

**BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL**

GENERAL OPTICAL COUNCIL

F(26)10

AND

ROHAIL AHMED NAWAZ (01-25274)

**DETERMINATION OF A SUBSTANTIVE HEARING
28 SEPTEMBER – 1 OCTOBER 2026**

Committee Members:	Sara Nathan (Chair) Asmita Naik (Lay) Diane Roskilly (Lay) Annabelle Magee (Optometrist) Gemma O'Rourke (Optometrist)
Legal adviser:	Megan Ashworth
GOC Presenting Officer:	Holly Huxtable
Registrant present/represented:	No
Registrant representative:	None
Hearings Officer:	Terence Yates
Facts found proved:	1.a and 1.b
Facts not found proved:	None
Misconduct:	Found
Impairment:	Impaired
Sanction:	9 months – (With Review)
Immediate order:	Yes

Proof of service

1. The Committee heard an application from Ms Huxtable on behalf of the Council for the matter to proceed in the Registrant's 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 Committee accepted the advice of the Legal Adviser.
2. The Legal Adviser advised that there are four elements which need to be established, in order to constitute good service. She advised that these were: the contents of the notice itself, as set out in Rule 28; the timeframe in which the notice is sent, namely 28 days before the substantive hearing as set out in Rule 34; the method by which the notice is sent, which includes by email if a Registrant has previously opted into receive documentation by email, as set out in the GOC Policy; and proof that the notice has been sent.
3. The Committee was provided with a service bundle, which included the notice of hearing itself, dated 27 August 2026. It was satisfied that within the body of the notice, the Registrant had been informed of each of the matters set out in Rule 28, namely: the Allegation and the grounds upon which it had been made; the Registrant's right to attend and be represented at the hearing; the power of the fitness to practise Committee to proceed in the Registrant's absence; his rights regarding calling and challenging evidence; and the Committee's powers of disposal of the case. The Committee noted that the notice had been sent out over 28 days before the hearing and that the Registrant had previously opted in to receive documentation by email. In terms of proof of sending, the Committee was also satisfied that the Registrant had, in fact, received the notice as he had responded to it by email. Accordingly, the Committee was satisfied that notice had been served in accordance with the Rules and that all reasonable efforts had been made to notify the Registrant of the hearing.

Proceeding in the absence of the Registrant

4. Ms Huxtable, on behalf of the GOC, took the Committee through the considerations as set out in the case of *R v Jones*. She submitted that the Registrant's absence was voluntary, in that he had acknowledged receipt of the notice and made clear that he was not intending to attend. She stated that the case was serious, in that it related to data protection and the alleged poor handling of patient records. She

pointed out that the Registrant had not requested an adjournment, rather he had provided the Committee with a written statement for the Committee to consider, including the reason for non-attendance and that as a result of the information provided within the statement, it was unlikely that an adjournment would result in the Registrant attending on a future date. Ms Huxtable submitted that there was a general public interest in proceeding, given the seriousness of the allegations and that there was a witness available this week.

5. The Committee then went on to consider whether it would be in the public interest to proceed in the Registrant's absence in accordance with Rule 22. The Committee accepted the advice of the Legal Adviser. She advised in accordance with the cases of *R v Jones [2002] UKHL 5* and *GMC v Adeogba; GMC v Visvardes [2016] EWCA Civ 162*. She advised that the case law confirmed that fairness to the individual Registrant was of primary importance, but that fairness to the Regulator and general public interest considerations were also important.
6. The Committee noted that the Registrant had responded to the GOC notice of hearing by email on 24 September 2026, saying that he would not be attending the substantive hearing and giving a reason why he would not be attending. In that email he had informed the GOC that he would send a prepared statement before 9am on the day the hearing began. The Committee noted that the Registrant had provided a written statement the day before the hearing began (27 September 2026), confirming his non-attendance and setting out his position.
7. The Committee further noted that he had not requested an adjournment, and that, given the content of the email of 27 September 2026, there was no indication the Registrant would be in a position to attend any hearing soon. The Committee noted that the Registrant had referenced [redacted], although he had not provided [redacted] evidence in support nor provided any [redacted] about his potential ability to participate in the hearing. The Committee bore in mind that the Registrant had set out his position in his written statement and that the GOC had a witness available to give evidence on day two of the hearing. In all the circumstances, the Committee was satisfied that it was fair and in the public interest to proceed with the hearing in the Registrant's absence.

Application for part of the hearing to be in private.

8. Ms Huxtable, on behalf of the GOC, made an application for part of the hearing to be heard in private. She explained that in light of the information provided by the Registrant about his [redacted] and personal circumstances, any reference to such information ought to be heard in private in order to protect his private life.

9. The Committee accepted the advice of the Legal Adviser, who advised in accordance with Rule 25. She advised that the right to a private life stemmed from Convention Rights and that a participant in a hearing had a right to a private life, which would properly include privacy in respect of their [redacted] as well as their sensitive personal circumstances. She advised that such matters ought not be aired in public.
10. In light of the Registrant's email, dated 27 September 2026, which disclosed matters relating to the Registrant's [redacted] and personal circumstances, the Committee was satisfied that any reference to such matters should be heard in private. Accordingly, the Committee decided to hear any information relating to the Registrant's [redacted] and personal circumstances in private in order to protect the Registrant's private life.

ALLEGATION

The Council alleges that you, Mr Rohail Nawaz (01-25274), a registered Optometrist, whilst at your former business address, [redacted];

- 1) *Between 19 August 2024 and 1 September 2024, you failed to maintain patient confidentiality in that you:*
 - a. *did not securely store and/or protect paper copies of confidential patient records to prevent loss, destruction, theft and/or inappropriate disclosure;*
 - b. *did not confidentially dispose of the paper copies of confidential patient records, when no longer required;*

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

DETERMINATION

Background to the allegations

11. The Registrant is an Optometrist registered with the GOC.
12. On 2 February 2024, the Registrant rented a commercial property from which to practise as an Optometrist. The rental period started on 2 February 2024 and was due to end on 1 February 2029. The Registrant rented the whole of the two-storey property, which comprised a main shop floor and a basement. The business was operating as [redacted] Ltd.

13. The Registrant was evicted from the property through a court order due to non-payment of rent.
14. On 20 August 2024, a forfeiture notice was placed on the door by the bailiffs and on the same date, the landlord attended the premises with the bailiffs, who had changed the locks and given the landlord a new set of keys. The property had been locked and there were no signs of any break in.
15. Whilst the Landlord was at the premises, it is alleged that she observed unsecured documents, including prescriptions and patient notes, which comprised patient records including names, dates of birth, addresses, contact details and medical details. In the basement there were patient records on a table as well as in a filing cabinet and there was another filing cabinet of records on the main shop floor. There was also an appointments book on the desk on the ground floor.
16. On 26 August 2024, the landlord sent a text message to the Registrant, informing him that he should contact the number on the forfeiture notice (the bailiffs), to which he replied "Many thanks".
17. The bailiffs initially permitted the Registrant to attend the premises until the 27 August 2024 to remove his belongings, which was extended until 30 August 2024. The Registrant did not attend in that time and the bailiffs confirmed with the landlord that she was able to dispose of the belongings.
18. On 1 September 2024, the landlord made an online referral to the GOC.
19. On 20 September 2024, the landlord contacted the Information Commissioners Office (ICO) to enquire about what she should do with the patient records and other information, which had been left at the premises.
20. On 29 September 2024, the landlord wrote to the Registrant at his last known personal address to inform him of a final chance to remove his belongings, but received no response.
21. On 29 October 2024, the landlord received a response from the ICO stating that she should dispose of the records securely, which she duly did on 21 January 2025, through a company called "Shred-It".
22. It is alleged by the GOC that the Registrant failed to maintain patient confidentiality in that he did not securely store and/or protect paper copies of confidential patient records to prevent loss, destruction, theft and/or inappropriate disclosure and nor did he confidentially dispose of the records.

Findings in relation to the Facts

23. The Committee was provided with a bundle of documents in support of the GOC case, which included the following:

- a. The Witness statement of the landlord, dated 22 September 2025 and addendum statement, dated 4 October 2025;
- b. Copies of the forfeiture notice and bailiff attendance note, dated 20 August 2024;
- c. Photographs of items in the premises taken at the time the landlord entered on 20 August 2024;
- d. Copies of communication between the landlord and the bailiffs regarding the property on the premises;
- e. Copy of a letter sent by recorded delivery from the landlord to the Registrant, regarding removal of property, dated 29 September 2024;
- f. Communication between the landlord and the ICO, dated 29 October 2024;
- g. Certificate of destruction from the company Shred-it, dated 21 January 2025;
- h. Screen shot of text message exchange between the landlord and the Registrant;
- i. A copy of the rental agreement between the landlord and the Registrant, dated 2 February 2024.

24. The Committee was also provided with the written submissions provided by the Registrant by email, dated 27 September 2026.

25. The Committee heard evidence from the landlord.

26. The Committee heard and accepted the advice of the Legal Adviser. Her advice included that the burden of proof was on the GOC and the standard of proof required was the civil standard, namely whether it was more likely than not that the alleged facts occurred. In relation to the alleged failure, the Legal Adviser advised that this was an allegation that the Registrant did not do whatever was alleged and that he was under a duty or obligation to act in the particular way required, according to the standards of expected optometric practice at the relevant time. In relation to the Registrant's non-attendance, she advised that in the circumstances of this case, the fact of his non-attendance should not be held against him.

27. As a failure was alleged in the stem of the Allegation, in that the Registrant failed to maintain patient confidentiality, the Committee first considered whether there was a duty on the Registrant to maintain patient confidentiality by both:

- a. securely storing and/or protecting copies of confidential patient records to prevent loss, destruction, theft and/or inappropriate disclosure; and
- b. confidentially disposing of paper copies of confidential patient records, when no longer required.

28. The Committee had regard to the GOC Standards of Practice for Optometrists and Dispensing Opticians, April 2016, (the Standards), in particular, standard 14, which relates to maintaining confidentiality and respecting patients' privacy. In relation to the secure storage of confidential paper records, the Committee had regard to Standard 14.7, which states:

14.7 - Securely store and protect your patient records to prevent loss, theft and inappropriate disclosure, in accordance with data protection law...

29. In relation to confidentially disposing of paper copies of confidential patient records, the Committee had regard to Standard 14.8, which states:

14.8 - Confidentially dispose of patient records when no longer required in line with data protection requirements.

30. The Committee was satisfied that there was a duty on the Registrant, both under the Standards and data protection law, to maintain patient confidentiality both by way of secure storage and the confidential disposal of paper patient records, which by their nature will contain confidential information about patients relating to their name, contact details and health.

31. The Committee next went on to consider whether the Registrant had not, in fact, dealt with the paper copies of patient records in accordance with his duty, in the ways alleged in particulars 1.a and 1.b.

Particular 1.a

1) *Between 19 August 2024 and 1 September 2024, you failed to maintain patient confidentiality in that you:*

- a. *did not securely store and/or protect paper copies of confidential patient records to prevent loss, destruction, theft and/or inappropriate disclosure;*

32. The Committee finds particular 1.a proved.

33. In reaching this decision, the Committee had regard to the written and oral evidence of the landlord, together with her contemporaneous exhibits. The Committee noted that on 2 February 2024, the Registrant entered into a rental

agreement with the landlord for a five year term in the property, as evidenced in the copy of the rental agreement signed by both the Registrant and the landlord. The Committee noted that on 20 August 2024, a forfeiture notice was placed on the door of the property, following the Registrant's eviction by a court order, as evidenced by a copy of the forfeiture notice.

34. The Committee took account of the evidence of the landlord, regarding her visit to the property with the bailiffs on 20 August 2024. In her witness statement, she described inside the premises as follows:

While at the premises, I observed, unsecured documents, including prescriptions, and patient notes. I had a chance to look through the unsecured documents and confirm they were confidential patient records, which included patient identifiable information such as names, date of birth, addresses, contact details as well as medical details.

In the basement there was a table full of patient records as well as a filing cabinet full of records. On the main shopfloor, there was also another filing cabinet also full of patient records.

35. The Committee noted that the landlord had taken photographs of the documentation at the time, which supported her account. The Committee considered that the landlord's oral evidence was consistent with her written evidence, as she described the large volume of patient records in insecure filing cabinets, and index cards of patient records on a desk in the basement. The landlord explained that of the paperwork she looked at, the patient records appeared to be historic, in that she did not see any which were dated after 2021.
36. The Committee noted that the Registrant, in his written submissions, did not deny that he had entered into the rental agreement or that there were paper patient records at the premises after he had been evicted, or that they were his responsibility. He stated that he had previously been in other premises some five minutes' walk away and had transferred the paper patient records to the new premises. The Registrant maintained that the records were old and not active patient records, as the most recent and active records had been kept on a computerised data management system. The Registrant stated that his [redacted] and personal circumstances had impacted on his ability to run the practice. He acknowledged that he should have 'tried harder' to dispose of the records, but his [redacted] had also impacted on that.
37. The Registrant also stated in his written submission that once the landlord had the locks changed, he had not had an opportunity to return to remove his belongings, which included the patient records, albeit he accepted that he should have tried harder. The Committee did not accept that the Registrant had not had the

opportunity to retrieve his belongings, including the patient records, preferring the evidence of the landlord. She told the Committee that both she and the bailiffs had tried to contact the Registrant through their business emails, WhatsApp messages, text messages and recorded delivery post, but had received no response from him since 26 August 2024. On this date the landlord had sent him a text message telling him he needed to contact the number on the forfeiture notice and he had replied "Many thanks".

38. The Committee took account of the copy of the letter, dated 29 September 2024, which had been sent to the Registrant by hand, post and email, which included the following:

We have provided you with numerous opportunities to remove your property from the above address [the rental premises]. You promised the Bailiffs that you would remove your property, they extended the removal date to 30/08/24, you failed to do so.

In addition, you have refused to communicate with the bailiffs, despite our requests that you remove your property...

39. The Committee noted that the letter also provided the Registrant with the email address and telephone number of the bailiffs, requesting that he make arrangements through them to collect the property left in the premises.
40. The Committee was satisfied that the Registrant had left confidential paper patient records at the premises, which had been left insecure, being in unlocked filing cabinets and piled up on a desk in the basement. As such, in the Committee's view, they were not securely stored and were at risk of being lost, destroyed, stolen or otherwise accessible by others with no lawful right to the information. The Committee considered that whether or not the patient records were historic, or did not relate to active patients, was irrelevant, as they still contained confidential identifying details about the patients. The Committee was also satisfied that the Registrant had been afforded the opportunity to collect the confidential paper patient records following his eviction, but had not taken up the repeated opportunities offered to him. Accordingly, the Committee was satisfied that the Registrant had failed to maintain patient confidentiality by not securely storing the patient records to prevent loss, destruction, theft, and/or inappropriate disclosure, as required of him by Standard 14.7.

Particular 1.b

- 1) *Between 19 August 2024 and 1 September 2024, you failed to maintain patient confidentiality in that you:*

b. did not confidentially dispose of the paper copies of confidential patient records, when no longer required;

41. The Committee finds particular 1.b proved.
42. The Committee had regard to the landlord's evidence to the effect that she had contacted the ICO to enquire about what to do with the patient records and had been informed by letter, dated 29 October 2024, to dispose of them securely. The Committee had been provided with a copy of that letter, which supported the landlord's account. The Committee also took into account the landlord's evidence that she had arranged for the paper records to be securely disposed of by a company called Shred-it, which had occurred on 21 January 2025, and she provided the certificate of destruction to the Committee in support. Therefore, the Committee was satisfied that it was the landlord and not the Registrant who had securely disposed of the confidential paper patient records.
43. The Committee took account of the Registrant's account in which he appeared to accept that he had not disposed of the records securely and acknowledging that *"the paper records needed to be discarded properly"*. Accordingly, the Committee was satisfied that the Registrant had failed to maintain patient confidentiality by not securely disposing of the paper copies of confidential patient records, when no longer required, as expected of him by Standard 14.8.

Findings in relation to misconduct

44. The Committee heard submissions from Ms Huxtable and had regard to the written submissions provided by the Registrant.
45. The Committee accepted the advice of the Legal Adviser. The Legal Adviser advised that not every breach of the expected standards will necessarily amount to misconduct. She advised that for conduct to amount to misconduct, it must be serious and a falling far below the expected *standards*. *She cited the cases of Roylance v GMC (No. 20 [2000] 1AC 311 and Nandi v GMC [2004 EWHC 2317 (Admin)]*.
46. The Committee had regard to the GOC's Standards for Optometrists and Dispensing Opticians (the Standards). The Committee considered that the Registrant had breached the following Standards:
- 14. 1 - Keep confidential all information about patients in compliance with the law, including information which is handwritten, digital, visual, audio or retained in your memory.*
- 14.7 - securely store and protect your patient records to prevent loss, theft and inappropriate disclosure, in accordance with data protection law. If you*

are an employee, then this would be in accordance with your employer's storage policy.

14.8 - confidentially dispose of patient records when no longer required in line with data protection requirements.

17.1 - ensure your conduct, whether or not connected to your professional practice, does not damage public confidence in you, or your profession.

17.3 - be aware of and comply with the law and regulations that affect your practice, and all the requirements of the General Optical Council.

47. The Committee was mindful that not every breach of the Standards will necessarily amount to misconduct and understood that for conduct to amount to misconduct, it must amount to a serious departure from the Standards expected. Therefore, the Committee considered the nature, context and circumstances of the conduct found proved.
48. The Committee acknowledged that this was a single episode of conduct by omission on the Registrant's part, but bore in mind that it had occurred over the period from 19 August 2024 to 1 September 2024. It had also occurred in circumstances where the landlord had repeatedly tried to contact the Registrant to arrange for him to collect his property, which included the confidential patient records, but he had not responded or arranged for collection. The Committee considered the scale and number of confidential patient records to be considerable, as shown in the photographs to comprise several filing cabinets and piled up records on the table in the basement.
49. The Committee noted the Registrant's written submissions whereby he had described his [redacted], and his account indicated that he may have been [redacted] at that time. Whilst the Committee acknowledged the Registrant's account, it did not have any further independent [redacted] information to assist it further. Nevertheless, the Committee noted that he also appeared to be aware of his responsibilities and the Committee did not consider the Registrant's [redacted] absolved him from his duties in respect of confidentiality and of adhering to the data protection requirements on him as a data controller and Practice Owner. The Committee was of the view that fellow practitioners would find his actions deplorable and members of the public would be very concerned about the vast number of confidential patient records left insecurely in the premises and at risk of being accessed by those without a legitimate reason to do so.
50. In all the circumstances, the Committee concluded that the Registrant's conduct fell far below the standards expected of an Optometrist and therefore found that the facts proved are so serious as to amount to misconduct.

Findings regarding impairment

51. The Committee heard submissions from Ms Huxtable, on behalf of the GOC. It also had regard to the written submissions provided by the Registrant. The Committee has accepted the advice of the Legal Adviser. The Legal Adviser advised in respect of a number of cases, including *GMC v Meadow* [2006] EWCA Civ 1319, *CHRE v NMC & Grant* [2011] EWHC 927 and *Cohen v GMC* [2008] EWHC 581 (Admin).
52. The Committee first considered whether the Registrant's fitness to practise is currently impaired in respect of public protection grounds, as identified in the case of *NMC v Grant* as follows: *(a) whether the Registrant has in the past acted and/or is liable in the future to act, so as to put a patient or patients at unwarranted risk of harm.*
53. Whilst the Committee acknowledged that this was not a clinical case which may expose patients directly to risk of harm, it considered that there was nevertheless a risk to patients. The risks identified by the Committee were twofold. Firstly, there was the risk that unsecured confidential patient information, including contact details, dates of birth and medical history could be accessed by those without a legitimate reason and used improperly, which, in turn, could place patients at risk. Secondly, the potential loss or improper destruction of confidential paper patient records could impact on continuity of care, which, in turn could also place patients at risk of harm. The Committee was, therefore, satisfied that the Registrant's misconduct had in the past placed patients at unwarranted risk of harm.
54. In terms of whether that was an ongoing risk, the Committee considered remediation as identified in the case of *Cohen v GMC*, namely whether the misconduct is capable of remediation, whether it has in fact been remedied and whether there is a risk of repetition.
55. The Committee was satisfied that the misconduct was, in principle, capable of remediation. The Committee considered that remediation might be achieved by the Registrant through, for example, self-reflection to achieve insight, managing his [redacted] and undertaking relevant training in confidentiality and data protection to refresh and embed his understanding of his obligations.
56. The Committee was of the view that the Registrant had not remedied his misconduct. Whilst the Committee acknowledged that he had, in his written submissions, demonstrated remorse and some insight in respect of how he could have dealt with the matter, the Committee did not consider that he had taken full responsibility for his actions. The Committee was of the view that he had focussed on himself and the impact of his [redacted] on his actions, but had not addressed

how he should act in the future, or identified any meaningful steps he had taken to prevent recurrence. Furthermore, the Committee did not consider that the Registrant had reflected on the impact of his misconduct on patients, members of the public or on the reputation of the profession.

57. Given the limited insight demonstrated and absence of evidence of any other meaningful remediation, the Committee was unable to conclude anything other than that the Registrant had not remedied his misconduct and that there remained a consequent risk of repetition. The Committee therefore concluded that the Registrant is currently impaired on public protection grounds.
58. In respect of the public interest, the Committee was mindful of its responsibility to protect the public, maintain public confidence in the profession and uphold professional standards. It also considered the public interest considerations identified in the case of *NMC v Grant* as follows: *(b) [the Registrant] has in the past brought and/or is liable in the future, to bring the profession into disrepute; and/or (c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the profession.*
59. In terms of protecting the public, the Committee was satisfied that this is a case that includes protecting the public from the risk of harm associated with not maintaining confidentiality in respect of patient records. In terms of maintaining public confidence, the Committee considered that patients were entitled to expect a registrant to rigorously maintain confidentiality in respect of their personal and sensitive information and not leave patient records accessible to others with no legitimate reason to access them. In terms of upholding professional standards, the Committee considered that the Registrant had not only brought the profession into disrepute but had also breached a fundamental tenet of the profession, namely, to maintain confidentiality and respect patients' privacy.
60. In all the circumstances, the Committee was of the view, following the further guidance from the case of *Grant v NMC*, that "*public confidence in the profession would be undermined if no finding of current impairment were made*" in respect of a registrant who had failed to maintain confidentiality by not securely storing a vast quantity of paper patient records or appropriately disposing of them if no longer required. Therefore, the Committee concluded that the Registrant's fitness to practise is also currently impaired on public interest grounds.
61. Accordingly, in the Committee's judgement, the Registrant's fitness to practise is currently impaired.

Decision on Sanction

62. The Committee announced its decision on misconduct and impairment and the written determination was emailed to the Registrant. The Committee heard submissions from Ms Huxtable and legal advice from the Legal Adviser in respect of sanction. Ms Huxtable addressed the Committee and submitted that the appropriate and proportionate sanction was a Suspension Order.
63. Subsequent to the decision up to impairment being announced but before the Committee had started to deliberate on sanction, the Registrant, having received the Committee's written determination up to impairment, emailed the Hearings Officer to ask whether he could provide a short statement to the Committee to consider at the sanction stage.
64. The Committee bore in mind that the Registrant is unrepresented and that he had been engaging with the GOC through email throughout the investigation, although he had chosen not to attend this hearing. In these circumstances, the Committee decided that it would be fair to the Registrant to allow him to submit further information for the Committee to consider at the sanction stage. However, the Committee was also mindful of the public interest considerations involved in conducting hearings expeditiously and that this case was scheduled to finish the next day (1 October 2026). Therefore, the Committee invited the Hearings Officer to respond to the Registrant informing him that the Committee would consider additional information from him, but that there needed to be a deadline of 4pm today (30 September 2026) by which to submit any additional information.
65. The Committee confirmed to Ms Huxtable that if any further information was received from the Registrant, it would give her an opportunity to address the Committee in relation to it. It also confirmed that it would not start its deliberations on sanction until after the expiry of the deadline to the Registrant to provide any further information.
66. The Registrant provided further written submissions to the Committee before the deadline. Ms Huxtable agreed that the submissions should be provided to the Committee and confirmed that she had no further submissions to make in light of them. The Committee agreed to have regard to the further submissions received from the Registrant.
67. The Committee accepted the advice of the Legal Adviser and has exercised its independent judgement. It had regard to the Hearings and Indicative Sanctions Guidance (the Guidance). In following the legal advice, the Committee adopted a stepped approach, considering the sanctions in ascending order of severity. The Committee was aware that the purpose of a sanction is not to be punitive but to protect members of the public and to safeguard the wider public interest, which

includes upholding standards within the profession, together with maintaining public confidence in the profession and its regulatory process.

68. The Committee identified the mitigating and aggravating factors, and evaluated them in respect of each sanction under consideration.

69. The Committee considered the following to be the mitigating factors in this case:

- a. No actual harm was caused to patients;
- b. The Registrant had engaged in the regulatory process and had provided two sets of written submissions for the Committee;
- c. The Registrant had demonstrated remorse and some limited insight.
- d. The Registrant was experiencing personal challenges and [redacted] issues over the period in question.

70. The Committee considered the following to be the aggravating factors in this case:

- a. The Registrant had made no attempt to address the improper storage of confidential paper patient records or of disposing of them appropriately, although he had been given many opportunities to do so by the landlord;
- b. The Registrant's improper storage had created a risk of harm to patients;
- c. The Registrant had been careless in his storage of the paper patient records and had not prioritised his responsibilities as required of a professional in respect of data protection.

71. The Committee did not consider that the options of taking no further action or a fine respectively to be appropriate or proportionate in the circumstances of this case. The Committee considered that neither of these options would address the risk of repetition that the Committee had been unable to rule out at the impairment stage. In any event, the Committee considered that the case is too serious and neither option would meet the significant public interest considerations, of maintaining public confidence in the profession or upholding professional standards.

72. The Committee did not consider that conditional registration would be appropriate or proportionate. It noted that this was not a case where there was evidence of clinical shortcomings in specific areas of the Registrant's practice which may be amenable to conditions. The Committee was also of the view that conditions would not address the seriousness of what was, in effect, the careless and improper storage of a vast quantity of confidential patient records, with the consequential risk of harm to patients if they were improperly accessed. The Committee also considered that conditions were not sufficient to meet the public interest considerations in this case.

73. The Committee next considered suspension. It had regard to the factors set out in the Guidance at paragraph 20.33 which may make a Suspension Order appropriate, namely:

- a. A serious instance of misconduct where a lesser sanction is not sufficient.*
- b. No evidence of harmful deep-seated personality or attitudinal problems.*
- c. No evidence of repetition of behaviour since incident.*
- d. The Committee is satisfied the registrant has insight and does not pose a significant risk of repeating behaviour.*
- e. ...[not relevant]*

74. The Committee was satisfied that this was a serious instance of misconduct where a lesser sanction was not sufficient, given the volume and scale of confidential information insecurely stored and the consequential risk of harm to patients if the information were improperly accessed, although the Committee acknowledged that there had been no actual harm. The Committee noted its observations at the impairment stage to the effect that the misconduct was capable of remediation. In addition, the Committee had regard to the Registrant's further statement submitted after the findings up to impairment had been announced. It seemed to the Committee that the Registrant had taken on board the observations of the Committee, albeit he had not specifically addressed them in his further written statement. It appeared to the Committee that the Registrant had demonstrated an inclination to address his misconduct, which, in the Committee's judgement, supported the view that the Registrant did not have harmful deep-seated personality or attitudinal problems. The Committee acknowledged that there had been no evidence of repetition before it, but equally noted that the Registrant indicated that he had not been practising in that time.

75. In relation to whether the Registrant has insight and does not pose a significant risk of repeating the behaviour, the Committee bore in mind its observations at the impairment stage. It had identified that the Registrant had demonstrated remorse and some insight, although he had not taken full responsibility for his conduct or demonstrated an understanding of its impact on patients, the public and the reputation of the profession. It was the absence of full insight and remediation, which had meant the Committee could not rule out a risk of repetition. Nevertheless, given the Registrant's apparent inclination to resolve matters, in the Committee's judgement, the risk of repetition could be reduced.

76. In all the circumstances, the Committee considered that a suspension order with a review would be the appropriate and proportionate sanction in the circumstances of this case. It was satisfied that the public would be protected for the period that the suspension order was in place. Furthermore, by requiring a review before expiry, the Committee was satisfied that the public would remain protected as the Registrant would only be permitted to return to practice if he satisfied a review Committee that the risk of repetition was sufficiently reduced.
77. In order to satisfy itself that a suspension order was appropriate, proportionate and sufficient, the Committee went on to consider erasure. Whilst the Committee recognised that this was a serious departure from the relevant professional standards, the Committee did not consider that the Registrant's misconduct was fundamentally incompatible with being a registered professional. The Committee recognised that the Registrant had demonstrated remorse, and some insight, had stated a willingness to resolve matters, and, in the Committee's judgement, may have the capacity to develop good insight and achieve remediation. The Committee also bore in mind that whilst the Registrant had not been present at the hearing, he had nevertheless engaged with it. In all these circumstances, the Committee concluded that erasure would be disproportionate.
78. The Committee decided to impose a suspension order of nine months with a review. It considered that such a length was necessary to achieve the appropriate level of public protection and to meet the public interest considerations. It also considered that this period would afford the Registrant the opportunity, if he wished to take it, to develop his insight and remediate his misconduct. The Committee concluded that a review before the expiry of the suspension order was required, so that a Review Committee would be able to assess whether the Registrant's insight and remediation had developed to a level sufficient to reduce the risk of repetition.
79. The review hearing will be held between four and six weeks prior to the expiration of this order. The Review Committee will need to be satisfied that:
- a. the Registrant has fully appreciated the gravity of the offence,
 - b. the Registrant has not repeated his misconduct and has maintained his or her skills and knowledge and
 - c. the Registrant's patients will not be placed at risk by resumption of practice or by the imposition of conditional registration.
80. The Committee did not seek to bind a future Review Committee, but was of the view that the following may assist such a committee when it assesses whether or not the Registrant's fitness to practise remains impaired:

- a. The Registrant's participation in a review hearing;
- b. A reflective piece which includes the Registrant's understanding of the impact of his misconduct on patients, the public and the reputation of the profession;
- c. Evidence of any relevant training, particularly in respect of data protection/GDPR (General Data Protection Rules);
- d. Any testimonials/character references from any subsequent employment or voluntary work, whether in the field of health care or not;
- e. Any independent evidence demonstrating a period of stability and that the Registrant's [redacted] have been addressed.

81. In terms of the principle of proportionality, the Committee noted that the Registrant would be prevented from working as an Optometrist by the sanction of suspension. However, it was of the view that the public interest in maintaining public confidence in the profession and declaring and upholding standards outweighs the Registrant's own interests.

82. Accordingly, the Committee directs that the Registrant, Mr Rohail Nawaz, be suspended from the register for a period of 9 months and that there be a review before its expiry.

Immediate order

83. The Committee heard submissions from Ms Huxtable on behalf of the Council. She invited the Committee to impose an immediate order of suspension to cover the appeal period and any subsequent appeal. Ms Huxtable submitted that an immediate order was necessary on the grounds of public protection and public interest, given the substantive findings of the Committee.

84. The Committee has accepted the advice of the Legal Adviser.

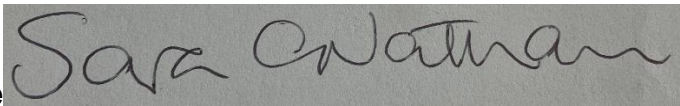
85. The Committee has decided to make an immediate suspension order to cover the appeal period and, in the event that the Registrant decides to appeal, the time taken for any appeal to be resolved.

86. The Committee was satisfied that immediate suspension was necessary given the seriousness of the misconduct together with the risk of repetition and consequential risk of harm as identified by the Committee in its substantive decision. The Committee considered that to find otherwise would be inconsistent with that substantive decision.

87. Further, the Committee was satisfied that immediate suspension was also required in the public interest. The Committee bore in mind its observations at the

misconduct and impairment stage, to the effect that: fellow professionals would consider the Registrant's actions to be deplorable; the Registrant had breached a fundamental tenet of the profession and he had brought the profession into disrepute. The Committee considered that to act otherwise would undermine public confidence in the profession and the regulatory process.

Chair of the Committee: Sara Nathan

Signature 

Date: 1 October 2026

Registrant: Rohail Nawaz

Signature not present – sent via email

Date: 1 October 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.	