BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(22)02

AND

ZAHRA MOGRA (01-28804)

DETERMINATION OF A SUBSTANTIVE HEARING
14 – 15 NOVEMBER 2022

Committee Members:	Hermione McEwen (Chair/Lay) Alice Robertson Rickard (Lay) Asmita Naik (Lay) Agnes Ali (Optometrist) Caroline Clark (Optometrist)
Clinical adviser:	None
Legal adviser:	Richard Price KC
GOC Presenting Officer:	Matthew Corrie
Registrant present:	Zahra Mogra
Registrant representative:	Rebecca Chalkley Katie Holland (AOP)
Hearings Officer:	Nazia Khanom
Facts found proved:	All by admission
Facts not found proved:	Not applicable
Misconduct:	Found
Impairment:	Not impaired

The Registrant appeared before the Fitness to Practise Committee to answer the following

Allegation:

1) *On or around 20 August 2019, you failed to conduct an appropriate examination of Patient 1's eyes in that you:*

   a. *Failed to detect signs of wet Age-related Macular Degeneration (AMD) during the patient's pre-operative visit;*
   b. *Failed to urgently refer Patient 1 for further investigation; and/or*
   c. *Failed to advise Patient 1 of the unpredictable outcome for their vision after surgery;*

2) *On or around 19 November 2019, you failed to conduct an appropriate examination of Patient 1's eyes in that you:*
   a. *Failed to record a visual acuity measurement;*
   b. *Failed to conduct and/or request an OCT scan;*
   c. *Failed to detect signs of wet AMD during the patient's post-operative visit; and/or*
   d. *Failed to urgently refer Patient 1 for further investigation;*

3) *On or around 8 October 2019, you failed to conduct an appropriate assessment of Patient 2's eyes in that you:*
   a. *Failed to detect signs of wet AMD during the patient's pre-operative visit;*
   b. *Failed to urgently refer Patient 2 for further investigation; and/or*
   c. *Failed to advise Patient 2 of the unpredictable outcome for their vision after surgery;*

1. This is a substantive hearing before the Fitness to Practise Committee (the "Committee") in respect of Ms Zahra Mogra (the "Registrant"), a registered Optometrist with the General Optical Council (the "Council") since 6 August 2015.

2. The Council alleged that the Registrant's fitness to practise is impaired by reason of misconduct.

3. This matter is governed by the Opticians Act 1989 (the "Act") and the General Optical Council (Fitness to Practise) Rules Order of Council (the "Rules").

4. The Council was represented by Matthew Corrie, of Counsel, and the Registrant attended the hearing, and was represented by Rebecca Chalkley of Counsel and Katie Holland of the Association of Optometrists (AOP).

Preliminary Matters

Application to amend the Allegation by withdrawal

5. At the outset of the hearing, Mr Corrie for the Council made an application under Rule 46 (20) of the Rules to withdraw allegations 1c, 2a and b, and 3c, on the

basis that these are not supported by the evidence of Professor Harper, the expert witness, and that the withdrawals could be made without prejudice to either party or detriment to the public interest. Ms Chalkley for the Registrant supported the application.

6. Rule 46 (20) provides that:

"Where it appears to the Fitness to Practise Committee at any time during the hearing, either upon the application of a party or of its own volition, that:

(a) the particulars of the allegation or the grounds upon which it is based and which have been notified under rule 28, should be amended; and

(b) the amendment can be made without injustice, it may after hearing the parties and consulting with the legal adviser amend the particulars or those grounds inappropriate terms".

7. The Legal Adviser advised the Committee that this application appeared to be justified for the reasons set out by the Council, and that the amendment could be made without injustice to the parties. The Committee accepted this advice.

8. Accordingly, the Committee directed that the application should be granted, and the relevant particulars of the allegation should be withdrawn.

Amended Allegation:

1) On or around 20 August 2019, you failed to conduct an appropriate examination of Patient 1's eyes in that you:
   a. Failed to detect signs of wet Age-related Macular Degeneration (AMD) during the patient's pre-operative visit;
   b. Failed to urgently refer Patient 1 for further investigation; and/or

2) On or around 19 November 2019, you failed to conduct an appropriate examination of Patient 1's eyes in that you:
   a. Failed to detect signs of wet AMD during the patient's post-operative visit; and/or
   b. Failed to urgently refer Patient 1 for further investigation;

3) On or around 8 October 2019, you failed to conduct an appropriate assessment of Patient 2's eyes in that you:
   a. Failed to detect signs of wet AMD during the patient's pre-operative visit;
   b. Failed to urgently refer Patient 2 for further investigation.

Application for parts of the hearing to be in private

9. Ms Chalkley for the Registrant informed the Committee that some of the evidence to be produced on behalf of the Registrant related to redacted matters, and applied for a direction that that evidence should be heard by the Committee in private, under Rule 25 (3). This application was made jointly by both Counsel.

10. The Legal Adviser advised the Committee that evidence relating to redacted matters was normally dealt with in private, was provided for by the Rules and that this application was properly made. The Committee accepted this advice.

11. The Committee granted the application and directed that evidence relating to redacted matters should be dealt with in private session.

Stage 1 – Facts

Admissions

12. The Registrant submitted a bundle of evidence which included a witness statement in which she admitted each of the allegations, and confirmed this at the outset of the hearing. The Chair of the Committee announced that the facts set out in the allegations had been found proved by admission, pursuant to Rule 46 (6).

13. The Council relied on the following evidence:

    i. The witness statement of Witness A, redacted at SpaMedica dated 12 November 2021;
    ii. The witness statement of Witness B, redacted at SpaMedica dated 15 November 2021;
    iii. The witness statement of Witness C, redacted at SpaMedica and the Registrant's manager at the material time, dated 24 November 2021;
    iv. The expert report of Professor Robert Harper dated 20 February 2022;
    v. The addendum report of Professor Robert Harper dated 10 November 2022.

14. The evidence of these witnesses, including the expert witness, was agreed by the Registrant, and so the Committee took their evidence as read.

Background

15. The Registrant was employed as a hospital Optometrist by SpaMedica between 18 February to 23 December 2019.

16. Witness C gave evidence that SpaMedica optometrists were involved in the management of patients in respect of both pre- and post- operative cataract surgery, as well as YAG capsulotomies.

17. The Registrant had been carrying out pre- and post-operative assessments in respect of cataract surgery and YAG capsulotomies since commencing her role in February 2019.

18. This case concerned alleged failures to diagnose (and the associated failure to refer in respect of) wet age-related macular degeneration (also known as neovascular age-related macular degeneration) ("nAMD") in respect of two patients. It is a sight threatening condition with a time critical referral requirement.

Patient 1

19. Patient 1 was a 91 year old male who was due to undergo cataract surgery and was assessed by the Registrant pre-operatively and post-operatively on 20 August and 19 November 2019 respectively.

20. Patient 1 had been referred for cataract surgery in the left eye. The patient had reported difficulty reading and had reduced visual acuity in both eyes. There was a cataract in the right eye but there had been no referral in respect of this. The Registrant requested an OCT scan of the left eye and upon review of the image recorded "*L ERM and Drusen, visual guarded prognosis given*" (Drusen are yellow deposits under the retina, ERM is epiretinal membrane).

21. Patient 1 went on to have the cataract surgery on 23 October 2019. Patient 1 attended a post- operative assessment conducted by the Registrant on 19 November 2019.

22. The Registrant's notes recorded that the patient was struggling with both eyes, that on examination there was an epithelial corneal oedema in the left eye, a prescription was made and the patient was listed for review in 4 weeks.

23. Witness B described in her evidence that she was providing remote support to the Registrant, who emailed her in respect of a prescription for epithelial corneal oedema. Witness B stated in her evidence that the vision was very poor and they emailed the Registrant to ask if the oedema was just epithelial and that whilst waiting for a reply she checked the OCT scan which had been taken on 20 August 2019. The OCT image appears within the bundle and showed, according to Witness B, very obvious nAMD.

24. Professor Harper stated in his report at 5.4.4:

"In my view, there was a reasonable expectation that Patient 1's retinal abnormality should have been flagged pre-operatively on OCT imaging in the first instance, but also, when a subsequent opportunity arose, post-operatively. The case should have been escalated for more expert decision making, and it falls far below the standard

expected of an optometrist working in this setting that this retinal pathology was not adequately identified nor flagged pre-operatively. Post-operatively, the problem did become flagged, because Patient 1's failure to secure an adequate improvement in vision resulted in the matter being escalated, albeit not because the Registrant recognised the cause as nAMD. The more serious failing in terms of patient care was that which arose pre-operatively, with no concerns apparently being flagged. Post-operatively, while in my view it also falls far below the standard expected of a reasonably competent optometrist working in cataract clinics to have failed to recognise suspect nAMD, the matter was at least escalated when the Registrant queried her proposed management plan for what she considered to be Patient 1's problem with Witness B. The Registrant then acted to refer for Patient 1's nAMD."

25. The Council's case in relation to allegations 1 a and b is that on 20 August 2019 the Registrant failed to detect signs of nAMD in Patient 1's left eye and failed to make a referral as required.

26. In respect of allegation 2 the Council's case is that the Registrant failed to detect signs of nAMD in Patient 1's left eye at the post operative assessment on 19 November 2019. Although the condition was, in fact, identified and a referral made this was only because of Witness B's intervention, in by chance, reviewing the OCT scan having been asked by the Registrant to consider her management plan in relation to the corneal oedema.

Patient 2

27. Patient 2 was a 75 year old male who had been referred to SpaMedica for a possible YAG capsulotomy following cataract surgery to his right eye around 18 months before.

28. On 8 October 2019 the Registrant carried out a YAG capsulotomy assessment in respect of Patient 2. The notes of this assessment recorded:

    i. Patient 2 reported difficulty reading and watching T.V.;
    ii. In relation to the right eye reduced visual acuity, dry AMD and posterior opacification;
    iii. The OCT scan was described as showing "*R Drusen, dry AMD L Normal macular profile, guarded visual prognosis given."*

29. Witness A gave evidence that on 21 November 2019 Patient 2 arrived at her clinic for YAG treatment. Witness A states that they reviewed the OCT scan taken by the Registrant on 8 October 2019 and found that Patient 2 had right eye subretinal fluid and so suspected nAMD. Witness A carried out a further OCT scan on 21 November 2019 which confirmed the presence of subretinal fluid and so recommended a referral to a rapid access macular clinic.

30. Professor Harper sets out in his report:

"5.8.1 The Registrant was assessing the Patient 2 because of the possible need for YAG laser capsulotomy, with the patient having been referred by Boots Opticians in redacted into the Spa Medica clinic following sight testing in August 2019.

5.8.2 Patient 2 was assessed by the Registrant on 8th October 2019 with a view to their suitability to undergo YAG laser capsulotomy to the right eye. Patient 2 was complaining about difficulty with reading and watching TV, having had right eye cataract surgery approximately 18 months earlier.

5.8.3 The Registrant has examined Patient 2 and identified right eye reduced visual acuity and what they believe to be 'dry AMD' as well as posterior capsular opacification. The OCT scan undertaken on 8th October 2019 were described by the Registrant as showing "R drusen, dry AMD"; however, the right OCT scan looks suspicious of nAMD (giving rise to the likelihood that Patient 2 had a dual cause of vision loss, that is, their posterior capsular opacification as well as nAMD). The nAMD is the more urgent condition here to have flagged and escalated.

5.8.4 I would not expect an optometrist working outside of specialist macular clinics to make an actual diagnosis of nAMD; however, it would be reasonable to have expected the Registrant to have suspected nAMD versus dry AMD and managed Patient 2 accordingly, i.e. sought an opinion/escalated to a colleague and/or made an urgent referral for medical retinal opinion.

5.8.5 Notwithstanding the mitigation discussed in 5.11 below, in my view, it falls far below the standard expected of a reasonably competent optometrist working in cataract services clinics to have failed to identify Patient 2's suspicious right macula appearance from the OCT scan taken on 8th October 2019."

31. In relation to allegations 3 a and b it is, therefore, the Council's case that the Registrant failed to detect the signs of nAMD and failed to make a referral in respect of Patient 2.

32. The Committee accepts that the background summary set out above accurately reflects the facts underlying allegations 1, 2 and 3, which have been admitted by the Registrant and found proved by admission.

Stages 2 and 3 – Misconduct and Impairment of Fitness to Practise

Misconduct

33. Ms Chalkley on behalf of the Council invited the Committee to find misconduct and impairment in accordance with section 13D(2)(a) of the Act, which provides:

    "A person's fitness to practice is to be regarded as impaired for the purposes of this Order by reason of:

    a. *Misconduct"*

34. The Committee accepted the advice of the Legal Adviser that the following principles set out by Mr Corrie for the Council in the skeleton argument are relevant to considering misconduct.

35. There is no strict definition of misconduct. However, Lord Clyde in *Roylance v General Medical Council (No.2)* [2000] 1 A.C. 311 at para [35] stated:

    "Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed.....in the particular circumstances."

36. In *R (Calhaem) v General Medical Council* [2007] EWHC 2606 (Admin) at para [26] Mr Justice Jackson stated:

    "*The word 'misconduct' in [the Medical Act 1983] section 35C (2) (a) does not connote any breach of the duty owed by a doctor to his patient: it connotes a serious breach which indicates that the doctor's fitness to practise is impaired*."

37. Mr Corrie also referred to *Remedy UK Ltd v General Medical Council* [2010] EWHC 1245 (Admin) in which the Court reviewed a number of authorities in relation to misconduct and derived a number of principles.

38. Ms Chalkley informed the Committee that the Registrant accepted that her admitted failings as set out in the allegations amounted to misconduct.

39. The Committee accepted the advice of the Legal Adviser that the authorities emphasised that misconduct must amount to serious professional misconduct, or conduct that fell far below the standard of a reasonably competent optometrist.

40. In determining misconduct, the Committee had regard to the Council's Standards of Practice for Optometrists and Dispensing Opticians, effective from April 2016.

The Committee considered that the Registrant had departed from the following standards by virtue of her conduct:

5. Keep your knowledge and skills up to date (sub-paragraphs 5.1, 5.2, 5.3 and 5.4)

6. *Recognise, and work within, your limits of competence (sub-paragraphs 6.1 and 6.2)*

7. *Conduct appropriate assessments, examinations, treatments and referrals (sub-paragraphs 7.1, 7.2, 7.7)*

…

17. *Do not damage the reputation of your profession through your conduct*

41. Further, the Committee noted the expert opinion of Professor Harper, who concluded that he considered that the Registrant's standard of practice in relation to both Patients 1 and 2 fell far below the required standard. He also set out, at paragraph 5 of his report, that he considered that conduct which falls far below the required standard of a reasonably competent optometrist is conduct which 'could cause harm or disadvantage the patient and/or bring the profession into disrepute'. The Committee agreed with Professor Harper's conclusions.

42. The Committee also noted in relation to Patient 1, that there was a delay in referral to a retinal clinic following the assessment on 20 August 2019. There was no referral until 19 November 2019. Significantly, Patient 1 was sent for surgery on the cataract prior to a referral in regard to the nAMD. Professor Harper addressed the issue of the risks associated with a patient with nAMD having cataract surgery. He stated that current research is inconclusive but states that the key point is that clinicians must use their clinical judgment. Additionally, he mentioned that a key consideration is the timing of surgical intervention, for example awaiting stability in one condition before pursuit of other interventions. The point is that no such judgment or consideration was exercised by the Registrant as she was unaware of the nAMD which was present.

43. In regard to the Registrant's assessment of Patient 1 on 19 November 2019, the Committee noted that but for Witness B's intervention the nAMD is likely to have gone undiagnosed for longer.

44. The Committee considered in relation to Patient 2, the risks, if any, of conducting the YAG capsulotomy in a patient with nAMD. Professor Harper identifies the potential risk of cystoid macula oedema following such a procedure. Professor Harper concluded that as a result of the Registrant's failure there was delay in

referral for a medical retinal opinion of Patient 2. The Committee accepted Professor Harper's evidence.

45. The Committee noted that the Registrant admitted that her conduct amounted to misconduct, but that this was a matter for the judgement of the Committee.

46. The Committee considered all of the facts and circumstances referred to above, and concluded that the Registrant's admitted conduct amounted to serious professional misconduct, and fell far below the standard to be expected of a reasonably competent Optometrist.

Impairment

47. Having found that the Registrant's conduct detailed in the allegations amounted to misconduct, the Committee then had to determine whether, by virtue of the misconduct, the Registrant's fitness to practise is currently impaired as of the date of the hearing.

48. The Committee heard Mr Corrie's submissions on behalf of the Council on the issue of impairment. Mr Corrie referred the Committee to Guidance on these issues contained at pages 22-23, paragraphs 16.1 to 16.7 of the "Hearings and Indicative Sanctions Guidance," December 2021.

49. The High Court in *CHRE v (1) NMC and (2) Grant* [2011] EWHC 927 (Admin), considered that an appropriate approach for panels considering impairment might be that which was formulated by Dame Janet Smith in the report to the Fifth Shipman Inquiry:

> *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*

50. The Council submitted that limbs (a)–(c) above were engaged in this case.

51. Silber, J set out guidance in *Cohen v General Medical Council* [2008] EWHC 581 (Admin) at paragraph 65:

"It must be highly relevant in determining if a doctor's fitness to practise is impaired that first his or her conduct which led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated."

52. In *Cheatle v General Medical Council* [2009] EWHC 645 (Admin) Cranston J at paras [21-22] stated:

"*21.There is clear authority that in determining impairment of fitness to practise at the time of the hearing regard must be had to the way the person has acted or failed to act in the past...*

22. In my judgment this means that the context of the doctor's behaviour must be examined. In circumstances where there is misconduct at a particular time, the issue becomes whether that misconduct, in the context of the doctor's behaviour both before the misconduct and to the present time, is such as to mean that his or her fitness to practise is impaired. The doctor's misconduct at a particular time may be so egregious that, looking forward, a panel is persuaded that the doctor is simply not fit to practise medicine without restrictions, or maybe at all. On the other hand, the doctor's misconduct may be such that, seen within the context of an otherwise unblemished record, a Fitness to Practice Panel could conclude that, looking forward, his or her fitness to practise is not impaired, despite the misconduct."

53. In *CHRE v Grant* [2011] EWHC 927 (admin) Cox J noted at para [74]:

"In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances."

54. Mr Corrie for the Council submitted that one of the key issues for the Committee to consider will be the extent, if any, to which the Registrant has remedied her conduct and whether she continues to present a risk of harm to members of the public.

55. Mr Corrie further submitted that the wider public interest of declaring and upholding proper professional standards and maintaining public confidence in the profession must be taken into account.

56. Mr Corrie referred to the Registrant's bundle, containing a witness statement, evidence of reflection, supervision reports, professional training undertaken and references. He submitted that it was a matter for the Committee to decide

whether on the basis of this material it considered that a finding of impairment is required.

The evidence adduced on behalf of the Registrant in relation to Impairment

57. The Registrant gave oral evidence to the Committee and answered questions from Mr Corrie for the Council and from the Committee. In the view of the Committee the Registrant's evidence was sincere and insightful.

58. The Registrant provided a detailed witness statement in which she accepted full responsibility for her misconduct, and set out the steps that she had taken to remediate her failures. She produced two reflective pieces in which she explained the various ways in which she had embarked on a wide range of learning activities in order to improve her clinical knowledge, skills and abilities.

59. Ms Chalkley for the Registrant drew the Committee's attention to the fact that for 18 months, the Registrant was the subject of interim orders. During that time she was under clinical supervision from Mr A MCOptom, who produced five supervision reports, which outlined in detail the various ways in which the Registrant had worked hard to improve her skills.

60. Ms Chalkley stated that when the Interim Conditions Order expired at the end of 18 months, the Council did not feel it was necessary to apply for an extension of the Order. Ms Chalkley also referred the Committee to the NHS Performers List Decisions Panel review hearing, dated 22 February 2022, following the Registrant's conditional inclusion on the NHS Ophthalmic Performer List. The Panel determined that it was appropriate and proportionate for the conditions placed on her inclusion on the Performers List to be revoked. The Panel determined that the Registrant should be allowed to practise without restrictions.

61. The Registrant also produced extensive evidence of relevant professional training and had attained the Professional Certificate in Medical Retina via the redacted course.

62. The Registrant produced two testimonials from Ms A, dispensing optician, dated 5 November 2022, and from Mr A, who was the Registrant's supervisor whilst she was subject to an Interim Order, dated 6 November 2022. Both testimonials were very supportive of the Registrant's achievements.

63. Ms Chalkley summed up by stating that the Registrant was a reformed Optometrist whose fitness to practise was no longer impaired.

64. The Committee accepted the advice of the Legal Adviser that determining whether the Registrant's fitness to practice was currently impaired was a matter for their judgement.

The Decision of the Committee on current impairment

65. At the end of the addendum expert report, dated 10 November 2022, Professor Harper stated: "*I believe that the Registrant's remediation appears impressive, and exemplary, and not least in her attaining the Professional Certificate in Medical Retina via the* redacted *course".* The Committee agreed with that assessment.

66. The Committee determined that the conduct which led to the Allegation was remediable because it related to clinical failings in relation to two patients but in respect to one specific eye condition. The Committee considered that the Registrant has taken comprehensive steps to remedy her misconduct and consider that it is highly unlikely that her misconduct will be repeated. The Committee considers that the Registrant has taken ownership of her failings, and her learning from these will inform her future practice.

67. In short, the Committee was fully satisfied with the steps the Registrant's had taken to remediate her failings as evidenced by her record of improvement and practical work. The Committee notes that she acknowledged her mistakes straight away and made unconditional admissions as to the Allegation, and all the evidence relied upon by the Council. The supervisor's reports are testament to the Registrant's remediation efforts. The Committee notes that, during the recent pandemic, the Registrant self-funded the redacted course in difficult circumstances.

68. The Committee had to consider whether the need to uphold professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the circumstances of this case.

69. The Committee considers that, in the circumstances of this case, there is no reason to protect public confidence in the profession or uphold professional standards by making a finding of impairment in the public interest. The Committee noted that, at University, the Registrant obtained a first-class degree in Optometry and has recently acquired the Professional Certificate in Medical Retina. She has been on a rigorous journey over the last three years, and the Committee has no doubt that the Registrant is now a much better, skilful and competent Optometrist than she was when the misconduct occurred. The Committee is impressed by the testimonials of Mr A and Ms A, both of whom have worked with the Registrant, and were well placed to assess her current skills and abilities.

70. The Committee considers that it is in the public interest to enable a good Optometrist to continue in practice without restrictions or conditions. The Committee considers that this is such a case.

71. For the reasons set out above, the Committee has decided that the Registrant is not currently impaired.

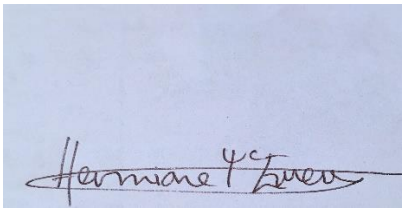
Submissions on Warning - Rule 46 (16) (b)

72. The Committee heard submissions from Mr Corrie for the Council and from Ms Chalkley for the Registrant as to whether it would be appropriate to issue a warning to the Registrant in this case. The Council, having considered the decision of the Committee on current impairment submitted that it was not necessary to issue a warning in this case. Mr Corrie stressed that the Committee had reached a clear decision on current impairment, in relation to the impressive remediation achieved by the Registrant, and there was no reason to or need to protect the public by issuing a warning in these circumstances. He further submitted that the bringing of these proceedings and the Committee's finding of misconduct were sufficient to mark the public interest. Ms Chalkley for the Registrant agreed that a warning was not appropriate in this case.

73. The Committee considered the guidance as to the issue of a warning when there is no finding of current impairment. It had regard to paragraphs 20.2 to 20.7 of the Hearings and Indicative Sanctions Guidance, in particular paragraph 20.7. The Committee considered that in this case, a warning was not justified as there had been a genuine expression of regret/apology; the Registrant had a previous good history; appropriate rehabilitative/ corrective steps had been taken; and relevant and appropriate reference and testimonials were provided.

74. For these reasons the Committee decided not to issue a warning.

Chair of the Committee: Hermione McEwen

Signature……  …… **Date:** 15 November 2022

Registrant: Zahra Mogra

Signature: …… In attendance remotely …… **Date:** 15 November 2022

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.
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.