BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(22)06

AND

NIRMAL KOASHA - (01-21288)

DETERMINATION OF A SUBSTANTIVE HEARING
10-13 OCTOBER 2022
11-12 & 17-19 JANUARY 2023
21 – 27 FEBRUARY 2023

Committee Members:	James Kellock (Part) (Chair/Lay - 10-13 October 2022 and 11-12, 17-19 January 2023) Ian Hanson (Chair/Lay – elected on 21 February 2023) Vivienne Geary (Lay) Gemma O'Rourke (OO) Denise Connor (OO)
Legal adviser:	Lucia Whittle-Martin 10-13 Oct 2022 Ralph Shipway 11-12, 17-19 Jan 2023 & 21 -27 February 2023
GOC Presenting Officer:	Mr Matthew Corrie
Registrant present/represented:	Not present and not represented
Registrant representative:	N/A
Hearings Officer:	Mr Terence Yates - 10-13 October 2022 11-12 & 17-19 January 2023 Mr Nazia Khanom – 21 – 27 February 2023
Facts found proved:	Refer to determination at paragraph 78
Facts not found proved:	Refer to determination at paragraph 78
Misconduct:	Found

Impairment:	Impaired
Sanction:	Suspension for 12 months with a review before the end of the period.
Immediate order:	Immediate Order of suspension

Proof of service

1. Mr Corrie applied for the hearing to proceed in the Registrant's absence. He asked the Committee to satisfy itself, first, that the relevant rules on service had been complied with, and only if satisfied as to that, to exercise its discretion to proceed. He relied on Section 23A of the Act and Rules 22, 28, 29, 34 and 61 of the Fitness to Practise Rules 2013 ("the Rules"). He informed the Committee that the full Allegation, namely Particulars 1 – 18 together with the accompanying Schedules A-M, had been sent to the Registrant when the Council disclosed its case by email on 14 February 2022. Mr Corrie confirmed that the copy of the Schedules in the Committee's bundle was identical to the copy sent on 14 February 2022. He explained that the Notice of Hearing had been sent to the Registrant by email on 4 August 2022, and this had included Particulars 1-18 but not Schedules A-M. Mr Corrie said that in his submission the Rules had been complied with because the Registrant had been sent the full Allegation when the GOC disclosed its case, on 14 February 2022, in compliance with Rules 28 and 29, and the Registrant had been informed that the hearing would be taking place on 10 October 2022 by means of the Notice of Hearing, dated 4 August 2022, in compliance with Rule 34.
2. The Committee accepted the advice of the Legal Adviser who advised on the GOC rules relating to service.
3. The Committee was satisfied that by notifying the Registrant of full details of the Allegation, namely Particulars 1-18 and Schedules A-M, on 14 February 2022, and by notifying the Registrant on 4 August 2022 that the hearing was listed for hearing on 10 October 2022, the Council had complied with the relevant rules on service.

Proceeding in the absence of the Registrant

4. The Committee then went on to consider whether to exercise its discretion to proceed in the Registrant's absence under Rule 22.
5. The Committee accepted the advice of the Legal Adviser who advised on the cases of *R –v Jones [2002] UKHL 5* and *GMC -v- Adeogba [22016] EWCA Civ 16.*
6. The Committee took account of a telephone attendance note, timed and dated 9.49 on 10 October 2022, the morning of the first day of the listed hearing (the day the Committee spent reading the papers), compiled by a GOC employee who had spoken with the Registrant. The note recorded that the Registrant phoned saying that she was sorry she had not been in contact. She set out a number of

domestic circumstances which she claimed had put pressure on her time. She also said that the fitness to practise process had impacted REDACTED. She was advised to attend the hearing if she wished.

7. The Committee also took account of attempts made by the GOC to contact the Registrant prior to the hearing, both by telephone and email. In the course of this, the Registrant stated, on 21 September 2022, that she would contact the GOC the following day. She did not do so. On 29 September 2022 the Registrant stated that she had not been replying to the GOC, or checking her correspondence from the GOC, in part because the process had affected her REDACTED. On 2 October 2022 the Registrant stated in an email: *"I would like to not partake in the process".* She cited reasons which again included her REDACTED.

8. The Committee concluded that the Registrant had decided to absent herself from these proceedings. She had not provided any REDACTED, nor had she requested an adjournment. She had not provided any detailed submissions or documentation in advance of the hearing for the Committee to consider, or engaged in any way other than to express her difficulties in attending. The Committee had been given no reason to conclude that if it adjourned the Registrant would attend. The Committee took account of the fact that three witnesses had made themselves available to give evidence on behalf of the GOC. The Committee was mindful of its duty to proceed with expedition.

9. In all the circumstances the Committee decided to proceed with the hearing in the Registrant's absence.

Application to amend

10. Mr Corrie applied for the following amendments to be made to the Allegation:

    - Allegation 11 - replace *"personal ocular history"* with *"previous ocular history"*
    - Allegation 18 – replace *"your actions set out in Allegation 18"* with *"your actions set out in Allegation 17"*
    - Withdraw the allegations set out at pages 2 to 4 of the Council's Skeleton Argument under the heading "Withdrawal of allegations", which consisted of a number of patients in relation to specified particulars of the Allegation.

11. Mr Corrie explained that the first two applications were to correct typographical errors and the third was to reflect the extent of the expert evidence the GOC relied on.

12. The Committee concluded that the proposed amendment to Allegation 11 was designed to reflect the state of the evidence with greater clarity and did not increase the scope of the overall Allegation. The Committee concluded that the proposed amendment to Allegation 18 was purely administrative in nature. The Committee was satisfied that in relation to both applications the proposed amendments could be made without injustice to either party.

13. The Committee concluded that the withdrawal of allegations, as specified in pages 2 to 4 of the Council's Skeleton Argument, did not result in under prosecution, as more than 300 matters remained for the Committee to consider,

as set out in the proposed amended Schedules A to M. The Committee also concluded that the amendments could be made without injustice as they better reflected the state of the evidence in the case.

14. Accordingly the Committee allowed the application to amend in its entirety.

ALLEGATION (as amended)

The Council alleges that you, Miss Nirmal Koasha (01-21288), a registered optometrist:

Registration Matter

1. *Between 10 April 2019 and 30 September 2019 undertook activities restricted to registrants on the register of optometrists:*

   a) Having not met the 2016 – 2018 CET cycle requirements;

   b) Having been notified by the GOC that you were not permitted to do so;

2. *You conducted around 353 sight tests between 10 April 2019 and 30 September 2019;*

3. *On 28 November 2019, you stated to the GOC that "I probably conducted about 20 eye tests earlier in the year";*

4. *Your conduct as set out in Allegation 3 was dishonest in that you knew your statement to be untrue about the number of sight tests you had conducted.*

Clinical Matter

5. *In relation to some or all of the patients in Schedule A, you failed to record sufficiently or at all:*

   a) *your assessment of their capacity;*
   b) *the details of the carer, nurse, or companion present and authorised to act on their behalf;*
   c) *who consented to their sight test; and/or*
   d) *the sight tests that you performed on them;*

6. *In relation to some or all of the patients in Schedule B, you failed to record why your issuing of a GOS3 voucher was clinically justified and/or in their best interests;*

7. *In relation to some or all of the patients in Schedule C, you failed to record either sufficiently or at all basic sight test information including, but not limited to, their visual acuity;*

8. *In relation to some or all of the patients in Schedule D, you failed to record your management of them and/or advice to them either sufficiently or at all;*

9. *In relation to some or all of the patients in Schedule E, you failed to record either sufficiently or at all their presenting symptoms;*

10. *In relation to some or all of the patients in Schedule F, you failed to record either sufficiently or at all why you had seen them before their expected recall date;*

11. *In relation to some or all of the patients in Schedule G, you failed to record either sufficiently or at all their previous ocular history;*

12. *In relation to some or all of the patients in Schedule H, you failed to record either sufficiently or at all their general health and/or medication;*

13. *In relation to some or all of the patients in Schedule I, you failed to record either sufficiently or at all:*
    a. *their visual acuity;*
    b. *why you were unable to obtain their visual acuity; and/or*
    c. *your analysis of their visual acuity;*

14. *In relation to some or all of the patients in Schedule J, you failed to record either sufficiently or at all your method of assessing their ocular health and/or ocular alignment;*

15. *In relation to some or all of the patients in Schedule K, you failed to record either sufficiently or at all whether the refraction was performed objectively or subjectively;*

16. *In relation to some or all of the patients in Schedule L, you failed to record either sufficiently or at all their family ocular health and/or family general health;*

17. *In relation to some or all of the patients in Schedule M, you inserted some or all of the same clinical data from their previous sight examinations into the record fields of their subsequent examinations;*

18. *Your actions as set out in Allegation 17 were misleading and/or dishonest, in that you knew the insertions failed to provide an accurate record of their subsequent examinations;*

AND that by reason of the matters alleged above your fitness to practise is impaired by reason of misconduct and/or deficient professional performance.

DETERMINATION

15. The Registrant made no formal admission of any of the Particulars of the Allegation. The Registrant had provided some written material which the Committee took into account but did not take the view that it constituted any admission.

Background to the Allegations

16. The Registrant was advised by the Council that between 10/4/19 and 30/9/19 she had not met her 2016-2018 Continuing Education and Training ("CET") requirements and was therefore not permitted to undertake the activities which are restricted to registered Optometrists. It was alleged that the Registrant had conducted 353 eye examinations on patients during the period in question and that she had dishonestly informed the Council by email to a Senior Investigations Officer, REDACTED, dated 29 November 2019 that she had probably conducted around 20 eye tests. Further she had allegedly failed to make an adequate record in the electronic record system in relation to the eye tests carried out in respect of multiple patients and in some cases had inserted the same clinical data from previous appointments with the relevant patient which was alleged to be misleading and/or dishonest.

Determination of the Facts

17. The Committee heard submissions on behalf of the Council but not on behalf of the Registrant, although the Committee did consider the written material submitted by the Registrant. The Committee were conscious of the fact that the Registrant had not given evidence which could be tested by cross examination. However, the Committee drew no adverse inference from the Registrant's non-attendance.

18. The Committee accepted the advice of the Legal Advisor in particular that the burden of proof rested upon the Council and the standard of proof was the civil standard, namely the balance of probabilities. The Committee also accepted legal advice relating to the meaning of the word "misleading" which was that the expression should be given its everyday meaning and, further, should be applied objectively so that to be satisfied no-one need in fact have been misled. The Committee also accepted the legal advice that the proper test of dishonesty had been set down by the Supreme Court in the case of Ivey v Genting Casinos.

19. The Committee first considered its assessment of the witnesses.

20. The Committee was satisfied that the witness Ms A was a credible and reliable witness. She gave evidence in a clear and helpful manner and much of her evidence related to the production of matters of record relating to tests carried out by the

Registrant over the relevant period. Ms A is the founder and Chief Operating Officer of a company providing optician services through franchises. Ms A gave evidence that the records of the eye examinations undertaken by the Registrant were identifiable because the Registrant had a unique password enabling her to create the records on the system. During the period 10 April 2019 to 30 September 2019 353 eye examinations had been recorded as being carried out by the Registrant. Ms A also gave evidence that patient information from the last eye examination would initially pre-populate the record for a subsequent examination. This would be incorporated into the record if electronically "ticked" by the optometrist undertaking the new examination.

21. The Committee was also satisfied that the witness Mr B was a credible and reliable witness in relation to the documents which were produced from the Council's records of correspondence with the Registrant. The correspondence related to CET requirements, suspension from the Register of Optometrists and subsequent restoration to the Register.

22. No formal evidence was submitted on the Registrant's behalf but her written material was taken into account.

23. The Committee then turned to consider the factual particulars of each allegation in turn.

24. The Committee first considered Allegation 1, namely:

    (1) That between 10/4/19 and 30/9/19, the Registrant undertook activities restricted to those on the Register. (Which was clarified in submissions to relate to the testing of sight in accordance with Section 24 of the Opticians Act 1989).

    (a) The Registrant had not during that period of time met the 2016-2018 CET requirements.

    (b) The Registrant had been notified by GOC that she was not permitted to do so.

25. The Committee accepted that the evidence of Ms A supported the allegation that the Registrant carried out sight tests during the period 10 April to 30 September 2019.

26. The Committee accepted that the evidence of Mr. B supported the allegation that the Registrant had not met her CET requirements and had been notified by the Council not to carry out restricted activities.

27. The Committee accordingly found proved Allegations 1(a) and (b).

28. With regard to Allegation 2, *namely that the Registrant "conducted around 353 sight tests between 10 April 2019 and 30 September 2019",* the Committee accepted the evidence of Ms A and found the Allegation proved.

29. With regard to Allegation 3, namely that "*On 28 November 2019, [the Registrant] stated to the GOC that "I probably conducted about 20 eye tests earlier in the year",* the Committee found it established as a matter of fact that the Registrant made this statement by email sent by her to REDACTED on 28/11/19. Accordingly, Allegation 3 is found proved.

30. With regard to Allegation 4, namely that the Registrant's *"conduct as set out in Allegation 3 was dishonest in that [the Registrant] knew [their] statement to be untrue about the number of sight tests [they] had conducted",* the Committee considered that the approach to the issue of dishonesty should be taken in 3 stages:

    (1) Is the act alleged to have been dishonest proven on the balance of probabilities?

(2) To determine what on the balance of probabilities was the Registrant's genuine belief as to the facts

(3) Once this is determined, consider whether the conduct was honest or dishonest applying the objective standards of reasonable, honest people.

31. The Committee noted the contact by letter, email and telephone between the Registrant and the Council between 10 April 2019 and 28 November 2019, and accepted that the Registrant knew it was being suggested that she may have carried out sight tests when she was not permitted to do so. The Committee further considered that the Registrant must have known that she had conducted more than 20 eye tests during the relevant period in view of the significant number (353) of eye examinations undertaken and recorded in the patient records as being carried out by the Registrant.

32. The Committee took the view that the Registrant was seeking to downplay the extent of the eye examinations undertaken in order to minimise the resulting consequences of such conduct. The Committee found that this conduct was dishonest and accordingly found Allegation 4 proved.

33. The Committee then turned to consider the clinical allegations and had regard to the following publications relevant at the time of the allegation:

- GOC Standards of Practice for Optometrists and Dispensing Opticians (April 2016) ("the GOC Standards");
- GOC Supplementary Guidance on Consent ("the GOC Consent Guidance");
- Optical Confederation Code of Practice for Domiciliary Eyecare (July 2014) ("the Optical Confederation Code");
- Optical Confederation document "Making Accurate Claims in England" (May 2014) (the "Confederation- Making Accurate Claims");
- Optical Confederation "Vouchers at a Glance" (1 June 2018) ("the "Confederation- Vouchers at a Glance");
- College of Optometrists Guidance for professional practice (2017) ("the College Guidance"); and
- the relevant legislation, specifically Section 24 of the Opticians Act 1989.

34. The Committee noted the report of the expert Dr Rakhee Shah and were greatly assisted by her evidence. However, the Committee took the view that in certain instances Dr Shah applied a higher standard than the required standard against which the clinical practice of the Registrant must be assessed. The Committee were careful to apply the standard of what a body of reasonably competent optometrists would have done in those circumstances. The Committee were mindful of their duty to consider each individual case set out in the Schedules applicable to each allegation.

35. The Committee were also mindful of their responsibility in relation to Allegations 5-16 to establish firstly, whether a duty as alleged was required of an optometrist and,

secondly, whether that duty had been carried out sufficiently in respect of each patient identified in the Schedule relevant to each Allegation.

36. The Committee then considered Allegation 5, namely that in respect of some or all of the Patients in Schedule A, the Registrant "*had failed to record sufficiently or at all [their]*

    (a) assessment of [the patient's] capacity

    (b) details of the carer, nurse or companion present and authorised to act on [the patient's] behalf

    (c) who consented to [the patient's] eye test

    (d) the sight tests performed [by the Registrant] on [the patient]

37. Allegation 5(c) was not pursued by the Council. The Committee concluded that there was a duty on Optometrists to record capacity, to record details of those involved in eye examinations, and to record what elements of the sight tests could or could not be done. The Committee were assisted by Paragraphs 8.2.4, 8.2.6. and 8.2.7. of the GOC Standards and A90, A109 and A110 of the College Guidance.

38. The Committee were acutely aware that one of the purposes of the patient record was to assist the Optometrist attending a patient at any subsequent appointment(s). Any limitations to the extent of the examination which could be carried out on patients, at a particular point in time, particularly for those patients living with dementia or other cognitive impairment was of vital importance to those providing future or ongoing optical care.

39. The Committee then considered each patient in Schedule A individually, by reviewing the record card and ascertaining whether some or no information relating to capacity, carer, or sight tests performed had been recorded.

40. The Findings of the Committee relating to patients in Schedule A are set out as follows:

    Patient 33

    5(a) Proved

    5(b) Proved

    5(d) Not Proved

    Patient 85

    5(a) Proved

    5(b) Proved

    5(d) Not Proved

    Patient 86

    5(a) Proved

    5(b) Proved

    5(d) Not Proved

Patient 87
5(a) Not Proved
5(b) Not Proved
5(d) Not Proved

Patient 109
5(a) Proved
5(b) Not Proved
5(d) Proved

Patient 112
5(a) Proved
5(b) Proved
5(d) Not Proved

Patient 127
5(a) Proved
5(b) Proved
5(d) Not Proved

Patient 138
5(a) Proved
5(b) Proved
5(d) Not Proved

Patient 166
5(a) Proved
5(b) Not Proved
5(d) Not Proved

Patient 172
5(a) Not Proved
5(b) Not Proved
5(d) Proved

Patient 176
5(a) Proved
5(b) Not Proved
5(d) Not Proved

Patient 192
5(a) Proved
5(b) Not Proved
5(d) Not Proved

Patient 202
5(a) Proved
5(b) Not Proved
5(d) Proved

Patient 217
5(a) Proved
5(b) Proved
5(d) Not Proved

Patient 218
5(a) Proved
5(b) Proved
5(d) Proved

Patient 224
5(a) Proved
5(b) Not Proved
5(d) Proved

Patient 244
5(a) Proved
5(b) Not Proved
5(d) Proved

Patient 272

5(a) Proved
5(b) Proved
5(d) Not Proved

Patient 283
5(a) Proved
5(b) Proved
5(d) Proved

Patient 293
5(a) Not Proved
5(b) Proved
5(d) Not Proved

Patient 296
5(a) Proved
5(b) Not Proved
5(d) Not Proved

Patient 299
5(a) Proved
5(b) Proved
5(d) Not Proved

Patient 303
5(a) Proved
5(b) Not Proved
5(d) Not Proved

Patient309
5(a) Proved
5(b) Proved
5(d) Not Proved

Patient 310
5(a) Proved

5(b) Proved

5(d) Not Proved

Patient 323

5(a) Proved

5(b) Proved

5(d) Not Proved

41. The Committee considered Allegation 6, namely that in respect of some or all the Patients in Schedule B, the Registrant had *"failed to record why [the Registrant's] issuing of a GOS3 voucher was clinically justified and/or in the Patient's best interests".* The Committee were mindful of the Council Standards Paragraphs 7.6 and 8.2.5, together with the College Guidance in relation to Patient Records at A16, A18, A20 and A22. The Committee were also assisted by the College Guidance on conducting the routine Eye Examination at A48, and the Confederation- Making Accurate Claims document. The Committee accepted that there was a duty to record the reasons for the issue of a GOS 3 voucher.

42. The Committee then considered each patient in Schedule B individually, by reviewing the record card and ascertaining whether the reasons for the issue of GOS 3 had been recorded:

Patient 53 - Proved

Patient 54 - Proved

Patient 85 - Proved

Patient 217- Proved

Patient 218 - Proved

Patient 219 - Proved

Patient 293 - Proved

Patient 296 - Proved

Patient 299 - Not Proved

Patient 303 - Proved

Patient 309 - Proved

Patient 310 - Proved

Patient 323 - Proved

43. The Committee considered Allegation 7 namely, that the Registrant "*failed to record either sufficiently or at all basic sight test information including, but not limited to, [Patients'] visual acuity"* Mr Corrie submitted that the GOC only to wish to pursue visual acuity so the Committee limited its considerations to that. The Committee were mindful of the GOC Standards at Paragraph 8.2.4., the College Guidance A20

and the Confederation-Making Accurate Claims document. The Committee concluded that there was a duty to record visual acuity.

44. The Committee then considered the 2 cases in Schedule C of the Allegation, by reviewing the Record Card and ascertaining whether sufficient or any information relating to visual acuity had been recorded.

45. The Committee were not persuaded in relation to Patient 210 or Patient 268 that any eye test or examination had in fact taken place. Accordingly, their findings were:

    Patient 210 - Not Proved

    Patient 268 - Not Proved

46. The Committee considered Allegation 8 namely that the Registrant had "*failed to record [their] management of some or all of [the Patients in Schedule D] and/or advice to [those Patients] either sufficiently or at all".* The Committee were mindful of GOC Standards at Paragraph 8.2.5., the College Guidance on Patient Records at A20, and the Optical Confederation Code. The Committee were satisfied that there was a duty to record management and advice.

47. The Committee then considered each patient in Schedule D individually, by reviewing their Record Card and ascertaining whether sufficient information relating to management and advice had been recorded.

    Patient 13 – Not Proved

    Patient 27- Not Proved

    Patient 33 - Not Proved

    Patient 40 - Not Proved

    Patient 48 - Not Proved

    Patient 53 - Not Proved

    Patient 79 - Proved

    Patient 86 - Not Proved

    Patient 87- Not Proved

    Patient 102 - Proved

    Patient 109 - Not Proved

    Patient 112 - Not Proved

    Patient 127- Not Proved

    Patient 131- Not Proved

    Patient 136 - Not Proved

    Patient 138 - Not Proved

    Patient 166 - Not Proved

    Patient 172 - Not Proved

    Patient 176 - Not Proved

    Patient 186 - Proved

    Patient 192 - Not Proved

    Patient 198 - Not Proved

Patient 204 - Not Proved

Patient 209 - Not Proved

Patient 210 - Not Proved

Patient 211- Not Proved

Patient 217- Not Proved

Patient 218 - Not Proved

Patient 219 - Not Proved

Patient 224 - Not Proved

Patient 244 - Not Proved

Patient 257- Not Proved

Patient 268 - Not Proved

Patient 272 - Not Proved

Patient 276 - Not Proved

Patient 282 - Not Proved

Patient 283 - Not Proved

Patient 285 - Not Proved

Patient 293 - Not Proved

Patient 296 - Not Proved

Patient 299 - Not Proved

Patient 303 - Not Proved

Patient 309 - Not Proved

Patient 310 - Not Proved

48. The Committee considered Allegation 9, namely that the Registrant had "*failed to record either sufficiently or at all [the] presenting symptoms [of some or all of patients in Schedule E]*". The Committee were mindful of GOC Standard 8.2.3. and the College Guidance on Patient Records at A20. The Committee was satisfied that there was a duty to record patients' presenting symptoms.

49. The Committee then considered each patient in Schedule E individually, by reviewing the Record Card and ascertaining whether presenting symptoms had been recorded. The Committee formed the view, based on the evidence presented, that they were not in a position to identify where any omission to record a patient's individual presenting symptoms (if any) had occurred. The Committee concluded that there was insufficient evidence to find Allegation 9 proved. Accordingly, the Committee's Findings were:

Patient 48 - Not Proved

Patient 53 - Not Proved

Patient 54 - Not Proved

Patient 102 - Not Proved

Patient 136 - Not Proved

Patient 176 - Not Proved

Patient 186 - Not Proved

Patient 198 - Not Proved

Patient 202 - Not Proved

Patient 204 - Not Proved

Patient 209 - Not Proved

Patient 218- Not Proved

Patient 224 - Not Proved

Patient 244 - Not Proved

Patient 257 - Not Proved

Patient 268 - Not Proved

Patient 276 - Not Proved

Patient 282 - Not Proved

Patient 285 - Not Proved

Patient 293 - Not Proved

Patient 296 - Not Proved

Patient 303 - Not Proved

Patient 310 - Not Proved

50. The Committee considered Allegation 10, namely that the Registrant had *"failed to record sufficiently or at all why [some or all of the Patients in Schedule F] had been seen before the expected recall date*". The Committee were mindful of the College Guidance on conducting Routine Eye Examinations which sets out a table of appropriate intervals, in particular A58 and A60 requiring a note to be taken for the reasons for any early recall or early examination. The Committee also took note of the Confederation-Vouchers at a Glance guidance and the Confederation- Making Accurate Claims document which sets out the reason for an early sight test should be clearly noted on the patient record. The Committee were satisfied that there was a duty to record why the patient had been seen before the expected recall date.

51. The Committee then considered each patient in Schedule F individually, by reviewing the Record Card and ascertaining whether the reason why the patient had been seen before the expected recall date had been recorded. The Committee had to be satisfied from their consideration of the records that a sight test had actually been carried out.

52. The Findings of the Committee in relation to Allegation 10 were as follows:

Patient 186 - Proved

Patient 202 - Not Proved

Patient 204 - Proved

Patient 209 - Not Proved

Patient 211- Not Pursued

Patient 224 - Proved

Patient 293 - Proved

Patient 296 - Proved

Patient 303 - Proved

Patient 309 - Proved

Patient 310 - Proved

53. The Committee considered Allegation 11, namely that the Registrant had "*failed to record sufficiently or at all the previous ocular history [of some or all of the Patients in Schedule G]"*. The Committee were mindful of GOC Standard 8.2.4. and the College Guidance on Patient Records at A20. The Committee accepted that there was a duty to record the previous ocular history where it was possible to do so, acknowledging that it was sometimes impossible to obtain such information from a patient with dementia or other cognitive impairment.

54. The Committee then considered each patient in Schedule G individually, by reviewing the Record Card and ascertaining whether the previous ocular history had been recorded sufficiently or at all. The Committee had to consider whether there was evidence to show on the balance of probabilities that there was a failure on the part of the Registrant to record something she had been made aware of.

55. The Findings of the Committee in relation to Allegation 11 were as follows:

Patient 13 - Not Proved

Patient 27- Not Proved

Patient 33 - Not Proved

Patient 40 - Proved

Patient 48 - Not Proved

Patient 79 - Proved

Patient 85 - Not Proved

Patient 86 - Not Proved

Patient 87- Proved

Patient 102 - Proved

Patient 112 - Proved

Patient 127- Not Proved

Patient131- Not Proved

Patient 136 - Proved

Patient 166 - Proved

Patient 172 - Proved

Patient 176 - Proved

Patient 186 - Not Proved

Patient 192 - Proved

Patient 198 - Not Proved

Patient 204 - Proved

Patient 209 - Not Proved

Patient 210 - Not Proved

Patient 211 - Proved

Patient 218 - Proved

Patient 224 - Proved

Patient 244 - Proved

Patient 257- Proved

Patient 268 - Not Proved

Patient 282- Proved

Patient 283 - Proved

Patient 285 - Not Proved

Patient 293 - Proved

Patient 296 - Not Proved

Patient 299 - Proved

56. The Committee considered Allegation 12, namely that the Registrant had "*failed to record adequately or at all general health and/ or medication [of some or all of the Patients in Schedule H]'*. The Committee were mindful of the College Guidance on Patient Records A20 and GOC Standard 7.1. The Committee accepted that there was a duty to record the general health and/ or medication being taken by the patient as it could impact upon ocular health.

57. The Committee then considered each patient in Schedule H individually, by reviewing the Record Card and ascertaining whether their general health and prescribed medication had been recorded.

58. The Findings of the Committee in relation to Allegation 12 were as follows:

Patient 13 - Proved

Patient 27- Not Proved

Patient 33 - Proved

Patient 40 - Not Proved

Patient 54 - Proved

Patient 79 - Proved

Patient 86 - Proved

Patient 87- Proved

Patient 102 - Proved

Patient 109 - Proved

Patient 127- Proved

Patient 131- Proved

Patient 138 - Proved

Patient 166 - Proved

Patient 192 - Proved

Patient 210 - Proved

Patient 257- Proved

Patient 272 - Proved

Patient 276 - Proved

Patient 285 - Proved

Patient 299 - Proved

Patient 303 - Proved

Patient 309 - Proved

59. The Committee considered Allegation 13, namely that in relation to some or all of the patients in Schedule I, the Registrant had, firstly, "*failed to record sufficiently or at all their visual acuity" and*, secondly*, had "failed to record why she* was *unable to obtain their visual acuity*". The alleged failure to analyse visual acuity was not pursued by the Council. The Committee were mindful of the GOC Standard 8.2.4 and the College Guidance on Patient Records at A20. The Committee concluded that there was a duty to record visual acuity or, where this could not be obtained, to record why it was not possible to obtain visual acuity.

60. The Committee then considered each patient in Schedule I individually, by reviewing the Record Card and ascertaining whether visual acuity had been recorded or, if not, why it had not been possible to record visual acuity.

61. The Findings of The Committee in relation to Allegation 13 were as follows:

Patient 13 - 13(a) Not Proved

13(b) Proved

Patient 27- 13(a) Not Proved

13(b) Not Proved

Patient 33 - 13(a) Not Proved

13(b) Proved

Patient 40 - 13(a) Not Proved

13(b) Proved

Patient 54 - 13(a) Not Proved

13(b) Proved

Patient 79 - 13(a) Not Proved

13(b) Proved

Patient 136 - 13(a) Not Proved

13(b) Not Proved

Patient 166 - 13(a) Not Proved

13(b) Proved

Patient 186 - 13(a) Not Proved

13(b) Not Proved

Patient 210 - 13(a) Not Proved

13(b) Not Proved

Patient 244 - 13(a) Proved

13(b) Proved

Patient 283 - 13(a) Proved

13(b) Proved

Patient 293 - 13(a) Not Proved

13(b) Proved

62. The Committee considered Allegation 14, namely that the Registrant "*failed to record sufficiently or at all the method of ocular alignment [in respect of some or all of the patients in Schedule J]*". The allegation relating to a failure to record the method of assessing ocular health was not pursued by the Council. The Committee was mindful of the College Guidance at A20 and accepted that there was a duty to record the method of ocular alignment.

63. The Committee then considered each patient in Schedule J individually by reviewing the record card and ascertaining whether the method of ocular alignment had been recorded. The Committee was cognisant they had to be satisfied there was evidence that, on the balance of probabilities, an eye examination had either been carried out or attempted to be carried out.

Patient 13 - Proved

Patient 27- Proved

Patient 33 - Proved

Patient 48 - Proved

Patient 53 - Proved

Patient 54 - Proved

Patient 79 - Not Proved

Patient 85 - Proved

Patient 86 - Proved

Patient102 - Proved

Patient 109 - Proved

Patient 112- Proved

Patient 127- Proved

Patient 131- Proved

Patient 136 - Proved

Patient 138 - Proved

Patient 166 - Proved

Patient 176 - Proved

Patient 186 - Proved

Patient 198 - Proved

Patient 202 - Proved

Patient 204 - Proved

Patient 210 - Proved

Patient 211- Proved

Patient 217- Proved

Patient 218 - Proved

Patient 219 - Proved

Patient 224 - Proved

Patient 244 - Proved

Patient 257- Proved

Patient 272 - Proved

Patient 276 - Proved

Patient 282- Proved

Patient 285 - Proved

Patient 296 - Proved

Patient 299 - Proved

Patient 309 - Proved

64. The Committee considered Allegation 15, namely that "*in respect of some or all of the patients in Schedule K [the Registrant had]* "*failed to record either sufficiently or at all whether refraction was carried out objectively or subjectively*." The Committee were mindful of the College Guidance at A20 and the College Guidance on examining patients with dementia or other acquired cognitive impairment at A110 and A111. The Committee were satisfied there was a duty to record whether the refraction was performed objectively or subjectively, having also noted Dr Shah's criticisms of a failure to so record in respect of cognitively impaired patients.

65. The Committee then considered each patient in Schedule K individually by reviewing the Record Card and ascertaining whether there was a record as to whether refraction had been carried out objectively or subjectively. The Committee were aware that they had to be satisfied, on the balance of probabilities that there was evidence of a refraction being carried out.

66. The findings of The Committee in relation to Allegation 15 were as follows:

Patient 85 - Proved

Patient 86 - Proved

Patient 102 - Proved

Patient 109 - Proved

Patient 131- Proved

Patient 138 - Proved

Patient 166 - Proved

Patient 172 - Proved

Patient 192 - Proved

Patient 202 - Proved

Patient 209 - Proved

Patient 210 - Not Proved

Patient 211- Proved

Patient 218 - Proved

Patient 224 - Proved

Patient 276 - Proved

Patient 293 - Proved

Patient 299 - Proved

Patient 303 - Proved

Patient 310 - Proved

67. The Committee considered Allegation 16, namely that "*in respect of some or all of the patients in Schedule L [the Registrant had] failed to record either sufficiently or at all family ocular health"*. The Committee were mindful of the College Guidance at A20 and accepted that family general health was relevant. However, the Committee were not persuaded by the evidence of Dr Shah and thought it unfair to criticise the Registrant when there was no available evidence as to whether enquiry was or was not made in relation to family history.

68. Accordingly, the Findings of the Committee in relation to Allegation 16 are as follows:

Patient 33 - Not Proved

Patient 53 - Not Proved

Patient 202 - Not Proved

Patient 209 - Not Proved

69. The Committee considered Allegation 17 namely that "*in respect of some or all of the patients in Schedule M [the Registrant had] inserted some or all of the clinical data from the previous sight examinations into the record fields of their subsequent examinations."*

70. The Committee carefully reviewed and scrutinised the Records of each patient in Schedule M individually to ascertain whether there was such similarity of clinical data so as to prove on the balance of probabilities, that previous clinical findings were inserted into a subsequent examination record.

71. The Findings of the Committee in relation to Allegation 17 were as follows:

Patient 27- Proved

Patient 33 - Proved

Patient 40 - Proved

Patient 48 - Proved

Patient 53 - Proved

Patient 54 - Proved

Patient 85 - Proved

Patient 86 - Proved

Patient 87- Proved

Patient 166 - Proved

Patient172 - Proved

Patient 210 - Not Proved

Patient 217- Proved

Patient 219 - Proved

Patient 244 - Proved

Patient 293 - Proved

On the balance of probabilities, the Committee considered that the duplicate information in the records of Patient 210 was so specific to the original examination that the inclusion in the later record must have been due to some human or technical error.

72. The Committee then addressed Allegation 18 and whether the Registrant's actions in respect of Allegation 17 found proved by the Committee were misleading and/or dishonest as alleged. The Committee considered whether their Findings in respect of Allegation 17 should be interpreted as being inevitably misleading and, therefore, improper.

73. The Committee carefully considered the case of Ivey v Genting Casinos and the need to determine on the balance of probabilities the Registrant's genuine belief as to the facts. The Committee took the view that there was a difference between lazy and poor practice as identified in respect of Allegation 17 and an intent to mislead and/or deceive.

74. The Committee took the view that a failure to record fresh clinical information following an eye examination as opposed to adopting or incorporating previous clinical records and so failing to provide accurate information may not be knowingly misleading. If the Registrant was exhibiting a lazy approach to the process, it may be poor practice but not dishonest.

75. The Committee was not persuaded that the Registrant had dishonest intent in her mind or that she appreciated that she may have failed to provide an accurate record by adopting or incorporating earlier records.

76. The Committee carefully reviewed the records of Patients 27, 33, 40, 48, 53, 54, 85, 86, 87, 166, 172, 217, 219, 244, and 293 and formed the view that dishonesty had not been proved.

77. Accordingly, the Committee did not find Allegation 18 proved.

78. The factual findings of the Committee may be summarised as follows:

1(a) Proved

1(b) Proved

2. Proved

3. Proved

4. Proved

5(a) Proved in respect of Patients 33, 85, 86, 109, 112, 127, 138, 166, 176, 192, 202, 217, 218,224, 244, 272, 283, 296, 299, 303, 309, 310 and 323

5(b) Proved in respect of Patients 33, 85, 86, 112, 127, 138, 217, 218, 272, 283 293, 299, 309, 310 and 323

5(d) Proved in respect of Patients 109, 172, 202, 218, 224, 244 and 283

6. Proved for all cases in Schedule B except 299

7. Not proved

8. Proved in the respect of Patients 79, 102 and 186

9. Not Proved

10. Proved in all cases in Schedule F except 186 and 209

11. Proved in respect of Patients 40, 79, 87, 102, 136, 166, 172, 176, 192, 204, 211, 218, 224, 244, 257, 282, 283, 293 and 299

12. Proved in all cases in Schedule H except 27 and 40

13(a) Proved for Patients 244 and 283

13(b) Proved for Patients 13, 33, 40, 54, 79, 166, 244, 283 and 293

14. Proved in all cases in Schedule J except 79

15. Proved in all cases in Schedule K except 210

16. Not Proved

17. Proved in all cases in Schedule M except 210

18. Not Proved

Findings regarding Impairment

The Establishment of Grounds for Impairment

79. Having made factual findings, the Committee proceeded to consider whether the grounds for Impairment had been established.

80. The Registrant did not attend the Hearing in person but submitted further written material to which the Committee gave consideration.

81. Mr Corrie relied upon the written representations in his Skeleton Argument. He drew the Committee's attention to Section 13(d)(2)(a) of The Opticians Act 1989.

82. The Committee received and accepted advice from the Legal Adviser as to the meaning of Misconduct and Deficient Professional Performance.

83. The Committee understood that there is no strict definition of Misconduct but were assisted by the guidance set out in the cases of;

- Roylance v General Medical Council (No 2) 2000 1 A.C.311
- R v(Calheim) v General Medical Council 2007 EWHC 2606
- Remedy UK Ltd v General Medical Council 2010 EWHC 1245 (Admin)

- Schodlock v General Medical Council 2015 EWCA Civ 769
- General Dental Council v Rimmer 2011 EWHC 3438

84. The Committee were further assisted by the guidance relating to Deficient Professional Performance set out in the cases of;

    - Calheim v General Medical Council (referred to in Paragraph 83)
    - Bolton v General Medical Council 2006 EWHC 2960

85. The Committee noted that Professional Performance should be that which is expected of a competent practitioner in such circumstances. Deficient Professional Performance is of an unacceptably low standard demonstrated by reference to a fair sample of work.

86. The Committee had regard to the Council's Standards of Practice for Optometrists and Dispensing Opticians effective from April 2016 with particular reference to

    - Standard 8.1 and 8.2 relating to the maintenance of adequate patient records,
    - Standard 16.1 relating to honesty and integrity and
    - Standard 17.1 relating to the reputation of and public confidence in the profession.

87. The Committee considered Allegations 1- 4 and took the view that the conduct constituted a breach of trust which was so serious that it did amount to Misconduct. The Committee found that a significant number of Sight Tests had been carried out over a five month period, despite the Registrant being informed by email and telephone that she should not be carrying out Sight Tests, which were acknowledged by the Registrant.

88. The Committee found that the Registrant had been dishonest with the Regulator by lying as to the number of tests undertaken in an attempt to downplay or minimise the extent of her conduct, which it felt constituted a serious breach of professional duty.

89. The Committee were in no doubt that trust and honesty are at the heart of a health care professional's relationship with the public who must have a reasonable expectation that such professionals will act with honesty and integrity.

90. The Committee then considered Allegations 5 -18 and bore in mind that Allegations 7, 9, 16 and 18 had not been found proved. Due to the number of duties breached for the number of individual patients in the sample, the Committee considered that the standard of record keeping was far below the required standard. It considered that this was indicative of a serious breach of duty by the Registrant towards vulnerable patients in a Domiciliary setting. The Committee bore in mind that one of the purposes of the record is to assist professional colleagues who may subsequently attend the patient. The failure to record details relating to Consent and justification for issuing GOS3 vouchers was of particular concern. The Committee was particularly assisted by the words of Mitting J. in the case of General Dental Council v Rimmer relating to "similar errors" affecting patients in relation to

procedures such as in this instance record keeping. The Committee took the view that these matters were so serious as to amount to Misconduct.

91. Accordingly, the Committee find that the grounds for Impairment have been established on the basis of Misconduct by the Registrant.

The Decision on Impairment

92. Having found one of the grounds for Impairment had been established, namely misconduct, the Committee proceeded to consider whether, by virtue of the misconduct, the fitness to practise of the Registrant was currently impaired as of the date of the hearing.

93. The Committee were greatly assisted by the Council's document Hearings and Indicative Sanction Guidance issued in November 2021 with particular reference to Paragraphs 16.1-16.7 relating to impairment.

94. The Registrant did not attend the hearing in person or give oral evidence. The Committee had sight of a short written submission from the Registrant on which she could not be cross examined. It contained very limited insight into matters of record keeping but no evidence of remediation of this. There was no acknowledgement of the dishonest conduct. The Registrant provided some information about courses she claims she has taken. However, the Committee noted that this was not specific to record keeping, honesty, integrity, or probity. Accordingly, the Committee had no assurance or evidence of the development of any insight relating to the dishonesty by the Registrant.

95. Mr. Corrie relied upon the written representations set out in his closing submission. He invited the Committee to consider that the appropriate approach might be that which was formulated by Dame Janet Smith in the report to the 5th Shipman Enquiry.

Do our findings of fact in respect of the doctor's 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 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 the 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

Mr Corrie submitted that all four limbs were engaged.

96. Mr. Corrie also brought to the attention of the Committee a case heard against the Registrant by a Fitness to Practise Committee of the Council in October 2022. That Committee found proved an allegation considered not to amount to dishonesty, however it did consider the conduct to be misleading and "sharp practice". That Committee was of the opinion that this "fell seriously below [that which] was acceptable". The Committee also noted that the Committee considering the matters of October 2022 found an isolated instance of poor record keeping proved. That Committee made a finding of misconduct, however considered that the behaviour did not meet the threshold for making a finding of current impairment both in relation to public protection and public interest. Mr. Corrie advised that the Registrant received a Warning.

97. The Committee received advice from the Legal Adviser upon the case law referred to by Mr. Corrie in his submissions and also that the Committee were entitled to take into account the fitness to practise history when considering current impairment.

98. The Committee were assisted by the guidance set out in the cases of;

- CHRE v(1) NMC and (2) Grant (2011) EWHC 927 (Admin)
- Cohen v General Medical Council (2009) EWHC 581 (Admin)
- Cheatle v General Medical Council (2009) EWHC 645 (Admin)
- Professional Standards Authority v HCPC & Ageneye (2006) EWHC (Admin)
- Yeong v General Medical Council (2009) EWHC 1923 (Admin)

99. The Committee were aware that their overall approach should not be to punish the Registrant for past misdoings but to protect the public from the acts and/ or omissions of those who were not fit to practise. The Committee looked forward and not backwards, and considered the way the Registrant has acted or failed to act in the past.

100. The Committee were cognisant of the fact that it was highly relevant as to whether the conduct was easily remediable, had been remedied or was highly unlikely to be repeated. The Committee was of the view that the issue of record keeping could have been but had not been remedied and that the dishonesty, which is not easily remediable, was at risk of repetition by the Registrant.

101. The Committee were aware of the need to uphold professional standards and public confidence in the profession. The Committee carefully considered whether that would be undermined if a finding of no impairment was made in the circumstances of this case.

102. The Committee took the view that the actions of the Registrant in working when her Continuing Education and Training was not up to date, despite being told not to do so, being dishonest in response to her Regulator, and the findings in respect of

record keeping practise which placed patients at unwarranted risk of harm, did bring the profession into disrepute and breaches a fundamental tenet of the profession. The lack of insight by the Registrant into matters of dishonesty and the importance of engaging appropriately and transparently with her regulator were matters of significant concern to the Committee. Her failure to keep up to date with CET requirements, combined with a deliberate failure to follow a clear direction given not to undertake regulated activities, and her providing dishonest and inaccurate information were of particular concern to the Committee.

103. Accordingly, the Committee found that fitness to practise is currently Impaired both in relation to public protection and public interest.

Sanction

104. Having found current impairment, the Committee proceeded to consider the sanction appropriate and proportionate to the case.

105. The Committee were greatly assisted by the Council's Hearings and Indicative Sanctions Guidance revised in November 2021 with particular reference to Paragraphs 21 and 22.4.

106. The Committee recognised that the purpose of sanctions was not punishment although it may be punitive in effect.

107. The Registrant did not attend to give oral evidence but did provide written submissions setting out her personal circumstances and indicating her willingness to receive mentoring. to which the Committee gave careful consideration.

108. Mr. Corrie relied upon the written representations set out in his closing submission. He set out the aggravating factors as follows;

(1) The fact that the dishonesty was in the context of communicating with the Council in relation to seeking to underplay the number of eye tests carried out during a period when the Registrant had been instructed not to carry out the tests owing to a CET shortfall
(2) The Registrant's fitness to practise history
(3) The scale of record keeping failures
(4) Lack of insight

109. Mr. Corrie also set out the potentially mitigating factors as follows:

(1) Personal matters referred to in representations
(2) Single incident (of dishonesty)
(3) Dishonesty low on spectrum

110. Mr. Corrie submitted that a 12 month period of suspension with a review by a Fitness to Practise Committee shortly before the end of the period of suspension was the appropriate and proportionate sanction in this case.

111. Mr. Corrie did bring to the attention of the Committee the case of Kamberova v NMC 2016 EWHC 2955 (Admin) which confirms that time spent under an interim order of suspension can be taken into account at the sanction stage.

112. The Committee received and accepted advice from the Legal Adviser upon the case law referred to by Mr. Corrie and the need to consider sanctions set out at Section13(F) of The Opticians Act in ascending order of seriousness. The Committee were advised that the minimum order must be imposed which safeguards members of the public, and the public interest.

113. The Committee were greatly assisted by the guidance set out in the following cases;

- Bolton v Law Society (1994) 1 WLR 512 at Para 519
- PSA v NMC(2015) EWHC 1887 (Admin)
- PSA v GDC Ikhlaq Hussain (2019) EWHC 2640 (Admin)
- Theodoroplous v GMC (2017) EWHC 1984 (Admin) (35)
- Naheed v GMC (2011) EWHC 702 (Admin) (22)
- Nicholas Pillai v GMC (2009) EWHC 1048 (Admin) (27)
- Yeong v GMC (2009) EWHC 1923 (50)
- GMC v Patel (2018) EWHC 171 (Admin) at 64
- GMC v Stone (2017) EWHC 2534 (Admin) at 34
- R on the application of Hassan v GOC (2013) EWHC 1887 (Admin)
- Siddiqui vGMC (2013) EWHC 1883
- Watters v NMC (2017) EWHC (Admin) 1888
- Lasinga v NMC (2017) EWHC (Admin) 1458
- Kamberina v NMC (2016) EWHC 2955 (Admin)

114. The Committee first considered the aggravating and mitigating factors.

115. The Committee took the view that the matter of dishonesty with one's Regulator was extremely serious and was not low on the spectrum of dishonesty.

116. The Committee noted the Registrant's fitness to practise history, and although there was no previous finding of dishonesty, there had been a previous finding of misleading behaviour within a professional context and the Committee were concerned that there were issues relating to the Registrants transparency and openness. To that extent, the Committee did not feel this could properly be described as a single incident.

117. The Committee acknowledged the scale of record keeping failures was an aggravating factor in the case currently before the Committee.

118. The continuing lack of insight was a matter of grave concern to the Committee, who noted that the written representation of the Registrant made no reference at all to dishonesty or the seriousness of the misconduct found.

119. It was brought to the attention of the Committee by Mr. Corrie that the Registrant had been the subject of an order of Interim Suspension since October 2020. The Committee regarded this as a further aggravating factor as the Registrant had no apparent insight upon the central issue of dishonesty despite having been suspended for a period of two years and three months.

120. The Committee did regard as mitigating circumstances the personal matters referred to in the Registrant's written representations, her clearly expressed desire

to be a good optometrist and an emerging insight into the importance of proper record keeping.

121. The Committee understood that there was a balancing act to perform, weighing the interests of the public against the interests of the Registrant, although greater weight had to be given to public confidence in the profession than the consequence to an individual.

122. The Committee understood that the seriousness of a case of dishonesty must be marked in a case which has undermined public trust, but at the same time, that the minimum order should be imposed which protects the public.

123. The Committee considered the available sanctions in ascending order. It decided that given the seriousness of the misconduct to make no order would not be sufficient to protect the public, maintain public confidence in the profession or to declare and uphold proper standards. A sanction was required in this case.

124. The Committee then considered whether the imposition of conditions which were appropriate, proportionate, workable and measurable could be devised which would protect the safety of the public as well as to mark the public interest. The Committee were not satisfied that this could be achieved, particularly in the light of their concerns as to the significant lack of insight into the issue of dishonesty.

125. The Committee then considered whether the public and the public interest could be adequately protected by a period of suspension with a review, or whether the Registrant's conduct was fundamentally incompatible with being a registered professional.

126. The Committee gave very careful consideration to the seriousness of the Registrant's misconduct, and her continuing lack of insight.

127. The Committee understood that the Registrant had not been represented in the Fitness to Practice proceedings and took this into account. It took the view after very careful consideration that erasure was not the only sanction which would be sufficient to protect patients and the public interest.

128. Accordingly, the Committee directs that a period of suspension should be imposed with a review before the end of the period of suspension.

129. The Committee took the view that the maximum period of suspension, namely 12 months was necessary to allow the Registrant time to develop insight and to undertake CPD training to ensure that she maintains her practical skill set. Such courses should include those relating to the subjects of honesty, integrity, probity and record keeping.

130. The period of 12 months suspension was required to mark the seriousness of the misconduct, and to declare and uphold the standards of the profession and maintain public confidence in the profession.

131. The Committee at the review hearing may be assisted by the Registrant supplying it with;

(1) Evidence of training undertaken to show development of honesty, integrity, probity, recognition of the importance of the role of the regulator and proper record keeping. Evidence of certificates of courses undertaken and detailed written personal reflections on the insight gained and how the Registrant will use this to improve her standard of practice.

(2) Testimonials from friends and colleagues who are aware of the circumstances.

(3) Written reflections on the misconduct, on how that has impacted on the reputation of the profession in the eyes of members of the public and of fellow professionals, as well as reflections on the importance of maintaining the standards of the profession.

(4) Evidence of practical experience to keep up to date with optometric environment, this could be for example; volunteering or undertaking a non-clinical role that gives the opportunity to observe the practice of other optometry professionals.

134. Accordingly, the Committee directs that an order of suspension for 12 months be made with a review before the end of the period.

Immediate Order

135. The Committee had been made aware that an Interim Order of Suspension had been in place since October 2020. The Committee were advised that Rule 46(19) of The General Optical Council (Fitness to Practise) Rules Order of Council 2013 provides that the Committee must revoke any interim order having made a substantive decision in accordance with section 13L(11) of the Opticians Act 1989, namely an order of suspension for 12 months with a review.

136. The Committee revoked the Interim Order which had been in place since October 2020.

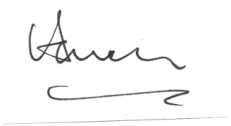
137. Mr. Corrie invited the Committee to make an immediate order as the substantive order would not take effect until 28 days after service of the decision. Mr. Corrie submitted that the shortfalls in the Registrant's practice which the Committee had identified and the risk of harm to patients were such that it was necessary for the protection of members of the public, or otherwise in the public interest, for an immediate order to be made.

138. The Committee received and accepted advice from the Legal Adviser to the effect that Section 13L of the Opticians Act gave it the power to make an immediate order following an order for suspension which would only take effect 28 days after service of the notice, provided that the Committee were satisfied that it was necessary, rather than desirable, for the protection of members of the public, otherwise in the public interest, or in the best interests of the Registrant.

139. The Committee were so satisfied that an immediate order was necessary and made an Immediate Order of suspension on all three grounds.

140. The Committee wished to make clear that Mr. James Kellock, who had chaired the first 9 days of the Hearing had withdrawn from the Hearing for personal reasons not connected with the Hearing. The Committee received legal advice to the effect that it remained quorate with four members with a new Chair being elected by the remaining members, and the Registrant consented to the continuation of the Hearing with two professional members and two lay members, one of whom Mr. Ian Hanson being elected to the Chair.

Chair of the Committee: Ian Hanson

Signature …  … **Date: 27 February 2023**

Registrant: Nirmal Koasha

Signature … Not Present … **Date: 27 February 2023**

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.

APPENDIX A

Schedules (as amended)

Schedule A

Patient 33, ~~Patient 40~~, Patient 85, Patient 86, Patient 87, ~~Patient 102~~, Patient 109, Patient 112, Patient 127, Patient 138, Patient 166, Patient 172, Patient 176, Patient 192, Patient 202, Patient 217, Patient 218, Patient 224, Patient 244, Patient 272, Patient 283, Patient 293, Patient 296, Patient 299, Patient 303, Patient 309, Patient 310, Patient 323

Schedule B

Patient 53, Patient 54, Patient 85, Patient 217, Patient 218, Patient 219, Patient 293, Patient 296, Patient 299, Patient 303, Patient 309, Patient 310, Patient 323

Schedule C

Patient 210, Patient 268

Schedule D

Patient 13, Patient 27, Patient 33, Patient 40, Patient 48, Patient 53, ~~Patient 54~~ Patient 79, ~~Patient 85~~ Patient 86, Patient 87, Patient 102, Patient 109, Patient 112, Patient 127, Patient 131, ~~Patient 135~~ Patient 136 Patient 138,, Patient 166, Patient 172, Patient 176, Patient 186, Patient 192, Patient 198, Patient 204, Patient 209, Patient 210, Patient 211, Patient 217, Patient 218, Patient 219, Patient 224, Patient 244, Patient 257, Patient 268, Patient 272, Patient 276, Patient 282, Patient 283, Patient 285, Patient 293, Patient 296, Patient 299, Patient 303, Patient 309, Patient 310, ~~Patient 323~~

Schedule E

Patient 48, Patient 53, Patient 54, Patient 102, Patient 136, Patient 176, Patient 186, Patient 198, Patient 202, Patient 204, Patient 209, Patient 218, Patient 224, Patient 244, Patient 257, Patient 268, Patient 276, Patient 282, Patient 285, Patient 293, Patient 296, Patient 303, Patient 310

Schedule F

~~Patient 13 Patient 27 Patient 33 Patient 40 Patient 48 Patient 53 Patient 54 Patient 79 Patient 85 Patient 86 Patient 87 Patient 102 Patient 112 Patient 127 Patient 131 Patient 135 Patient 136 Patient 166 Patient 172 Patient 176 Patient 186 Patient 198~~ Patient 202, Patient 204, Patient 209, ~~Patient 210 Patient 211 Patient 217 Patient 218 Patient 219~~ Patient 224 ~~Patient 244 Patient 257 Patient 282 Patient 283 Patient 285~~ Patient 293, Patient 296 ~~Patient 299~~ Patient 303, Patient 309, Patient 310

Schedule G

Patient 13, Patient 27, Patient 33, Patient 40, Patient 48, Patient 79, Patient 85, Patient 86, Patient 87, Patient 102, ~~Patient 109~~ Patient 112, Patient 127, Patient 131 Patient, ~~135~~ Patient 136 ~~Patient 138~~ Patient 166, Patient 172, Patient 176, Patient 186, Patient 192, Patient 198, ~~Patient 202~~ Patient 204, Patient 209, Patient 210, Patient 211, Patient 218, Patient 224, Patient 244, Patient 257, Patient 268, ~~Patient 272, Patient 276~~, Patient 282, Patient 283, Patient 285, Patient 293, Patient 296, Patient 299

Schedule H

Patient 13, Patient 27, Patient 33, Patient 40, Patient 54, Patient 79, Patient 86, Patient 87, Patient 102, Patient 109, Patient 127, Patient 131, Patient 138, Patient 166, Patient 192, ~~Patient 209~~ Patient 210, Patient 257, Patient 272, Patient 276, Patient 285, Patient 299, Patient 303, Patient 309

Schedule I

Patient 13, Patient 27, Patient 33, Patient 40, Patient 54, Patient 79, Patient 136, Patient 166, Patient 186, Patient 210, Patient 244, Patient 283, Patient 293

Schedule J

Patient 13, Patient 27, Patient 33 ~~Patient 40~~ Patient 48, Patient 53 Patient 54 Patient 79, Patient 85, Patient 86, Patient 102, Patient 109, Patient 112, Patient 127, Patient 131, ~~Patient 135~~ Patient 136, Patient 138, Patient 166 Patient 176, Patient 186, Patient 198, Patient 202, Patient 204, Patient 210, Patient 211, Patient 217, Patient 218, Patient 219, Patient 224, Patient 244, Patient 257, Patient 272, Patient 276, Patient 282, Patient 285, Patient 296, Patient 299 Patient 309

Schedule K

Patient 85, Patient 86, Patient 102, Patient 109, Patient 131, Patient 138, Patient 166, Patient 172, Patient 192, Patient 202, Patient 209, Patient 210, Patient 211, Patient 218, Patient 224, Patient 276, Patient 293, Patient 299, Patient 303, Patient 310

Schedule L

Patient 33, Patient 53, ~~Patient 54~~, Patient 202, Patient 209

Schedule M

Patient 27, Patient 33, Patient 40, Patient 48, Patient 53, Patient 54, Patient 85, Patient 86, Patient 87, Patient 166, Patient 172, Patient 210, Patient 217, Patient 219, Patient 244, Patient 293