

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

GENERAL OPTICAL COUNCIL

F(26)14

AND

IQRA IKRAM (01-34706)

**DETERMINATION OF A SUBSTANTIVE HEARING
5-6 OCTOBER 2026**

Committee Members:	Mr Adrian Smith (Chair/Lay) Ms Vivienne Geary (Lay) Mr Ben Summerskill (Lay) Ms Gemma O'Rourke (Optometrist) Ms Caroline Clark (Optometrist)
Legal adviser:	Mr Timothy Akers
GOC Presenting Officer:	Ms Siân Beaven
Registrant present/represented:	Yes and represented
Registrant representative:	Ms Eleanor Curzon
Hearings Officer:	Ms Natasha Bance
Facts found proved:	1) a. 1) b. 1) c. 2) Proven by admission
Facts not found proved:	N/A
Misconduct:	Found
Impairment:	Impaired
Sanction:	One-month suspension – Without Review
Immediate order:	None

ALLEGATION

1. The Registrant faced the following allegations (as amended):

1) *Between 1 to 11 December 2024, you;*

a. forged the signature of your supervisor Ms 2 on a prescription for Patient X, without permission from Ms 2; and/or

b. used the GOC registration number of Ms 2 on a prescription for Patient X, without permission from Ms 2;

c. submitted a falsified prescription for Patient X for dispense;

2) *Your actions as set out above at 1 above were dishonest in that you knowingly falsified the prescription for Patient X and/or submitted it for dispense;*

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

DETERMINATION

Preliminary matters

1. The Committee confirmed it had received and read a skeleton argument on behalf of the Council (C1), a Council bundle of evidence (C2), a list of allegations (C3), a notice of hearing (C4), and updated notice of hearing (C5) and a Registrant's bundle (R1).
2. At the outset of the hearing, Ms Beaven, on behalf of the Council, made an application pursuant to Rule 46(20) of the General Optical Council (Fitness to Practise) Rules 2013 to amend the Allegation from "*your fitness to train is impaired*" to "*your fitness to practise is impaired*", on the basis that the Registrant was now qualified. Ms Curzon, on behalf of the Registrant, did not oppose the application.
3. The Committee received and accepted the advice of the Legal Adviser that it was a matter for the Committee whether to permit the amendment and that the relevant test was whether the amendment could be made without injustice. The Committee carefully considered the application and concluded that no injustice would be caused by permitting the amendment. It also noted the absence of any objection from Ms Curzon. Accordingly, the Committee permitted the Allegation to be amended.

Admissions in relation to the particulars of the allegation

4. The Registrant admitted all allegations, namely allegations 1) a.-c. and 2). The Committee therefore found all allegations proven by way of admission.

Background to the allegations

5. At the time of the incident, the Registrant was a pre-registrant Optometrist. She became a fully qualified Optometrist on 19th February 2026.
6. At the relevant time, the Registrant was employed at the Boots Opticians in [redacted] and was supervised by Ms 2.
7. The Registrant signed a prescription using the name of the supervising Optometrist along with the supervising Optometrist's GOC registration number. The prescription was intercepted by a colleague Ms 3, who identified some missing information and queried this with the supervisor Ms 2. Ms 2 confirmed that she had not signed the prescription.
8. Ms 3 informed Ms 1 and the hub manager of the situation. Ms 1 began an investigation into what had happened. She spoke with the Registrant who initially claimed Ms 2 had given her permission to write her name on the prescription. Ms 2 however, stated she had never given such permission.
9. Ms Beaven then opened the case for the Council.
10. Ms Curzon then called the Registrant to give evidence.

Oral evidence of the Registrant

11. The Registrant gave evidence and stated that the incident had helped her to realise that transparency and accountability were paramount and that, as a professional, she should not compromise on such matters. She said that she should have taken matters more seriously and that studies she had undertaken since the incident had benefited her thinking in this regard.
12. The Registrant stated that her inexperience at the time and her working environment had affected her. She accepted that her conduct would have had a negative impact upon her supervisor and the profession. She stated that she had reflected upon and analysed what had happened and had created an action plan to ensure that it was not repeated. She stated that she had felt very [redacted] and generally under pressure at the time. She accepted that she had a duty of care to her patients, that on this occasion she had not put her patient first, and that her conduct was capable of affecting the reputation of the profession.
13. The Registrant was then cross-examined by Ms Beaven on behalf of the Council. The Registrant stated that the subsequent training she had undertaken was online and that the courses required assessments at the end. She stated that she had discussed her dishonesty with colleagues and mentors when she started her new job and had informed them that the GOC proceedings were ongoing. She stated that she had discussed matters extensively with her new supervisor and that, if she found herself in the same situation again, she would stop and consider how to ensure that the patient came first.

14. When asked why she had not raised the matter with her supervisor at the time, the Registrant stated that, when she had previously asked this supervisor for help, her supervisor's responses had left her feeling "stupid" for asking questions and that her supervisor had appeared annoyed by being asked questions in the first place. The Registrant accepted that she still made mistakes but stated that, if she were unsure at any point, she would now seek assistance from a senior optometrist with whom she worked and who had been qualified for more than nine years or other more experienced colleagues.
15. In response to questions from the Committee, the Registrant stated that the Boots branch at which she had been working was short-staffed most of the time and that there was considerable pressure to see patients. She stated that she was inexperienced, had to carry out her own screening and was under pressure. She accepted that this did not excuse what she had done, but stated that duties were not delegated equally amongst staff.

Findings regarding misconduct

16. The Committee heard submissions on misconduct from Ms Beaven and Ms Curzon. Ms Curzon accepted on behalf of the Registrant that the conduct constituted misconduct, while submitting that the Committee should nevertheless determine the issue for itself.
17. The Committee received and accepted the advice of the Legal Adviser, who referred to *Cheatle v General Medical Council* [2009] EWHC 645 (Admin), *Roylance v General Medical Council* (No. 2) [2000] 1 AC 311 and *Meadow v General Medical Council* [2006] EWCA Civ 1390.
18. The Committee considered the issue of misconduct and determined that the Registrant's conduct amounted to misconduct. In reaching that decision, it noted Ms Curzon's acceptance of the same. The Committee concluded that the Registrant had breached paragraphs 15.1, 15.4 and 15.6 of the GOC Standards for Optical Students (effective from 2016), which require students to be honest and trustworthy, including by acting with honesty and integrity and not making false or misleading statements. In finding the breaches of the relevant Standards, the Committee determined that the Registrant had effectively held herself out to be a qualified optometrist when she was not.
19. The Committee considered the misconduct to be serious: it was a deliberate act in breach of the trust between the Registrant and her supervisor. By forging her supervisor's signature and using her supervisor's GOC registration number, the Registrant held herself out, so far as the patient was concerned, as authorised to issue the prescription. The Committee also noted the risk of harm to patients, given that the Registrant was not authorised to issue prescriptions and that a reading addition had been inadvertently omitted from the prescription by the Registrant. The Committee did not treat this omission as a separate allegation of misconduct, given that it was not referred to in the Allegation. However, it considered it as part of the overall factual context when assessing the seriousness of the conduct and the risk arising from it.
20. The Committee concluded that the Allegation amounted to misconduct.

Findings regarding impairment

21. Having found misconduct, the Committee went on to consider the issue of impairment. It heard submissions from Ms Beaven and Ms Curzon. Ms Beaven submitted that the Registrant's fitness to practise was impaired. Ms Curzon submitted that it was not. To support her submissions, Ms Curzon provided the Committee with a 10-page skeleton argument.
22. The Committee received and accepted the advice of the Legal Adviser, namely that impairment is a matter of judgment rather than proof, that the purpose of fitness to practise proceedings is not to punish the practitioner, and that the Committee must look forward while also taking account of past matters. The Legal Adviser referred the Committee to the test identified by Dame Janet Smith in the Fifth Shipman Report, as considered in *Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council and Grant* [2011] EWHC 927 (Admin), and to the questions identified by Silber J. in *Cohen v General Medical Council* [2008] EWHC 581 (Admin).
23. In reaching its determination, the Committee considered the Registrant's bundle in full, including her written reflection, testimonials and evidence of further study, together with her oral evidence.
24. The Committee noted it was dealing with a single incident of dishonesty which the Registrant had admitted immediately and which had not been repeated. The Committee considered that the dishonesty had been remediated to a degree, but noted that the Registrant continued to attribute her misconduct in part to the pressures of the clinic.
25. The Committee concluded that forging her supervisor's signature and inserting her supervisor's GOC registration number on a prescription without authorisation amounted to a fundamental breach of the tenets of the optical profession. The Committee was not persuaded by the Registrant's explanation for not raising the matter with her supervisor at the time (that, when she had previously asked this supervisor for help, her supervisor's responses had left her feeling "stupid" for asking questions). The Committee concluded that this would have been a simple routine matter of asking her supervisor to approve and sign a patient prescription, and not a potentially awkward clinical query.
26. The Committee noted that the Registrant, while regretful, did not appear to have expressed significant remorse while giving evidence. It also recognised the inevitable impact upon the Registrant's supervisor, in whose name a prescription had been fraudulently passed off. Moreover, the Committee took the view that the Registrant had failed to fully appreciate the wider impact of her actions and the impact on public confidence in the profession.
27. The Committee considered that the misconduct was unlikely to be repeated and took account of the Registrant's junior status within the profession at the time. Also in the Registrant's favour, the Committee noted that she had fully engaged with the proceedings and with her regulator. It considered the risk of repetition to be remote. The Committee accepted that the experience had been a salutary one for the Registrant.

28. Applying *Cohen*, the Committee considered that the misconduct was remediable, given the isolated nature of the dishonesty and the stage at which it had occurred in the Registrant's career. It determined, however, that the misconduct had not been fully remediated because the Registrant continued to attribute her behaviour in part to the pressures of the clinic. The Committee however considered that there was no significant risk of repetition.
29. Applying the approach in *Grant*, the Committee considered that, by her past conduct, the Registrant had put a patient at unwarranted risk of harm, brought the profession into disrepute, breached a fundamental tenet of the profession and acted dishonestly. Looking to the future, however, the Committee did not consider that she was liable to do so again.
30. Viewing the matter in the round, the Committee determined that a finding of impairment was not required on public protection grounds. However, when considering the public interest, the Committee took the view that the Registrant's actions represented a conscious choice to fraudulently sign a prescription in the name of her supervisor and that public confidence in the optical profession would be undermined if the Registrant's fitness to practise were not found to be impaired in such circumstances.
31. Accordingly, the Committee found the Registrant's fitness to practise to be impaired.

Sanction

32. The Committee heard submissions from Ms Beaven on behalf of the Council. In her submissions, Ms Beaven adopted the submissions contained within the Council's skeleton argument. Ms Beaven also highlighted relevant parts of the Hearings and Indicative Sanctions Guidance and the sanctions available to the Committee. Ms Beaven submitted that this was not a case in which the public interest would adequately be served by the imposition of conditions on the Registrant's registration and that a financial penalty would be insufficient in all the circumstances. Ms Beaven submitted that the most proportionate sanction would be a period of suspension.
33. Ms Curzon then made submissions on behalf of the Registrant. She submitted that a short period of suspension, namely one month, would be proportionate in all the circumstances. Ms Curzon submitted that no harm had been caused to any patients, that the Registrant regretted what she had done, that she had undertaken targeted CPD, that she had been honest and open in her conversations with professionals, and that she had fully engaged with both the internal investigation and these proceedings. Ms Curzon further emphasised that there had been no concerns regarding the Registrant's fitness to practise since these matters came to light, that the misconduct was now of some age, that the Registrant had been working in a pressurised environment, and that there had been no repetition of the misconduct. Ms Curzon submitted that there was evidence of insight and that the Registrant accepted she would act differently if placed in the same situation again. She also drew the Committee's attention to two previous cases before the GOC Fitness to Practise Committee in which two registrants had received periods of suspension for matters of dishonesty and submitted that a review hearing was not necessary.

34. The Committee received and accepted the advice of the Legal Adviser. The Legal Adviser advised the Committee that the purpose of sanction is not to punish the Registrant and referred to section 1 of the Opticians Act 1989 and the Council's overarching objective. The Committee was reminded that any sanction imposed must be necessary and proportionate, and that sanctions should be considered in ascending order of seriousness. The Legal Adviser highlighted the sanctions available to the Committee and the relevant provisions of the Hearings and Indicative Sanctions Guidance, including those concerning *Student Registrants* and *Dishonesty*. The Legal Adviser also referred the Committee to *Abbas v General Medical Council* [2017] EWHC 51 (Admin).
35. The Committee retired to deliberate on sanction. The Committee had been provided with electronic access to the decision notices of the previous GOC cases referred to by Ms Curzon, and it also noted that two members of the Committee had sat on one of the previous cases that had been highlighted. The Committee took the view that the factual contexts of the previous cases were materially different from the circumstances of the present case and considered the present case on its own facts.
36. The Committee considered the nature and seriousness of the dishonesty. It determined that the Registrant had deliberately misrepresented that she was authorised to issue an optical prescription and had, in effect, impersonated her supervisor by forging her supervisor's signature and using her GOC registration number without authority. This created a potential risk to patients. The Committee considered that the misconduct was capable of damaging the reputation of the optical profession and the reputation of the Registrant's supervisor, who could potentially have faced investigation by the Council on the basis that she had permitted a student to issue a prescription in her name.
37. The Committee determined that the Registrant had made a calculated decision to act as she did because the clinic was running late. It noted, as part of the factual context and not as a separate allegation of misconduct or an aggravating factor, that the matter came to light only after the reading addition had been omitted from the prescription and the prescription was subsequently brought to the attention of the Registrant's supervisor.
38. Conversely, the Committee considered that the dishonesty was an isolated incident and was brief in duration. On the spectrum of dishonesty, although serious, it involved no financial gain or other material benefit to the Registrant and was a single, ill-judged act committed while the Registrant was a student. The Committee therefore considered that the dishonesty fell towards the lower end of the spectrum and regarded the conduct as a momentary, albeit serious, lapse of judgment.
39. In relation to mitigation, the Committee determined that the mitigating factors outweighed the aggravating factors. It found that the Registrant posed no significant clinical concerns and placed significant weight on the fact that this was a single incident on one specific day. The Committee also took into account that the Registrant was a pre-registrant optometrist at the time and had since learned how to manage matters differently. It placed significant weight on the Registrant's early admissions to the misconduct, her engagement with the internal investigation and these proceedings, and the relevant training and targeted CPD she had undertaken.

in relation to probity and ethics. The Committee found that the Registrant had clearly gained insight since the misconduct, albeit this was still developing.

40. The Committee placed less weight on the Registrant's assertion that she had been under pressure at the time of the misconduct. It also placed less weight on the absence of repetition as a freestanding mitigating factor, instead taking this principally as evidence that the dishonesty had been isolated and very limited in extent. As to the Registrant's character testimonials, the Committee noted that they were uniformly positive and treated them principally as evidence of the Registrant's current clinical competence rather than as a significant mitigating factor in and of themselves.
41. Turning to aggravating factors, the Committee determined that this was a meaningful act of dishonesty with a potential impact on patient safety. It also noted that, although the Registrant had made early admissions to the misconduct, during the investigation she had not fully accepted responsibility and had attributed some blame to her supervisor. The Committee found as a matter of fact that the Registrant's supervisor could not properly be blamed for the Registrant's actions.
42. The Committee then considered the available sanctions in ascending order of seriousness.
43. The Committee first considered taking no further action. It determined that this would not be appropriate given the dishonest nature of the misconduct and the departure from the Standards for Optical Students. The Committee did not consider the circumstances sufficiently exceptional to justify taking no further action. It took the view that such an outcome would not adequately mark the seriousness of the misconduct or properly address the public interest in maintaining public confidence and proper professional standards in the optical profession.
44. The Committee next considered whether a financial penalty would be appropriate and proportionate. It determined that it would not. The misconduct was not financially motivated and did not result in financial gain. More importantly, the Committee considered that a financial penalty would not adequately address the public interest in maintaining confidence in the profession, proper professional standards, or the reputation of the optical profession.
45. The Committee then considered whether conditional registration would be appropriate. It determined that it would not. The misconduct was essentially attitudinal in nature, and the Committee could identify no workable, measurable or proportionate conditions that would adequately address it. The Committee also noted that the Registrant had continued to work without restriction since the misconduct, which further reduced the utility of imposing conditions at this stage.
46. The Committee next considered suspension. Applying the Hearings and Sanctions Guidance, it determined that this was a serious instance of misconduct for which a lesser sanction would not be sufficient. At the same time, the Committee noted that there was no evidence of harmful, deep-seated personality or attitudinal problems, there had been no repetition of the behaviour, the Registrant had developing insight, and the Committee had found no significant risk that the misconduct would be repeated. The Committee therefore considered that a period of suspension would be sufficient to uphold public confidence in the profession and maintain proper professional standards.

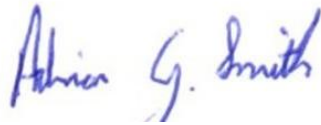
47. The Committee went on to consider erasure. It determined that erasure would be disproportionate in the specific circumstances of this case. In arriving at this decision, the Committee was satisfied that erasure was not the only sanction capable of protecting patients and the wider public interest, and that the seriousness of the case was compatible with the Registrant remaining on the register following an appropriate period of suspension.
48. The Committee therefore determined that a period of suspension was necessary and proportionate. In deciding upon the length of suspension, it considered the isolated and limited nature of the dishonesty, the Registrant's junior practitioner status at the time, her early admissions and engagement, the remediation undertaken and her developing insight, the absence of repetition and the absence of any significant ongoing risk to patients. The Committee concluded that a suspension for a period of one month was sufficient and proportionate to mark the seriousness of the misconduct and satisfy the public interest.
49. The Committee determined not to direct a review hearing. In reaching that decision, it noted that the suspension was being imposed on public interest grounds and that it had identified no significant concerns regarding the Registrant's current clinical practice or any significant risk of repetition. It also took into account the remediation already undertaken and the fact that the Registrant had continued to practise without restriction since the misconduct. In those circumstances the Committee was satisfied that the Registrant would be fit to return to unrestricted practice at the expiry of the one-month suspension and that a review hearing was not required, taking the view that a one-month suspension, in and of itself, would be sufficient to meet the public interest.

Immediate order

50. An application for an immediate order of suspension was made by Ms Beaven on public interest grounds, referring to the Committee's findings of impairment and dishonesty.
51. Ms Curzon opposed the application on behalf of the Registrant, inviting the Committee to take into account the fact that the Registrant had practised unrestricted for almost two years, that the Committee had already determined that the Registrant posed no significant public safety concerns, and on the basis that it would not be in the public interest to deprive the public of a capable practitioner for any longer than the Committee had already determined by way of the imposition of its formal sanction.
52. The Committee received and accepted the advice of the Legal Adviser, namely that, for an immediate order to be imposed, the Committee must be satisfied that to do so is necessary for the protection of members of the public, otherwise in the public interest or in the best interests of the Registrant. The Committee also considered *R (Shiekh) v General Dental Council* [2007] EWHC 2972 (Admin) (a case on interim orders), where it was held that it would be a relatively rare case where a suspension order will be made on public interest grounds alone.
53. The Committee carefully considered the matter and determined that an immediate order was neither necessary nor proportionate in this instance. In reaching this

conclusion, the Committee was mindful of its finding that the Registrant posed no significant risk to patients and also that the Registrant had been practising unrestricted for a lengthy period of time. The Committee considered that to impose an immediate suspension on public interest grounds alone - which would effectively prevent the Registrant from working until the immediate suspension came into effect - would be disproportionate when weighed against the overall factual background of the case. Moreover, the Committee took the view that an immediate order would not be in the Registrant's best interests. Therefore, the Committee decided not to impose an immediate suspension order.

Chair of the Committee: Adrian Smith



Signature

Date: 6 October 2026

Registrant: Iqra Ikram

Signature *Registrant present, sent via email*

Date: 6 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.	