BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(25)44

AND

JASPAL SIHRA (01-23733)

DETERMINATION OF A SUBSTANTIVE HEARING
18-19 &25-26 June 2026

Committee Members:	Sarah Hamilton (Chair/Lay) Ann McKechin (Lay) Victoria Smith (Lay) Gemma O'Rourke (Optometrist) Danielle Ellis (Optometrist)
Legal adviser:	Dr. Francis Graydon
GOC Presenting Officer:	Jon Trussler
Registrant present/represented:	Yes and represented
Registrant representative:	Rebecca Vanstone
Hearings Officer:	Latanya Gordon
Facts found proved:	All proved following Registrant's admissions
Facts not found proved:	None
Misconduct:	Found
Impairment:	Impaired
Sanction:	Suspension Order for two months (Without Review)
Immediate order:	None

ALLEGATION

The Council alleges that you, Jaspal Sihra (01-23733) a registered optometrist, whilst working at [redacted]:

1. On or around 29 October 2024, you failed to maintain adequate patient records in that you:

a. Falsified Patient A's record by recording repeat visual field plots for Patient A when these had not been measured; and/or

b. Falsified Patient B's record by recording that a repeat visual field test had been carried out, despite Patient B not being present;

2. Your conduct as set out at above at 1a. and/or 1b. is:

a. Dishonest; and/or

b. Misleading;

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

PRELIMINARY ISSUES

1. One of the registrant Committee members disclosed that she knew Roma Malik professionally. Ms Malik had provided a Clinical Opinion to the Council, and which was relied upon by the Council in the proceedings. The Committee member explained that she knew Ms Malik through her work and that while she did not work directly with Ms Malik, she had sat in on some meetings with her at work.

2. There was no objection raised by Mr Trussler, on behalf of the Council or by Ms Vanstone, on behalf of the Registrant to the registrant Committee member remaining on the Committee and deciding the case.

DETERMINATION

Admissions in relation to the particulars of the allegation

3. The Registrant admitted the facts of the Allegation in their entirety. The Committee therefore found all of the facts proved by reason of the Registrant's admissions under Rule 40(6) of the Rules.

Background to the allegations

4. At the time of the events in the Allegation, the Registrant was employed as an optometrist at [redacted] ('the Practice').

5. A member of staff at the Practice raised a concern that the Registrant had falsified the visual field tests of a patient after the patient had left the practice. A referral was later received from the Professional Services Manager of [redacted], dated the 13th November 2024. This notified the Council that following a local investigation, they had discovered that repeat visual field tests for two patients had been processed at the Practice on the 29th October 2024 by the Registrant at points in time when both patients had left the Practice after they had been seen by the Registrant. Both patients had missing points on their visual fields test at the pre-screening stage, but these points were seen on repeat field tests.

6. The Council relied upon the witness evidence of Witness A Professional Services Manager, Witness B Central Area Manager, and the Clinical opinion of Ms Roma Malik none of whom were required to attend the hearing to give live evidence.

7. The Council acknowledged that the Registrant had admitted the facts of the allegation.

Misconduct

8. As the Registrant admitted the Allegation in its entirety, and the facts were accordingly found proved, the case proceeded to the next stages.

9. No objection was raised by either party to the Committee Chair's suggestion that misconduct and impairment should be dealt with within the next stage together, rather than separately and in consecutive stages. The Committee considered and decided the two issues separately and in turn.

10. Counsel for the Registrant Ms Vanstone, indicated that the Registrant did not challenge misconduct, but he would be giving evidence in relation to Impairment.

11. Following Mr Trussler opening the case on behalf of the Council, the Registrant gave evidence and was questioned by his representative Ms Vanstone, and Mr Trussler on behalf of the Council.

Evidence of the Registrant

12. The Registrant gave live evidence under affirmation to the Committee in relation to impairment.

13. In response to questions from Ms Vanstone, the Registrant confirmed that he had drafted the reflective statement included in his bundle of documents. He stated that in relation to the last sentence of page 119 of the Council's bundle and the record of the interview with Witness B, he believed that there was a typing error.

14. In particular, he clarified to the Committee that what he said at the time in the interview was that he felt that the original test would have been completed accurately and felt sure there were no issues with the customer's vision. He maintained that the word "not" (shown in the record) was not included in what he told Witness B.

15. The Registrant confirmed that during the interview with Witness B he admitted that he had recorded the field tests on the customers' files without the customers being present. He also stated that he would have asked for the test to be completed, but when he realised at the end of the day they had not, he ran the tests alone and scanned them on the respective customers' files. He said he was sorry for this, and regretted his actions, and was sorry for letting himself and the company down.

16. In response to further questions from Ms Vanstone, the Registrant told the Committee that on the day of the incident, he was under extreme pressure from the support staff. He said he did ask his support staff to repeat the test for the patients. He asked them and they said it was done. This was not the case because he was subsequently told something happened to the computer system.

17. He further told the Committee that there was no store manager at that point in the store. There was no one to fall back on and he was "running the show himself". He added that this did not excuse his actions, but the manager had left, and he did not know who to turn to. He stated that he sincerely regretted what happened on the day, and he could only apologise to everyone. He said the previous store manager had been Person A.

18. In response to questions from Ms Vanstone about the impact of his actions on public confidence in the profession, the Registrant told the Committee that he had sincere regret for his actions on the day they took place. He stated that it was an isolated incident. He told the Committee he would never do anything to harm any of his patients. He added that he loved his patients and his profession and his job, and the public who came to him for help.

19. The Registrant said he had a substantial number of patients who followed him throughout his career and said that it showed he genuinely did a good job. He again expressed sincere regret because of what happened on the day and he could only apologise to the Council, the public, and everyone who was at the hearing today about his actions on that date.

20. The Registrant confirmed that he completed various CPD that focused on ethics, record keeping, professional accountability, and clinical governance, and provided the list of some of those he had undertaken in his documentary evidence.

21. In response to questions about the changes made to his practice, the Registrant told the Committee that all his records are checked immediately while the patient is present in the practice. They are verified by him and before anyone leaves the practice. He stated that he is fully accountable for everything and now takes much longer time to check all his records. He considered that the safety of the patient is most important. He has to make sure that whoever comes to see him on a daily basis is looked after.

22. The Registrant also responded to questions from Ms Vanstone about making sure that stress at work or workload pressure did not have an adverse impact on him again. He stated that he is currently working as a refractive optometrist and there are such measures in place. He now has a clinical support hotline, and this is only a phone call away. All safeguarding is implemented in his daily practice routines. If anything needs to be escalated, it is done immediately and with the patient in the practice.

23. He also told the Committee that there is a manager present on site on the days when he works. There is also support staff and machinery is serviced regularly. He considered that the support is good and helpful. He added that if faced with significant time pressure to either complete an examination or to complete patient records in the future, he would focus on patient safety and send a patient to the waiting area while matters were checked out. He would explain there was a delay while matters were checked and repeated.

24. The Registrant told the Committee that if he was faced with the same scenario again and realised that visual fields should have been repeated but were not, and the patient had left the practice, he would immediately call the patient back. He would verify if the repeat tests were completed. If not, he would arrange for them to be done and repeated at a time of their convenience.

25. When asked by Ms Vanstone whether he would ever behave in the way he admitted to in the future, the Registrant stated never. He stated that he looked after many patients in his career and was proud to admit that he had a big following. These people relied on him but through his actions on that day he let

himself down, his patients, the GOC, and the practice, but it would never happen again.

26. The Registrant told the Committee that he undertook regular self-reflections now with his peers and got their opinions on different things. In response to being asked about whether the public could have confidence in him as a practitioner going forward, he apologised sincerely to everyone. He said he was the kind of person who loved seeing patients every day. He believed he was there to help them going forward. He would love to continue to do that and be pardoned for his actions. He sincerely regretted it and repeated that going forward he would like to help people in life. He said that one of the values of being an honest person was having strong moral and ethical values. This was very important to him going forward. He would like to uphold this and be given an opportunity to redeem himself.

27. In response to questions from Mr Trussler, the Registrant told the Committee that his current employers are aware of these proceedings and his admissions. The Registrant agreed with Mr Trussler, on behalf of the Council, that he accepted the seriousness of the allegation. He also accepted that the element of dishonesty crossed a significant threshold and that the deliberate and dishonest falsification of documents potentially had a very significant impact on public confidence in the profession.

28. The Committee had no questions for the Registrant.

Submissions on misconduct

29. The Committee heard submissions on misconduct from Mr Trussler, on behalf of the Council, and from Ms Vanstone, on behalf of the Registrant.

30. Mr Trussler, on behalf of the Council, submitted that it was axiomatic that the matters to which the Registrant had admitted plainly amounted to misconduct. He added that Ms Vanstone had conceded the point on behalf of the Registrant that deliberate and dishonest falsification of records amounted to misconduct.

31. He concluded by submitting that misconduct remained entirely a matter for the Committee's determination.

32. Ms Vanstone, on behalf of the Registrant, submitted that he recognised the seriousness of the allegation and that his conduct represented a falling far short of what was expected. She submitted that this was reflected in his admissions of the facts and the Registrant did not seek to challenge that there was misconduct.

Legal Advice

33. The Committee was advised that misconduct was not statutorily defined (*Roylance v General Medical Council* [2000] 1 AC 311 (PC), at 330F–332E) and was a matter of its own independent judgment. There was no burden or standard of proof applied. The Legal Adviser further advised that not every case of misconduct resulted in a finding of impairment (*Cohen v GMC 2008* EWHC 581).

34. For guidance on the approach to assessing misconduct, the Legal Adviser referred the Committee to several authorities and the approach it should take to determining it. In *Roylance v. General Medical Council (No 2)* [2000] 1 AC 311, the court specifically described the essential elements of misconduct:

> *"misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a practitioner in the particular circumstances. The misconduct is qualified in two respects. First it is qualified by the word 'professional' which links the misconduct to the profession …secondly the misconduct is qualified by the word 'serious.' It is not any professional misconduct which will qualify. The professional misconduct must be serious".*

35. In *Meadow v. General Medical Counci*l [2007] 1 All ER 1, the Court of Appeal made clear that "misconduct" should not be viewed as anything less than "serious professional misconduct".

36. The Legal Adviser further advised the Committee that it should have regard to The Standards of Practice for Optometrists and Dispensing Opticians that were in effect at the relevant time of the proven allegations.

37. In summary, the Committee had to consider each of the proven facts and determine using its own judgment whether the conduct or omission for each was sufficiently serious to amount to misconduct having regard to the standards ordinarily required to be followed by the Registrant.

38. There was no comment from Mr Trussler on behalf of the Council or from Ms Vanstone on behalf of the Registrant on the Legal Advice.

Findings on misconduct

39. The Committee proceeded to consider whether the admitted facts, which were found proved, amounted to misconduct, which was serious.

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

41. The Committee agreed that the Registrant's conduct breached the Council's Standards of Practice for optometrists and dispensing opticians in that the Registrant had departed from the following standards:

    Standard 8: Maintain adequate patient records

    Standard 16: Be honest and trustworthy

42. The Committee was of the view that the dishonest conduct was damaging to the reputation of the profession and had brought it into disrepute. Further, fellow professionals would consider it deplorable. It involved the deliberate falsification of records for two patients which showed that tests had been undertaken when they had not. The dishonest behaviour was a proactive step involving the Registrant physically taking the visual field tests on behalf of the patient and recording the false results in their records.

43. The Committee was satisfied that the conduct of the Registrant amounted to professional misconduct, which was serious. Therefore, the Committee concluded that the admitted facts found proved did amount to misconduct.

Submissions on impairment

44. The Committee heard submissions on impairment from Mr Trussler, on behalf of the Council, and from Ms Vanstone, on behalf of the Registrant.

45. Mr Trussler submitted that the position of the Council was that the Registrant had undertaken significant reflection. This, he highlighted, was more than apparent from his detailed statement and the great deal of training he completed. He submitted that the Council accepted significant remediation had taken place. He further submitted that the clinical expert had concluded that a future risk to the public from the Registrant was low, provided appropriate remediation was undertaken. He submitted that the Committee may take the view that remediation had indeed taken place and the risk to the public was low.

46. However, Mr Trussler further submitted that public confidence in the profession was part of the Committee's wider considerations in respect of the Registrant's admission to a deliberate falsification of important documents with the clinical implication identified by Ms Malik in her expert witness statement. He added that the Committee would be aware that the dishonest falsification of documents took the matter "fairly and squarely" into the realms of justification for an order for erasure.

47. He submitted that the Council's position was regardless of the significant reflection and remediation undertaken by the Registrant, he remained impaired because of the seriousness of the matter, the clinical implications of his conduct, and the element of dishonesty in it.

48. In conclusion, Mr Trussler, submitted that the case was so serious that it would be quite wrong for the Committee to find that there is no current impairment.

49. Ms Vanstone, on behalf of the Registrant, invited the Committee to conclude that the Registrant's fitness to practise was not currently impaired.

50. She highlighted that impairment was not defined as set out in the Council's skeleton argument. She referred the Committee to the case of *Fopma v General Medical Council* [2018] EWHC 714 (Admin) which involved a number of serious allegations of fundamental dishonesty including failures to declare criminal convictions that had spanned 11 years. That case could not be more different to the present case.

51. Ms Vanstone referred the Committee to the Registrant's reflective statement and submitted that it was thorough, comprehensive, and a thoughtful analysis of the impact of his dishonest conduct both on patient care and on the wider public interest. She also submitted that the Registrant had carefully taken those steps that were necessary to ensure that there would never be a repetition of his behaviour. She added, quoting from his reflective statement, that the Registrant understood that accurate, contemporaneous, and truthful clinical records were fundamental to safe patient care and professional practice.

52. Ms Vanstone further submitted that the Registrant recognised both his failures and also the impact of those failures. He offered sincere apologies to the public, to the regulator, to his former employer, and to the Committee. Ms Vanstone added, on behalf of the Registrant, that he also recognised that his conduct fell significantly below the professional standards expected of him.

53. Ms Vanstone submitted that when Committees are looking at cases of dishonesty, it was incorrect to approach them from the position that because dishonesty was such a serious breach of proper professional standards, that a finding of impairment was required. She reminded the Committee that even with dishonesty, there was a scale of seriousness, based on the authorities from the higher courts and the approach to take. There were instances where a finding of dishonesty can be made but there can also be a finding that fitness to practise is not currently impaired.

54. Ms Vanstone reminded the Committee that the Registrant's dishonesty had occurred over 20 months ago and the two false entries made in the records were at 4:24 p.m. and 4:30 p.m. on the 29th of October 2024 and during a period of 6 minutes.
55. Ms Vanstone referred to the evidence of Ms Malik and the Clinical Opinion relied upon by the Council. She submitted that although Ms Malik would have expected a reasonably competent optometrist to repeat the visual fields test for

the two patients, Ms Malik concluded that there were "no serious clinical concerns" in respect of the two patients that the Registrant had tested.

56. Ms Vanstone referred the Committee to the questions set out in *Cohen v GMC* [2008] EWHC 581. She submitted that the Registrant's misconduct was remediable, it had been remedied and was highly unlikely to recur. She referred the Committee to the Registrant's reflective statement, the CPD and the testimonials in support. She submitted that the Registrant had completed CPD that were in excess of what was required. She submitted that the Registrant had carried out "proper reflections" and showed real engagement in the process to demonstrate his commitment to the profession and to remedying the defects that occurred in his practice on the 29 October 2024.

57. Ms Vanstone also referred the Committee to the very positive testimonials included in the Registrant's documents particularly from his current employer and his previous manager Person A when he worked at [redacted]. Ms Vanstone submitted that the testimonials painted a picture of someone in "direct contradiction" to the allegations that the Committee was dealing with. She also submitted that the testimonials demonstrated clearly that the incident in October 2024 was an isolated error.

58. Ms Vanstone turned to submissions about whether a finding of impairment was required in the public interest. She submitted that an informed member of the public would consider that a finding of current impairment was not required in this case. This was because of the specific facts, no previous regulatory history, and no further matters arising since the date of the incident. In addition, there were also the reflections and remediation carried out, as well as the regret that the Registrant had plainly expressed to the Committee in his oral evidence.

59. Ms Vanstone also submitted that the public was served by this comprehensive and public regulatory process, and the requirement for the Registrant to answer the allegations before the regulator. While this was not always the case, it was the case with this Registrant because he had undertaken comprehensive remediation. She further submitted that Mr Trussler's reference to sanction during his submissions on impairment at this stage of the hearing was misconceived.

60. Ms Vanstone referred the Committee to the case of *PSA v (1) GMC (2) Uppal* [2015] EWHC 1304. In that case a trainee had admitted dishonesty and where misconduct was found. The court upheld the appeal in part, agreeing that in view of the nature of the misconduct (Registrant informed her GP trainer, that she had spoken to a patient's mother following the patient's discharge from hospital, when in fact, she had not done) it was unduly lenient not to have imposed a warning. The court rejected an argument that a finding of dishonesty necessarily required a finding of impairment. Ms Vanstone submitted that it was open to the Committee in this case to conclude that patients and the public were not at risk.

61. Ms Vanstone referred the Committee to the case of *CHRE v NMC & Paula Grant* [2011] EWHC 927 (Admin) where one of the considerations was whether public confidence in the profession would be undermined if a finding of impairment was not made. She submitted that *Grant* could be distinguished from the present case because there was no power to issue a warning from the NMC following a finding of no impairment and there was simply no mechanism to mark the misconduct. The option to issue a warning was available in this case.

62. In conclusion, Ms Vanstone submitted that having regard to all the circumstances of the case against the Registrant, there were no outstanding public protection concerns. Public confidence in the profession, and the maintenance of proper professional standards was upheld. She added that the informed observer, having all of the knowledge and information about this case that was before the Committee would not consider that there was a requirement for a finding of impairment. Accordingly, she invited the Committee to find that the Registrant's fitness to practise was not currently impaired.

Legal advice

63. The Legal Adviser advised that impairment was not statutorily defined, there was no burden or standard of proof, and that the question was a matter of the Committee's independent judgement taking into account all of the evidence it had considered so far. He advised that not every case of misconduct results in a finding of impairment: *Cohen v GMC* [2008] EWHC 581.

64. The Legal Adviser referred to the case of *Meadow v General Medical Council* [2007] 462 and the court's approach on the purpose and approach to take:

> *"In short, the purpose of FTP proceedings is not to punish the practitioner for past misdoings but to protect the public against the acts and omissions of those who are not fit to practise. The FTP thus looks forward not back".*

65. The Legal Adviser also set out the approach and factors for the Committee to determine if the Registrant was currently impaired as set out in the case of *Cohen v GMC* [2008] EWHC 581 (Admin). This included considering if the misconduct is easily remediable, whether it has been remedied and the risk of repetition.

66. The Legal Adviser referred the Committee to the test for considering impairment as set out by Dame Janet Smith in the fifth report of the Shipman Inquiry (para 25.67) and cited with approval in the case of *CHRE v NMC & Paula Grant* [2011] EWHC 927 (Admin), para 76, by Mrs Justice Cox:

"Do our findings of fact in respect of the doctors misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:

(a) Has in the past acted and/or is liable in the future to so act so as to put a patient or patients at unwarranted risk of harm and/or;

(b) Has in the past brought and/or is liable in future to bring the medical 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 medical profession and/or

(d) Has in the past acted dishonestly and/or is liable to act dishonestly in the future."

67. The Legal Adviser further advised that the Committee should also consider the public interest and the need to maintain public confidence in the profession and maintain appropriate standards of behaviour may mean that a clinician's fitness to practise is impaired by reason of misconduct. He advised that even in the absence of ongoing risk, a finding of impairment may be necessary to reaffirm to the public and optometrists the standard of conduct expected: *Yeong v GMC* [2009] EWHC 1923.

68. The Legal Adviser referred the Committee to the case of *GMC v Armstrong* [2021] EWHC 1658 (Admin), which highlighted that dishonesty could arise in a variety of circumstances with a range of seriousness. Committees must have proper regard to the nature and extent of the dishonesty and engage with the weight of the public interest factors tending towards a finding of impairment. The Legal Adviser advised that the case of *Armstrong* had considered the case of *Uppal*, referred to by Ms Vanstone. In case of *Armstrong* the court also highlighted that in cases of dishonesty, the impact on public confidence in the profession was not diminished by a low risk of repetition. The Committee must consider the weight that it puts on personal mitigation as it may have a more limited role in cases of dishonesty. The case also set out that it was a rare or unusual case where dishonesty did not lead to a finding of impairment.

69. The Legal Adviser also referred the Committee to several cases regarding the importance of insight in the assessment of impairment. In *Sawati v General Medical Counci*l [2022] EWHC 283 (Admin) the court emphasised that insight was a necessary precondition for remediation and maintaining public confidence in the profession. In the *General Medical Council and another v Bramhall* [2021] EWHC 2109 (Admin) the court defined insight as the development of a fair and objective understanding of the nature and gravity of the misconduct that "required empathetic identification with the perspectives of others". In *Hyder v*

General Medical Council [2024] EWHC 2945 (Admin), the court highlighted that insight must be specific to the misconduct in question and involve an understanding of the motivations and triggers behind the behaviour.

70. The Legal Adviser concluded by advising that whether the Registrant had shown insight into his misconduct and how much insight he had *were "classically matters of fact and judgment for the professional disciplinary committee in the light of the evidence before it*": *Professional Standards Authority v Health & Care Professionals Council and Doree* [2017] EWCA Civ 319.

71. There was no challenge to the legal advice by either of the advocates.

72. Ms Vanstone submitted that although the court referred to the case of *Uppal* in the case of *Armstrong*, *Uppal* was still good law.

Findings on impairment

73. The Committee accepted the advice of the Legal Adviser.

74. In making its findings on current impairment, the Committee had regard to all the evidence it had received to date, including the Registrant's detailed oral evidence, CPD records and testimonials, the submissions of Mr Trussler on behalf of the Council, as well as the submissions of Ms Vanstone on behalf of the Registrant. The Committee also carefully considered the Hearings and Indicative Sanctions Guidance (from 2021), the Council's Standards of Practice for Optometrists and Dispensing Opticians (from April 2016), and its earlier findings.

75. The Committee considered whether the Registrant's conduct was capable of being remediated, whether it had been remediated and whether there is a risk of repetition of the conduct in future. The Committee considered that while dishonesty can be difficult to remediate, it was not impossible to do so.

76. The Committee very carefully considered the level of insight and remediation that had been demonstrated by the Registrant and the steps that he has taken since the misconduct occurred on the 29 October 2024.

77. The Committee noted that the Registrant had apologised for his misconduct, made admissions at an early stage, and made full admissions to the Allegation in the proceedings. The Committee also considered that the Registrant had shown remorse and sincere regret and had fully engaged with these proceedings.

78. The Committee next considered the Registrant's insight, as shown by his reflective statement and his oral evidence to the Committee. The Committee was particularly impressed by the extent of the Registrant's reflections.

79. The Committee was also impressed by the range of targeted CPD courses that he had undertaken, his commitment to the profession, and the positive references provided from colleagues and patients. In particular, the Committee considered the very positive reference from the Clinical Director at his current employer dated 5 June 2026. The Registrant is described as follows

> *"During the period of our professional relationship, I have had no experience that has given me cause to question Mr Sihra's honesty or integrity in a workplace context. My observations are confined entirely to his conduct within our professional relationship".*

80. The Committee concluded that the Registrant had developed sufficient insight and had undertaken appropriate remediation, by attending targeted and relevant courses and had continued to practise without any further concerns being raised about his honesty or integrity in the workplace.

81. The Committee formed the view that the Registrant had made serious errors of judgment in committing the dishonesty, but that he had since adequately reflected, developed insight and had adequately remediated. The dishonesty had taken place on one day, set against an otherwise unblemished career of almost 20 years. The Committee therefore took the view that the risk of repetition of similar conduct in future was negligible and that the Registrant was not a risk to the public. It decided that a finding of current impairment was not required on public protection grounds.

82. The Committee next considered the wider public interest and the guidance in the case of *CHRE v (1) NMC and (2) Grant* [2011] EWHC 927 (admin). In particular, the Committee had regard to the test approved in the case and as set out above.

83. The Committee was satisfied that limbs (b)-(d) of this test were engaged in this case, namely that the Registrant's conduct brought the profession into disrepute, breached one of the fundamental tenets of the profession and was dishonest. The Committee considered that these limbs were engaged based on the Registrant's past conduct in relation to the misconduct found proved, rather than being 'liable in future'. This was because of the Committee's findings on the very low-level risk of repetition in the future.

84. The Committee very carefully considered whether a finding of impairment was necessary on the basis of the wider public interest, in order to uphold proper professional standards and public confidence in the profession. It considered the submissions of Ms Vanstone, on behalf of the Registrant, regarding the case of *Uppal*, that a finding of impairment may not be necessary in the public

interest. However, the Committee considered that the facts of *Uppal* were quite different to the present case.

85. The Committee was of the view that despite the impressive remediation that had been undertaken by the Registrant since the misconduct, given the seriousness of the conduct, the public would be concerned and public confidence in the profession would be undermined, if a finding of impairment was not made. The Committee had regard to the fact that there were two patients involved in instances of deliberate dishonesty. The Committee considered that it had to mark the seriousness of the misconduct and uphold proper standards of conduct in the profession. The public would be concerned in this case if a finding of no impairment was made. The Committee decided that it was necessary to make a finding of impairment in this case in order to maintain confidence in the profession and in order to uphold proper professional standards.

86. For the reasons set out above, the Committee decided that the Registrant's fitness to practise as an Optometrist is currently impaired on the public interest component only.

Sanction

87. The Committee went on to consider what would be the appropriate and proportionate sanction, if any, to impose in this case. It heard oral submissions from Mr Trussler, on behalf of the Council, and Ms Vanstone, on behalf of the Registrant. No further evidence was placed before the Committee at this stage of the hearing.

88. Mr Trussler, on behalf of the Council, referred the Committee to the Hearings and Indicative Sanctions Guidance (the Guidance) as well as the statutory provisions in the Opticians Act 1989 that allowed the Committee to impose a sanction on Registrants.

89. He submitted that while he previously suggested that the starting point in sanction for the deliberate and dishonest falsification of documents was an order for erasure, he was not submitting that this was the appropriate sanction in this case.

90. He further submitted that a suspension order may be appropriate and referred the Committee to the factors set out at paragraph 21.29 of the Guidance. In relation to a suspension order, he submitted that this was a case in which a lesser sanction was not sufficient, there was no evidence of harmful, deep-seated personality or attitudinal problems, no evidence of a repetition of the behaviour since the incident, and the Registrant did not pose a significant risk of repeating the behaviour.

91. Mr Trussler further submitted that the imposition of conditions of practice would protect the public. However, this sanction would not be appropriate in this case. He added that the Committee already understood the seriousness of the case and a suspension order may be the appropriate sanction.

92. Ms Vanstone, on behalf of the Registrant, referred the Committee to her submissions at the impairment stage and invited the Committee to also take them into account at the sanction stage of the hearing. She invited the Committee to take no action against the Registrant in respect of the finding of impaired fitness to practise. This was on the basis of the findings already made by the Committee, and the Committee's reasons for the findings made.

93. Ms Vanstone addressed the Committee on the sanctions available and reminded the Committee that it was required to impose the least restrictive sanction necessary to uphold the public confidence in the profession and was required to consider them from the least restrictive first.

94. Ms Vanstone first referred to the Registrant's mitigation. She submitted that the Registrant admitted to the allegations and accepted misconduct from the very start of these proceedings. The admission was first made to the Registrant's employer in the investigatory meeting in 2024. Ms Vanstone also referred to the Registrant's "genuine remorse and insight" and his written reflections on what he would do differently to prevent a recurrence in the future. She added that the misconduct was over a short period and the dishonesty was isolated. Ms Vanstone also submitted that there was no patient harm and the risk of harm was low, based on the evidence of the Council's own expert.

95. Ms Vanstone then referred to the aggravating factors set out within the Guidance at paragraph 14.3. She submitted that the only applicable factor was the Registrant's dishonesty and so the facts of the case alone were aggravating.

96. Ms Vanstone invited the Committee to have regard to the large number of testimonials for the Registrant which she submitted were positive and which she had already referred to during her submissions on impairment. She informed the Committee that the Registrant had continued to practise without any restrictions being imposed by the Regulator even though he had made admissions to his employer in 2024 about what he had done. She submitted that it was unclear why any restriction was now required in the context of this history.

97. Ms Vanstone further made submissions to the Committee on the appropriateness of taking no action against the Registrant and referred the Committee to the paragraphs 21.4 to 21.7 of the Guidance. Ms Vanstone submitted that the Registrant was a competent optometrist. She further submitted that based on the guidance in cases with exceptional circumstances, it was open to the Committee to take no action. She added that an impairment

finding with no further action was a way to mark the seriousness of the misconduct in the public interest, where a restrictive sanction could not be justified.

98. Ms Vanstone invited the Committee to have regard to the level of insight, reflection, and remediation that Registrant had undertaken when considering whether this was an exceptional case. She referred to paragraph 21.7 of the Guidance and submitted that in the Registrant's case, no action may be appropriate because the Registrant had demonstrated considerable insight into the misconduct and had already completed remedial action. In conclusion, Ms Vanstone's primary submission on behalf of the Registrant was that no further action was required.

99. Ms Vanstone then made submissions to the Committee on the alternatives in the event that the Committee concluded that this was not a case where no action was appropriate.

100. Ms Vanstone submitted that a financial penalty was not appropriate as there was no financial motivation or financial gain. She submitted that the primary purpose of conditions of practice was to protect the public. However, she agreed with Mr Trussler that conditions were not appropriate in this case.

101. Ms Vanstone referred to the paragraph 21.29 of the Guidance on suspension as a sanction and the factors that the Committee should consider. She submitted that the factors were not exhaustive. In particular she referred the Committee to paragraph 21.29 (a) which states that suspension may be appropriate when '*a serious instance of misconduct where a lesser sanction is not sufficient'.* She argued that a lesser sanction was available in this case. If the Committee accepted this conclusion, she further submitted that any suspension would be disproportionate.

102. Ms Vanstone referred to the Council's skeleton argument that the dishonesty crossed the threshold for erasure. She submitted that the Registrant's mitigation was such that erasure was not appropriate and the Committee was being invited to approach sanction from the "wrong end of the telescope". She further submitted that the Committee must first approach the sanction stage from the least restrictive option and not the most restrictive. She reminded the Committee that there was no blanket rule that erasure was the appropriate sanction in cases of dishonesty and referred to paragraph 22.4 of the Guidance.

103. Ms Vanstone referred to the case of *Professional Standards Authority for Health and Social Care v General Medical Counci*l [2019] EWHC 1638 (Admin) where a tribunal made a finding of no impairment and had not issued a warning. The court held on appeal in respect of the facts of that case, that a warning was required as a "sanction" in the absence of a finding of impairment. Ms Vanstone

highlighted that the Registrant's case was different, because the Committee was considering a sanction following a finding of impairment.

104. Ms Vanstone referred the Committee to paragraph 22.5 of the Guidance and the approach the Committee should take when deciding on the appropriate sanction for dishonesty. She submitted that the Committee must first assess the conclusions about the act of dishonesty itself, the extent of the dishonesty, and its impact on the wider reputation of the profession and the public perception of the profession. Ms Vanstone reminded the Committee of its findings at the impairment stage and in particular that the Registrant had apologised and expressed genuine remorse for his actions. She submitted that the Registrant was held in high regard by his colleagues, and had an otherwise unblemished 20-year career.

105. Ms Vanstone submitted that while the Committee found that a well-informed member of the public would expect a finding of impairment, this finding alone would serve to declare and uphold proper standards of conduct and behaviour in the profession. Consequently, she submitted there was no requirement for further action to be taken and the imposition of a sanction.

106. Ms Vanstone further submitted that should the Committee conclude that a period of suspension was appropriate, there was no requirement for a lengthy period of suspension. In conclusion, she submitted that maintaining proper standards of conduct and behaviour in the profession, and the maintenance of public confidence could be achieved by the imposition of a very short term of suspension.

Legal advice

107. The Legal Adviser advised the Committee that at the sanction stage of proceedings there was no burden or standard of proof. The decision on sanction was a matter for the Committee's judgment alone.

108. The case of *Raschid v GMC [2007]* 1 WLR 1915 indicated that although sanctions may have a punitive (even a devastating) effect on a Registrant, the Committee was for the most part concerned with the reputation of the profession and protection of the public. In *Bijl v GMC [2001]* UKPC 42 the court said that a Committee should not be obliged to erase an otherwise competent and useful healthcare professional who presents no danger to the public, in order to satisfy public demand for blame or punishment.

109. The Legal Adviser referred the Committee to the guidance in the Hearings and Indicative Sanctions Guidance (the Guidance). The Guidance was intended to be flexible and was not comprehensive. Although a Committee need not

adhere to the Guidance, it should have proper regard to it following the case of *General Medical Council and another v Bramhall* [2021] EWHC 2109 (Admin).

110. The Legal Adviser referred the Committee to paragraph 8 of the Guidance and highlighted that the Committee should take a proportionate approach in deciding what sanction, if any, to impose. He also referred the Committee to paragraphs 22.4 and 22.6 of the Guidance that covered cases of dishonesty that were relevant to its consideration. He highlighted that there was no blanket rule or presumption that erasure was the appropriate sanction in all cases of dishonesty. However, a failure to impose any sanction for dishonesty may be found to be unreasonable in light of the importance of maintaining public confidence in the profession (*Professional Standards Authority for Health and Social Care v General Medical Council* [2019] EWHC 1638 (Admin)).

111. The Legal adviser further advised that the Committee should have regard to all the circumstances of the case, any aggravating and mitigating features that may be present, and any personal mitigation submitted by the Registrant. Mitigation could affect the type of sanction and the length of a relevant order. Where there were only two options for sanction such as erasure or suspension, it was critical that the available mitigation was applied when evaluating the proportionality of each alternative (*Wisniewska v NMC* [2016] EWHC 2672). Although mitigation could reduce the length of suspension, it could also pull a case back from the brink of erasure and mean that a suspension is proportionate.

112. The Legal Adviser further advised the Committee that while there might be a public interest in enabling a practitioner's return to safe practice, protection of patients and the wider public interest remained a primary concern. The impact on public confidence in cases involving dishonesty was not diminished just because the practitioner in question was unlikely to repeat their dishonesty, if that was the case (*GMC v Armstrong* [2021] EWHC 1658).

113. In deciding what sanction was appropriate, the Committee should start with the least severe and only move on to consider the next sanction if the one under consideration did not sufficiently protect the public, promote, and maintain public confidence in the profession and promote and maintain proper professional standards and conduct, having regard to the circumstances of the case and the overarching objective. The Committee should also take account of the principle of proportionality and the need to weigh the interests of the public against those of the Registrant.

114. The Committee should consider the seriousness of the misconduct as well as balancing any aggravating and mitigating factors against the central aim of the sanctions, namely, protection of the public which includes the public interest. In

doing so, the Committee had to consider all the evidence of remorse, insight and remediation, including CPD certificates and any relevant testimonials. The Committee also had to take account of submissions from the parties.

Findings on sanction

115. The Committee accepted the unchallenged advice of the Legal Adviser and took account of the Guidance which confirmed that sanctions are to be considered in ascending order of severity. The Committee accepted that the purpose of a sanction was not to be punitive, but to protect members of the public and also the wider public interest which includes declaring and upholding professional standards and maintaining public confidence in both the profession and the regulatory process.

116. In reaching a decision on sanction, the Committee took account of all the evidence, its previous findings, the submissions from Mr Trussler on behalf of the Council and from Ms Vanstone on behalf of the Registrant and carefully considered the principles in the Guidance, the statutory overarching objective, and relevant law.

117. The Committee took account of its decisions at earlier stages of this hearing in its deliberations on sanction. The Committee considered and balanced the aggravating and mitigating factors identified in the case.

118. The Committee first considered Paragraph 14.3 of the Guidance and identified the following aggravating factors:

(i) The nature of the misconduct was deliberate dishonesty.

119. The Committee identified this as serious.

120. The Committee also considered relevant parts of paragraph 14.1 of the Guidance and identified the following mitigating factors:

(i) The misconduct centred on a one-off event involving two patients;
(ii) The Registrant had developed insight and the risk of repetition was very low;
(iii) The Registrant had undertaken considerable remediation;
(iv) The Registrant had cooperated with the investigation and had engaged with the hearing process throughout.
(v) The Registrant had expressed remorse, and regret and had admitted the allegations against him in full;
(vi) The Registrant's unblemished record in a 20 year career.

121. The Committee also took account of the fact that there was no evidence of actual harm to the two patients and the positive testimonials for the Registrant from colleagues and patients.

122. The Committee next considered the sanctions available to it from the least restrictive to the most severe, starting with no further action. The Committee carefully considered the Guidance at paragraphs 21.3 to 21.8. The Committee noted that following a finding of impairment, a sanction was usually imposed, unless there are exceptional circumstances, which can justify taking no further action. The Committee had regard to the case of *R v Kelly (Edward)* [2000] QB 198, where the court stated the following:

> *"We must construe 'exceptional' as an ordinary, familiar English adjective, and not as a term of art. It describes a circumstance which is such as to form an exception, which is out of the ordinary course, or unusual, or special, or uncommon. To be exceptional a circumstance need not be unique or unprecedented, or very rare; but it cannot be one that is regularly, or routinely, or normally encountered."*

123. The Committee had considered the submissions of Ms Vanstone, however it was of the view that while there were several mitigating factors in this case identified above, these did not, even when taken together, amount to exceptional circumstances.

124. In addition, the Committee was also of the view that crucially there was no compelling evidence that the Registrant faced exceptional or unusual circumstances in the practice on the day of the misconduct. The Committee considered that the falsification of records was wholly unacceptable and the other staff in the practice should have been able to trust the records the Registrant made for the two patients. Additionally, the Committee was of the view that taking no further action would be insufficient to address the public interest concern in a case which involved deliberate dishonesty. Consequently, the Committee decided that a sanction was required in order to uphold proper standards of behaviour and public confidence in the profession.

125. The Committee next considered the imposition of a financial penalty order. It noted that this was available as a sanction. However, it was of the view that such an order was not appropriate, given that this case did not involve financial motivation or gain. Furthermore, the Committee was of the view that a financial penalty would not reflect the seriousness of the misconduct, nor would it meet the public interest concerns in the case.

126. The Committee went on to consider the Guidance for the imposition of conditions. The Committee noted from the Guidance that conditions may be appropriate where there was evidence of shortcomings in a specific area or areas of a Registrant's practice which was not the case in this instance. Accordingly, the Committee was of the view that this sanction was not appropriate in this case because even if conditions could be formulated that

were workable and practical, such conditions would not reflect the gravity of the dishonest misconduct. The imposition of conditions would not sufficiently address the promotion of public confidence in the profession and the maintenance of proper standards of professional conduct and behaviour.

127. The Committee then considered suspension and had regard to paragraphs 21.29 to 21.31 of the Guidance. The Committee considered the list of factors set out at paragraph 21.29 that indicated when a suspension may be appropriate. These factors were as follows:

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

128. The Committee was of the view that factors (a) to (d) listed in paragraph 21.29 were applicable. In relation to factor (a), this was a serious matter, where a lesser sanction was not sufficient, as set out above. When assessing factor (b), the Committee did not find evidence of a harmful deep-seated personality or attitudinal problems and took account of the positive testimonials provided and the insight that the Registrant had demonstrated. In relation to factor (c), the Committee noted there was no evidence of any repetition of the behaviour since the misconduct occurred. When considering factor (d), the Committee had earlier found that the Registrant had developed insight, and the risk of repetition was very low. Consequently, the Committee was satisfied that many of the relevant factors in the Guidance were established indicating that suspension may be appropriate in this case.

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

standards of professional conduct and behaviour.

130. In relation to erasure, the Committee considered that the Registrant's misconduct was not fundamentally incompatible with continued registration and erasure would be disproportionate.

131. The Committee considered the appropriate length of the order of suspension. It balanced the mitigating and aggravating factors against the public interest and decided that a suspension period of two months would be proportionate and appropriate. When considering the appropriate length of order, the Committee had regard to the considerable mitigation, including the Registrant's insight and the remediation he had achieved. However, the Committee also had regard to the aggravating factor, including the nature of the deliberate dishonesty and the need to adequately meet the public interest and send a signal to the public and the profession that such deliberate dishonesty was wholly unacceptable.

132. The Committee took into account that the dishonesty was not for financial gain, occurred on one day against a backdrop of an otherwise unblemished career of 20 years, and did not result in any patient harm. In these circumstances, the Committee was of the view that two months was an appropriate and proportionate period of suspension to sufficiently mark the seriousness of the Registrant's misconduct and to address the public interest concerns it had identified.

133. The Committee next considered whether to direct that a review hearing should take place before the end of the period of suspension. The Committee noted at paragraph 21.32 of the Guidance, that it states that a review should normally be directed before an order of suspension is lifted, because the Committee will need to be reassured that the Registrant is fit to resume unrestricted practice. However, the Committee concluded that it had found that the Registrant had developed insight, had remediated his misconduct and that it was unlikely to be repeated. In addition, the finding of impairment was on public interest grounds only and the Registrant does not pose a risk to the public. Consequently, the Committee determined that it was not necessary or appropriate to direct a review hearing before the order of suspension expired.

134. The Committee therefore imposed a suspension order for a period of two months, without a review hearing.

Immediate Order

135. The Committee heard submissions from Mr Trussler, on behalf of the Council, regarding the imposition of an immediate order. Mr Trussler invited the Committee to impose an immediate order of suspension for 18 months under the relevant statutory provisions because and on the basis that it was otherwise

in the public interest. He submitted that the test was one of necessity which had been met in this case.

136. Ms Vanstone, on behalf of the Registrant, submitted that there was no basis for an immediate suspension order. She submitted that there was no risk to the public by the Registrant returning to unrestricted practice until the suspension order came into force. She referred to the relevant case law (*Sheik, Davy*) which clarified that there was a high bar to meet for the imposition of an immediate suspension on the basis of the public interest ground alone. She argued that the high bar had not been met in this case and consequently she invited the Committee not to impose an immediate suspension order.

137. The Committee heard and accepted advice from the Legal Adviser, namely that the Committee should refer to Paragraphs 23.1-23.5 of the Guidance, that the Committee may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the Registrant.

138. The Committee took account of the relevant paragraphs of the Guidance and case law and also carefully considered the submissions made on behalf of the parties. The Committee noted that the application was made on the basis of the public interest only. It concluded that the high bar required for the public interest ground had not been established, particularly taking in to account that the suspension order was only for 2 months without a review.

139. Accordingly, the Committee decided that it was not otherwise in the public interest that an immediate order of suspension be imposed.

Revocation of interim order

140. There was no interim order to revoke.

Chair of the Committee: Sarah Hamilton

Signature .... **Date:** 26 June 2026

Registrant: Jaspal Sihra

Signature Present via MS Teams. **Date: 26 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 10 Old Bailey, London, EC4M 7NG or, by telephone, on 020 7580 3898.