BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(25)41

AND

AASIYA CHOHAN (01-44561)

DETERMINATION OF A SUBSTANTIVE HEARING
29 May-2 June 2026

Committee Members:	Gerry Wareham (Chair/Lay) Lisa Hill (Lay) Ben Summerskill (Lay) Louise Gow (Optometrist) Caroline Clark (Optometrist)
Legal adviser:	Kelly Thomas
GOC Presenting Officer:	Holly Huxtable
Registrant present/represented:	Yes and represented
Registrant representative:	Eleanor Curzon (Days 1&2) Kevin Saunders (Day 3) Chloe Jeram – legal representative
Hearings Officer:	Latanya Gordon
Facts found proved:	Allegation 1a, 1bi, 1bii, 1biii, 2 and 3 – by way of admission
Facts not found proved:	None
Misconduct:	Accepted and found on allegations 1a, 1bi, 1bii, 1biii, 2 and 3
Impairment:	Impaired
Sanction:	Two months suspension order
Immediate order:	Not imposed

ORIGINAL ALLEGATION

The Council alleges that you, Aasiya Chohan (01-44561), a registered optometrist:

1. *In or around February 2024 and/or March 2024, whilst registered as a student optometrist, you:*
   a. *accessed Patient A's clinical records without justification and/or consent; and/or*
   b. *created records in respect of Patient A for the following which had not taken place:*
      i. *Contact lens initial fitting appointment dated 24 February 2024; and/or*
      ii. *Contact lens check on collection appointment dated 1 March 2024; and/or*
      iii. *Follow up appointment dated 5 March 2024.*
2. *You presented falsified records for Patient A as evidence of your competency in respect of the Scheme for Registration.*
3. *Your conduct as outlined in allegation 1a and/or 1bi and/or 1bii and/or 1biii and/or 2:*
   a. *was dishonest in that you knowingly created and/or presented false patient records; and/or*
   b. *misleading; and/or*
   c. *displayed a lack of integrity*

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

Preliminary applications

Application to amend allegation/withdraw particulars

1. Ms Huxtable, on behalf of the Council, made an application under *Rule 46(20)* of the *Rules* to In essence, the Council seeks to better particularise allegation 3 as follows:
   - to withdraw 1a from the particulars;
   - to withdraw "displayed a lack of integrity" and "misleading".

2. The Council submitted that the amended allegation did not materially differ from the allegation that was referred to the Committee and could be made without prejudice to the Registrant.

3. Further to the proposed amended allegation as drafted, the Council sought to amend the wording in allegation 2 from “falsified” to “false” to avoid any prejudice to the Registrant. The Council submitted that this is because the ordinary dictionary interpretation of the word falsified may connote an element of deception, which is perhaps synonymous with dishonesty. Whether the Registrant’s conduct at allegation 2 was dishonest should be considered distinctly at allegation 3.

4. Ms Curzon, on behalf of the Registrant, raised no objections to the proposed amendments.

5. The Committee received and accepted advice from the Legal Adviser who advised that under *Rule 46(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.”

6. The Committee considered the prejudice to the Registrant and balanced this against the overarching objective of protection of the public. The Committee noted that there were no objections from the Registrant. The Committee decided that the allegations should be amended, as the proposed allegations better reflected the evidence and caused no prejudice to the Registrant.

AMENDED ALLEGATION

The Council alleges that you, Aasiya Chohan (01-44561), a registered optometrist:

1. *Between 23 February 2024 and 6 March 2024, whilst registered as a student optometrist, you:*
   a. *accessed Patient A’s clinical records without justification and/or consent; and/or*
   b. *created records in respect of Patient A for the following appointments which had not taken place:*
      i. *Contact lens initial fitting dated 24 February 2024; and/or*
      ii. *Contact lens check on collection dated 1 March 2024; and/or*
      iii. *Follow up dated 5 March 2024.*

2. *In March 2024, you presented false records to the College of Optometrists for Patient A as evidence of your competency in respect of the Scheme for Registration.*

3. *Your conduct as outlined above at 1bi and/or 1bii and/or 1biii and/or 2 was dishonest in that you knowingly created and/or presented false patient records.*

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

ADMISSIONS

7. The allegations were read in full to the Registrant. The Registrant admitted allegations 1a, 1bi, 1bii, 1biii, 2 and 3.

8. The Committee therefore found allegations 1a, 1bi, 1bii, 1biii, 2 and 3 proved by admission as per *Rule 40(6)* of the *Rules*.

BACKGROUND

9. The Registrant registered with the Council as a Student Optometrist on 26 October 2020 and as a fully qualified Optometrist on 27 November 2024. At the material time, the Registrant was employed at Specsavers, [redacted] ("the Practice").

10. A referral was made to the Council by the College of Optometrists on 21 June 2024 in respect of the Registrant's misconduct during Stage 1 of the Scheme for Registration.

11. Patient A was employed by Specsavers [redacted] and started receiving emails from Specsavers querying how she was getting on with her contact lenses. She had not signed up for any contact lenses and therefore she looked at her clinical records. She noted a record of a contact lens fitting that had not taken place. This is set out in the witness statement of Patient A.

12. On 26 March 2024, the matter was duly referred to Witness A, Optometry Director, who conducted an internal investigation. It was established that the Registrant had created three false records for Patient A in respect of appointments on 24 February 2024, 1 March 2024 and 5 March 2024. Patient A had not been seen or examined by the Registrant on any of these dates. This is set out in the witness statement Of Witness A.

13. The Registrant admitted accessing Patient A's records and ordering contact lenses without having seen Patient A. She did this to meet a competency required by the College of Optometrists. The College of Optometrists also conducted an internal investigation, during which the Registrant admitted creating false records for Patient A. This is set out in the witness statement of Witness B, the Deputy Lead Assessor at the College of Optometrists.

14. Ms Huxtable and Ms Curzon agreed that Stages 1 & 2, namely misconduct and impairment, could be dealt with together during the hearing.

SUBMISSIONS AND ADVICE ON MISCONDUCT

15. The Registrant gave evidence. In her oral evidence the Registrant adopted her written statement dated 5 May 2026 and confirmed that there were no corrections or updates.
16. The Registrant said she had reflected extensively on the circumstances surrounding her misconduct, including the stress and pressure she was experiencing at the time, and had considered the impact of her actions on patients, colleagues and the wider profession. She described discussions with colleagues regarding the importance of accurate record keeping, appropriate access to records, and the need to avoid shortcuts when under pressure. In hindsight, she stated that she would have sought support earlier, spoken openly about her difficulties, requested additional training and supervision, or taken a break from her studies rather than acting dishonestly.
17. The Registrant stated that she had undertaken targeted CPD on probity and ethics, which had enhanced her understanding of honesty, insight, remediation and reflection. She explained that the training had helped her appreciate that falsifying records could compromise patient safety, damage trust between colleagues and undermine confidence in the profession.
18. The Registrant stated that she is now encountering similar pressures while undertaking a Professional Certificate in Glaucoma (“Prof Cert”) alongside full-time employment but had managed these studies appropriately through forward planning, time management and seeking support from colleagues. She said this demonstrated that she had developed effective coping strategies and would respond differently if faced with similar circumstances in the future.
19. The Registrant accepted that her conduct had been dishonest and wrong. She acknowledged that trust is fundamental to the optometry profession and that her actions had breached the trust placed in her by patients, colleagues and directors. She accepted that fellow Optometrists would likely be disappointed in her conduct and view it as taking an unfair shortcut. She further accepted that members of the public who became aware of her actions might be concerned about patient safety and their confidence in the profession could be undermined.
20. The Registrant stated that the regulatory process had made her appreciate the seriousness of her misconduct and its potential consequences. She explained that the misconduct occurred when she was overwhelmed, under significant pressure and fearful of failure, and that she panicked when she believed she would be unable to complete a competency that was difficult to attain due to the scarcity of multi focal contact lens wearers. She emphasised that the incident related to a single competency record over a short period rather than multiple competencies but accepted that it remained

serious. The Registrant also noted that she had retained the support of her directors and had been permitted to continue her training at the same Practice, and that she had resumed her professional development at a pace she considered manageable and sustainable.

21. The Committee had no questions for the Registrant and there was no re-examination.

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

23. The Committee was invited to have regard to the General Optical Council *Standards of Practice for optical students ("the Standards"),* in particular *Standards 7, 15 and 16*. Ms Huxtable submitted that the Registrant's actions amount to misconduct in that her actions were serious and must be regarded as deplorable by fellow practitioners, such that a finding of misconduct is justified.

24. Ms Curzon accepted that the facts proved by way of admission amounted to misconduct.

25. The Legal Adviser outlined that even where the parties agree that there should be a finding of misconduct as per *Rule 46,* it is still a matter for the Committee to decide. The Legal Adviser outlined the case law and the *Hearings and Indicative Sanctions Guidance ("the Guidance")* at *Paragraphs 15.5-15.9* in relation to misconduct, reminding the Committee of the descriptions of misconduct in the cases of *Roylance* and *R (on the application of Vali) v General Optical Council (2011) EWHC 310 (Admin).* The Committee should consider each of the proven allegations in turn and decide whether each amounted to serious misconduct. Misconduct was a matter for the Committee's own independent judgement and no burden or standard of proof applied. The Committee should only move on to the impairment stage if it found serious misconduct.

SUBMISSIONS AND ADVICE ON IMPAIRMENT

26. Ms Huxtable submitted that the Committee should find that the Registrant's fitness to practise was currently impaired. She submitted that fitness to practise proceedings were not punitive of the Registrant but protective of the public, requiring a forward-looking assessment, while properly taking account of past misconduct in accordance with *Meadow v GMC[2007] 1 All ER 1*. The Council submitted that the Committee should apply the approach

set out in *CHRE v (1) NMC and (2) Grant [2011] EWHC 927 (Admin)*, and that all four limbs of the *Grant* test were engaged, given the serious clinical failures in the care of Patient A and that inaccurate patient records can cause serious harm for patients and be misleading to other practitioners. This placed patients at unwarranted risk of harm, brought the profession into disrepute, breached fundamental tenets of the profession and was also dishonest.

27. The Council submitted that the Registrant's fitness to practise is currently impaired due to the following:

    i. the Registrant knowingly created false patient records to submit for her College of Optometrists assessment. Whilst her conduct occurred over a relatively short period of time, it was repetitive and deliberate. Her conduct was dishonest and therefore attitudinal, which is not easy to remedy;
    ii. whilst the Registrant's conduct did not cause harm to Patient A, her willingness to dishonestly create false patient records for personal gain potentially places patients at risk of serious harm;
    iii. the circumstances of this case are such that a finding of impairment is required to meet the wider public interest, notably to uphold proper professional standards and maintain public confidence in the profession.

28. The Council submitted that a finding of impairment was required both to protect the public from ongoing risk and to uphold professional standards and maintain public confidence in the profession, even if the Committee was to conclude that the likelihood of repetition is limited.

29. Ms Huxtable emphasised that false or inaccurate clinical records have the potential to place patients at risk of harm and undermined confidence in the Registrant's ability to practise safely. She submitted that, notwithstanding the Registrant's completion of targeted CPD and engagement in reflection, there had not been insufficient remediation and insight to address the ongoing risk arising from serious clinical failings.

30. Ms Huxtable submitted that the Council's primary concern related to dishonesty, which she submitted was attitudinal in nature and therefore difficult to remediate. Accordingly, the Council invited the Committee to find that the Registrant remained impaired in order to protect the public and to uphold professional standards and public confidence in the profession.

31. Ms Curzon submitted that the Registrant's fitness to practise is not currently impaired. She submitted that impairment is a forward-looking assessment concerned with public protection rather than punishment, and that the Committee should focus on whether the misconduct is remediable, whether it has been remedied, and whether it is likely to be repeated. Ms Curzon

emphasised that Ms Chohan has no previous fitness to practise history, has consistently admitted her wrongdoing from the outset, and that there has been no repetition of the concerns since the events occurred.

32. In support of remediation, Ms Curzon relied heavily on the Registrant's reflective statement, oral evidence, and targeted continuing professional development. She submitted that the Registrant had demonstrated substantial insight into the seriousness of her dishonest conduct, including its potential impact on patient safety, the integrity of the pre-registration process, and public confidence in the profession. The Registrant was said to have taken full responsibility, undertaken extensive self-reflection, completed relevant CPD on ethics, reflection, insight and remediation, and implemented practical safeguards to ensure accurate record-keeping, appropriate access to records, and greater openness in seeking support when under pressure. Ms Curzon argued that this reflected genuine personal and professional growth and a mature understanding of the standards expected of an Optometrist.

33. Ms Curzon further submitted that the risk of repetition was extremely low. She pointed to the fact that more than two years had passed without any further concerns, despite the Registrant continuing to work in the same profession and Practice and undertaking additional academic study alongside full-time employment. The misconduct was said to have been entirely out of character and has arisen in the specific context of the Registrant's pre-registration year, a situation that would not recur, and the Registrant had since demonstrated that she could manage similar pressures appropriately. Ms Curzon submitted that strong evidence of remediation and trustworthiness was said to come from numerous positive references from senior colleagues and managers, all of whom described her as professional, honest, dependable and committed to patient care, as well as positive patient feedback and employer support for further professional qualifications.

34. On the issue of public interest, Ms Curzon submitted that there was no ongoing risk to patients or the public and that public confidence would not be undermined by a finding that fitness to practise was not impaired. She submitted that the regulatory process itself, together with the Registrant's admissions, remediation and demonstrated insight, would reassure an informed member of the public that appropriate action had been taken.

35. Accordingly, she invited the Committee to find misconduct but no current impairment, contending that such a finding would sufficiently mark the seriousness of the conduct. In the alternative, she submitted that, if the Committee considered a formal response necessary, a warning would be the appropriate outcome given the Registrant's remorse, previously unblemished record, extensive remediation and positive testimonials.

36. The Committee heard and accepted advice from the Legal Adviser who outlined *Paragraphs 16.1* to *16.7* of the *Guidance*. The Legal Adviser advised the Committee to consider the two separate elements of impairment namely the public interest component, which concerns the reputation of the profession and upholding professional standards, and the public protection component which concerns the risk to the public of repetition. She advised the Committee to consider any insight displayed by the Registrant as set out in *Cohen v GMC (2008) EWHC 581*. The Legal Adviser also highlighted the four questions in the *Grant* case.

37. The Legal Adviser addressed the issue of dishonesty in impairment with the case of *PSA v HCPC and Ghaffar (2014) EWHC 2723 (Admin)* in which the Court held that a finding of impairment did not necessarily follow upon a finding of dishonesty, although it would be an unusual case where dishonesty is not found to impair fitness to practise. The Legal Adviser also referred to the case of *PSA v (1) GMC (2) Uppal (2015) EWHC 1304 Admin* which confirmed that a finding of dishonesty does not always mean that impairment is inevitable.

38. The Legal Adviser further advised the Committee that at the impairment stage, there is no burden or standard of proof, but ultimately it is a question of judgement for the Committee alone.

FINDINGS ON MISCONDUCT

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

40. The Committee noted that both parties agreed that misconduct was present given this was a case of dishonesty. The Committee was satisfied that the Registrant's conduct engaged a number of the Council's *Standards*. In particular, the Committee noted *Standard 7 Maintain adequate records; Standard 15 Be honest and trustworthy and Standard 16 Do not damage the reputation of the profession by your conduct.*

Allegation 1a: Between 23 February 2024 and 6 March 2024, whilst registered as a student optometrist, you accessed Patient A's clinical records without justification and/or consent;

41. The Committee found it was inappropriate to access Patient A's clinical record without the consent of Patient A, who thought it was "*a bit odd*" and "*strange*" when she found out about this access of her data without consent. The Committee considered that members of the public would be shocked to find out that her data was accessed without consent. The Committee found that this fell far below the required standards, particularly that of *Standard 16,* and amounted to serious misconduct.

Allegation 1bi: Between 23 February 2024 and 6 March 2024, whilst registered as a student optometrist, you created records in respect of Patient A for appointments which had not taken place, namely a contact lens initial fitting dated 24 February 2024

42. The Committee determined that creating false records for patients would cause confusion for colleagues and potential risks to patients at follow up appointments. The Committee found that this caused a real risk of harm to Patient A, fell far below *Standards 15* and *16,* and therefore amounted to serious misconduct.

Allegation 1bii: Between 23 February 2024 and 6 March 2024, whilst registered as a student optometrist, you created records in respect of Patient A for appointments which had not taken place, namely a contact lens check on collection dated 1 March 2024

43. The Committee determined that creating false records for patients would cause confusion for colleagues and potential risks to patients at follow up appointments. The Committee found that this caused a real risk of harm to Patient A and fell far below *Standards, 15* and *16,* and therefore amounted to serious misconduct.

Allegation 1biii: Between 23 February 2024 and 6 March 2024, whilst registered as a student optometrist, you created records in respect of Patient A for appointments which had not taken place, namely a follow up dated 5 March 2024

44. The Committee determined that creating false records for patients would cause confusion for colleagues and potential risks to patients at follow up appointments. The Committee found that this caused a real risk of harm to Patient A and fell far below *Standards, 15* and *16,* and therefore amounted to serious misconduct.

Allegation 2: In March 2024, you presented false records to the College of Optometrists for Patient A as evidence of your competency in respect of the Scheme for Registration

45. The Committee noted that false records were presented deliberately to the College in support of the Registrant's Scheme for Registration without having completed the necessary competency. The Committee concluded that there was personal gain involved, namely passing the Scheme without completing the required competency. In her evidence, the Registrant accepted it would be an unfair advantage on other pre-registration Optometrists going through the same process.

46. The Committee considered that it undermined the examination process and the Scheme itself when the Registrant could have passed Stage 1 of the registration process even though she had not completed this competency. The Committee considered that the public would be seriously concerned as this undermined the integrity of the examination system. The Committee concluded that this failure fell far short of *Standards 7, 15* and *16* and amounted to serious misconduct.

Allegation 3: Your conduct as outlined above at 1bi and/or 1bii and/or 1biii and/or 2 was dishonest in that you knowingly created and/or presented false patient records

47. The Committee reminded itself that it was only considering dishonesty in relation to allegation 1bi, 1bii, 1biii and 2. It had found that the Registrant knowingly created records for Patient A for examination which she knew had not taken place. The Registrant had accepted being dishonest in doing so. The Committee considered that dishonesty was a fundamental breach of professional standards, in particular *Standard 15*. The Committee concluded that this conduct constituted serious misconduct.

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

FINDINGS ON IMPAIRMENT

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

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

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

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

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

52. The Committee had found that the Registrant had created records for Patient A for examinations that she knew had not taken place, therefore falling far below *Standards 7, 15* and *16.* It is accepted by the Registrant that she did so dishonestly. The Registrant's actions had placed Patient A at unwarranted risk of harm and undermined the reputation of the profession amongst members of the public, professional colleagues and patients. The Committee therefore found that the Registrant had, in the past, a) put Patient A at unwarranted risk of harm, b) brought the optical profession into disrepute, c) breached one of the fundamental tenets of the profession, and b) had, in the past, acted dishonestly.

53. The Committee then went on to consider the issues in the case of *Cohen* as found at *Paragraph 16.1* of the *Guidance.*

54. Firstly, the Committee considered whether the conduct which led to the allegations is remediable. The Committee recognised that it is difficult to remediate a finding of dishonesty as this a serious matter. The Committee did not find the misconduct to be repetitive. It occurred over a brief period of time, has not been repeated, and the Registrant has no previous fitness to practise history. For those reasons, the Committee found that the Registrant's misconduct is potentially remediable.

55. Secondly, the Committee considered whether the conduct has been remedied. The Committee considered the references from those who worked with the Registrant to be exceptional. The Committee noted in particular the statement from Person A:

"In addition to her clinical skills, Aasiya works collaboratively and contributes positively to the wider team, Aasiya helps support our newer cohorts of pre regs with experiences from her own journey supporting them to be the best they can be, she is supportive, approachable and willing to share her knowledge, which has a tangible impact on team morale and performance. When faced with challenges, Aasiya responds constructively and demonstrate good judgement, I have complete confidence in her character. I consider Aasiya to be trustworthy, dependable and committed to maintaining the values and standards expected of a clinical professional."

56. The Committee noted that those who supplied other references included other clinicians, directors and managers who are fully aware of these allegations and have had regular contact with the Registrant over the last two years. The Committee noted that the directors of the Practice have continued to support the Registrant in her continued employment as well as funding the 'Prof Cert' course.

57. The Committee noted that since the incident, the Registrant has consistently apologised for her behaviour without reservation. There has been no repetition of any such behaviour. The Registrant has engaged fully with the initial investigation, the Council investigation and the Fitness to Practise proceedings. The Registrant also gave oral evidence which demonstrated further insight, commenting that she has reflected on this incident and learned much from this mistake.

58. The Committee considered whether there was a risk of repetition. The Committee found that the Registrant had demonstrated in her oral and written evidence the extensive steps she has taken to demonstrate insight and to prevent any repetition of becoming overwhelmed with a full workload. In undertaking her 'Prof Cert' the Registrant stated that she now conducts forward planning including time management and seeking support from colleagues. The Committee considered that this demonstrated that she had developed effective coping strategies and would respond differently if faced with similar challenging circumstances in the future.

59. The Committee concluded that the remedial action undertaken met with its concerns with regard to repetition of a similar issue and found that it was highly unlikely that the Registrant would repeat the behaviour if the same circumstances were to arise again.

60. The Committee was satisfied that the conduct was a brief episode under challenging circumstances, which occurred when the Registrant was a young student. The Committee did not consider the behaviour to reflect a deep-seated or attitudinal failing. For the reasons above, the Committee found that it was also highly unlikely that there was a risk of repetition of dishonesty in general.

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

62. The Committee had found that the Registrant's actions were dishonest and were a serious falling short of the *Standards.* The Committee acknowledged that the conduct took place over a relatively short period of time. She has shown she has developed an appreciation as to the seriousness of what she did which was not apparent to her at the time. The Registrant's evidence, reflections and behaviour since all support her current position that she takes this matter seriously. The Committee has outlined the evidence of

remediation and insight to enable it to conduct a risk assessment as to whether such conduct will be repeated in the future.

63. Given those findings, the Committee determined that there was a very low risk in the future that the misconduct which engaged limbs a), b), c) and d) would be repeated. The Committee considered that the steps the Registrant had taken to remediate met the concerns of the Committee in relation to the future risk of unwarranted harm to patients, bringing the optical profession into disrepute, breaching fundamental tenets of the profession and being dishonest.

64. The Committee then considered the public interest elements of the overarching objective. The Committee reminded itself of its findings that the actions as admitted in allegations 1bi, 1bii and 1biii were carried out dishonestly. Even in her own evidence, the Registrant accepted that the public would be caused concern by these actions and may worry about their safety. The Registrant had been aware of the *Standards* expected of her at the time and was well aware of the personal gain she would receive in creating and submitting false records. Whilst the Committee considered that the Registrant might personally be highly unlikely to repeat such dishonest behaviour, it had a duty to consider the reputation of the profession and the public interest.

65. The Committee noted the examples given in the *Hearings and Indicative Sanctions Guidance ("the Guidance")* at *paragraph 17.1 and* noted *"Dishonesty is particularly serious as it may undermine confidence in the profession."*

66. The Committee also considered the case law outlined and accepted that it would be rare for a person who has committed serious professional misconduct by way of dishonesty to escape a finding of impairment, unless there were exceptional reasons. The Committee considered in particular the case of *GMC v Armstrong [2021] EWHC 1658 (Admin)* in which examples of cases where a finding of dishonesty did not lead to a finding of impairment:

    "… the dishonest conduct in each of them was an isolated incident; and that there was no question of financial gain. They were in the nature of uncharacteristic lapses in what may be described as "front-line" challenging clinical situations involving direct interaction between professional and patient (or patient's relative)." The Committee did not consider that the Registrant's dishonesty had occurred in such similar circumstances. This was not a front line challenging clinical situation involving direct interaction with a patient.

67. The Committee had found that the dishonesty by the Registrant was directly relevant to the proper regulation of the profession and people entering the profession. The Registrant accepted she had taken a "shortcut" where other

pre-registration Optometrists had not. The Registrant had submitted and relied upon the created records as evidence of her competency in this area. This was only discovered when Patient A received emails and then made enquiries with the Practice. As such, the Committee was not persuaded that this was an exceptional case.

68. The Committee considered that a well informed and fair-minded member of the public, apprised of those facts, even with the extensive reflective material provided by the Registrant, would be shocked by the Registrant's misconduct. The Committee concluded that it was therefore necessary to make a finding of impairment of fitness to practise in order to uphold professional standards and public confidence in the profession.

69. The Committee therefore found that the Registrant's fitness to practise as an Optometrist is currently impaired on public interest grounds only.

SUBMISSIONS AND ADVICE ON SANCTION

70. On Day 2 of the hearing, Ms Curzon was not able to attend due to a family emergency. Ms Huxtable for the Council made an adjournment application for the matter to be put over to the following day so that new Counsel could be instructed to represent the Registrant. On Day 3, Mr Saunders appeared on behalf of the Registrant.

71. Ms Huxtable made submissions on sanction and submitted that the appropriate sanction was one of suspension.

72. Ms Huxtable outlined the case law from her written skeleton argument. In applying those principles, Ms Huxtable submitted that the appropriate mitigating features were firstly that there has been no harm caused to any patient. Further, the Registrant fully admitted her conduct to her employer, demonstrated remorse and fully co-operated with the internal investigations. Moreover, she has fully engaged with the regulatory process and made full admissions, including in her oral evidence.

73. In terms of aggravating features, Ms Huxtable submitted that the Registrant's actions were repetitive, deliberate and motivated by a desire to pass her optical assessment. In essence, she was seeking to "cheat the system". Her willingness to falsify patient records, especially for personal gain, must contribute to a risk of harm to patient.

74. In respect of mitigating and aggravating factors, the Council submitted that the recent decision of the High Court in *Ajana v NMC [2025] EWHC 3179 (Admin)* outlined that mitigating and aggravating factors require a two-stage test. Firstly, the Committee should identify the relevant mitigating and aggravating factors. Secondly, the Committee should evaluate how much

weight to give to these factors. The Council respectfully invites the Committee to reference these factors in its decision, even where those factors may have been given little weight.

75. The Council submitted that this matter is too serious to take no further action or to impose a fine on the Registrant, and that conditional registration would be inappropriate given the nature of the misconduct. The Council submitted that the Registrant's dishonest conduct is attitudinal and it cannot be readily addressed by conditions.

76. The Council submitted that suspension would be an appropriate and proportionate response in this case which involves a serious instance of misconduct. The Council accepted that the Committee has determined that there is a very low risk of repetition. Ms Huxtable also accepted that there has been no evidence of repetition since the incident, and that whilst dishonesty is by its nature attitudinal, there is no evidence of harmful deep-seated personality issues. In terms of length of suspension, the Council submitted it was a matter for the Committee to decide.

77. Mr Saunders provided written representations and made oral submissions in the hearing.

78. On behalf of the Registrant, Mr Saunders submitted that the Committee's findings at the impairment stage are highly material to sanction. The Committee had accepted that the misconduct was a brief and isolated episode, occurring when the Registrant was a young student, and that it was neither repetitive nor indicative of any deep-seated attitudinal failing. The Committee had also accepted that the conduct is remediable, that there has been no previous fitness to practise history, and that the risk of recurrence is very low. Mr Saunders submitted that the Registrant has demonstrated insight, both in written material and oral evidence, and has taken meaningful remedial steps, including targeted professional development and implementation of safeguards. The Registrant has demonstrated significant mitigation, including the absence of harm, full and early admissions, consistent expressions of remorse, and complete engagement with all investigative processes. The Registrant has continued to practise without further incident over a sustained period. The Committee, in its findings, had also placed weight on 'exceptional' character evidence from colleagues and employers, who have continued to support the Registrant. Mr Saunders submitted that the impairment finding was made on public interest grounds only, there being no ongoing risk to patients.

79. Mr Saunders submitted that in light of those findings, the purpose of sanction in this case is not for public protection, but to mark the seriousness of the misconduct and to uphold public confidence and professional standards. Mr Saunders conceded that lesser sanctions such as no action, a

financial penalty or conditions would fail adequately to reflect the seriousness of dishonesty. However, against the background, Mr Saunders submitted that erasure would be wholly disproportionate and inconsistent with the Committee's own findings.

80. Mr Saunders therefore submitted that a short period of suspension is the least restrictive sanction that properly meets the statutory objective. Such an order would provide a clear public marking of the misconduct and act as a deterrent, while recognising the high degree of remediation and low risk of repetition.

81. In terms of length of order, Mr Saunders referred to two cases, *GOC v Halima Khan (May 2026)* and *GOC v Ruman Dhaliwal (February 2026),* and submitted, given the findings in those cases, that a well-informed member of the public would not require this Registrant to be subject to a lengthy suspension or removal from the register in order to maintain confidence in the profession. Mr Saunders submitted that a well-informed member of the public would identify that this young student optometrist committed a short lapse of judgment, co-operated with all organisations involved in the investigation and has developed insight and remediation. Given those facts, Mr Saunders submitted that public interest would be properly and proportionately met by a short period of suspension which marks the seriousness without removing a Registrant from the profession who displays significant promise. Mr Saunders invited the Committee to consider a short suspension at the lower end of the available range as the only sanction that is sufficient and proportionate in all the circumstances.

82. Mr Saunders submitted that the Committee should not direct a Review Hearing for this Registrant. As the Committee had found there were no deep seated or attitudinal issues, the findings related not to managing continuing risk to patients but to manage the risk to public confidence in the profession, and therefore a Review Hearing would not be necessary.

83. The Legal Adviser referred to the *Guidance* at *Paragraphs 20-23 and 13F - 13H of the Opticians Act 1989* in outlining the sanctions available to the Committee. The Legal Adviser stated that the purpose of sanctions is not to punish, but the Committee should consider proportionality and balance the interests of the public against those of the Registrant, although the interests of the profession take precedence according to *Bolton v Law Society (1994) 1 WLR 512*.

84. The Legal Adviser also outlined *Paragraphs 22.4* to *22.6* of the *Guidance* in relation to sanctions on dishonesty. The Legal Adviser advised that the Committee should consider the aggravating and mitigating factors, and then, according to *Paragraph 8.3* of the *Guidance*, work through the sanctions starting with no further action and then the least restrictive sanction first, erasure only being appropriate where actions are fundamentally

incompatible with being a registered professional, and if it is the only means of protecting patients and/or maintaining public confidence in the optical profession as outlined in *Paragraph 21.37* of the *Guidance*.

85. The Legal Adviser outlined that the cases referred to by Mr Saunders were not precedents and the Committee was not bound by them, although it may properly consider them if helpful. Finally, the Legal Adviser advised that *Paragraphs 8.4* and *8.5* of the *Guidance* assists in relation to Registrants at the early stages of their careers and should be considered when determining sanction.

FINDINGS ON SANCTION

86. In reaching its decision on sanction, the Committee took into account the legal advice, the submissions from both parties, the facts found proved and its previous findings on misconduct and impairment. Throughout its deliberations the Committee had regard to the *Guidance*, in particular *paragraphs 20-23*, as well as the overarching objective.

87. The Committee considered the *Guidance* at *paragraph 14.3* and considered the following to be aggravating features:

- There was a potential risk of harm to Patient A
- The misconduct was motivated by a desire to deceive the examiners for the College of Optometrists Scheme for Registration

88. The Committee considered the *Guidance* at *paragraph 14.2* and considered the following to be mitigating factors:

- Patient A did not suffer actual harm.
- The dishonesty occurred over a short period of time.
- The Registrant was a young optical student at an early stage in her career
- The Registrant has fully engaged with the regulatory process and admitted her misconduct from an early stage
- The exceptional testimonials and CPD demonstrate that the Registrant is a useful and competent member of the profession.
- The Registrant has expressed satisfactory insight, remediation, and remorse.

89. The Committee considered and weighed the aggravating and mitigating factors above when applying the *Guidance.* The Committee noted that the mitigating factors were strong and found that they outweighed the

aggravating features in this case. The Committee then looked at *paragraph 8.3* and considered the possible sanctions, starting with the least severe.

90. The Committee considered taking no further action but decided, having regard to the *Guidance*, that there were no exceptional circumstances to justify doing so, as to take no action would not reflect the seriousness of the dishonest misconduct and therefore it would be inappropriate.

91. The Committee considered a financial penalty and noted that the Registrant did not gain financially from this misconduct. In any event, the Committee decided that a financial penalty would not reflect the seriousness of the misconduct.

92. The Committee next considered a period of conditional registration. The Committee discussed whether there were appropriate, proportionate, workable, and measurable conditions which would meet the Committee's concerns relating to the possible repetition of the Registrant's dishonest misconduct.

93. The Committee concluded that a conditions of practice order was not appropriate because the impairment finding was not based on clinical competence or remediable clinical deficiencies. There had been no finding of impairment on clinical grounds, and the misconduct was instead rooted in dishonesty and public interest considerations. As such, conditions directed at clinical practice would not properly address the nature of the concerns identified.

94. The Committee further concluded that conditions would not sufficiently satisfy the public interest. Although the dishonesty was not at the most serious end of the spectrum, the misconduct was nonetheless too serious to be satisfactorily addressed by conditions. A conditions of practice order would fail to mark the seriousness of the conduct or maintain public confidence in the profession and the regulatory process.

95. The Committee moved on to consider a suspension order and the relevant factors in the *Guidance* contained within *paragraph 21.29* namely:

    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 the incident.*
    d. *The Committee is satisfied the registrant has insight and does not pose a significant risk of repeating behaviour.*
    e. *[not relevant]*

96. The Committee decided that factors a), b), c) and d) were engaged. The Committee had already made findings that there was no evidence of harmful deep-seated personality or attitudinal problems. There had been no repetition since the incident occurred. The Committee had found that the Registrant had insight and did not pose a significant risk of repeating the misconduct. It therefore concluded that all of the relevant factors in respect of suspension applied.

97. The Committee went on to test this proposition against the sanction of erasure and the relevant sections of the *Guidance* at *paragraph 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. [not relevant];*
>
> *d. [not relevant];*
>
> *e. [not relevant];*
>
> *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."*

98. The Committee noted that factor a) was relevant in so far as any finding of dishonest misconduct is serious. For factor b), the Committee did not consider there to be a continuing risk of harm to patients. For factor g) the Committee did not consider there to be any breach of the duty of candour.

99. The Committee found that clearly factor f) was relevant to this case. However, the Committee found that the dishonesty was not persistent or covered up, was not at the upper end of seriousness and did not amount to a complete breakdown of trust between the Registrant and the profession. The Committee decided that any sanction imposed needed to reflect that trust in the Registrant had not been wholly lost. In reaching that conclusion, the Committee noted that the dishonesty occurred over a short period and had not been repeated. Taken together, those features meant that the

conduct could not properly be characterised as persistent dishonesty. Finally, the Committee had found that there was insight and therefore h) was not engaged.

100. The Committee therefore concluded that two of the factors in respect of erasure applied.

101. The Committee acknowledged that dishonesty is serious. The Committee was mindful that erasure would only be appropriate where the conduct is fundamentally incompatible with being a registered professional, and if it is the only means of protecting patients and/or maintaining public confidence in the optical profession. The Committee weighed up each of the factors in *paragraphs 21.29 (suspension), and 21.35 (erasure)* and for the reasons above took the view that to erase the Registrant would be disproportionate.

102. The Committee therefore concluded that the sanction of suspension would strike the appropriate balance of upholding the public interest in maintaining professional standards against the interests of returning a competent professional to practise. The Committee found that a lesser sanction would not mark the seriousness of dishonest misconduct.

103. The Committee noted that it was referred to two other General Optical Council decisions made recently, to support the submission that a short period of suspension would be appropriate in this case. Whilst the Committee noted the points made, it placed little weight on these determinations and preferred to focus on the facts of this Registrant's case and her particular circumstances.

104. In terms of length of order, the Committee decided that two months would be the most appropriate length in order to mark the seriousness of the misconduct. There have been several acts of dishonestly creating false records which undermined the integrity of the registration scheme, and as such the matter was serious. The Committee balanced this with the interests of the profession in returning this promising young Registrant back into practise. The Committee determined that a two-month suspension would maintain public confidence in the profession and uphold proper professional standards.

105. The Committee decided not to set a Review Hearing as the Registrant has sufficiently demonstrated her insight and substantial remediation which met the concerns of the Committee in relation to repetition. The Committee determined that there would be no benefit to a review hearing where the findings against the Registrant relate purely to protective public interest factors.

106. The Registrant will therefore be suspended from the register for a period of two months.

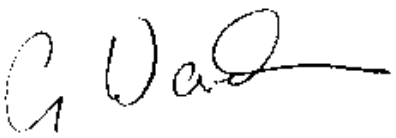
IMMEDIATE ORDER

107. Ms Huxtable did not make any application for an immediate order.

108. Mr Saunders submitted that an immediate order was not necessary because it is not otherwise in the public interest, as the findings indicate that there is no ongoing risk requiring intervention.

109. The Committee concluded that an immediate order was not necessary because there was no pressing public interest justification for immediate suspension or restriction. It was satisfied that there was no ongoing risk requiring urgent intervention and that the substantive sanction sufficiently addressed public confidence in the profession. The absence of an immediate order also allowed a short period for any necessary alternative arrangements for the Registrant's professional commitments to be put in place, which the Committee considered appropriate in the circumstances.

Chair of the Committee: Gerry Wareham

Signature :  **Date :** 2 June 2026

Registrant : Aasiya Chohan

Signature : Present via MS Teams **Date :** 2 June 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.