many complaints that had been made about him by customers and that Ms B's evidence had been influenced by Mr G.

120. In her response to the furlough allegations, Ms Bariya stated that "*we are aware of our obligations under the scheme*" and that the staff members that came into the store during furlough were attending training on health and safety, repair of spectacles and different types of contact lenses, when no clinics were running. Ms Bariya stated that Ms B may have been confused when giving evidence on this issue in interview as English is not her first language. In relation to Mr G being in work whilst on furlough, Ms Bariya stated that he was there for training and he had come in to re-do a measurement so that he could learn how to do it properly.

121. The Committee had regard to the above account put forward by Ms Bariya but was mindful that she had not attended these proceedings to give evidence before the Committee and therefore her account had not been tested under cross-examination, which affected the weight that could be attached to it.

122. Throughout its deliberations the Committee bore in mind that both Registrants were of good character, with no prior to fitness to practise history and that this was relevant to their credibility (whether they were being truthful) and propensity (of how

likely it is they acted as alleged). However, in considering the weight to attach to the Registrants' good characters the Committee was again mindful that it did not hear direct accounts from either of the Registrants. The Committee did not draw adverse inferences from the Registrants' non-attendance.

123. The Committee considered the submissions made by Mr Geering at the outset of his closing arguments, which related to the case against both director Registrants being essentially the same and that they had acted together. The Committee was mindful that the two directors had differing qualifications and roles, with Ms Rughani being an Optometrist and Clinical Director and Ms Bariya being a Dispensing Optician and Retail Director. Notwithstanding this, the Committee formed the view that it was a common theme from the evidence before the Committee that the two directors worked closely together in the general daily operation of the store, which was a small practice, and they both maintained a close oversight of staff. Additionally, both directors had a financial interest in the performance of the store, as they both received a share of the profits.

124. The Committee therefore broadly agreed with Mr Geering's submission that the two directors shared responsibility for the operation of the store and that it is likely that they acted jointly in making key decisions regarding the store and implementing material practices and procedures.

125. The Committee considered each of the disputed particulars of the Allegation in turn and against each Registrant separately and in turn.

Allegation particular 1. On one or more occasions intentionally did the following, and / or encouraged and / or pressurised members of staff to do the following:
a. provide OCT scans which were inappropriate and/or not clinically indicated

126. The Committee considered whether OCT scans had been provided, on one or more occasions, that were inappropriate and/or not clinically indicated. The Committee was of the view that there was clear evidence from the local investigation that OCT scans had been carried out on patients who were under 25 (finding that over a 2-year period 329 OCT scans were performed on patients under 25 including children).

127. The Committee noted that Specsavers policy was that OCT scans were generally only recommended for over 25-year-olds, which was supported by the expert evidence of Mr Booth. In his expert reports Mr Booth stated that,

> "*Whether the patient is offered an OCT scan is a matter of clinical judgement. In my opinion unless there is a history of retinal disease or an appropriate family*

history, OCT scans on all patients below the age of 35 are unhelpful as they are unlikely to reveal any pathology. However, I understand that there may be a reasonable body of optometrists who believe that OCT should be performed on all patients over the age of 21. I cannot find any evidence to suggest that OCT scans on children would be beneficial."

128. The Committee accepted the expert opinion of Mr Booth and was satisfied on the evidence before it that patients under 21 generally do not require an OCT scan (unless there is a particular clinical indication to do so for a specific patient).

129. The Committee had regard to the evidence of Ms C, which was to the effect that OCTs were provided to everyone and all children and when asked in her investigation interview who recommended that OCTs be carried out on children she replied, "*The directors have said to do it*." When asked whether anyone ever explained to her which customers would need an OCT scan she replied, "*No that's never been explained to me*."

130. The Committee considered that Ms C had been a credible and reliable witness, and it accepted her evidence. It further noted that Ms C was told to include the OCT cost with the eye test and offer it to everyone.

131. The evidence of Ms C was also corroborated by the evidence of Ms E and Mr E. Mr E's evidence was that in his experience of working at the store OCTs were routinely done for children, which he was surprised about. In his investigation interview Mr E was asked where he thought the culture to try and get customers to spend more money came from and he replied,

"*I think Sapna and Bansri, you would see them do it, even with pre-test and even with children, which I thought was pretty strange, they would always try and push OCT even though its only supposed to be for 25 and over, they would encourage you to sell it to them*."

132. The Committee noted that not all staff were consistent on this issue, as Ms F in her witness statement was not aware of such a practice. However, the Committee had not heard directly from Ms F, whose evidence had been admitted as hearsay and was untested. Accordingly, the Committee considered that this evidence had less weight and it preferred the evidence of the live witnesses that it had heard from.

133. Additionally, the Committee noted that the Allegation did not require them to find proved that this was conduct carried out by all staff, but rather whether this conduct was carried out by the directors directly or whether some staff had been encouraged or pressurised to so act.

134. The Committee was of the view that to perform OCT tests on categories of patients for whom there was no clear benefit, such as children, incurring for them an increased financial cost that was unnecessary, would be inappropriate and in many cases would not be clinically indicated.

135. The Committee was satisfied on the basis of the witness evidence it had heard that this was a practice that was undertaken by the directors themselves and that some members of staff had been pressurised by the directors to undertake. The Committee was satisfied that there were sufficient accounts from staff members supporting that this conduct occurred for it to be proved on the balance of probabilities that the directors had instructed them to provide OCT scans that were inappropriate and/or not clinically indicated.

136. The Committee additionally considered it relevant that there was no motivation or benefit to junior members of the staff in offering OCT scans to patients that were inappropriate and/or not clinically indicated, without being instructed to do so. Whereas there was a clear financial benefit to the directors.

137. Accordingly, the Committee found this particular proved in relation to both directors, Ms Rughani and Ms Bariya.

On one or more occasions intentionally did the following, and / or encouraged and / or pressurised members of staff to do the following:
b. charge for OCT scans without advising the patient it was optional,

138. The Committee heard evidence from several members of staff at the store that they were instructed to include the cost of the OCT scan together with the cost of the eye test, in effect removing the choice from customers to decline to have the OCT scan. Ms C's evidence was that she had been instructed by the directors to tell customers that the sight test was £35 (by including the cost of the OCT with the cost of the eye test).

139. Furthermore, this practice was shown to have occurred on the mystery shopper footage. The evidence of this practice was further corroborated by the evidence of Ms E, who confirmed that the directors told her to say the sight test was £35.00 and the Committee found Ms E to be a reliable and credible witness.

140. Additionally, Ms C gave evidence that OCTs were provided routinely to all patients including all children and patients would not be informed that OCTs were optional. Ms C stated in her investigation interview,

> *"I take the customer in the room and Sapna and Bansri told me to confirm the cost of the sight test as £35.00 but I'm not sure what conversation they've had*

with the customer beforehand…..I been told to say that the test is £35 which includes the OCT as standard and this instruction has come from Sapna and Bansri…"

141. The Committee also noted that Ms Kothari also gave an account of this practice in her investigation interview stating that both directors told her to say the eye test cost £35 and to not give patients the option of having the OCT scan, although the Committee bore in mind that it had not heard direct evidence of this from Ms Kothari in the hearing.

142. In relation to Ms Bansri the Committee noted that she had accepted in the local investigation interview that by not telling customers that they do not need to have the OCT she was deliberately misleading customers, to which she had agreed:

"*PB… Right, you are telling a customer that the sight test is £35, what you're not saying to the customer is, the sight test is £35, yeah, but actually you don't have to have the OCT you could have a sight test which is cheaper than the £35 including the OCT. So, you are misleading, deliberately misleading a customer into thinking that their sight test, the only sight test is £35. Am I wrong?*
SB: No
PB: So, you're misleading the customer? Deliberately?
SB: Yeah
PB: Who is the OCT test being offered to? Are you doing it on everyone? What do you mean? Who do you offer the OCT test to?
SB: Anyone over 21"

143. The Committee considered the explanation given by Ms Bariya during the investigation which was that she had not directed the staff members to charge customers for the OCT without explaining that it was optional, and in essence that they were lying on these issues. The Committee considered that it was significant that the staff members had no motivation or benefit to act in this manner, whereas there was a clear financial benefit to the directors, from increased revenue for the store. The Committee preferred the evidence of the witnesses it had heard from during the hearing over the account provided during the investigation by Ms Bariya.

144. The Committee noted that there was evidence from some staff members that they would break down the cost of the eye test and make clear that the OCT was optional, for example, the evidence of Mr E and Ms D. The Committee noted that the Allegation did not require them to find proved that this was conduct carried out by all staff, but rather whether this conduct was carried out by the directors directly and/or whether some staff had been encouraged or pressurised to so act.

145. The Committee was satisfied that there was clear evidence that this was a practice that was undertaken by the directors themselves and that some members of staff

had been encouraged or pressurised by the directors to undertake this practice and that the evidence supported that it was an instruction provided to staff by both directors.

146. Accordingly, the Committee found this particular proved in relation to both directors, Ms Rughani and Ms Bariya.

On one or more occasions intentionally did the following, and / or encouraged and / or pressurised members of staff to do the following:
c. misdiagnose patient(s),

147. The Committee considered that there was clear evidence that patients had been misdiagnosed with dry eye conditions and/or blocked glands, and this had been admitted by the two junior employee Registrants Ms Patel and Ms Kothari, by virtue of their admissions to these allegations, as a result of which those matters had been found proved. The key issue was whether the director Registrants had also done so, and/or encouraged and/or pressurised the staff to do so.

148. Ms Kothari's account in her investigation interview was that she had misdiagnosed ocular surface dryness because she was told to by Ms Rughani, who was her supervisor (Ms Kothari being a pre-registration Optometrist at the relevant time). Ms Kothari's evidence was that the pressure to sell eye products increased when she returned from furlough and that she was told by Ms Rughani to advise patients that their glands were blocked to sell the eye products. In Ms Kothari's witness statement for these proceedings, she states that:

> *"…I was instructed by Bansri and Sapna to perform the test (applying Sodium Fluorescein) on all adult customers and to tell all adult customers that they had dry eyes according to the test performed, even if there was no clinical indication of such."*

149. Ms Patel's account is that she oversold products to patients who did not necessarily need them or have severe enough issues to warrant them and that she was instructed to push the product sales by both directors. Whilst neither Ms Kothari or Ms Patel had given evidence in these proceedings, they had provided witness statements, signed by a statement of truth, which the Committee considered to give open and credible accounts. Furthermore, they had made admissions to serious allegations, and these admissions were credible and consistent. The Committee was satisfied that the evidence of Ms Kothari and Ms Patel was reliable, and it accepted this evidence.

150. The Committee also bore in mind that there was no motive for junior members of staff to misdiagnose patients of their own accord but that there was a clear financial motive for the store directors to increase their profits from selling more eye care products.

151. The Committee also had regard to the statistical analysis carried out in the investigation report regarding the sales of eye care products in the store and Mr Booth's evidence of the rate of dry eye found in the Specsavers' audit, which was high. Mr Booth found instances within the patient records of no symptoms being recorded that would suggest the products were clinically indicated but they were diagnosed with dry eyes nevertheless.

152. The Committee, having accepted the evidence of Ms Kothari and Ms Patel on this issue, was satisfied that there was sufficient evidence on the balance of probabilities to find that both directors had pressurised staff to misdiagnose patients in order to sell more eye care products. The Committee was satisfied on a balance of probabilities that both directors were engaged in this practice jointly. Accordingly, the Committee found this allegation proved against both directors, Ms Rughani and Ms Bariya.

On one or more occasions intentionally did the following, and / or encouraged and / or pressurised members of staff to do the following:
d. recommend eyecare products which were not clinically indicated for:
i. dry eye conditions, and/or
ii. blocked glands,

153. The Committee considered that this allegation was inextricably linked to particular (c) and that one flowed from the other, in that the recommendation for eyecare products would follow the misdiagnosis and the motive for both was likely to be to increase the sales of the eye care products, which would financially benefit the directors.

154. The Committee's findings in relation to particular (c) apply in relation to this particular. The Committee considered that the evidence of Ms Kothari, Ms Patel, Mr Booth and the statistical analysis on the increased sales of products from the investigation all support this allegation. Additionally, the evidence of Ms D and Ms E corroborates more generally that there was a pressure from the directors for staff to sell eye care products and that the pressure increased after training on dry eyes had been provided.

155. Ms E described in her investigation interview that "*I would say almost every patient is recommended some kind of dry eye products whether it be drops or an eye*

bag...". Ms D in her interview described the pressure to sell eye care products as "toxic" stating,

> "*It was a toxic pressure and what I mean by this if I didn't recommend the eye drops then the Directors would give me a 'look' or would make a comment that made me almost afraid to tell them that the patients didn't need anything*."

156. The Committee considered the explanation given by Ms Bariya for the increase in sales of eye care products being due to the pandemic. However, it was satisfied, based upon the expert evidence of Mr Booth who had given evidence on this issue, that whilst this may explain an increase in sales it would not do so to the extent found to have been sold in the store.

157. The Committee was satisfied on the balance of probabilities that both directors had pressurised staff to recommend eye care products to patients that were not clinically indicated and that both directors were engaged in this practice jointly. Accordingly, the Committee found this allegation proved against both directors, Ms Rughani and Ms Bariya.

On one or more occasions intentionally did the following, and / or encouraged and / or pressurised members of staff to do the following:
e. overcharge for certain eye care products,

158. In relation to this allegation, the prices that the store should have been charging for products are set by Specsavers and pricing is not deemed to be part of the directors' remit under the director's agreement, which was a commercial agreement between both directors and Specsavers. Ms Bariya in her investigation interview accepted that the store had charged higher prices for Scope products, stating that "*We thought we could charge over the recommended retail price.*"

159. The Committee considered that it was clear that Ms Bariya had admitted the facts of this allegation, as she accepted that they had increased the prices (albeit maintaining that she believed this was allowed). The Committee noted that it had no account from Ms Rughani on this issue. However, it was noted that Ms Bariya had referred to "we" when talking about charging more and there was nothing to suggest that Ms Bariya had made this decision to increase prices unilaterally without her co-director Ms Rughani being aware of and in agreement with it.

160. The Committee noted there was evidence that both directors would work at the front of the store, using the till system and preparing manual receipts. The Specsavers investigation report had analysed the sale of products through the system and found that sales had been processed by both directors. Further, there was evidence that the store was not using the stock keeping unit ('SKU') codes on the system for these

products, as use of those codes would have processed the sale for the lower Specsavers set price and instead they had devised an alternative way to charge for them. The Committee considered that the two directors worked closely together in the day-to-day operation of the store and considered it more likely than not that Ms Rughani would have been jointly involved in a material decision such as charging more for products than the Specsavers set prices.

161. The Committee was satisfied on the balance of probabilities that both directors had on one or more occasions intentionally overcharged for certain eye care products. Accordingly, the Committee found this allegation proved against both directors, Ms Rughani and Ms Bariya.

On one or more occasions intentionally did the following, and / or encouraged and / or pressurised members of staff to do the following:
f. offer an "express service" for collecting glasses,

162. The Committee was satisfied that an express service was offered by the store, as could be seen from the mystery shopper footage. Furthermore, this had been admitted by Ms Bariya in the investigation interview, who did not dispute that an express service was offered to customers. Ms Bariya's explanation was that she thought it was something that they were allowed to do.

163. Whilst the Committee did not have an account from Ms Rughani, the Committee was satisfied that it was likely that both directors jointly decided to implement this system. The Committee accepted the evidence of Ms C who had given evidence that both directors had asked her to carry out an express service to make glasses. The oral evidence of Ms B was also that she would be asked to carry out the express service by Sapna and sometimes Bansri.

164. The Committee was therefore satisfied on the balance of probabilities that both directors had on one or more occasions intentionally offered an express service for the making of glasses. Accordingly, the Committee found this allegation proved against both directors, Ms Rughani and Ms Bariya.

On one or more occasions intentionally did the following, and / or encouraged and / or pressurised members of staff to do the following:
g. produce receipts which were not itemised and/or did not accurately reflect all the patients' purchases

165. The Committee heard evidence from witnesses that staff would provide customers with a card receipt (PDQ receipt), but if they required an itemised receipt this would

be produced by the director Registrants, which would usually be completed by them at the end of the day and either printed or emailed to customers.

166. Ms Bariya, in her response to this allegation during the investigation, accepted that if they did not provide customers with itemised receipts this was due to the till receipt printer not working.

167. The Committee considered that if the printer was not working it should only have been a temporary issue and this excuse would not explain the whole period in question. Additionally, staff witnesses had given evidence that the directors would print receipts at the end of the day. Ms C's evidence in her investigation interview was that customers would be given PDQ slips when they pay, as the till receipt would not be printed out until later when the directors complete the transaction on the till.

168. When asked if the till printer worked, Ms C stated that "*I think its always worked. I've never seen it not working*." Similarly, Mr E's evidence was that the till printer worked, and he had never known it not to work whilst he has worked at the store. Mr E further gave evidence that he saw both directors preparing manual receipts for customers when they requested an itemised receipt.

169. The Committee further noted that several customers had complained about not being provided with itemised receipts, including the initial customer complaint that started the investigation.

170. The Committee considered that this allegation was interlinked with the allegation of not accurately recording products and services on the Specsavers' Socrates system. By routinely not providing patients with an itemised receipt patients would be less likely to query their purchases. This meant the directors could avoid entering items such as the express service accurately on the till system. The Committee was satisfied on the evidence before it that the directors intentionally would not provide patients with itemised or accurate receipts. Accordingly, the Committee found this allegation proved against both directors, Ms Rughani and Ms Bariya.

On one or more occasions intentionally did the following, and / or encouraged and / or pressurised members of staff to do the following:
h. not accurately record the products/services purchased on Specsavers' Socrates system

171. The Committee considered that there was clear evidence that the Registrants would not record products and services accurately on the system, for example by scanning an accessory through four times, in order to process through the till the

price they wished to charge for the express service. The purpose for this was because the Registrants were selling eye products at a higher price than the Specsavers price and offering the express service, which did not have an SKU code on the system, as it was not a Specsavers authorised price or service. Therefore, the directors bypassed the usual process by scanning other items several times.

172. The Committee noted that this was accepted by Ms Bariya when she was interviewed as part of the investigation. Ms Bariya acknowledged that by doing so the actual products and services provided to the customer were not accurately recorded on the Socrates system, which would make it difficult for Specsavers to ascertain what products and services the customer had actually received. Furthermore, in her interview Ms Bariya stated that only herself, Ms Rughani and the store manager Mr G operated the till and that other staff members did not have access to it.

173. The Committee was therefore satisfied on the balance of probabilities that both directors had on one or more occasions intentionally not accurately recorded the products/services purchased on Specsavers' Socrates system. Accordingly, the Committee found this allegation proved against both directors, Ms Rughani and Ms Bariya.

On one or more occasions intentionally did the following, and / or encouraged and / or pressurised members of staff to do the following:
i. dispense high index lenses when not clinically indicated and/or without offering the patient an informed choice

174. The Committee considered the various witness accounts on this issue. It noted that several members of staff had given consistent evidence to each other that they would be required to ask one of the directors which lens to recommend to the patient. They would then be told which lens and the price, without giving the patient the range of options available. Mr E had given clear evidence that there was a culture in the store of pushing more expensive lenses upon customers and that this came from both directors.

175. The Committee also had regard to the mystery shopper video in which one of the mystery shopper patients was told the price for a high index lens by Ms Bariya and was not given a choice of lenses. In all three mystery shopper videos the patients were not given a choice of lenses. The Committee considered that the mystery shopper footage showed this practice in action and corroborated the witness evidence on this issue.

176. The Committee additionally had regard to the expert evidence of Mr Booth on this issue, which was that it was not appropriate to encourage or train staff to automatically dispense higher index lenses unless there is a clinical need for them, which would be dependent on the prescription. Mr Booth's opinion, as explained in his oral evidence, was that below a power value of 3.50, high index lenses were unnecessary and there was no advantage to the patient.

177. The Committee noted that in the original complaint that commenced the investigation, the patient stated that he had been offered the high index lenses despite having a low prescription. The patient stated that he was told it would reduce the thickness of his lens, but when he visited a different optician, he was told that the high index lenses would not make any difference.

178. Additionally, the Committee considered that the Specsavers statistical analysis, which was carried out as part of the local investigation, supported that this practice was in operation. This showed that the store was dispensing high index lenses at a much greater proportion, than at an area or national level. The average sale rates for high index lenses for the region were 11% and the UK was 6%, whereas the store's sales rate was 35%.

179. The Committee considered Ms Bariya's explanation given in interview that this was due to the store being in an affluent area. However, the Committee was of the view that this would not account for the full extent of the discrepancy in the statistics. This account was also not supported by the weight of the evidence before the Committee, and it concluded that this explanation was not plausible. Notwithstanding the store may be in an affluent area, the Committee considered it unlikely that patients would purchase more expensive lenses than they required if they were of no material benefit to them. The Committee concluded that it was more likely that the patients concerned were not being given an informed choice regarding the lens options.

180. The Committee was of the view that given the respective roles of the Registrant directors, with Ms Bariya being the Dispensing Optician and Ms Rughani being an Optometrist, this was intentionally done by Ms Bariya, as the Committee was satisfied that she deliberately dispensed high index lenses when not clinically indicated and without offering an informed choice, as shown by the mystery shopper footage, as well as pressurising others to do so (by telling the Optical Assistants which lenses to dispense).

181. In respect of Ms Rughani, the Committee was satisfied that she, in her role as joint director, did not dispense lenses herself directly, when not clinically indicated or without offering patients a choice, but pressurised others to do so. The Committee was satisfied that Ms Rughani was also involved in this practice, as she would also

operate, and put purchases through, the till. The Committee was satisfied that both directors would know that most patients would not require high index lenses and that patients should be given a choice of lenses, including cheaper lenses. The Committee found that this was a practice that benefited both directors, through the increased sales of high index lenses, which were more expensive for patients to purchase.

182. The Committee was therefore satisfied on the balance of probabilities that this allegation was proved against both directors, Ms Rughani and Ms Bariya.

On one or more occasions intentionally did the following, and / or encouraged and / or pressurised members of staff to do the following:
j. not provide patient(s) with a copy of their prescription

183. The Committee accepted the expert evidence of Mr Booth regarding the importance of patients being issued with a prescription at the end of their appointment and that this was a legal requirement. However, the Committee heard evidence that prescriptions were often not provided to customers at the store.

184. The Committee noted that the responsibility to provide a patient with a copy of their prescription sat with the testing Optometrist. However, it heard evidence from Ms D that there was no means of printing prescriptions from within the examination room. The Committee considered that there was strong evidence that patients were regularly not being provided with a copy of their prescription and that this had become part of the store's usual practice, rather than isolated incidents.

185. Ms C's evidence was that the prescription would be provided if patients asked for it. This was supported by the evidence of Mr E, which was that prescriptions were not always provided on the day of the appointment. The Committee further had regard to the mystery shopper footage where none of the three mystery shopper patients were provided with a copy of their prescriptions. Additionally, the Committee noted that there had been customer complaints relating to this issue.

186. The Committee considered that whilst there was a specific duty upon the Optometrists practising at the store to provide patients with a copy of their prescriptions, both directors also had an overall responsibility to ensure that the store had adequate systems and processes in place to enable the Optometrists to comply with this legal duty. The Committee considered that it was likely that each director was aware of the practices within the store regarding issuing of prescriptions, which was a fundamental part of the eye test.

187. The Committee considered that it was reasonable to infer that Ms Rughani, as an Optometrist, had on one or more occasions intentionally not provided patients with a copy of their prescription and in respect of both directors on one or more occasions encouraged other members of staff to not do so. Accordingly, the Committee found this allegation proved against both directors, Ms Rughani and Ms Bariya.

2. In respect of 1 (e) and (f) you knew you were not permitted to set these prices and/or offer this service

188. The Committee was provided with a copy of the Specsavers directors agreement that had been signed by both directors. This was an important legal agreement setting out the scope of the directors' roles as part of a franchise agreement with Specsavers and the Committee was satisfied that by signing this document it was reasonable to draw the inference that both directors had read and understood it.

189. The directors' agreement defines the director role as being the day-to-day management of the store and at Clause 3.2.15, it lists matters that are not part of the day-to-day management of the store, listing 'pricing' as one of those matters not within the remit of the directors.

190. The Committee considered that the terms of this agreement were clear and prevented the directors from charging their own prices (as this was outside of the scope of the director role and sat with Head Office). It was also satisfied that it was clear from the terms of the agreement that the directors could not introduce their own additional services, such as the express service, without permission from Specsavers Head Office, which was not sought.

191. The Committee was of the view that Ms Bariya's acceptance that they were scanning items through multiple times to charge for the increased prices and express service, because they did not have a SKU code for them, indicates that the directors knew that they were not permitted to makes these changes, as they had to subvert the usual process in order to scan them through the till.

192. The Committee considered the explanation given by Ms Bariya, which was that she thought that RRP was just a recommended price and that she thought she could increase it and that they were selling Scope products, which were not Specsavers products. However, the Committee did not consider that this was a credible account. The Committee did not consider the fact that the eye care products were Scope products was material to the issues, as Specsavers sold Scope products and had provided SKU codes for them, which the directors were not using (because they wanted to charge higher prices).

193. The Committee considered that the terms of the agreement were very clear that directors were not permitted to set their own prices nor offer the express service and was therefore satisfied on the balance of probabilities that this allegation was proved against both directors, Ms Rughani and Ms Bariya.

3. In respect of 1 (g) and (h) you intended to disguise from the patient what particular products/services had cost them, and/or to disguise from Specsavers that you were offering an "express service"

194. Ms Bariya, in her account given during the local investigation, had maintained that the store had been transparent with patients and she gave explanations for why itemised receipts had not been provided, or products not accurately recorded on the system, for example because the printer was not working. However, Ms Bariya had also accepted that because they did not have SKU codes for the increased prices or the express service, they would have to scan other items such as accessories through multiple times. This would be likely to be queried by customers when they checked their receipts, for example, with one mystery shopper their receipt showed that eye wipes had been scanned through five times, when they had not purchased five packs of eye wipes.

195. The Committee was of the view that the most likely explanation for producing receipts that were not itemised and to not accurately record products and services that were purchased on the Specsavers' Socrates system, was to disguise from both the patient what particular items had cost and to disguise from Specsavers that an express service was being offered, when it was not permitted under the franchise agreement.

196. The Committee considered Ms Bariya's explanations on these issues, but did not consider them to be credible, particularly as creating manual receipts at the end of the day would be a time-consuming exercise that would only likely be practised if there was a clear benefit to the directors in doing so.

197. The Committee found that the directors having an intention to disguise these matters from patients and Specsavers to be more inherently likely, applying common sense. The Committee was satisfied that both directors were involved in this practice, as it had before it several examples of manual receipts that had been created by both directors, as their names appeared on them (there was a third unknown signature on them and the Committee considered that this was consistent with only three people being allowed to operate the till).

198. The Committee therefore satisfied on the balance of probabilities that both aspects of this allegation was proved against both directors, Ms Rughani and Ms Bariya.

4. Your actions at 1 a-i, 2 and 3 were dishonest

199. The Committee has found all parts of particulars 1 a-i, 2 and 3, proved in relation to both directors. The Committee considered each particular again with respect to whether the facts found proved were dishonest.

200. In relation to the sub-particulars of particular 1, the Committee was satisfied that its findings of fact were in many instances inherently dishonest, for example by finding the directors had intentionally (and/or through pressurising staff to do so) misdiagnosed patients with dry eye conditions in order to sell them eye products that they did not require.

201. Where the actions in a sub-particular may not necessarily be dishonest per se if viewed in isolation (for example increasing prices), the Committee considered that it was nonetheless dishonest when considered in the context of this case and given its other findings. The Committee considered that the actions found proved established a pattern of dishonest conduct, by the directors deliberately (either directly or pressurising staff to do so) not being honest with patients regarding the pricing of services (for example in relation to the cost of the eye test and not giving patients the option to decline the OCT) and operating the store in a manner that put increasing profits over patient best interests, by over-selling eye products (through misdiagnosis), overcharging for products and the sale of high index lenses, when they were not clinically indicated or without offering patients an informed choice.

202. The Committee was satisfied that to sell high index lenses when not clinically indicated and without giving patients a choice of more affordable lenses, was clearly motivated to increase profits, which was inherently dishonest conduct. The Committee noted that this was occurring on a significant scale, with 3763 patients with a “low prescription” dispensed with high index lenses in a two-year period. The Committee found that both directors had deliberately chosen to run the practice in this manner, to maximise profits at the expense of patients and their actions were financially motivated.

203. In respect of particular 2, the Committee had found that the directors knew they were not permitted to increase prices or offer the express service. The Committee agreed with the Council’s submissions that this was another example of the directors seeking to inflate revenue for the store. The Committee had further found that the directors’ actions in particular 3 were intended to disguise their actions from

patients and Specsavers, effectively to conceal their actions, likely to avoid complaints and/or detection of these practices.

204. The Committee considered the test in *Ivey v Genting Casino's* and was satisfied that both directors had intentionally acted in the manner alleged, which an ordinary decent person, in knowledge of the facts, would consider to be dishonest.

205. The Committee therefore was satisfied on the balance of probabilities that this allegation was proved against both directors, Ms Rughani and Ms Bariya.

5. On one or more occasions you intentionally did and/or allowed and/or acquiesced in the insertion of the following false information in patient records:

a. email address(es) linked to you as the patient's personal email address, and/or
b. the optician's address as the patient's home address, and/or
c. recommendations for products prior to any examination being undertaken

206. The Committee noted that the investigation report sets out that 1,400 customers had the store's address recorded as their address, 105 customers had Ms Rughani's email address recorded at theirs and 58 had Ms Bariya's email address recorded as theirs in the store's records. Significantly, it was found that both directors' email addresses were used instead of the correct email addresses for patients. The Committee was provided with examples within the bundle of false addresses being recorded on the system for patients, as well as evidence of other staff members, whose email address had also been used, receiving emails that were meant for patients.

207. The Committee was satisfied that for the patients who were the subject of the allegation, false information had been recorded in their patients' records, as the emails and/or home addresses were not correctly recorded for them. This would have caused issues in the store contacting those patients if that was necessary.

208. This allegation was put to Ms Bariya in interview, and she did not deny the factual findings underpinning this allegation, although she put forward an explanation that the patients concerned were her friends and family. It was also suggested that the store address may be used if the patient was homeless or that it was necessary to add incorrect details as a "process issue" to enable an online booking to be made. The Committee considered these explanations but concluded that they were not credible given the number of patients whose records were affected. The process issue was not corroborated by other staff members. The Committee took the view that the most likely explanation, given its other findings, is that the Registrants' emails and store address were used instead of the patients in order to break the

connection between Specsavers and the patient, to divert correspondence away from the patient.

209. The Committee considered that this must have been a deliberate act and could not have been accidental due to the scale of incidents found. Further, it was likely that both directors were aware of this practice as they likely would have been receiving automated emails intended for the patient, given that both of their email addresses had been used in this manner. Ms Bariya, when discussing this issue, stated "*we did see that*…", which the Committee interprets as a reference to both directors. The Committee was satisfied on the evidence before it that this was a practice that was either carried out by the directors themselves and/or by staff at their direction.

210. The Committee therefore satisfied on the balance of probabilities that both parts of this allegation, a) and b), concerning false email addresses and home addresses, was proved against both directors, Ms Rughani and Ms Bariya.

211. When considering particular 5 c), which relates to the insertion of false information in patient records regarding recommendations for products prior to any examination being undertaken, the Committee took the view that the H&B stamp which this allegation is based upon was used as a prompt to Optometrists to discuss dry eye issues with the patient. Evidence to this effect, that the stamp was used as a reminder, was given by the witness Ms D. The Committee was satisfied that this was part of the pressure put on Optometrists in the practice to misdiagnose dry eye issues and to sell more of the dry eye products.

212. However, the Committee noted that this was stamped onto the TR form (a patient details form), which was handed to the Optometrist at the start of the appointment. This is used during the examination but does not form part of the patient records and would usually be shredded afterwards. As such, the Committee was not satisfied that false information regarding product recommendations made prior to examination had been entered into patient records, which is what is alleged.

213. Accordingly, the Committee was not satisfied that the Council had discharged the burden of proving the allegation 5(c).

6. On one or more occasions you did and/or allowed and/or requested the creation of:
a. false email accounts for the purpose of submitting false patient feedback,
b. false patient feedback which was submitted to the MAZE Customer Service Portal

214. The Committee had heard live witness evidence from Ms B that she had made up about 50 false email accounts and that she submitted false patient feedback. Her

evidence was that she had been asked to do so by both directors. Ms B further stated that Ms Bariya had asked her for the passwords for the false email accounts, which in the Committee's view she would not need unless she was involved in creating the false feedback.

215. The investigation found that 406 false email accounts were recorded on the store's systems. The Committee was also provided with photographs of false email account lists that were sent to Ms Bariya. The Committee was therefore satisfied that false email accounts had been created and that the purpose of doing so was to submit false patient feedback, which in the Committee's view was the only reasonable explanation for creating the false email accounts.

216. The Committee considered Ms Bariya's account in respect of this allegation. In her investigation interview, Ms Bariya had not denied that false email accounts had been created but suggested that it was done by a member of staff (Mr G) who had received several complaints and claimed that he may have been seeking to improve his MAZE feedback. However, the Committee noted that the feedback that was flagged as suspicious in the investigation was usually generic and vague and did not refer to Mr G, so would have been of no benefit to him. Ms Bariya stated that she was going to take further action once she had investigated this further, but her investigation was delayed by the staff member being absent and the Christmas break. The Committee did not consider this to be a credible account, as if such serious conduct was discovered by a director, the Committee was of the view that immediate action would be taken to pursue that matter further, including suspending the staff member and informing Specsavers for advice and support.

217. The Committee preferred the evidence of Ms B, whom the Committee considered gave clear and credible evidence, which was consistent with her final interview during the internal investigation. Therefore, the Committee found that she had been asked to create the false email accounts and submit false patient feedback to the MAZE Customer service portal at the instruction of both directors. The Committee considered that the conduct benefited the store generally and it was unlikely that it would have been carried out by staff members, unless they had been instructed by the directors to do so.

218. The Committee was therefore satisfied on the balance of probabilities that both aspects of this allegation was proved against both directors, Ms Rughani and Ms Bariya, that they did this directly and/or requested the creation of both a) and b).

7. Your actions at 5 a-c and 6 a-b, were dishonest

219. The Committee considered whether the actions it had found proved, namely 5 a)-b) and 6 a)-b), were dishonest. In respect of the actions at 5 a)-b), the Committee was satisfied that both directors had intentionally inserted false information into patient records, which was an inherently dishonest act. It broke the communication link between the store and those patients with the likely motive to control those communications. The Committee had rejected the explanation put forward by Ms Bariya on this issue as not being credible and it was satisfied that both directors were fully aware of this practice.

220. Similarly, with the actions in 6a)-b), false patient feedback was submitted on behalf of those patients, which the directors had instructed staff to complete, to provide extremely positive feedback, which may not have been provided had the patient had had the opportunity to provide feedback themselves. The Committee also considered this to be an inherently dishonest act, as the patients were effectively being impersonated. The likely motive was to balance out any negative MAZE feedback that the store had received.

221. The Committee had rejected the explanation put forward by Ms Bariya that she was not involved in the submission of false patient feedback as not being credible. The Committee was satisfied that both directors were fully aware that false feedback was being submitted and that they both knew it was wrong to do so.

222. The Committee considered the test for dishonesty in *Ivey* and was sure that ordinary decent people would consider the above actions to be dishonest.

223. Accordingly, the Committee was satisfied on the balance of probabilities that this allegation was proved against both directors, Ms Rughani and Ms Bariya.

8. On one or more occasions, as a director, you allowed and/or acquiesced in staff members working whilst on furlough

224. The Committee had evidence before it of the staff who had been placed upon furlough in the form of the documentation submitted to HMRC. The Committee was provided with WhatsApp/text messages between Ms Bariya and two members of staff (Mr G and Ms B), which discussed making arrangements with them for them to go into work whilst on furlough. These messages included planning for Ms Bariya to pick the staff members up to drive them to work.

225. The Committee considered Ms Bariya's explanation that they were both going into the store to complete training rather than work. However, the content of the

messages specifically referred to work, such as stating "*I need you to work Tommorow* [sic]" and do not mention training.

226. In addition, the Committee heard live evidence from Ms B in which she gave clear evidence that she went into the store whilst on furlough to work (such as sorting out contact lenses) and not to carry out training, which the Committee accepted. Furthermore, the Committee heard evidence from Ms D that when she was working as a locum Optometrist during periods of furlough, she saw Mr G working in store, dispensing. This is corroborated by evidence that Mr G had processed purchases through the till while he was on furlough.

227. The Committee agreed with the closing submission of Mr Geering that Ms Bariya's explanation about training lacked all credibility.

228. The Committee was satisfied on the evidence before it that both directors were aware of and allowed staff to work on furlough. Whilst Ms Bariya made the arrangements directly with staff to come into work, witness evidence of Ms B and Ms D supported that both directors were present in the store when this occurred. The Committee considered both witnesses to be credible and their evidence reliable given that although the furlough period was now some time ago, it was a distinctive and memorable period due to the COVID-19 pandemic. Furthermore, the Committee considered that it would be inconceivable for only one director to make such an important decision, about staff on furlough working, without the knowledge and agreement of the other.

229. Accordingly, the Committee was satisfied on the balance of probabilities that this allegation was proved against both directors, Ms Rughani and Ms Bariya.

9. You knew that employees were not permitted to undertake work for their employer under the terms of the furlough scheme

230. The Committee were provided with the terms of the furlough scheme. The Committee was of the view that businesses being given support during furlough was a significant event for businesses and it would not have been possible to apply for that support under the scheme without an awareness of how furlough worked.

231. The directors had placed some staff members on furlough and had required them to sign furlough contracts. Ms Bariya in her investigation interview has acknowledged that she understood what furlough entailed and she explained how she had placed some of the staff members on furlough. Furthermore, she accepted that working whilst on furlough would be fraudulent.

232. Whilst Ms Bariya appeared to be the director that made the arrangements for furlough, she explained that her fellow director Ms Rughani was working in the store during this time. Given how important the furlough scheme was for small businesses and how closely the directors worked together, the Committee was satisfied that both directors would be aware that it was not permitted for employees to undertake work for their employer under the terms of the furlough scheme.

233. Furthermore, in her investigation interview, Ms Bariya accepted that she knew that staff could not work whilst on furlough but that she understood that they could complete training, putting forward that as an explanation. The Committee considered that it was a reasonable inference to make that Ms Rughani would also have known that staff could not work whilst on furlough.

234. Accordingly, the Committee satisfied on the balance of probabilities that this allegation was proved against both directors, Ms Rughani and Ms Bariya.

10. Your actions at paragraph 8 and 9 above were dishonest;

235. The Committee was of the view that for the directors to allow staff to work on furlough when they knew that was not permitted was inherently dishonest, as to do so was to financially exploit public funds during the pandemic. Ms Bariya had accepted in her interview that to work whilst on furlough would be fraudulent.

236. The Committee considered the test for dishonesty in *Ivey v Genting Casinos* and was sure that ordinary decent people would consider the above actions to be dishonest. Accordingly, the Committee satisfied on the balance of probabilities that this allegation was proved against both directors, Ms Rughani and Ms Bariya.

You allowed or were aware that the visual acuity chart had been inappropriately cut to remove print sizes N5 and N6 (Particular 12 for Ms Rughani, Particular 11 for Ms Bariya)

237. The Committee received evidence that a visual acuity chart had been found during a store inspection, which had been cut to remove print sizes N5 and N6. The Committee was provided with a photograph of the chart in question.

238. The explanation given by Ms Bariya in her interview was that this chart was only used for visually impaired patients, with reduced visual acuity, who would not be able to read print sizes N5 and N6. She explained that this reduced chart was used so these patients would not be concerned about not being able to read the small print sizes when they collected their glasses. The Committee noted that other staff

members had made similar observations as to the purpose of this chart and Ms Bariya's account was supported in that regard by the written evidence of the Registrants Ms Patel and Ms Kothari.

239. The Committee considered that a key issue for it to determine was whether use of such a chart was inappropriate. The Committee heard expert evidence from Mr Booth regarding the visual acuity chart and how to cut the chart off to remove print sizes may be inappropriate, although he appeared to acknowledge that it may be appropriate in some circumstances.

240. The Committee was not clear on whether this allegation related to all of the charts that were being used when glasses were being dispensed or collected or whether this was one chart that had been found during the store inspection. The Committee considered that given this uncertainty and the evidence of Mr Booth, which it did not consider to be definitive on this issue, it was not satisfied that this allegation had been proven on a balance of probabilities.

241. Therefore, the Committee found this particular of the allegation not proven.

Between 10 August 2020 and 25 September 2020 you allowed or acquiesced in Registrant C conducting NHS sight tests when not on the NHS England Ophthalmic Performers List (NB. This is Particular 13 for Ms Rughani, Particular 12 for Ms Bariya)

242. The Committee considered that it was clear from the evidence before it that this conduct had occurred. Ms Patel (Registrant C) had made admissions, accepting that she had conducted NHS sight tests when she was not on the NHS England Ophthalmic Performers List. When questioned in interview on this issue, Ms Bariya did not deny this testing occurred but stated that she had misunderstood the rules on what was permitted. Ms Bariya explained that she understood that Ms Patel could continue to test under the supervision of Ms Rughani, as she had done as a pre-registered Optometrist.

243. The Committee considered that Ms Patel would not be conducting NHS sight tests, when not on the NHS England Ophthalmic Performers List, without the directors being aware. Furthermore, the evidence of Ms Patel was that both directors were aware that at that time she was not yet on the Performers List, as she had raised this with them and they told her she should continue testing.

244. In light of the above, the Committee was satisfied that this allegation was proved in respect of both directors Ms Rughani and Ms Bariya.

Allegations against Ms Rughani only

14. On one or more occasions, you signed a GOS1 form(s) declaring you had conducted the sight test when you knew Registrant C had conducted the sight test

245. The Committee was provided with copies of the GOS1 forms that show that the declaration had been signed by Ms Rughani. The Committee also had before it a screenshot of the clinical test reports, which showed that Ms Patel did the sight tests in question. The Committee noted that Ms Rughani was Ms Patel's supervisor whilst she was a pre-registrant Optometrist and during that time Ms Patel was testing under the supervision of Ms Rughani.

246. The Committee noted that whilst it had an account from Ms Bariya given during the investigation, Ms Rughani had not provided an account. However, it did not appear to be disputed that Ms Rughani had signed the forms, when she knew that Ms Patel had conducted the tests. Ms Bariya accepted that she had been aware of this and in the Committee's view Ms Rughani would also have been aware.

247. Accordingly, the Committee was satisfied on the balance of probabilities that this allegation was proved against Ms Rughani.

15. Your actions at 14 above were dishonest;

248. The Committee considered the expert evidence of Mr Booth, who in his evidence explained what the declaration means on the GOS1 form, which is in effect that the signatory had completed the examination. On the face of it, the declaration was incorrect, as Ms Patel had been the Optometrist who had conducted these examinations.

249. However, the Committee noted that Ms Rughani would sign the form when Ms Patel was a pre-registration Optometrist, which was permitted, Under the rules of the scheme, that should not have continued once Ms Patel qualified, as Ms Patel then needed to join the Performers List in her own right.

250. The Committee did not have an account from Ms Rughani, as to her knowledge or belief, and she had not engaged in these proceedings. Therefore, the Committee did not have direct evidence of Ms Rughani's state of mind. However, it considered the account given by her co-director Ms Bariya, on this issue, which was they thought that the position for pre-registrants carried on once Ms Patel qualified until she was on the Performers List.

251. The Committee noted that when Ms Bariya gave an account on this issue, she appeared to be referring to the position of both directors, as she was referring to 'we'. The Committee was mindful that neither director had attended to give evidence before the Committee and so the account given by Ms Bariya had not been tested.

252. However, the Committee considered that the account that had been put forward by Ms Bariya, namely that this was effectively an oversight by believing the pre-registration position could continue until Ms Patel was on the list herself, was plausible. The Committee was of the view that the nuance of the rules changing upon qualification may not have been appreciated by the directors.

253. The Committee also bore in mind that in his investigation report, Mr A described that after speaking to Ms Patel and Ms Bariya, "*it is clear that both had misunderstood the rules".* Whilst the Committee did not have Ms Rughani's direct account, the Committee had found that the directors were working jointly, and therefore the Committee considered that it was a reasonable inference to draw that this was also likely to be Ms Rughani's state of mind.

254. The Committee considered the test for dishonesty in *Ivey* and was not satisfied that an ordinary decent person would consider that this state of mind, of misunderstanding the rules, was dishonest. Accordingly, the Committee was not satisfied that the Council had discharged the burden of proof in respect of this particular of the allegation.

Misconduct

255. The Committee went on to consider, pursuant to Rule 46(12) of the Rules, whether the facts admitted and/or found proved in respect of each Registrant, amounted to misconduct. No further material was put before the Committee at this stage.

256. The Committee heard submissions on misconduct from Mr Geering, on behalf of the Council. Mr Geering reminded the Committee that misconduct was a matter for the Committee's judgment and the burden and standard of proof did not apply.

257. Mr Geering referred the Committee to the case law on misconduct. He submitted that whilst misconduct had been described as conduct which a fellow practitioner finds deplorable, this was one expression of it, rather than a statutory test. Mr Geering reminded the Committee that conduct had to be serious to amount to misconduct. He referred to the case of *Shaw v General Osteopathic Council* [2015] EWHC 2721 (Admin), which highlighted that whilst misconduct was conduct that was morally blameworthy, it should not be overlooked that there are a range of

sanctions to address it and it can be dealt with by a lenient sanction (such as an admonishment in that case).

258. Mr Geering referred the Committee to the Council's "*Standards of Practice for Optometrists and Dispensing Opticians"*, effective from April 2016. He submitted that the Registrants have departed from the following standards by virtue of their conduct:

- Standard 7: Conduct appropriate assessments, examinations, treatments and referrals
- Standard 10: Work collaboratively with colleagues in the interests of patients
- Standard 11: Protect and safeguard patients, colleagues and others from harm
- Standard 12: Ensure a safe environment for your patients
- Standard 16: Be honest and trustworthy
- Standard 17: Do not damage the reputation of your profession through your conduct

259. Mr Geering also referred the Committee to the equivalent applicable standards for students in respect of Ms Kothari who was a pre-registration Optometrist at the time of the events in question, although he submitted that there was no material difference between them for the conduct in question.

260. Mr Geering stated that several of the allegations involve a rider of dishonesty, which was inherently serious conduct, as honesty lies at the heart of a professional's responsibilities. Mr Geering stated that whilst the Council accepted that Ms Patel and Ms Kothari had mitigation, as they were junior employees who were young and inexperienced, this would not prevent findings of misconduct in respect of them. He submitted that junior employees are still expected to act with honesty and abide by their professional responsibilities.

261. Mr Geering addressed the Committee on the various allegations. In relation to the misdiagnosis of patients, Mr Geering submitted that this was self-evidently serious conduct and a breach of trust, which potentially could have caused patients harm by giving them anxiety about a health condition that they did not have. Furthermore, other professionals would accept the diagnosis as a genuine one and this would inform their own professional judgment in respect of future care.

262. In relation to pressuring staff to sell products that were unnecessary, Mr Geering submitted that this was also inherently serious and involved the financial exploitation of patients. He submitted that the directors had put their own greed before the best interests of patients. Whilst Ms Patel and Ms Kothari had not

financially benefited from this conduct, they had allowed themselves to be party to it.

263. Turning to the express service allegations, which applied to the directors only, Mr Geering stated that this again was conduct that caused financial loss to patients. Mr Geering submitted that the non-itemised receipt allegations, which again related to the directors only, were part and parcel of the same deceptive conduct, which was for the directors' financial gain.

264. Mr Geering described the allegations relating to the sale of high index lenses as abusing a position of trust between the directors and their patients, which inevitably crosses the threshold for misconduct.

265. Mr Geering submitted that this case involved conduct that was wide-ranging and that significant sums had been accrued through these dishonest practices. It also involved pre-meditated and sustained fraud, which was extremely serious.

266. In relation to not providing customers with prescriptions, Mr Geering highlighted that this was a statutory obligation of an Optometrist and the fact that it was built into the legislation was indicative of its seriousness. In relation to Ms Kothari signing a prescription when not authorised to do so as a pre-registration Optometrist, Mr Geering submitted that this was serious as every prescription needed to be checked by a supervisor.

267. As regards the allegation against the directors of inserting false information into patient records, Mr Geering stated that this was serious conduct as it affected the integrity of the patient records. In relation to staff working whilst on furlough, Mr Geering stated that this was a form of financial fraud against the Revenue, which was inherently serious.

268. In relation to Ms Patel performing NHS sight tests when not on the Performer's List, Mr Geering submitted that the NHS has its own regulatory framework, separate to the Council, which had been breached. Mr Geering invited the Committee to find that this conduct was misconduct regardless of what mitigation Ms Patel may have, as she still has to comply with her legal duties.

269. Mr Geering submitted that in relation to the allegations of signing the GOS1 forms, regardless of whether the Registrants had misunderstood the requirements, this was misconduct given the serious requirements of the NHS Regulations and there was an obligation upon the Registrants to be cognisant of their responsibilities. Further, this was breached on numerous occasions.

270. In relation to Ms Patel's conduct of failing to assess three patients adequately, Mr Geering submitted that she had failed to carry out an important part of the eye test, which was sufficiently serious to cross the misconduct threshold. Turning to the conduct in respect of not following adequate PPE procedures, this could have exposed customers to the risk of harm in the context of a pandemic.

271. Mr Geering reminded the Committee of the expert evidence of Mr Booth, who had given his opinion of the conduct in question falling far below the standards to be expected. Mr Geering stated that whilst a defence expert had provided a report, it was unclear to what extent this was relied upon and in any event he invited the Committee to prefer the evidence of Mr Booth, who had given evidence.

272. Finally, in respect of Ms Kothari failing to raise concerns with her tutor, Mr Geering submitted that she was obligated to be open and transparent. She had breached her professional obligations and whilst she may have mitigation, this nonetheless constituted misconduct.

273. Mr Geering invited the Committee to find that misconduct had been established in relation to all four Registrants.

274. Mr Mumford made no submissions regarding misconduct on behalf of Ms Kothari, leaving misconduct as a matter for the Committee's judgment.

275. Mr Hall, on behalf of Ms Patel, similarly did not make submissions on the issue of misconduct apart from stating that Ms Patel accepts that all of the allegations that she has admitted constitute misconduct.

276. The Committee heard and accepted the advice of the Legal Adviser, who referred the Committee to the relevant section of the Hearings and Indicative Sanctions Guidance (the Guidance). The Legal Adviser reminded the Committee that misconduct was a matter for its own independent judgement and no burden or standard of proof applied at this stage. Further, that the Committee needed to consider whether the various incidents of conduct was sufficiently serious to amount to professional misconduct, with any conduct not reaching that threshold falling away at this stage (the Council not having sought to take a cumulative approach to any of the Allegations).

The Committee's Findings on Misconduct

277. In making its findings on misconduct, the Committee had regard to the evidence it had received to date, the submissions made by the parties, and the legal advice given by the Legal Adviser.

278. The Committee considered the Standards of Practice for Optometrists and Dispensing Opticians (effective from 2016) and the equivalent Standards for Optical Students (effective from 2016). The Committee considered that the most following relevant standards from the Standards for Optometrists were particularly relevant:

- *Standard 7: Conduct appropriate assessments, examinations, treatments and referrals, especially:*
  Standard 7.1 – Conduct an adequate assessment
  Standard 7.6 – Only provide or recommend examinations, treatments, drugs or optical devices if these are clinically justified, and in the best interests of the patient
- *Standard 8 and 8.2 – maintaining accurate patient records*
- *Standard 9 – ensure that supervision is undertaken appropriately and complies with the law (regarding the directors)*
- *Standard 10: Work collaboratively with colleagues in the interests of patients, especially:*
  Standard 10.1 – Work collaboratively with colleagues within the optical professions and other healthcare practitioners in the best interests of your patients (in respect of the directors)
  Standard 10.5 – Where disagreements occur between colleagues, aim to resolve these for the benefit of the patient (in respect of Ms Patel)
- *Standard 11: Protect and safeguard patients, colleagues and others from harm, especially:*
  Standard 11.5 – If patients are at risk because of inadequate resources (re PPE equipment) put the matter right
- *Standard 12: Ensure a safe environment for your patients, particularly:*
  Standard 12.1.6 – minimise the risk of infection by following appropriate infection controls
- *Standard 16: Be honest and trustworthy, particularly*
  Standard 16.1 – act with honesty and integrity to maintain public trust and confidence in the profession
  Standard 16.3 – ensure all incentives, targets and similar factors do not affect your professional judgement. Do not allow personal or commercial interests to compromise patient safety
  Standard 16.5 – Be honest in your financial and commercial dealings and give patients clear information about the costs of your professional services and products before they commit to buying
- *Standard 17: Do not damage the reputation of your profession through your conduct*

279. The Committee considered the equivalent standards in the Standards for Optical Students in respect of Ms Kothari, in particular in relation to Standard 10 and 10.2, which involves promptly raising concerns.

280. The Committee considered all of the Allegations, which had been admitted and/or found proved and determined whether there had been a falling far short by the Registrants of the standards to be expected in the circumstances, which was serious.

281. The Committee first considered the conduct found proved against the directors Ms Rughani and Ms Bariya. In relation to the directors' conduct of encouraging and/or pressurising staff to provide OCT scans which were inappropriate and/or not clinically indicated, and charging for OCT scans without advising patients that it was optional (Allegation 1(a) and (b)), this was conduct which the Committee considered was financially motivated at the expense of patients. In the view of the Committee, this conduct involved a breach of trust and put the financial interests of the store (and the directors) above the patients' best interests. The Committee further noted that this conduct had been found to be dishonest, which is inherently serious. The Committee was satisfied that this conduct fell far below the standards to be expected and that fellow professionals would consider this conduct to be deplorable. Accordingly, the Committee was satisfied that this conduct constituted misconduct, which was serious.

282. Turning to the conduct in respect of misdiagnosing patients (Allegation 1(c)), the Committee considered that this conduct constituted a significant breach of trust, as patients rely upon professionals to appropriately diagnose conditions. This was deliberate misdiagnosis for financial gain of the store and the directors, which fellow professionals would consider deplorable. The Committee further considered that this conduct may have caused anxiety to patients by being misdiagnosed with a condition that they did not have and could have also misled future practitioners, potentially causing confusion or affecting future clinical judgments. The Committee was satisfied that this conduct was damaging to the confidence and trust patients have in the profession and that it constituted misconduct, which was serious.

283. In relation to the conduct of recommending eyecare products which were not clinically indicated for dry eye conditions and/or blocked glands (Allegation 1(d)(i) and (ii)), the Committee was of the view that this was conduct that was motivated by the financial benefit of the store and directors, as they were seeking to increase the sale of these products. Again, this involved deceiving patients that they required unnecessary products, which was a breach of the patients' trust and put the directors' interests above the best interests of the patients. The Committee was satisfied that this was deplorable conduct that was dishonest and amounted to misconduct, which was serious.

284. The Committee considered the conduct of overcharging for certain eye care products (particular 1(e) of the Allegation). The Committee reminded itself of its findings made at the fact stage, that whilst increasing prices may not necessarily be dishonest per se if viewed in isolation, the Committee had found that it was nonetheless dishonest when considered in the context of this case and given its other findings, including that the directors knew they were not permitted to increase the prices, as it was in breach of the Directors Agreement with Specsavers. The Committee considered that this conduct was part and parcel of the dishonest practices undertaken by the directors in the store to maximise profits. The Committee was satisfied that this conduct falls far below the standards to be expected and was part of a pattern of dishonest behaviour, which is inherently serious. The Committee determined that this amounted to misconduct, which was serious.

285. In relation to offering an express service for collecting glasses, the Committee was of the view that this was yet another means of the directors overcharging patients and seeking to maximise profits at the patients' expense. The express service was not part of the Specsavers' model, which the directors knew, but had been introduced by the directors to charge customers more and the directors went to elaborate lengths to hide the charge for this service from Specsavers (as there was no SKU code for it on the system). The Committee was satisfied that this was also part of the directors' pattern of dishonest conduct, which is serious and amounts to misconduct.

286. The Committee considered Allegations 1(g) and (h) together as they are interlinked, relating to not providing itemised receipts and not accurately recording products on the Socrates system. The Committee was of the view that this was deceptive and dishonest behaviour and that the directors' motive was to conceal their actions (for example of increased pricing) from customers and from Specsavers. The Committee had found that this conduct was dishonest, which is inherently serious. The Committee was satisfied that this conduct fell far below the standards to be expected and was misconduct, which was serious.

287. In relation to the dispensing of high index lenses when not clinically indicated and/or without offering the patients an informed choice (Allegation 1(i)), the Committee considered that this was a practice that was motivated by securing as much money as possible from patients, by selling them high index lenses that they did not need and would not benefit from. This was pre-meditated conduct that put the financial interests of the directors above the best interests of the patient and was a form of financial exploitation of customers. Again, this was an abuse of the patient's trust, as patients expect that they will be given honest advice and not mis-sold lenses. The Committee considered that this conduct is damaging to public confidence and the reputation of the profession. The Committee further noted that this conduct is particularly serious given the scale of this practice and the amount of increased

sales (and resulting profit to the directors) over time, as set out in the investigation report of Mr A. The Committee was satisfied that this amounted to misconduct, which was serious.

288. In relation to the conduct in Allegation 1(j) which concerns not providing customers with a copy of their prescriptions, the Committee noted that this was not linked to an allegation of dishonesty. However, the Committee was of the view that it fell far below the standards to be expected, as it was a breach of a legal requirement and part of the fundamental duties of an Optometrist carrying out a statutory eye test. The Committee considered that there was a culture of only giving prescriptions to patients if they asked for them, however this was inadequate as not all patients would have been aware that they could request it and it removed choice from patients in respect of buying glasses or lenses elsewhere. The Committee considered that this conduct also impacts on public trust and confidence in the profession. Accordingly, the Committee was satisfied that this conduct amounted to misconduct which was serious.

289. The Committee considered the linked allegation in respect of Ms Patel (particular 5 of her Allegation), of failing to issue patients with their prescriptions. Notwithstanding the above, the Committee additionally considered in relation to Ms Patel that she had barriers to being able to comply with her professional obligations, as the directors had created a culture that made it difficult for her to provide prescriptions. The Committee noted that in her statement Ms Patel had explained that she had no means of printing prescriptions in the testing room and she had not seen other Optometrists do it. Given Ms Patel's limited experience and her challenging work environment, the Committee concluded that in respect of her conduct, this fell below, but not seriously below, the standards expected, therefore did not amount to misconduct.

290. In relation to the conduct of the directors set out in particulars 2,3 and 4, this related to repeated dishonesty. These were not isolated incidents of dishonesty, but dishonest business practices that were committed at scale, with the financial motivation by the directors to increase the profits of the store and in turn, their own individual financial gain (through taking a share of the store's increased profits). The Committee considered that this conduct impacts public trust and confidence in the profession, damaging the reputation of the profession and would be considered to be deplorable by fellow professionals.

291. In relation to the conduct of inserting false information into patient records (particulars 5(a)and (b)), the Committee took the view that the directors were deliberately manipulating patient records, which would make them inaccurate and affect the integrity of the patient records. The Committee considered that this was conduct that fell far short of the standards to be expected and would fundamentally impact trust in the profession. There was a potential for harm, as patients could be

difficult to contact when required, for example in relation to a referral, if their contact details were not accurate. The Committee was therefore satisfied that this was misconduct, which was serious.

292. In relation to the directors' conduct of creating false email accounts and false patient feedback (particulars 6(a) and (b)), the Committee considered that the purpose of this conduct was to manipulate the Specsavers feedback system and to deceive Specsavers into thinking that the store was performing better than it was. It was conduct that was sustained over a significant period of time. The Committee considered that this was clearly dishonest conduct and would be considered to be deplorable by fellow professionals. The Committee was satisfied that this amounted to misconduct that was serious.

293. The Committee considered the furlough allegations together (particulars 8, 9 and 10) as they are interlinked. The Committee considered that this conduct amounted to financial fraud of the furlough scheme, which was taking advantage of a scheme funded by tax-payers money, to assist businesses struggling in a pandemic. In the circumstances, this would be considered to be deplorable conduct, that amounted to misconduct that was serious.

294. In relation to the conduct concerning the NHS sight tests being conducted when Ms Patel was not on the NHS England Ophthalmic Performers List (Ms Rughani particular 13, Ms Bariya particular 12) and the linked allegation of signing the GOS1 forms (Ms Rughani particular 14), the Committee reminded itself of its findings at the fact stage. The Committee had not found this conduct to be dishonest as it had accepted that Ms Rughani had not properly appreciated the nuances of the rules in relation to this issue. The Committee had therefore found that this was committed due to a mistaken belief of what was permissible rather than deliberately seeking to deceive. On balance, the Committee determined that whilst this was breach of the rules and so was poor practice and a falling below of what was required, it was not seriously below and therefore did not amount to misconduct.

295. Similarly, the Committee did not consider that Ms Patel's linked conduct (particular 6), of conducting sight tests when not on the Performer's List, was in the circumstances sufficiently serious to amount to misconduct. It was a falling below of the standards to be expected, however, the Committee had regard to Ms Patel's account in her statement that she had raised the issue with the directors and was told that it was allowed. Ms Patel should not have relied upon this as it was incorrect, but the Committee considered that it was not a falling far below the standards in the circumstances.

296. The Committee went on to consider the remaining conduct admitted by Ms Patel and Ms Kothari. In relation to the dishonest conduct that had been admitted (particulars 1, 2, 3 and 4), the Committee considered that this was serious conduct

that fell far below the standards expected, for the same reasons as set above for the linked conduct of the directors. Diagnosing patients goes to the heart of the role of an Optometrist and is a significant breach of patients' trust. The Committee was mindful that Ms Patel and Ms Kothari had mitigation in that they were junior employees at the start of their careers, being pressured by the directors to act as they did, however this did not, in the Committee's view, detract from this amounting to misconduct.

297. In relation to the conduct of Ms Patel not adequately assessing three patients (arising from the mystery shopper footage) in or around December 2020, as she did not assess binocular function at distance and near (particular 7), the Committee considered that whilst this was not a complete eye test, the seriousness of this had to be assessed in the context of the COVID pandemic and the approach to testing at that time. The Committee considered that testing during the pandemic was symptoms and needs led and the situation was constantly changing as to what was required. The Committee also bore in mind that Ms Patel was newly qualified at that time. Overall, whilst the Committee was satisfied that there was a falling short of what was expected, the Committee did not consider that this was a serious falling short of standards and did not therefore amount to misconduct.

298. In relation to failing to follow infection control procedures (Ms Patel particular 8 and Ms Kothari particular 6), the Committee noted that gloves and masks were worn, as they had been made available to staff, but the full infection control procedures were not adhered to. The Committee considered that significant responsibility for ensuring that staff had appropriate equipment available and were informed of procedures (which would change), lay with the directors, as it was a key part of the operation of the store during the pandemic. The Committee concluded that there had been a falling short of what was required in this regard but that in the circumstances, it was not sufficiently serious to amount to misconduct.

299. Turning to the further conduct admitted by Ms Kothari, including issuing a prescription on 11 December 2020 to a patient when she was not authorised to do so as a pre-registration Optometrist, the Committee considered that this was a breach of standards, as she should have ensured that the prescription was checked by her supervisor. However, the Committee noted that this was a single instance of not doing so and in the circumstances the Committee did not consider that it was sufficiently serious enough conduct to amount to misconduct.

300. In relation to Ms Kothari failing to raise concerns with her tutor in respect of her supervisor, in the three respects set out in particular 7, including that she was being instructed to misdiagnose, the Committee considered that this was a clear and serious breach of standards that she ought to have taken action in respect of. The Committee was of the view that as a student Ms Kothari had a route to raise concerns about her supervisor, via her tutor, and ought to have done so. Whilst that

may have been a difficult situation for her, there was a clear obligation upon her under the student standards of practice. The Committee was therefore satisfied that this was conduct that fell far below the standards to be reasonably expected of a pre-registration Optometrist and that it was sufficiently serious as to amount to misconduct.

301. The Committee concluded that in the circumstances the facts that had been admitted by the Registrants Ms Patel and Ms Kothari amounted to misconduct in respect of the dishonest conduct (particulars 1,2,3 and 4) and additionally for Ms Kothari, that the failure to raise concerns with her tutor (particular 7) amounted to misconduct. In relation to Ms Rughani and Ms Bariya, the Committee considered that all of the facts found proved relating to Allegations 1-10 amounted to misconduct.

Impairment

302. The Committee next considered, pursuant to Rule 46(14), whether the fitness to practise of the four Registrants was currently impaired, as a result of the misconduct found.

303. The Committee was provided with further material from both Ms Patel and Ms Kothari relevant to the issue of impairment. Ms Patel provided the Committee with a reflective statement, curriculum vitae, CPD statements, CPD certificates and reflections, testimonials, patient feedback and a clinical audit from January 2026. Ms Kothari's documents included personal reflections, CPD statements, certificates and reflections upon the courses undertaken, customer surveys and testimonials.

304. Both Ms Patel and Ms Kothari gave oral evidence to the Committee, confirming and expanding upon, the evidence set out in their witness statements.

305. In summary, Ms Patel's evidence was that the workplace at the time of the events was stressful and there was an intense pressure to sell as many products as possible, regardless of symptoms. However, she understood now that it was her responsibility to question these things, despite the pressure that she was under. Ms Patel acknowledged that it was important to take responsibility for her own actions because they reflect not only upon herself but also the reputation of the profession.

306. Ms Patel was asked about the impact of dishonesty in a professional setting and she explained that with dishonesty, patients were not being put first, there could be a risk of patient harm and it affects public trust and the reputation of the profession. Ms Patel went on to describe the impact that misdiagnosing patients and recommending unnecessary products could have, causing patients anxiety about a

condition that did not exist, which may lead them to make unnecessary lifestyle changes. In addition, patients may not trust the clinical advice that they receive in future, which could be detrimental to their own health.

307. Ms Patel also discussed her reflections on failing to raise concerns, stating that it was important to raise concerns even if it feels difficult to do so, because Optometrists needed to make patient care and meeting the standards their first priority. Ms Patel explained to the Committee what she would do if she had concerns now about a workplace, which included speaking to an area manager and seeking advice from the AOP or College of Optometrists.

308. Ms Patel explained the various courses that she had undertaken and what she had learnt from them. She also explained the patient feedback and clinical audit documents which had been provided to the Committee.

309. Ms Patel was asked what she would want a member of the public to know regarding her misconduct and she replied that she would want them to know that she is regretful of her actions and that she has become a different clinician to who she was at that time, now making sure that her decisions are based on patients' best interests and not influenced by outside factors.

310. When questioned by Mr Geering, on behalf of the Council, Ms Patel accepted that she had been misdiagnosing a significant proportion of patients each day so that unnecessary products could be sold to them. She also accepted that she understood at the time that her actions were wrong and inappropriate. Ms Patel stated that she felt very remorseful that she may have caused patients anxiety about spending money on products that they may not have been able to afford if they had other financial pressures.

311. The Committee asked Ms Patel questions about how she had responded to feedback and whether she had any example of disagreeing with a colleague and if so, how she had dealt with that. Ms Patel explained that one issue that arises is conversion rates and how she disagreed with a colleague about whose responsibility this is, which she had spoken to her current store directors and colleagues about how to make improvements.

312. Ms Kothari then gave evidence. Ms Kothari confirmed the contents of her witness statement, which stood as her evidence-in-chief. She explained that she had undertaken an additional qualification, which was the Professional Certificate in Medical Retina, awarded by the College of Optometrists in February 2025.

313. Ms Kothari was also questioned by Mr Geering regarding the scale of misdiagnosis, which Ms Kothari estimated was just over half of the patients that she saw in a

typical day. When Mr Geering suggested that Ms Kothari had put her own interests above the patients' interests, she replied that she did not do so with intention but because her supervisor told her to do it. Ms Kothari accepted that she had knowingly been part of a fraud against patients to get them to spend money on products that they did not need and that she was doing it to protect her job.

314. Ms Kothari was asked about her tutor and she explained that she knew her from September 2019 when she started her course, but she did not see her tutor as often as a pre-registrant usually would because of the COVID pandemic. Ms Kothari accepted that her tutor would have been an ideal person to raise concerns to about her supervisor and that she should have done so, but she stated that at that time she did not feel close to her and she felt that she was in a difficult situation. Ms Kothari also acknowledged that she was a member of the AOP at the time and with hindsight she should have approached them for advice.

315. Ms Kothari was asked questions about the impact of misdiagnosing patients and she explained that such conduct would lose patients' trust, increase their anxiety and make them spend money unnecessarily on products they did not need and she stated that she was deeply apologetic for this.

316. The parties made submissions at the end of the impairment stage on the issue of current impairment.

317. Mr Geering referred the Committee to the test that was formulated by Dame Janet Smith in the report to the Fifth Shipman Inquiry, which was approved in the case of *CHRE v NMC and Grant* [2011] EWHC 927 (Admin), namely that impairment may be found where a midwife (but applicable to Optometrists) has either in the past, or is liable in future to:

    a. put a patient(s) at unwarranted risk of harm, and/or
    b. brought the profession into disrepute, and/or
    c. breached one of the fundamental tenets of the profession and/or
    d. acted dishonestly.

318. Mr Geering highlighted that this test was posed both in past terms and also looking at whether there is a risk of repetition, which he submitted was a relevant factor, but not determinative. Mr Geering submitted that each of these four limbs had been engaged in respect of each Registrant, as they have all put patients at risk of harm, brought the profession into disrepute, and have breached fundamental tenets of the profession (the tenets of acting honestly and putting the patient's interests ahead of their own). Additionally, they have all demonstrated repeated dishonest behaviour.

319. Mr Geering reminded the Committee that they also had to consider the wider public interest, referring to the following from the case of *CHRE v NMC and Grant,*

> *"In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances."*

320. Mr Geering submitted that the wider public interest was highly relevant in this case given the extent of the dishonesty. Mr Geering invited the Committee to consider where on the wide spectrum of dishonest conduct the misconduct in this case falls. He submitted that the public interest was bound to require a finding of impairment in respect of both director Registrants, as they had engaged in a deliberate plan to exploit patients over many months in numerous different ways.

321. Mr Geering submitted that there was a clear and significant risk of repetition in respect of both directors, as neither had shown insight, reflection or remediation. Mr Geering submitted that in their cases the dishonesty was ingrained and indicative of attitudinal concerns. In any event, regardless of the risk of repetition, Mr Geering stated that findings of impairment were required for both directors in the public interest, given the seriousness of the dishonesty findings in relation to them.

322. In relation to Ms Patel and Ms Kothari, Mr Geering stated that it was a matter for the Committee as to what findings it made in respect of insight, reflection and remediation. However, the Council did not consider that either junior employee Registrant poses a risk of repetition. Mr Geering acknowledged that it was significant that they were both young and at the start of their careers and that they were being exploited by the people in positions of responsibility over them. Mr Geering acknowledged that both had shown insight and had worked safely since the events over the past five years. However, he submitted that their misconduct also met all four limbs of the test in *Grant* (set out above).

323. Mr Geering invited the Committee to make findings of impairment in relation to Ms Patel and Ms Kothari on public interest grounds. He submitted that because the directors had acted so egregiously, the misconduct of Ms Patel and Ms Kothari may appear small in comparison. However, if focusing on their actions, for months they allowed themselves to be party to a fraud against patients, which was not a momentary misjudgement or an isolated incident. Mr Geering highlighted that the dishonesty was not separate to their professional obligations but part of their duties and exposed patients to potential risk of harm and anxiety (either financial or about their diagnosis).

324. Mr Geering submitted that their actions undermined public trust in the profession and affected patients trusting future care, as they may be reticent about getting tested or accepting advice in future. Mr Geering reminded the Committee of the scale of the dishonesty, that approximately £240 per day was being obtained from patients of Ms Kothari for products that they did not need and that on one particular date in November, 19 out of 21 patients of Ms Patel were misdiagnosed with dry eye issues. Mr Geering submitted that this was a serious course of conduct and whilst it was accepted that there was no financial benefit to either Ms Patel or Ms Kothari (other than keeping their jobs), he submitted that they did have a choice and could have raised concerns but instead put their own interests above those of the patients.

325. Mr Geering stated that having mitigation did not mean that no finding of impairment was required in the public interest, as the impact upon the Registrants was of lesser significance than the damage done to the reputation of the profession as a result of their conduct. He invited the Committee to find both Ms Patel and Ms Kothari currently impaired on wider public interest grounds.

326. Mr Hall, on behalf of Ms Patel, stated that his overarching submission was that Ms Patel was not currently impaired on either public protection or public interest grounds. She was capable of safe and effective practice and had admitted her dishonesty. Mr Hall acknowledged that dishonesty is serious and that this related to numerous patients over a period of time. However, he submitted that dishonesty needed to be seen on a spectrum and in the particular circumstances of this case, a finding of impairment was not required in the public interest.

327. Mr Hall accepted that this was finely balanced and invited the Committee to look at the case as a whole. He highlighted that if no finding of impairment was made, a warning could still be a potential outcome, which would find the correct balance, mark the conduct and uphold the public interest. Mr Hall stated that this would also acknowledge Ms Patel's engagement, admissions, insight and mitigating circumstances. It would also allow Ms Patel to continue her safe practice and would not deprive the public of a safe practitioner.

328. Mr Hall submitted that dishonesty can cover a range of seriousness, some criminal, some not, some undermining the public interest more than others. Further, a finding of impairment does not necessarily flow from a finding of misconduct and impairment is not intended to be punitive.

329. Mr Hall highlighted that there has been no actual patient harm (albeit a risk of harm), no financial gain, the dishonesty was not covered up, there was no evidence that patients are aware of the misdiagnosis and the context of the dishonesty was extreme professional pressure. Mr Hall reminded the Committee of evidence it had heard that there was a bullying environment and Mr Booth (the expert witness) had

acknowledged that someone of Ms Patel's inexperience may not be aware of whistleblowing.

330. Additionally, Ms Patel was very early in her career, was facing very difficult personal circumstances and the misconduct occurred during the COVID pandemic, which were not usual circumstances. Mr Hall submitted that the junior Registrants had been manipulated into their poor decision making by the directors, and that this was situational dishonesty rather than being deep-rooted or attitudinal.

331. Mr Hall submitted that the dishonesty was capable of being remediated and the Council had accepted that public protection was not engaged and the case for impairment had been put entirely on public interest grounds. Mr Hall highlighted that Ms Patel had made early admissions and had not sought to shy away from the misconduct, showing a high degree of remorse. Mr Hall stated that a member of the public would find it relevant that Ms Patel had engaged with these proceedings for a number of years and had given evidence, which was not an easy task.

332. Mr Hall stated that there was no real risk of repetition, and there had been no repeat concerns from Ms Patel's continuation of practice since August 2021, in both NHS and private settings. Mr Hall submitted that Ms Patel has shown insight which was not superficial, giving evidence regarding what she would do differently if put under pressure again and she has now increased confidence in the workplace. She has taken responsibility for actions and not sought to blame others. Furthermore, Mr Hall submitted that it could be seen that Ms Patel's insight had developed over the past five years since these events.

333. Mr Hall took the Committee through the contents of Ms Patel's bundle for this stage of the hearing. Mr Hall highlighted comments from the testimonials, which refer to Ms Patel as a reliable and trustworthy individual.

334. Mr Hall stated that it had to be acknowledged that there had been delay in this case, which had been ongoing for a considerable period of time, during which these proceedings weighed heavily on Ms Patel. Despite that, Ms Patel focused upon her remediation and professional development. Mr Hall stated that this stands in stark contract to the conduct of the directors.

335. In relation to the public interest, Mr Hall invited the Committee to consider what a fair-minded informed member of the public would consider was required to maintain standards, public confidence and what they would consider proportionate. He submitted that a finding of impairment was not required given the delay, Ms Patel's insight, remediation, patient feedback and audit, and also that Ms Patel was suspended from work for six months during the workplace investigation. Mr Hall submitted that this suspension was a relevant factor, although he confirmed, when

asked by the Committee, that this was a paid period of suspension and was not a disciplinary outcome.

336. Mr Hall invited the Committee to conclude that a finding of impairment would be unnecessary and disproportionate. He submitted that there was a public interest in having a capable and diligent Optometrist available to treat the public. Furthermore, a warning can play an important role in upholding public confidence in the profession and would acknowledge the difficult circumstances of this case.

337. Mr Mumford made submissions on the issue of current impairment on behalf of Ms Kothari.

338. At the outset of his submissions, Mr Mumford raised that the Allegation for Ms Kothari referred to her being unfit to undertake training, as opposed to being unfit to practise, as she was a pre-registration Optometrist at the time of the events in question, but had since qualified. Mr Mumford proposed that the Committee may wish to amend the Allegation to make it accurate.

339. Mr Geering and Mr Hall indicated that they had no objection to such an amendment being made and the Committee, after hearing legal advice on its powers to amend the Allegation under Rule 28, determined to make the proposed amendment. The Committee considered that it was appropriate to amend the wording of the last line of the Allegation to refer to 'fitness to practise' rather than 'fitness to undertake training' as the existing wording was no longer relevant given that Ms Kothari had since qualified and the Committee was satisfied that this amendment could be made without causing injustice.

340. Mr Mumford also invited the Committee to note the time period in the Allegation, which ended on 30 March 2021. Mr Mumford stated that there is no suggestion that there was any misconduct continuing after the directors had been removed from the store around 21 January 2021. Mr Mumford stated that no action was required in relation to this, he simply invited the Committee to note that there is no suggestion of any misconduct taking place in either February or March 2021.

341. Mr Mumford invited the Committee to find that Ms Kothari's fitness to practise is not currently impaired. Mr Mumford referred the Committee to the section on determining impairment in the Hearings and Indicative Sanctions Guidance ('the Guidance'). He invited the Committee to consider the genuine expressions of regret and apology made by Ms Kothari to her patients, regulator and profession as a whole.

342. In relation to whether Ms Kothari's misconduct was remediable, Mr Mumford submitted that, whilst not seeking to deny responsibility for her actions, Ms Kothari's conduct was controlled by the directors and would not have occurred but for their

insistence. Mr Mumford stated that there is no suggestion of Ms Kothari independently or spontaneously behaving in a dishonest manner. In addition, the misconduct was carried out under threat of reprimand or sanction by the directors, which Mr Mumford submitted formed the background to her failing to raise her concerns with her tutor.

343. Mr Mumford stated that the conduct was not inherent dishonesty nor motivated by direct financial gain, rather it was a result of intense and sustained pressure on her as a subordinate. Mr Mumford submitted that as a result of this, together with the early stage of her career, the misconduct was capable of being remedied from improved ethical awareness and confidence to challenge bad practices.

344. Mr Mumford submitted that Ms Kothari had remedied the misconduct, which began with her full and frank co-operation in the investigation, including bringing some matters to light from her candid explanations of practices and procedures in the store. Mr Mumford submitted that Ms Kothari continued to remediate with her response to these proceedings, making full factual admissions, and actively participating including giving evidence before the Committee.

345. Mr Mumford highlighted further remediation that Ms Kothari has undertaken over the past five years, including her targeted CPD, engaging with supervision, mentorship and auditing. Mr Mumford highlighted comments from the positive testimonials, including that Ms Kothari's recordkeeping is '*second to none'*, with perfect records, which he submitted speaks to her professionalism. Mr Mumford stated that it is evident from the testimonials that not only has Ms Kothari avoided repetition but she has flourished in her career, completing her training and obtaining an additional qualification in medical retina assessment.

346. In relation to the risk of repetition, Mr Mumford submitted that the Committee can be assured that the misconduct will not be repeated, referring to Ms Kothari's continued professional development over the past five years notwithstanding the disruption to her pre-registration training due to these events, the testimonials and positive attitude towards mentoring and auditing of records.

347. Turning to the public interest considerations in the case, Mr Mumford acknowledged that the Committee is required to have regard to the public interest when reaching a decision on impairment. Mr Mumford submitted that a fair-minded member of the public with knowledge of the relevant facts and circumstances of the case would conclude that a finding of impairment against Ms Kothari was not necessary to achieve the goals of upholding proper professional standards and maintaining public confidence in the profession. Mr Mumford highlighted Ms Kothari's early admissions and assistance in the investigation, her junior role in events, the salutary effect of these proceedings on her over the past five years and her subsequent unblemished career.

348. Mr Mumford invited the Committee to not make a finding of current impairment in relation to Ms Kothari, submitting that the public interest would be best served by allowing her to continue to serve the public through continued diligent practice.

349. The Committee heard and accepted the advice of the Legal Adviser who advised the Committee that the question of impairment was a matter for its independent judgement taking into account all of the evidence it has seen and heard so far. She reminded the Committee that a finding of impairment does not automatically follow a finding of misconduct and outlined the relevant considerations set out in the case of *Cohen v GMC* [2008] EWHC 581(Admin), namely whether the conduct is remediable, whether it has been remedied, and whether it is likely to be repeated.

350. The Legal Adviser referred the Committee to the case of *GMC v Armstrong* [2021] EWHC 1658 (Admin), which sets out that dishonesty can arise in a variety of circumstances and in a range of seriousness and that Committees must have proper regard to the nature and extent of the dishonesty and engage with the weight of the public interest factors tending towards a finding of impairment. This case also sets out that, in cases of dishonesty, the impact on public confidence in the profession is not diminished by a low risk of repetition and that the Committee must consider the weight that it puts on personal mitigation as this may have a more limited role in cases of dishonesty. It also sets out that it is a rare or unusual case where dishonesty does not lead to a finding of impairment.

The Committee's findings on current impairment

351. In making its findings on current impairment, the Committee had regard to the evidence it had received to date, the submissions made by the parties, the Guidance and the legal advice given by the Legal Adviser.

<u>Ms Bansri Rughani and Ms Sapna Bariya</u>

352. The Committee considered the positions of both directors together, given that they had been operating the store together jointly, in concert with each other, and that it had made the same findings of misconduct against both.

353. The Committee considered whether the director Registrants' conduct was remediable, whether it had been remedied and whether the conduct is likely to be repeated in future.

354. The Committee noted that the misconduct related to dishonesty, which is generally more difficult to remediate than other types of misconduct, such as clinical concerns. In this case, the dishonesty was not isolated instances of misjudgement, but rather was serious, persistent and systemic, designed to exploit patients

financially, in order to maximise the profits for the store and to financially benefit the directors themselves. The Committee considered that it also involved the exploitation of staff, who were pressurised to act in this manner, disregarding the impact on the future careers of their pre-registrants and junior staff.

355. The Committee considered that the dishonesty was deliberate, calculated and multifaceted, defrauding patients in numerous ways, ranging from pressurising staff to misdiagnose, sell unnecessary products and high index lenses, to increasing prices and offering the express service, contrary to the agreement with Specsavers, breaching furlough arrangements and creating false customer feedback. Aspects of this conduct was concealed from customers and Specsavers, for example by not providing itemised receipts.

356. The dishonesty was also large scale, as it was sustained over many months, affecting many customers and significantly increased profits (for example through the increased sale of high index lenses). In acting in this manner, both directors showed complete disregard for the best interests of their patients and their staff, doing what they could to maximise profits regardless of the impact upon patients or on the reputation of the profession. The Committee considered that there was a real risk of potential harm to patients from being misdiagnosed and sold unnecessary products, which could cause anxiety and impact their ability to trust and accept professional advice in future.

357. The Committee had earlier found that the misconduct would be considered to be deplorable by fellow professionals and would undermine public trust and confidence in the profession and significantly damage the reputation of the profession. The Committee concluded that given the seriousness of the dishonesty, as summarised above, this was at the upper end of the spectrum of seriousness and as a result was misconduct that would be extremely difficult to remediate.

358. In relation to whether the misconduct had been remediated, the Committee noted that both directors were in the same position in that neither had engaged in these proceedings, nor had they provided the Committee with any evidence relevant to the issue of current impairment, such as evidence of reflection, insight or remediation. There had been some involvement at the local investigation stage by Ms Bariya, however this was minimal.

359. The Committee took the view that there was no evidence that the directors had taken responsibility for or shown remorse for their actions. The Committee noted that Ms Bariya had not made frank admissions during the investigation stage and Ms Bariya had sought to challenge many aspects of the case, including seeking to deflect blame onto staff members, for example in relation to the fabricated patient feedback. Ms Rughani had not taken part in the local investigation and the

Committee had no information about her position at the time or subsequently in relation to the facts now found proved.

360. In light of all of the above, the Committee took the view that the dishonesty of the director Registrants in this case was deep-seated and attitudinal and would likely have continued if it had not been detected following the mystery shopper investigation. In light of the complete absence of evidence of insight and remediation, the Committee therefore concluded that the director Registrants had not remediated the misconduct. Accordingly, the Committee determined that given the lack of insight, remediation and remorse, there was a very high risk of repetition.

361. Having regard to all of the above, the Committee determined that the director Registrants' fitness to practise was impaired on public protection grounds.

362. The Committee next had regard to public interest considerations and to the case of *CHRE v NMC and Grant* [2011] EWHC 927 (admin), particularly the test that was formulated by Dame Janet Smith in the report to the Fifth Shipman Inquiry. The Committee agreed with the submission of Mr Geering that all four limbs (a), (b), (c) and (d) of this test are engaged in this case, namely conduct which puts patients at unwarranted risk of harm, brings the profession into disrepute, breaches a fundamental tenet of the profession and is dishonest. The Committee considered that these limbs of the test were engaged both on the Registrants' past conduct in relation to the misconduct found proved and also in relation to being 'liable in future' to so act, given the very high risk of repetition found.

363. 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 had found that the directors' dishonesty was particularly serious, at the upper end of the scale, for the reasons set out above. In the circumstances, the Committee took the view that given the seriousness of the conduct, the public would be extremely concerned and public confidence in the profession would be significantly undermined, if findings of impairment were not made. The Committee determined that it was necessary to make findings of impairment in this case in respect of both director Registrants in order to maintain confidence in the profession and in order to uphold proper professional standards.

Ms Meera Patel

364. The Committee next considered whether the Registrant, Ms Patel's, conduct was remediable, whether it had been remedied and whether the conduct is likely to be repeated in future.

365. The Committee noted that the misconduct related to dishonesty, which is more difficult to remediate than other types of misconduct, such as clinical concerns, albeit not impossible to remediate. Although the Committee had found that the dishonesty of the directors would be extremely difficult to remediate, it did consider that the context of the junior employee Registrants was different to that of the directors. The extent of the dishonesty in respect of the junior employee Registrants was more limited and the Committee accepted the submission made by Mr Hall that the dishonesty here was situational, in reaction to pressure from the directors, rather than being inherent or at Ms Patel's own instigation. The Committee did not find that the dishonesty of the junior employee Registrants was deep-seated or attitudinal.

366. The Committee considered whether the Registrant's misconduct had been remedied by her since the events took place approximately five years ago. The Committee noted the steps that the Registrant has taken in order to remediate, which include reflecting, as set out in her reflective statements and the relevant CPD undertaken, including on targeted topics such as ethics and remediation. The Committee considered that the Registrant has developed herself as a professional since the events in question, which was evidenced from her positive testimonials, including from her mentor.

367. The Committee was of the view that the Registrant had showed in her oral and written evidence that she had reflected and developed insight, and was satisfied that she understood the impact of her misconduct upon the public and the profession. She made admissions at an early stage and has also shown remorse for her actions and explained what she would do differently if she was in a similar situation again. The Committee was satisfied that the Registrant was now much more aware of her professional obligations and the importance of adhering to the standards of practice.

368. Dishonesty is difficult to remediate but overall the Committee considered that the Registrant had undertaken all of the remediation that she reasonably could. Overall the Committee considered the level of insight demonstrated by the Registrant, in her written reflective statement and the oral evidence that she gave during this hearing, to be good.

369. The Committee turned to consider the likelihood of repetition. The Committee had regard to the testimonials from the Registrant's work colleagues, which were positive. The Committee noted that it was now approximately five years since the misconduct occurred and there had been no further concerns raised. The Committee had been reassured by the evidence of the Registrant that she has learnt from her conduct, developed insight and has shown a good level of remediation, which mitigates the risk should she be placed in a similar position

again. The Committee therefore considered that the risk of repetition of similar misconduct was low.

370. Accordingly, the Committee determined that the Registrant's misconduct is unlikely to be repeated. The Committee concluded that the Registrant Ms Patel's fitness to practise is not currently impaired on public protection grounds.

371. The Committee next had regard to public interest considerations and to the case of *CHRE v NMC and Grant* [2011] EWHC 927 (admin), particularly the test that was formulated by Dame Janet Smith in the report to the Fifth Shipman Inquiry. The Committee agreed with the submission of Mr Geering that all four limbs (a), (b), (c) and (d) of this test are engaged in this case, namely conduct which puts patients at unwarranted risk of harm, brings the profession into disrepute, breaches a fundamental tenet of the profession and is dishonest. The Committee considered that these limbs of the test were engaged only on the Registrant's past conduct in relation to the misconduct found proved and not in relation to being 'liable in future' to so act, given the remediation undertaken and the low risk of repetition found.

372. 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.

373. The Committee considered the extent and seriousness of the Registrant's dishonesty in respect of the misdiagnosis and selling of unnecessary eye care products. The Committee had regard to the mitigation and the different context of the dishonesty in respect of the junior employee Registrants. However, notwithstanding those factors, the Committee still considered the dishonesty was serious, going to the heart of the patient relationship. The Committee considered it serious that although there was no direct financial gain linked to the conduct for Ms Patel, she was knowingly taking part in a fraudulent scheme that lied to many patients and put the store and directors' financial gain before the best interests of patients. Furthermore, this was not an isolated incident and was repeated on multiple occasions over a significant period.

374. It is the Committee's view that the dishonesty in this case was serious and systematic, breaching the trust of the Registrant's patients, and was a breach of fundamental standards, as set out above. The Committee had regard to the mitigation presented on behalf of Ms Patel, including that she was a junior employee being pressured by the directors to act in that manner, and it recognised that she was placed in a difficult position. However, notwithstanding that, in the Committee's view this did not detract from her own professional responsibility, to act in the patients' best interests and report concerns.

375. Additionally, the Committee had regard to the following guidance in the case of *GMC v Armstrong,* which it considered to be relevant to this case,

> "52. *The fact that the assessment of impairment us forward-looking means the Tribunal must appreciate that any loss of public confidence in the regulatory regime, resulting from erroneously lenient decisions, is likely to be of an ongoing nature. It does not necessarily fall to be discounted or downplayed, merely because the practitioner in question is unlikely to repeat their dishonesty. Undue leniency risks undermining general public confidence in the ability of the regulatory regime to protect the public from harm…*
>
> 53. *This brings me to the issue of exceptionality….the consequences of a finding of dishonesty in the professional regulatory context are likely to be so profound, in terms of the overarching regulatory objective, that the factors on the other side, viewed as a whole, will need to be extremely strong, in order for a finding of no impairment to be justified. Competing factors of the required overall strength are unlikely to be frequently encountered."*

376. The Committee was of the view that despite the remediation that had been undertaken by the Registrant and the mitigation that she had, given the seriousness of the conduct, which was not an isolated incident of dishonesty, but multiple occasions involving numerous patients, the public would be concerned and public confidence in the profession and the regulator would be undermined, if a finding of impairment was not made. Additionally, it would send the wrong signal to the profession and undermine the maintaining of standards within the profession. The Committee considered that there were factors in favour of Ms Patel but they were not sufficiently strong to justify a finding of no impairment.

377. The Committee therefore determined that it was necessary to make a finding of impairment in this case in order to maintain confidence in the profession and in order to uphold proper professional standards.

Ms Maneeka Kothari

378. The Committee next considered whether the Registrant, Ms Kothari's, conduct was remediable, whether it had been remedied and whether the conduct is likely to be repeated in future.

379. As above, the Committee noted that the misconduct related to dishonesty, which is more difficult to remediate than other types of misconduct, such as clinical concerns, albeit not impossible to remediate. Although the Committee had found that the dishonesty of the directors would be extremely difficult to remediate, it did consider that the position and context of the junior employee Registrants was

different and situational, rather than deep-seated or attitudinal. It did consider that the dishonesty in relation to the junior employee Registrants could be remedied.

380. The Committee considered whether the Registrant's misconduct had been remedied by her since the events took place approximately five years ago. The Committee noted the steps that the Registrant has taken in order to remediate, which include detailed reflection, as set out in her thorough reflective statements and the relevant CPD undertaken and being mentored. The Committee noted that the Registrant had undertaken a significant amount of CPD and an additional qualification, which showed commitment to the profession. The Registrant also had positive testimonials from work colleagues, who hold her in high regard.

381. The Committee was of the view that the Registrant has set out detailed reflections in her written reflective statements, which showed a good level of insight and remorse. The Committee considered that Registrant was in a difficult position being a pre-registration Optometrist at the time of events, being put under pressure to act dishonestly by her supervisor, although she did have access to a tutor that she could have raised concerns with. The Committee noted that she was under particular [redacted]. The Committee was satisfied that she had made early admissions, engaged with the investigation and had learnt a salutary lesson from these proceedings. Dishonesty is difficult to remediate and the Committee considered that the Registrant had undertaken all of the remediation that she reasonably could.

382. The Committee turned to consider the likelihood of repetition. The Committee had regard to the references from the Registrant's work colleagues, which were positive. The Committee noted that it was now approximately five years since the misconduct occurred and there had been no further concerns raised. The Committee had been reassured by the evidence of the Registrant that she has learnt from her conduct, developed insight and has shown a good level of remediation, which mitigates the risk should she be placed in a similar position again. The Committee considered that the risk of repetition was low.

383. Accordingly, the Committee determined that the Registrant's misconduct is unlikely to be repeated. The Committee concluded that the Registrant Ms Kothari's fitness to practise is not currently impaired on public protection grounds.

384. The Committee next had regard to public interest considerations and to the case of *CHRE v NMC and Grant* [2011] EWHC 927 (admin), particularly the test that was formulated by Dame Janet Smith in the report to the Fifth Shipman Inquiry. The Committee agreed with the submission of Mr Geering that all four limbs (a), (b), (c) and (d) of this test are engaged in this case, namely conduct which puts patients at unwarranted risk of harm, brings the profession into disrepute, breaches a fundamental tenet of the profession and is dishonest. The Committee considered

that these limbs of the test were engaged only on the Registrant's past conduct in relation to the misconduct found proved and not in relation to being 'liable in future' to so act, given the remediation undertaken and the low risk of repetition found.

385. 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.

386. The Committee considered the extent and seriousness of the Registrant's dishonesty in respect of the misdiagnosis and selling of unnecessary eye care products. The Committee considered it serious that although there was no direct financial gain linked to the conduct for Ms Kothari, she was knowingly taking part in a fraudulent scheme that put the store and directors' financial gain before the best interests of patients. Furthermore, this was not an isolated incident and was repeated on multiple occasions over a significant period. In the Committee's view the dishonesty in this case was serious and systematic, breaching the trust of the Registrant's patients, and was a breach of fundamental standards, as set out above. The Committee noted that the same standards for professional responsibility apply for students as they do for qualified Optometrists to act in the patient's best interests and to report concerns.

387. As with Ms Patel, the Committee had regard to the guidance from the case of *Armstrong*. The Committee considered that there were factors in favour of Ms Kothari, such as the context of her dishonesty and her personal mitigation, but they were not sufficiently strong to justify a finding of no impairment, given the significant impact upon the public interest of serious findings of persistent dishonesty.

388. The Committee was of the view that despite the remediation that had been undertaken by the Registrant and the mitigation that she had, given the seriousness of the conduct, the public would be concerned and public confidence in the profession and the regulator would be undermined, if a finding of impairment was not made. It would also undermine the maintaining of standards in the profession. The Committee determined that it was necessary to make a finding of impairment in this case in order to maintain confidence in the profession and in order to uphold proper professional standards.

389. Accordingly, the Committee found that the fitness to practise of all four Registrants is currently impaired. The fitness to practise of Ms Bansri Rughani and Ms Sapna Bariya is impaired on both public protection and public interest grounds. The fitness to practise of Ms Meera Patel and Ms Maneeka Kothari is impaired on public interest grounds only.

Sanction

390. The Committee next went on to consider what would be the appropriate and proportionate sanction, if any, to impose in this case. It heard submissions from Mr Geering on behalf of the Council and from Mr Hall and Mr Mumford, on behalf of Ms Patel and Ms Kothari respectively.

391. Mr Geering referred the Committee to the Council's 'Hearings and Indicative Sanctions Guidance' ('the Guidance'). He reminded the Committee that when imposing a sanction it should impose the least restrictive sanction that would satisfy the public interest, having regard to the principle of proportionality and having weighed the aggravating and mitigating factors in the case.

392. Mr Geering submitted that there was a spectrum of dishonesty and it was for the Committee to weigh where upon that spectrum the dishonesty in this case lies. He referred to the section on dishonesty in the Guidance at paragraphs 22.4 onwards, highlighting that matters such as workplace pressures may be less significant than the features of the dishonesty such as the length of time it persisted.

393. In relation to an earlier reference in Mr Hall's impairment submissions on behalf of Ms Patel, that she had previously been suspended from work for six months, Mr Geering submitted that action taken by an employer was not relevant, as that served a different function to a regulatory sanction and the Committee was concerned with meeting the public interest.

394. In relation to the directors, Ms Rughani and Ms Bariya, Mr Geering stated that the Council's case was that the appropriate sanction was one of erasure. He reminded the Committee that this case involved prolonged dishonesty, which exploited patients and staff, for financial gain, there was potential for patient harm and the Committee had found a real risk of repetition. The only potential mitigation for the directors was their previous good characters. Mr Geering submitted that they had shown no insight nor evidence of remediation and both were an ongoing danger to the public and the profession. For those reasons, Mr Geering submitted that their misconduct was right at the top end of the spectrum of dishonesty.

395. Mr Geering submitted that when applying the Guidance on sanction to this case, this would lead the Committee to the conclusion of erasure being the only appropriate sanction. He referred the Committee to paragraph 21.35 of the Guidance and submitted that several of the factors ((a), (b), (c) and (f)) applied, indicating that erasure was the appropriate outcome. Mr Geering submitted that no lesser sanction would vindicate the public interest in light of the Committee's findings.

396. Mr Geering accepted that Ms Patel and Ms Kothari bear reduced culpability compared to the directors, given that they were junior employees exploited by their managers. Mr Geering submitted that this does not excuse their actions but will be relevant to the assessment of what would be an appropriate and proportionate sanction, which the Council considered would be one of suspension. Mr Geering confirmed that the Council did not consider that for Ms Patel and Ms Kothari, erasure was necessary.

397. Mr Geering submitted that aggravating factors in the case included that the dishonesty was serious and systematic, taking place over months, involving numerous patients. Additionally, patients were put at potential risk. In relation to mitigation, Ms Patel and Ms Kothari were junior staff who had been exploited by the directors and were working in a toxic working environment. It had been found that their dishonesty was situational, was not of their own accord and they had not gained financially. Once discovered they had both done everything right, including reflecting, developing insight and had remediated, practising safely in the years since.

398. However, Mr Geering submitted that on any view, this was serious dishonesty, which had a significant impact on the public interest. He stated that this kind of conduct would sometimes justify erasure, given that it was persistent, but when giving appropriate weight to the mitigation the appropriate outcome would be a mid-level period of suspension.

399. Mr Geering reminded the Committee that they ought to start with consideration of the least restrictive sanction first. However, he submitted that taking no further action and a Conditional Registration Order would both be clearly inappropriate, and in reality, given the seriousness of the misconduct, the Committee's focus would likely be on suspension, as being the least sanction that would meet the public interest. Mr Geering referred the Committee to paragraph 21.29 of the Guidance, which indicates when a suspension may be appropriate and submitted that most of those applied (with (e) not being relevant). Further, it was accepted that there may a public interest in allowing Ms Patel and Ms Kothari to return to practice.

400. Mr Geering stated that the Council's position was that a review hearing would not be necessary for Ms Patel and Ms Kothari following their period of suspension, given the Committee's findings in relation to ongoing risk and insight, and the Committee may think it would serve no useful purpose.

401. Mr Hall, on behalf of Ms Patel, submitted that his overarching submission was that the appropriate sanction for Ms Patel would be a low level suspension of 28 days, without a review. Mr Hall acknowledged that given the finding of impairment for dishonesty, a suspension would likely be required to meet the public interest.

However, in relation to the length of the period of suspension, Mr Hall submitted that the fact of any suspension, of any length, was a formidable sanction in itself. He submitted that a fully informed member of the public would consider that a period of suspension of 28 days would uphold the public interest and would mark the conduct, whilst remaining proportionate.

402. Mr Hall reminded the Committee that the purpose of imposing a sanction was to protect the public and it was not intended to be punitive. He highlighted that in this case the junior staff had been exploited, it was situational dishonesty, which was now historic due to the delay. Further, the Registrant had shown insight, had extensively remediated and there had been no repetition in the past four years. He submitted that Ms Patel had a high degree of personal mitigation and testimonials and had demonstrated lasting change.

403. Mr Hall submitted that a period of suspension has a greater impact upon junior registrants, as they are only at the start of their careers and are not as financially established as more experienced registrants. Furthermore, the suspension removes a safe practitioner from being able to serve the public, disrupts their employment, professional standing and impacts their reputation. It could also put a strain on their employer and themselves financially and personally.

404. In relation to whether a review hearing was required, Mr Hall submitted that this was not necessary as the finding of impairment in this case was solely on public interest grounds and there was no ongoing risk. He stated that the public interest would be met by the substantive order and there would be no practical purpose to a review hearing, which would not be effective at protecting the public. Mr Hall submitted that allowing the suspension to lapse would be fair and proportionate.

405. Mr Mumford, on behalf of Ms Kothari, submitted that multiple options were open to the Committee in relation to sanction. He submitted that it would be appropriate and lawful for the Committee to take no further action against Ms Kothari, as it could find exceptional circumstances justifying that course of action. Mr Mumford submitted that the potential exceptional circumstances were twofold, firstly the misconduct itself and the duress that Ms Kothari was acting under at the time. Mr Mumford highlighted that Ms Kothari was a pre-registrant Optometrist and it would have been extremely difficult for her to leave and try to find another training post during that time; she was effectively trapped. Additionally, she was (and still is) [redacted] and this was a weighty consideration for her continuing in her position at the store.

406. Secondly, Mr Mumford suggested that it was an exceptional circumstance that more than five years had passed since the conduct in question and her first interview, in which she accepted all the relevant facts. There had been no repetition of the conduct since in that lengthy period. Mr Mumford submitted that these matters do

take the case 'outside of the norm' and would justify the Committee taking no further action.

407. Mr Mumford highlighted on behalf of Ms Kothari that she had personal mitigation [redacted], her previous good character, the impact of the [redacted], and that much of the misconduct took place during the COVID pandemic. Mr Mumford referred the Committee to paragraph 21.7 of the Guidance and submitted that the factors applied.

408. Alternatively, to taking no further action, Mr Mumford submitted that conditions could be imposed on Ms Kothari's registration. He referred the Committee to an email that had been sent from Mr H, which confirmed that he would be willing to act as Ms Kothari's workplace supervisor. Mr Mumford suggested that this could be a condition imposed, together with other conditions such as notification requirements. Mr Mumford, when asked by the Committee regarding how conditions would address the public interest, replied that the public perception would be that the misconduct had been marked with a regulatory response of conditions, and the public would be keen to see that all reasonable steps had been taken to prevent repetition. Additionally, Ms Kothari would be able to demonstrate a period of safe practice under supervision.

409. Mr Mumford, when addressing the Committee on suspension, submitted that if the Committee was considering a period of suspension, this should be for as short a period as would meet the public interest and in his submission a period of 28 days would be a sufficient period. He agreed that a review hearing would not be necessary. Mr Mumford submitted that erasure would not be appropriate as paragraph 21.37 of the Guidance states that this is only appropriate where it is the only means of protecting the public and meeting the public interest.

410. The Committee accepted the advice of the Legal Adviser, which was in summary, for the Committee to take into account the factors on sanction as set out in the Guidance; to assess the seriousness of the misconduct; consider any aggravating and mitigating factors; and to consider the range of available sanctions in ascending order of seriousness. Further, the Committee is required to act proportionately by weighing the interests of the registrant against the public interest. The Legal Adviser highlighted the sections of the Guidance on dishonesty and taking a proportionate approach to students (in relation to Ms Kothari who was a pre-registration Optometrist at the time of the misconduct).

The Committee's findings on sanction

411. When considering the most appropriate sanction, if any, to impose in this case, the Committee had regard to all of the evidence and submissions it had heard and the Guidance. The Committee also had regard to its previous findings.

412. The Committee firstly considered the appropriate and proportionate sanction for the director Registrants, Ms Rughani and Ms Bariya. The Committee considered these two registrants together given that it had found that they had carried out the misconduct jointly and the same findings of misconduct and impairment had been found in relation to both. Neither had engaged with these proceedings and the Committee could not identify any factors or reason to treat them differently to each other.

Ms Bansri Rughani and Ms Sapna Bariya

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

(i) the serious, repeated and prolonged nature of the dishonesty, which was cynical, systematic, and multifaceted, involving many patients, putting them at risk of harm, which did not stop until discovered by the investigation;
(ii) the fundamental abuses of trust (in respect of patients, colleagues and Specsavers), which was of particular significance given that the Registrants had positions of responsibility as directors;
(iii) the misconduct was motivated by financial gain, to increase profits for the store and to financially benefit themselves;
(iv) there was no evidence of insight and remediation (as detailed in the impairment determination) and a high risk of repetition was found;
(v) the misconduct was exploitative of patients and their staff.

414. The Committee considered that the following mitigating factors were present:

i) the Registrants had no prior fitness to practise history.

415. The Committee next considered the sanctions available to it from the least restrictive to the most severe, starting with no further action.

416. The Committee considered taking no further action as set out in paragraphs 21.3 to 21.8 of the Guidance. It concluded that taking no action would not be an appropriate outcome in this case. The Committee considered that taking no further action was not proportionate nor sufficient given the seriousness of the case and the public interest concerns. Furthermore, there were no exceptional circumstances to justify taking no action in this case.

417. The Committee considered the issue of a financial penalty order. However, it was of the view that such an order was not appropriate. Whilst the case involved financial gain, it had no information relating to the financial position of the Registrants and their ability to pay a financial order. It also would not be a sufficient sanction to meet the public interest, given the seriousness of the misconduct.

418. The Committee considered the Guidance in relation to the imposition of conditions. It was of the view that conditional registration would not be practicable due to the nature of the misconduct, which did not involve identifiable clinical areas of practice in need of assessment or retraining, which conditions often seek to address. In addition, conditions would not sufficiently mark the serious nature of the Registrants' misconduct or address the public interest concerns identified. The Committee concluded that conditions could not be devised which would be appropriate, proportionate, workable or measurable in this case. Furthermore, in relation to the directors, the Committee had found that the dishonesty was likely deep-seated and attitudinal, which would make conditions inappropriate.

419. The Committee next considered suspension and had regard to paragraphs 21.29 to 21.31 of the Guidance. In particular, the Committee considered the list of factors contained within paragraph 21.29, that indicate that a suspension may be appropriate, which are as follows:

> **Suspension (maximum 12 months)**
>
> *21.29 This sanction may be appropriate when some, or all, of the following factors are apparent (this list is not exhaustive):*
>
> *a. A serious instance of misconduct where a lesser sanction is not sufficient.*
>
> *b. No evidence of harmful deep-seated personality or attitudinal problems.*
>
> *c. No evidence of repetition of behaviour since incident.*
>
> *d. The Committee is satisfied the registrant has insight and does not pose a significant risk of repeating behaviour.*
>
> *e. In cases where the only issue relates to the registrant's health, there is a risk to patient safety if the registrant continued to practise, even under conditions*.

420. The Committee was of the view that the majority of the factors listed in paragraph 21.29 were not applicable to the directors. Factor a) was clearly relevant, namely this was serious misconduct, where a lesser sanction was not sufficient. However, in relation to b), the Committee was of the view that this does not apply as the Committee had found it was likely deep-seated and attitudinal in nature. In relation to c), whilst there was no evidence of repetition of the behaviour since the incidents,

the dishonesty itself had persisted over a prolonged period. In relation to d), the Committee had earlier found that there is no evidence that the Registrants have developed insight and there remained a very high risk of repetition. Factor e) was not applicable to the facts of this case.

421. Given the seriousness of the misconduct, which the Committee considered was at the upper end of the spectrum of dishonesty, the Committee was of the view that a suspension would be insufficient to address the public interest concerns that it had identified. It considered that a suspension order would not adequately mark the seriousness of the Registrants' conduct, maintain confidence in the profession and declare and uphold proper standards of professional conduct and behaviour.

The Committee went on to consider erasure. The Committee was of the view that several of the factors listed in the Guidance at paragraph 21.35 (a)-(h), which lead towards the sanction of erasure being appropriate, applied in this case. Paragraph 21.35 states as follows:

Erasure

21.35 Erasure is likely to be appropriate when the behaviour is fundamentally incompatible with being a registered professional and involves any of the following (this list is not exhaustive):

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. Abuse of position/trust (particularly involving vulnerable patients) or violation of the rights of patients;

d. Offences of a sexual nature, including involvement in child pornography;

e. Offences involving violence;

f. Dishonesty (especially where persistent and covered up);

g. Repeated breach of the professional duty of candour, including preventing others from being candid, that present a serious risk to patient safety; or

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

422. The Committee was of the view that factors a), b), c), and f) were all engaged in this case. In relation to factor f), the Committee considered that this especially applied given that the Registrants' dishonesty was persistent, multifaceted, for financial

benefit and to an extent covered up. The Committee concluded that that under the Guidance there were more factors indicating that erasure was the appropriate sanction rather than in relation to suspension.

423. The Committee had regard to the section on dishonesty at paragraph 22.4 of the Guidance. It noted that there was no blanket rule or presumption that erasure is the appropriate sanction in all cases of dishonesty and that it was required to balance the circumstances of the case against the effect of a finding of dishonesty has on public confidence in the profession.

424. The Committee determined that given that the seriousness of the Registrants' misconduct, the degree of dishonesty involved, and the aggravating factors detailed above, which significantly outweighed the mitigating factor present, the Registrants' behaviour was fundamentally incompatible with being on the Register. The Committee was of the view that a reasonable and well-informed member of the public would be extremely concerned if a Dispensing Optician and an Optometrist, who were both store directors, had been dishonest to the extent which they had in this case and were allowed to return to practise. The Committee concluded that the only proportionate and appropriate sanction in this case for both director Registrants, and the only sanction that was sufficient to protect the public and the wider public interest, was one of erasure and any lesser sanction would not uphold standards and would undermine confidence in the profession and the regulator.

425. The Committee therefore ordered that both director Registrants, Ms Bansri Rughani and Ms Sapna Bariya, be erased from the Register.

Ms Meera Patel

426. The Committee next went on to consider sanction in relation to the junior employee Registrants separately and in turn, firstly considering sanction in relation to Ms Meera Patel.

427. The Committee firstly considered the aggravating and mitigating factors. In the Committee's view, the aggravating factors in relation to Ms Patel are as follows:

i) The persistent and repeated nature of the dishonesty, there being multiple instances over an extended period of time, affecting a large number of patients;
ii) There was a breach of fundamental tenets of the profession and a breach of patients' trust;
iii) Patients were financially disadvantaged and there was a risk of harm in terms of anxiety;
iv) There was a failure to raise concerns.

428. The Committee found that the following mitigating factors were present:

i) The Registrant was a very junior member of staff at the very start of her career, which took place in a toxic work environment;

ii) This was situational dishonesty and not deep-seated or attitudinal;

iii) The Registrant did not directly gain financially from the misconduct;

iv) The Registrant had apologised and shown remorse for her actions;

v) The Registrant has engaged throughout and made admissions at the investigation stage and to the Allegation in these proceedings;

vi) The Registrant had previous good character. Additionally, there had been positive testimonials from her work colleagues over the past four years and there had been no repetition of the misconduct since;

vii) The Registrant has reflected, shown insight and undertaken a lot of remediation over the past 5 years, including targeted and appropriate CPD.

429. The Committee next considered the sanctions available to it from the least restrictive, starting with taking no further action.

430. The Committee considered taking no further action as set out in paragraphs 21.3 to 21.8 of the Guidance. The Committee noted that exceptional circumstances would be required and although there was significant mitigation, found that this was not sufficient to amount to exceptional circumstances. Additionally, the Committee considered that taking no action would be insufficient to address the public interest concerns in this case.

431. The Committee next considered the imposition of a financial penalty order. The Committee did not consider that this was an appropriate nor proportionate sanction, as the junior employee Registrants did not directly benefit financially from their misconduct.

432. The Committee next considered conditions. The Committee noted that impairment had only been found on public interest grounds and there were no ongoing public protection concerns. The Committee was of the view that conditional registration would not be practicable due to the nature of the misconduct, which did not involve identifiable clinical areas of practice in need of assessment or retraining, which conditions often seek to address. In addition, the Committee was of the view that conditions would not sufficiently mark the serious nature of the Registrant's misconduct or address the public interest concerns identified. The Committee

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

433. The Committee next considered suspension and had regard to paragraphs 21.29 to 21.31 of the Guidance. In particular, the Committee considered the list of factors contained within paragraph 21.29, that indicate that a suspension may be appropriate (as set out at paragraph 419 of this determination above).

434. The Committee was of the view that all of the factors listed in paragraph 21.29 were applicable, apart from factor e), which was not relevant in this case. In relation to factor a), this was a serious matter, where a lesser sanction was not sufficient, as set out above.

435. In relation to b), the Committee was of the view that although there were repeated instances of dishonesty, the Committee did not find that there is evidence of harmful deep-seated personality or attitudinal problems.

436. In relation to c), there was no evidence of repetition of the behaviour since the incidents.

437. In relation to d), the Committee had earlier found that the Registrant has developed insight and the risk of repetition was low. The Committee was therefore satisfied that all of the relevant factors indicating that suspension may be appropriate were established in this case.

438. The Committee balanced the mitigating and aggravating factors in the case and considered the principle of proportionality. Whilst this was a serious case of dishonesty, there were also significant mitigating factors. The Committee was of the view that a suspension order was an appropriate and proportionate sanction to address the public interest concerns that it had identified. It considered that a suspension order would adequately mark the seriousness of the Registrant's conduct, maintain confidence in the profession and declare and uphold proper standards of professional conduct and behaviour.

439. The Committee found that suspension would be an appropriate and proportionate sanction. In relation to erasure, the Committee was of the view that the conduct was not fundamentally incompatible with continued registration. Although some of the factors in paragraph 21.35 of the Guidance were present, such as persistent dishonesty, the Committee was of the view that erasure was not the only order that would satisfy public interest concerns and it would be disproportionate and unnecessarily punitive in this case, in light of the mitigating factors, particularly the early stage of the Registrant's career, the insight and the remediation undertaken. The Committee also took the view that the Registrant was a well regarded

Optometrist and there is a public interest in allowing such an Optometrist to be able to return to practice.

440. The Committee gave consideration to the appropriate length of the order of suspension. It determined that, having balanced the mitigating and aggravating factors against the public interest, it would be proportionate and appropriate to suspend the Registrant for a period of two months. When considering the appropriate length of order, the Committee had regard to the mitigation, the testimonials, and the impact upon the Registrant. However, the Committee also had regard to the repeated nature of the dishonesty and the need to adequately meet the public interest.

441. In the circumstances, the Committee was of the view that two months was an appropriate and proportionate period of suspension to sufficiently mark the seriousness of the Registrant's misconduct and to address the public interest concerns it had identified.

442. The Committee considered whether to direct that a review hearing should take place before the end of the period of suspension. The Committee noted that at paragraph 21.32 of the Guidance, it states that a review should normally be directed before an order of suspension is lifted, because the Committee will need to be reassured that the Registrant is fit to resume unrestricted practice. However, the Committee bore in mind that it had found that the Registrant had developed insight, had adequately remediated and the misconduct was unlikely to be repeated. Additionally, the finding of impairment was on public interest grounds only. In the circumstances, the Committee was not satisfied that it was necessary or appropriate to direct a review hearing before the order of suspension expired.

443. The Committee therefore imposed a suspension order on Ms Meera Patel for a period of two months, without a review hearing.

Ms Maneeka Kothari

444. The Committee then went on to consider the appropriate and proportionate sanction in relation to Ms Maneeka Kothari.

445. The Committee firstly considered the aggravating and mitigating factors. In the Committee's view, the aggravating factors in relation to Ms Kothari are as follows:

i) The persistent and repeated nature of the dishonesty, there being multiple instances over an extended period of time, affecting a large number of patients;

ii) There was a breach of fundamental tenets of the professional and a breach of patients' trust;
iii) Patients were financially disadvantaged and there was a risk of harm in terms of anxiety;
iv) There was a failure to raise concerns.

446. The Committee found that the following mitigating factors were present:

i) The Registrant was a pre-registration Optometrist, in the middle of her training position, which would have been difficult to change, in a toxic work environment;
ii) This was situational dishonesty and not deep-seated or attitudinal;
iii) The Registrant did not directly gain financially from the misconduct;
iv) The Registrant had apologised and shown remorse for her actions;
v) The Registrant has engaged throughout and made admissions at the investigation stage and to the Allegation in these proceedings;
vi) The Registrant had previous good character. Additionally, there had been positive testimonials from her work colleagues over the past four years and there had been no repetition of the misconduct since;
vii) The Registrant has reflected, shown insight and undertaken a lot of remediation over the past 5 years, including targeted and appropriate CPD;
viii) The Registrant had very difficult personal circumstances at the time of the misconduct.

447. The Committee considered taking no further action as set out in paragraphs 21.3 to 21.8 of the Guidance. The Committee carefully considered the submissions of Mr Mumford that invited the Committee to find exceptional circumstances. The Committee considered that the circumstances of this case were unusual and challenging for the Registrant, particularly as she was in her pre-registration training, which she felt she could not leave. However, although there was significant mitigation, the Committee was not satisfied that was sufficiently unusual or rare so as to amount to exceptional circumstances. Additionally, the Committee considered that taking no action would be insufficient to address the public interest concerns in this case.

448. The Committee next considered the imposition of a financial penalty order. The Committee did not consider that this was an appropriate nor proportionate sanction, as the junior employee Registrants did not directly benefit financially from their misconduct.

449. The Committee next considered conditions. The Committee considered the conditions that had been proposed by Mr Mumford and his submissions on this sanction. The Committee noted that the primary purpose of conditions is to protect the public and impairment had only been found on public interest grounds, as no ongoing public protection concerns had been identified. The Committee was also of the view that conditional registration would not be practicable due to the nature of the misconduct, which did not involve identifiable clinical areas of practice in need of assessment or retraining, which conditions often seek to address. In addition, the Committee was of the view that conditions would not sufficiently mark the serious nature of the Registrant's misconduct or address the public interest concerns identified. The Committee therefore concluded that conditions could not be devised which would be appropriate, proportionate, workable or measurable in this case.

450. The Committee next considered suspension and had regard to paragraphs 21.29 to 21.31 of the Guidance. In particular, the Committee considered the list of factors contained within paragraph 21.29, that indicate that a suspension may be appropriate (as set out at paragraph 419 above).

451. The Committee was of the view that all of the factors listed in paragraph 21.29 were applicable, apart from factor e), which was not relevant in this case. In relation to factor a), this was a serious matter, where a lesser sanction was not sufficient, as set out above. In relation to b), the Committee was of the view that although there were repeated instances of dishonesty, the Committee did not find that there is evidence of harmful deep-seated personality or attitudinal problems and took account of the testimonials provided that speak to the Registrant's honesty.

452. In relation to c), there was no evidence of repetition of the behaviour since the incidents.

453. In relation to d), the Committee had earlier found that the Registrant has developed insight and the risk of repetition was low. The Committee was therefore satisfied that factors indicating that suspension may be appropriate were established in this case.

454. The Committee balanced the mitigating and aggravating factors in the case and considered the principle of proportionality. The Committee was of the view that a suspension order was an appropriate and proportionate sanction to address the public interest concerns that it had identified. It considered that a suspension order would adequately mark the seriousness of the Registrant's conduct, maintain confidence in the profession and declare and uphold proper standards of professional conduct and behaviour.

455. The Committee found that suspension would be an appropriate and proportionate sanction. In relation to erasure, the Committee was of the view that the conduct was not fundamentally incompatible with continued registration. Although some of the factors in paragraph 21.35 of the Guidance were present, such as persistent dishonesty, the Committee was of the view that erasure was not the only order that would satisfy public interest concerns and it would be disproportionate and unnecessarily punitive in this case, in light of the mitigating factors. The Committee also took the view that the Registrant was a well regarded Optometrist and there is a public interest in allowing such an Optometrist to be able to return to practice.

456. The Committee gave consideration to the appropriate length of the order of suspension. It determined that, having balanced the mitigating and aggravating factors against the public interest, it would be proportionate and appropriate to suspend the Registrant for a period of two months. When considering the appropriate length of order, the Committee had regard to the mitigation, the testimonials, and the impact upon the Registrant. However, the Committee also had regard to the repeated nature of the dishonesty and the need to adequately meet the public interest.

457. In the circumstances, the Committee was of the view that two months was an appropriate and proportionate period of suspension to sufficiently mark the seriousness of the Registrant's misconduct and to address the public interest concerns it had identified.

458. The Committee considered whether to direct that a review hearing should take place before the end of the period of suspension. The Committee noted that at paragraph 21.32 of the Guidance, it states that a review should normally be directed before an order of suspension is lifted, because the Committee will need to be reassured that the registrant is fit to resume unrestricted practice. However, the Committee bore in mind that it had found that the Registrant had developed insight, had remediated and the misconduct was unlikely to be repeated. Additionally, the finding of impairment was on public interest grounds only. In the circumstances, the Committee was not satisfied that it was necessary or appropriate to direct a review hearing before the order of suspension expired.

459. The Committee therefore imposed a suspension order on Ms Maneeka Kothari for a period of two months, without a review hearing.

Immediate Order

460. The Committee went on to consider whether to impose an immediate order of suspension in respect of any of the four Registrants and invited representations from the parties on this issue.

461. Mr Geering confirmed that in respect of Ms Patel and Ms Kothari, the Council was not inviting the Committee to impose an immediate order of suspension under Section 13I of the Opticians Act 1989, as one was not necessary in the circumstances and none of the grounds were met.

462. However, in relation to the director Registrants, Ms Rughani and Ms Bariya, Mr Geering invited the Committee to impose an immediate order of suspension on public protection and public interest grounds. Mr Geering submitted that the necessity test was well met and it would be inappropriate for them to be able to practice during any appeal period.

463. Mr Hall and Mr Mumford both agreed with the Council's position and opposed the imposition of an immediate order in respect of their clients, submitting that an immediate order was not necessary given the Committee's findings. Mr Hall also highlighted that imposing an immediate order would in effect add 28 days onto the suspension order.

464. The Committee accepted the advice of the Legal Adviser, which was that to make an immediate order, the Committee must be satisfied that the statutory test in section 13I of the Opticians Act 1989 was met. The Committee was referred to the relevant section in the Guidance on making an immediate order.

The Committee's decision on an immediate order

465. The Committee was not satisfied that there was any necessity for an immediate order in respect of either Ms Patel or Ms Kothari, to protect the public as there were no public safety concerns regarding the Registrants. The Committee was also not satisfied that an immediate order of suspension would be otherwise in the public interest, as the public interest had been met by the two month suspension orders. Nor would an immediate order be in the Registrants' own interests.

466. Therefore, the Committee decided not to impose an immediate suspension order in respect of Ms Patel or Ms Kothari.

467. However, in relation to the director Registrants, the Committee was satisfied given its earlier findings, that there was a real risk to the public if no immediate order was made, given that it had found that the risk of repetition was high. Additionally, given that the Committee had imposed the most severe sanction of erasure, it was the

view of the Committee that an immediate order of suspension was also otherwise in the public interest.

468. Accordingly, the Committee determined to impose an immediate order of suspension in relation to Ms Rughani and Ms Bariya.

Revocation of interim orders

469. There are no interim orders to revoke.

Chair of the Committee: Louise Fox

Signature  **Date: 1 May 2026**

Registrant: Bansri Rughani

Signature *Registrant not present, sent via email* **Date: 1 May 2026**

Registrant: Meera Patel

Signature *Registrant present, sent via email* **Date: 1 May 2026**

Registrant: Sapna Bariya

Signature *Registrant not present, sent via email* **Date: 1 May 2026**

Registrant: Maneeka Kothari

Signature *Registrant present, sent via email* **Date: 1 May 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.