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

**GENERAL OPTICAL COUNCIL**

**F(23)12**

**AND**

**KARINA GAHIR (01-30825)**

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**DETERMINATION OF A SUBSTANTIVE HEARING**
**TUESDAY 09 AUGUST – FRIDAY 11 AUGUST 2023**

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| **Committee Members:** | Ms Rachel O'Connell (Chair/Lay)<br>Mr Ubaidul Hoque (Lay)<br>Ms Ann McKechin (Lay)<br>Ms Sanna Nasrullah (Optometrist)<br>Ms Caroline Clark (Optometrist) |
| **Legal adviser:** | 08 – 09 August: Ashraf Khan<br>10 – 11 August: Aaminah Khan |
| **GOC Presenting Officer:** | Ms Ayanna Nelson |
| **Registrant present/represented:** | Yes and represented |
| **Registrant representative:** | Mr Christopher Hamlet<br>Ms Katie Holland (AOP) |
| **Hearings Officer:** | Ms Abby Strong-Perrin |
| **Facts found proved:** | Particulars 1(a) (b), 2 (a) (b) and 3 (a) of the allegation. |
| **Facts not found proved:** | N/A |
| **Misconduct:** | Found |
| **Impairment:** | Found |
| **Sanction:** | Suspension for three months – (With Review) |

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| **Immediate order:** | No |

## PRELIMINARY APPLICATION

1. Counsel for the General Optical Council (GOC) made an application to amend the particulars of the allegation.

2. The allegation currently before the Committee was:

*The Council alleges that you, Karina Gahir, a registered optometrist;*

1. *On or around 24 October 2020, whilst working at Vision Express,* REDACTED *you;*
   *(a) knowingly sent text messages to several patients to cancel appointments without their authorisation.*
   *(b) used an expired PIN from a former employee to enable you to cancel patients' appointments.*

2. *On or around 06 November 2020 whilst working at Vision Express,* REDACTED
   *(a) you knowingly sent text messages to several patients to cancel appointments without their authorisation.*
   *(b) you used an expired PIN from a former employee to cancel patients appointments.*

3. *Your actions in 1 and/or 2 above were*
   *(a) dishonest and/or inappropriate*

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

3. The GOC applied to amend the particulars to read as follows:

*The Council alleges that you, Karina Gahir, a registered optometrist*

*1) On or around 24 October 2020, whilst working at Vision Express,* REDACTED *("the store") you;*

*a) knowingly sent text messages to several patients to cancel appointments without the store's authorisation;*

*b) used an expired PIN from another employee to cancel patients' appointments.*

*2) On or around 06 November 2020, whilst working at the store you:*

a) *knowingly sent text messages to several patients to cancel appointments without the store's authorisation;*

b) *used an expired PIN from another employee to cancel patients' appointments.*

3) *Your actions in 1 and/or 2 above were:*

a) *dishonest and/or inappropriate.*

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

4. The Committee heard and accepted the legal advice and considered the submissions from both parties. It noted that Counsel for the GOC submitted the amendment sought clarifies the particulars but the case against the Registrant has not altered in any way. Counsel on behalf of the Registrant raised no objection to the proposed amendments.

5. The Committee noted that pursuant to Rule 46(20) of The General Optical Council (Fitness to Practice) Rules 2013 ("the Rules"), the Committee may amend the allegation before findings of fact, provided that the Committee is satisfied that, "having regard to all the circumstances, the amendments can be made without injustice".

6. The Committee took into account:
   - the reason why the amendment is requested;
   - the type of amendment, for example is it to correct a typographical error or a minor change which does not affect the gravamen of the charge, or is it something more significant which alters the very nature or mischief of the charge or the way in which the defence has been advanced;
   - the stage of the proceedings;
   - the representations made by the parties;
   - the nature and extent of the amendments requested; and
   - whether they are likely to cause injustice.

7. Considering all the representations and the legal advice, the Committee was satisfied the Allegation is not being changed in any way other than to make matters clearer and given there is no objection to this amendment, the Committee determined there was no injustice and therefore granted the application to amend.

**ALLEGATION (as amended)**

*The Council alleges that you, Karina Gahir, a registered optometrist:*

1. *On or around 24 October 2020, whilst working at Vision Express,* REDACTED *("the store") you;*
    *(a) knowingly sent text messages to several patients to cancel appointments without the store's authorisation;*
    *(b) used an expired PIN from another employee to cancel patients' appointments.*

2. *On or around 06 November 2020, whilst working at the store you:*
    *(a) knowingly sent text messages to several patients to cancel appointments without the store's authorisation;*
    *(b) used an expired PIN from another employee to cancel patients' appointments.*

3. *Your actions in 1 and/or 2 above were:*
    *(a) dishonest and/or inappropriate.*

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

## DETERMINATION

8. Admissions in relation to the particulars of the allegation

9. The Registrant admitted particulars 1(a) (b), 2 (a) (b) and 3 (a) of the allegation.

### Background to the allegations

10. On 7 April 2021, BLM Law on behalf of Vision Express (UK) Ltd ("the complainant") submitted a complaint regarding their employee, Karina Gahir ("the Registrant"). The Registrant had cancelled patient appointments and sent text messages to patients informing them of the cancelled appointments without the store's authorisation. The complainant carried out an internal investigation and the Registrant was summarily dismissed after a disciplinary hearing on the grounds of gross misconduct. The complainant provided the Council with their internal investigation report, witness interview and internal contemporaneous interview records with the Registrant.

11. The internal investigation report, which began on 6 November 2020 and concluded on 19 November 2020, provided the background to how the concerns were identified, the investigation process and conclusion. A series of cancellation texts were sent to patients of the complainant's REDACTED store on 24 October 2020 and on 6 November 2020 without authorisation. This came to light when at least

one patient called the store to query the reason for cancellation. The IT department were asked to investigate, and it was found that the expired PIN was linked to a user based in another store operated by the complainant who was not working at the REDACTED store on either day in question.

12. A member of the IT team confirmed that on 24 October 2020, two separate batches of cancellation texts were sent from an account that logged out at the same time the registrant logged in the computer at 14.07. The texts on 6 November were sent from the Registrant's room and she logged in 3 mins before and after the texts were sent, between 9.04 and 9.05am. The practice work rota evidenced that across the two dates that the texts were sent, the only person who had the opportunity to input the text messages was the Registrant.

13. At the first internal investigation meeting with the Registrant on 6 November 2020, the Registrant denied sending the cancellation texts insisting 'I wouldn't do something like that'. The likelihood of another user sending the texts from the Registrant's PC was explored but this was not pursued as the Registrant herself stated 'people come in and talk to me but not when I am not here'. The Registrant stated that she was logging in to check her diary for the day ahead when informed that she had logged in within a few minutes of the cancellation texts being sent. The Registrant stated that maybe someone else had used her PIN and went on to say another colleague used her PIN for under 16s. She was informed that the colleague was not working on 6 November 2020 and it did not explain the texts.

14. The investigation meeting resumed on 12 November 2020 the Registrant stated that she shared her PIN with a trainee when she was running behind, to check under 16s. It was discussed with her the considerable risk this could pose to patients and the consequences to herself. She was also informed that the colleague she started sharing her PIN with denied ever having her PIN. The Registrant alleged her whereabouts on the morning of 6 November evidenced that she did not send the texts. She claimed that at the time the texts were sent she was putting in eye drops for a colleague, but it was ascertained by the complainant that that colleague did not clock in until 9.01 and dropped off belongings before going to the Registrant for the eyedrops, concluding that the Registrant was not instilling eye drops at the time the texts were sent. Colleagues present that morning were confirmed to be elsewhere which further supported the Registrant being in the Optometrist's room alone when the texts were sent. The Registrant also couldn't explain logging in at the exact minute the account sending the texts logs out at 14.07 on 24 October 2020. The Registrant also showed a good understanding of the system used to send cancellation texts to patients for various reason negating that this was done in error.

15. A further investigation meeting was schedule with the Registrant on 19 November 2020 and she was informed of the GOC standards namely 'being honest when things go wrong'. It was at this point that the Registrant stated that she did not

realise the severity of her actions and admitted that she did in fact send the cancellations texts and apologised for not being honest sooner. At the conclusion of the investigation the Registrant took full responsibility for her actions and stated that she sent the texts because she was panicked about her clinic falling behind and not having enough time to clean up between patients. She did not raise concerns because she did not want to complain and wanted to get on with work.

16. Vision Express (UK) Ltd instructed BLM Law to make a referral to the Council as they considered the actions breached several of the standards of practice for Optometrists and Dispensing Opticians.

17. Upon receipt of the referral, the Council notified the Registrant of the Fitness to Practise investigation on 19 May 2021. On 16 March 2023, the Registrant was notified that the matter had been referred to the Fitness to Practise Committee by the case examiners.

**Findings in relation to the facts**

18. The Committee found the alleged facts proved by way of admission.

**Findings in relation to misconduct and Impairment**

19. The Committee heard evidence from the Registrant and submissions on behalf of the Council and the Registrant.

20. All parties agreed the Committee could hear evidence and receive submissions on misconduct and impairment together. The Committee decided this would be appropriate as it was told the Registrant admitted misconduct and impairment and that the Registrant intended to give evidence addressing both issues together.

21. During her evidence, the Registrant confirmed that she qualified as an Optometrist in March 2018 and currently works at Boots Opticians between two stores in REDACTED.

22. The Registrant was referred to her statement dated 7 August 2023. She confirmed she had read the contents and that it was true to the best of her knowledge and belief.

23. The Registrant was also referred to her undated reflective piece. She confirmed it was produced on 4 August 2023 and that it was true to the best of her knowledge and belief. The Registrant told the Committee that REDACTED branch of Vision Express was one of the top 50 busiest of its stores in the UK. At the time of her

misconduct, it was the height of the COVID-19 Pandemic with national restrictions in place. “The country was going into the Amber phase” and opticians were expected to resume normal eye tests and clinics. Consequently, times were reduced for carrying out tests. The sudden change of going back to normal time slots after red alert was difficult. The testing time was reduced from 40 minutes back to 25 minutes and has remained since.

24. The Registrant informed the Committee there was still a need to disinfect the rooms after every eye test, despite going back to 25 minute slots. No additional allocated time was allowed for that task and this put additional pressure on her. She accepted she did not raise her concerns with any of her managers.

25. The Registrant admitted she used another employee’s expired PIN to cancel the appointments on 24 October 20 and 06 November 2020. When asked how she came across another employee’s expired PIN, she told the Committee that her own PIN was her date of birth. One day, she came across another employee’s PIN by accident when she entered a digit in error and decided to use it to cancel appointments.

26. The Registrant complained that she was expected to see walk in appointments as well as pre-arranged appointments. She felt that if she cancelled the pre-arranged appointments, it would give her extra time.

27. The Registrant confirmed she was one of three Optometrists in the store at the time. One of the other two was in his/her pre-registration year. The others were slower than her and she found herself helping the others by taking patients from their clinics. She stated REDACTED was a busy area and patients were demanding and wanted appointments on time.

28. The Registrant confirmed that she admitted all the allegations and conceded her actions were dishonest. She stated she had not personally gained by the cancellations. At the time, she did not think patients were being put at potential risk. She was under stress during the height of the COVID-19 pandemic. She did not want to compromise the eye tests of the patients she was seeing because of pressure of time.

29. With the benefit of hindsight, the Registrant acknowledged patients must have wanted to visit the Optometrist during the COVID period for very good reasons. By cancelling appointments at a time which was most difficult to access health care services, she may have caused them harm as they were not seen to. Furthermore, she stated patients could have lost their trust in Vision Express’s brand or opticians.

30. Having reflected, the Registrant acknowledged the impact of her dishonesty on the public. She accepted she was providing an important public service.

31. The Registrant told the Committee she has learned from her experience and has changed. She is now married and her family are also in health care. The experience has made her understand the importance of taking a mature approach. The Registrant stated she loved her job and always told her patients how much she likes optometry. She stated she was helping the public and making someone else's day better. She said if she could go back and change things, she would have spoken to management and asked for help to manage her clinics better.

32. She accepted that when she was first investigated, she was not honest. On reflection, she wishes she was honest from the 'get go'. She now tries to be more open with management and express her concerns. Whenever she has expressed her concerns, management have always tried to help.

33. When asked to explain why she initially denied the allegations, she said it was because she was scared of the outcome and the consequences. She thought the matter would go away. She then spoke to her parents about it and understood that she needed to take responsibility for her decisions. After reflection, she then made her admission. She said she was 'really immature and made a mistake'. She said she 'didn't know how to handle the investigation at the time'.

34. When asked about the risk of repeating the similar conduct, the Registrant said she would not make a mistake like this again. This kind of behaviour has not been repeated since. She managed her clinics better now and her current place of work was not as busy.

35. The Registrant stated she was not a dishonest person. She said she was honest and religious. At the time she was 24/25 years old. She has matured since and is now 28. Her whole life has changed and she has 'matured massively'. She conducted Colorimetry assessments and so much more for the community. She said 'it was one pathetic immature mistake which I will not repeat again'.

36. She confirmed that if the Committee did find her fitness to practise impaired, she would abide by any conditions set. She confirmed she has support from her employers.

37. Under cross examination, the Registrant stated that she discovered the other PIN and made the cancellations the same day. She knew she was not using her own PIN because she 'thought it was a way of concealing my identity if it was ever investigated. I accept that the purpose was to cover my tracks.'

38. She confirmed one of the three Optometrists at the store was 'slower' than she was and she 'did have to take some of the slack from her'. She said she was not the slowest. She said it wasn't a question of having to be quicker, it was more to do with fitting in cleaning up after each test and changing PPE and then seeing a patient, all within 25 minutes. She complained she didn't have allocated time for the cleaning and PPE. She said she can normally manage within 25 minutes but the additional cleaning and PPE made it harder.

39. The Registrant stated there was pressure from management to meet sales targets.

40. The Registrant accepted that as it was the height of COVID, patients would only come if they needed.

41. The Registrant accepted there was the potential for something to be discovered in a patient during a routine eye test and that something may have been missed because of the cancellations. The Registrant however emphasised they were routine appointments without prior reason for any concern.

42. The Registrant told the Committee she also did pre-screening for about 30% of the time. She confirmed that at her current employment, she is the sole optometrist. She carries out sight tests and Minor Eye Condition Services (MECS) and deals with whatever arises during the day.

43. She stated she now has a strategy in place if appointments overrun or it gets busy. Recently her manager asked her to reduce contact lens appointments from 20 minutes to 10 minutes. She told him how she felt and he kept 20 minutes in place.

44. The Registrant confirmed that in 2020 she worked at REDACTED 5 days a week. She explained that a 'ghost clinic' was an extra clinic booked up in case there were cancellations. This would be in addition to the walk in clinic.

45. The Registrant stated management had not asked her about cancelled appointments between 24 October 2020 and 6 November 2020. She said she was not aware of any discussions about it.

46. Since these incidents, the Registrant stated she had undertaken CPD relating to time management, stress and ethics. She stated she completed CPD late last year on mental health in optometrists. She also undertook training in safeguarding and risks to public. She enquired by email this week about a course on duty of care in optometric practice to which she has had no response. Boots have their own CPD about safeguarding.

47. She provided reflection on a webinar on 'Dishonesty allegations in practice' which she accessed on 7 August 2023.

48. The Committee asked the Registrant to confirm the amount of time saved by the cancellations. When it was put to her that it was over 3 hours on the morning of 24 October 2020, the Registrant explained that because there was a full ghost clinic that day it remained a very busy clinic. She said other days were generally very busy but there would be time to allow for catch up. There would be more room for managing better.

49. When asked to explain how she selected which patients to cancel, the Registrant stated it was random but later accepted there was an element of selection. She said she only cancelled the ones without concerns and which were routine.

50. The Registrant stated she qualified in March 2018. This happened, 2 ½ years after she qualified. At that stage she was still learning how to manage clinics. She classed herself as 'very newly qualified'.

51. The Registrant also said that during the COVID period, she never had to test 16-18 patients a day. Coming out of COVID and doing that was hard. She said she would be 100% better prepared now. She can manage clinics a lot better now. Back then she struggled with time management. She stated she is completely different now.

52. When asked to confirm what she told her referees, she said that she had shown them the allegations and that she was admitting them.

53. The Registrant was asked why she called this 'a costly mistake of dishonesty'. She said she used the word mistake because as a person and optometrist, 'her nature is completely different to that period of out of characterness'. She said that it's not been repeated and that she didn't realise the consequences, 'maybe a young naïve mind, I'm not sure, because it's not repeated, it was a mistake'.

54. The Registrant accepted she was aware of the GOC Standards. She said she didn't think she was completely aware until they were read to her during the investigation. She then decided she needed to be honest. At the time when she cancelled appointments, she did not have a clear understanding of it. She claimed she now has a lot more understanding and knowledge of the Standards and that she had 'learnt a lot of lessons'.

55. When asked what lessons she has learned, the Registrant stated she had learned that during the investigation, she acted dishonestly. She stated that she understood there is a professional standard to uphold and for the public to know that the profession is approachable and that an Optometrist should be able to give a thorough eye examination. She stated that she learnt not to beat around the bush and try to deny anything and make it look like as though she was trying to conceal things and to be honest about everything she does.

56. On behalf of the Council, it was submitted the Registrant's admitted misconduct amounted to serious professional misconduct. It was further submitted the Registrant's behaviour would be considered as 'deplorable'.

57. Counsel for the GOC submitted that the Committee was considering an allegation of inherent dishonesty. The Registrant had explained how she came about the PIN of another colleague. It was a calculated decision to use another's PIN to cover up her own actions. She did this because she considered at the time, if there was an

investigation, the investigation would not reveal she was the one who cancelled the appointments.

58. Counsel further submitted that the Registrant had pointed out this happened over the period of COVID. She had conceded that if patients felt the need to come out of their house to have their eyes tested, even though they were standard appointments, they would have been much needed appointments at a time when access to optical services was clearly restricted. Whilst some patents were eventually seen, others were not seen. Whilst it is acknowledged no harm has been identified, there was nevertheless the risk of harm.

59. Counsel for the GOC invited the Committee to make an objective assessment of how this conduct would be viewed by practitioners. She reminded the Committee that patients had been upset and made angry calls to the store to complain about their appointments being cancelled.

60. Counsel also drew the Committee's attention to relevant paragraphs of the GOC's Standards of Practice for Optometrists and Dispensing Opticians, namely standards 9, 16, 17 and 19.

61. So far as impairment is concerned, Counsel for the GOC submitted all four limbs of *CHRE v NMC & Paula Grant [2011] EWHC 927 (Admin)* are engaged and that the Committee would be entitled to find impairment on the grounds of necessity to protect the public and to maintain public confidence in the profession.

62. Counsel for the GOC questioned the degree of the Registrant's insight into what took place at a specific period of time. Counsel for the GOC accepted there were a number of challenges, which may not present again in the same way but what remains is the question of dishonesty which is a particular type of conduct which is not easily remediable.

63. On behalf of the Registrant it was submitted there was no issue between the parties on the law, and there was a proper basis to find the conduct amounts to misconduct and impairment. Counsel submitted the Committee should have regard to the overarching objective at paragraph 8 of Sanctions Guidance - whether there is a need to protect the public and maintain proper standards.

64. Counsel for the Registrant submitted that notwithstanding the fact that there were relevant mitigating features, any dishonesty may require the Committee to take action on the public interest component of impairment. He invited the Committee however to find the Registrant not impaired on the personal component. He submitted that the Registrant had demonstrated good if not complete insight into the nature of her conduct. She was remarkably straightforward and honest during her evidence and had not tried to minimise her conduct.

65. Counsel submitted the use of the words ‘a costly mistake’ by his client does not imply minimization and that it was more likely to be a poor choice of words in that moment of her evidence.

66. Counsel referred the Committee to the references in support of the Registrant which point to the Registrant being a good professional.

67. Counsel acknowledged the Registrant denied the allegations at a local level. He submitted this was immature and her understanding of the seriousness of her conduct was lacking at the time. She freely volunteered without any prompting that she had tried to cover her tracks. He submitted her candour reflects well on her insight and she was entirely frank about what she did and why. He submitted that this should allay any concerns about repeating the conduct. He submitted there was no risk now. She was a young woman at the time and fairly newly qualified. He submitted the Registrant’s age is of particular relevance and said she made isolated errors of judgement. She was working in an exceptionally busy environment during the height of COVID. She was very different now and there was no practical risk to patients or real risk of repetition.

68. Finally, Counsel for the Registrant submitted not all four limbs of *Grant* are engaged. He argued that there was no risk to patients going forward and that that impairment was limited to the public component not the personal component.

69. In relation to misconduct, the Committee received and accepted the advice of the Legal Adviser. He referred the Committee to the of case of *Cheatle v General Medical Council [2009] EWHC 645 (Admin) where Mr Justice Cranston said at paragraph 19:*

70. *“A Committee must engage in a 2-step process. First, it must decide whether there has been misconduct. Then it must go on to determine whether, as a result, fitness to practise is impaired. But it may be that despite a practitioner having been guilty of misconduct, the Committee may decide that his or her fitness to practise is not impaired.”*

71. The Committee was advised that there is no definition of misconduct. It is for the Committee to exercise its judgement to determine whether an act or omission amounts to misconduct.

72. The Committee was further advised that misconduct is a word of general effect and that in *Roylance v GMC (No.2) [2000] 1 AC 311*, misconduct was described as:

*“a falling short by omission or commission of the standards to be expected among practitioners and such falling short must be serious. It is of course possible for negligent conduct to amount to serious professional misconduct, but the negligence must be to a high degree”.*

73. The Committee was advised that in deciding whether something is to be considered "serious", it should note that in *Johnson & Maggs v NMC [2013] EWHC 2140 (Admin)* the courts have said the question to ask yourself is:

*"would the facts found proved be considered deplorable by other members of the profession?"*

74. The Legal Adviser referred to the case of *Remedy UK Ltd v General Medical Council [2010] EWHC 1245 (Admin)* where the Court derived a set of principles in respect of misconduct. For example the following is provided at paragraph 37:

*"Misconduct is of two principal kinds. It may involve sufficiently serious misconduct in the exercise of professional practice such that it can properly be described as misconduct going to fitness to practise. Second, it can involve conduct of a morally culpable or otherwise disgraceful kind which may, and often will, occur outside the course of professional practice itself, but which brings disgrace upon the doctor and thereby prejudices the reputation of the profession."*

*"Misconduct within the first limb need not arise in the context of a doctor exercising his clinical practice, but it must be in the exercise of the doctor's medical calling. There is no single or simple test for defining when that condition is satisfied."*

*"Conduct falls into the second limb if it is dishonourable or disgraceful or attracts some kind of opprobrium; that fact may be sufficient to bring the profession of medicine into disrepute. It matters not whether such conduct is directly related to the exercise of professional skill."*

75. The Committee was advised to give careful regard to the context and circumstances of the matters found proved and to take into account all the evidence and the submissions made. The Committee was advised that misconduct is a matter for its own judgement and that it can take into account the Registrant's admission.

**Findings in respect of misconduct**

76. The Committee gave careful consideration to all the evidence and the submissions made.

77. The Committee considered this was a pre-meditated and persistently covered up course of dishonest conduct. The Registrant abused her position of trust, as she knew she was using someone else's PIN. The Committee noted that on 24 October 2020, seven patients were cancelled in the morning and five in the afternoon and on 6 November 2020, three patient appointments were cancelled. The total amount of time cancelled was over 3 hours on the morning 24 October 2020 alone. The Registrant's explanation for cancelling the patients' appointments was to reduce the volume of patients that she had to examine. Cancellations were made purely to facilitate less work for the Registrant. There was no store authorisation for cancelling the appointments and the Committee heard that some patients were upset.

78. The Committee considered the Registrant's perceived pressure she felt under during the COVID period with the extra infection control measures. The Committee was aware that in this period it was very difficult for patients to access *healthcare* services.

79. There was potential risk to patients as a result of the Registrant's actions, as although the cancelled appointments were for 'routine sight examinations', these could still reveal sight threatening conditions.

80. In all the circumstances, the Committee determined that the Registrant's conduct was serious and would be viewed as deplorable by fellow members of the profession.

81. The Committee had regard to the Council's Standards, and considered that there was a breach in respect of the following standards:

- Standard 16.1: Act with honesty and integrity to maintain public trust and confidence in your profession;
- Standard 17.1: Ensure your conduct, whether or not connected to your professional practice, does not damage public confidence in you or your profession; and
- Standard 19: Be candid when things have gone wrong.

82. The Committee found that the facts found proved do amount to misconduct pursuant to Section 13D(2)(a) of the Opticians Act 1989.

**Findings regarding impairment**

83. The Committee acknowledged that the Registrant had engaged in these proceedings and had answered questions. She had provided a reflective statement and made full admissions.

84. The Committee noted that the Registrant consistently referred to her course of dishonest conduct as a mistake, both in her reflective statement and in her oral evidence to the Committee. The Registrant attributed her 'mistake' to her immaturity at the time, her newly qualified status and COVID pressures. The Registrant did not initially demonstrate full understanding of the consequences for patients of the cancellation of their appointments, although during questioning she accepted there had been a risk of missing serious eye pathology and consequently the opportunity of being able to access prompt referral and care.

85. The Committee determined the Registrant demonstrated a lack of remorse, as she has never articulated in her evidence an apology to the patients. Having examined the Registrant's reflective piece, the Committee noted that it focused more on the Registrant's pressures and less on the wider consequences for patients and colleagues.

86. Whilst the Committee noted that dishonesty is not easily remediable, it was of the view that measures can be taken by Registrants to demonstrate to a Committee that appropriate and relevant remediation has been undertaken.

87. The Committee noted that the Registrant only took steps to address the need to undertake relevant training on dishonesty in the 72 hours before the hearing commenced. This did not reassure the Committee that she had adequately addressed her mind to the professional obligations of integrity and honesty previously. A webinar on dishonest allegations in practice the night before a hearing does not allow for sufficient time for reflection and demonstrated that she had not taken this matter sufficiently seriously.

88. Taking all of the above into consideration, the Committee has determined that the Registrant lacks full insight into the gravity of her course of conduct and the consequences of her actions for others and has demonstrated a lack of appropriate and timely remediation. In these circumstances, the Committee considered that there is a risk of repetition.

89. Consequently, the Committee found the Registrant's fitness to practise is currently impaired on the personal component.

90. The Committee noted that impairment on public interest grounds was admitted.

91. The Committee determined that in light of the serious misconduct, which involved a course of dishonest conduct, public confidence in the profession and the regulator would be undermined if a finding of impairment were not made.

92. The Committee found that the fitness of Karina Gahir to practise as an optometrist was currently impaired.

**Findings regarding Sanction**

93. The Committee next went on to consider what would be the appropriate and proportionate sanction, if any, to impose in this case. It heard submissions from Ms Nelson on behalf of the Council and from Mr Hamlet on behalf of the Registrant (in the Registrant's absence at this stage of the hearing).

94. Ms Nelson reminded the Committee that the purpose of imposing a sanction was not to punish the Registrant, although it may have that effect. The primary purpose of sanctions was to protect the public and to meet the overarching objective. She invited the Committee to have close regard to the GOC's '*Hearings and Indicative Sanctions Guidance*' (updated November 2021) ('the Guidance').

95. Ms Nelson made specific reference to the paragraphs in the Guidance on dishonesty, at paragraphs 22.4 -22.5, highlighting that in cases of dishonesty a registrant was at risk of being removed from the Register, although there was no presumption that erasure would be appropriate in all cases. Ms Nelson submitted that the Committee should balance the particular circumstances of this case

against the effect any sanction would have on public confidence in the profession and maintaining standards and the reputation of the profession.

96. Ms Nelson submitted that as this was a case of dishonesty, it was at the upper end of the scale of seriousness. However, she made clear that the Council were not suggesting that erasure was the only appropriate sanction. She reminded the Committee to begin with the least restrictive sanction first and to work through the Guidance until it reached a sanction that met both the public interest and the Committee's findings made at the misconduct and impairment stage.

97. Ms Nelson submitted that the Registrant may suggest an order of conditions would be appropriate and she outlined what had happened at an earlier stage in the proceedings when an Agreed Panel Disposal (APD) had been suggested by the GOC. She outlined that an APD report had been sent by the GOC to the Registrant proposing conditions, however that was an error and the report was revoked four days later. The GOC then sent an APD report proposing a six month suspension with no review. Ms Nelson submitted that this attempt at resolving the case by way of APD did not bind this Committee and it would be wrong for the Committee to place any reliance upon the initial report which proposed conditions, as it was quite clearly an error.

98. Turning to the sanctions available to the Committee, Ms Nelson submitted that conditions would be inherently unsuitable and when considering the GOC's bank of conditions, there were no appropriate conditions to address the misconduct in this case and address the risk of repetition. Any conditions imposed need to be practical and workable, which they would not be in this case.

99. Ms Nelson referred the Committee to the factors set out in the Guidance, at paragraph 21.29 (set out below) which indicate that a suspension may be appropriate and she invited the Committee to consider the applicability of these factors to this case. Ms Nelson reminded the Committee that it ought to have proper regard to the Sanctions Guidance and if it were not followed, the Committee would need to have sound reasons to depart from it.

100. The Committee had regard to the submissions of Mr Hamlet, on behalf of the Registrant. He submitted that whilst he did not disagree with what Ms Nelson had submitted regarding the APD process not being binding on the Committee, the detail of that process was important to understand in the interests of fairness. Mr Hamlet took the Committee through the history of the APD process and the schedule of related correspondence. Mr Hamlet submitted that it was evident that the Registrant was clear that she was fully admitting the Allegation, that the GOC had been considering APD since at least April 2023, and that the GOC withdrew a fully drawn up APD report (proposing conditions) just days after it was sent.

101. Mr Hamlet submitted that the initial APD report proposing conditions was not simply a mere error, and he referred to the sections of the report, which correctly set out the background and the detailed analysis of the sanction proposed. He submitted that this showed that the GOC had carefully weighed up the relevant factors and circumstances of the case before concluding that conditions would be

appropriate. He stated that it was impossible to frame this as an error and it was better characterised as a change of heart.

102. Mr Hamlet acknowledged that under the APD policy, the Committee had a discretion whether to accept or reject a proposed sanction, however this does not mean that this aspect of the case was irrelevant and it was a matter of fairness, as the Registrant had a legitimate expectation that this process would be followed. Mr Hamlet submitted that the Committee was entitled to take this into account. The Registrant had engaged with the APD process, made admissions at an early stage and the GOC had reneged from a clearly stated position, which led to at least perceived unfairness, if not actual unfairness, to the Registrant.

103. In relation to dishonesty, Mr Hamlet acknowledged that dishonesty is serious misconduct. However, he submitted that it must be considered on a scale, and it must not lead automatically to any one particular sanction. Considering the circumstances of this case, he submitted that it was at the lower end of the scale of dishonesty cases, particularly when compared with the features of other dishonesty cases, where there may be financial gain, risk or harm to patients and no acknowledgment of fault.

104. Mr Hamlet highlighted sections of the Committee's determination on misconduct and impairment, which were not accepted on behalf of the Registrant. Firstly, it was not accepted that the Registrant had persistently covered up her actions and he cautioned the Committee from using this as an aggravating factor, as using another's PIN was an ingredient of the dishonesty itself, rather than an act following the underlying conduct. To use as an aggravating factor would involve double counting this aspect of the case. Secondly, Mr Hamlet highlighted that the Committee's observation that the Registrant had cancelled patient appointments purely for less work, ignores the Registrant's unchallenged evidence that her motive was to reduce the work pressures that she was under and it would be unfair to reject that evidence and conclude it was due to laziness. Thirdly, Mr Hamlet queried the Committee's observations on lack of remorse, and he took the Committee through the detail of the Registrant's apology, which he submitted was heartfelt and sincere.

105. Turning to mitigation, Mr Hamlet submitted that the key points of mitigation were that:

1) These were isolated events within the context of the Registrant's career;
2) They were outwith the Registrant's character (as set out in the testimonials);
3) Events were now almost three years ago and there had been no repetition;
4) The Registrant made full admissions from the outset (whilst there was an initial denial at local level, this was then corrected at local level);
5) The Registrant had made a fulsome and genuine apology;
6) The Registrant had provided a reflective piece, which shows good, if not full, insight;
7) There had been no financial benefit to the Registrant from her actions.

106. Mr Hamlet referred the Committee to the Guidance and whilst it was proper to start at the lowest sanction and work up, he acknowledged that realistically the lowest appropriate sanction in this case was one of conditions. Whilst the Guidance refers to conditions being appropriate in cases of health or performance, this should not be interpreted as limiting the sanction to only those cases and there is no reason why in principle conditions cannot be imposed for dishonesty.

107. Considering the factors which indicate that conditions may be appropriate, at paragraph 21.25 of the Guidance, Mr Hamlet submitted that these applied. He stated that it was possible to form appropriate and practical conditions in this case, as the Registrant's actions were rooted in her lack of confidence when dealing with management, her time management and lack of understanding of consequences on patients, all of which could be addressed by conditions.

108. Mr Hamlet submitted that his primary position was that conditions would be the most appropriate and proportionate sanction, however his secondary position was that if the Committee were considering a suspension, neither a member of the public, nor the profession, would consider a lengthy suspension necessary. Further, erasure would be wholly disproportionate given the mitigation in the case and that would be more than necessary to meet the public interest.

109. The Committee accepted the advice of the Legal Adviser, which was for the Committee to take into account the factors on sanction as set out in the Guidance; to assess the seriousness of the misconduct; to consider and balance any aggravating and mitigating factors; and to consider the range of available sanctions in ascending order of seriousness. Further, the Committee is required to act proportionately by weighing the interests of the registrant against the public interest.

110. When considering the most appropriate sanction, if any, to impose in this case, the Committee had regard to all of the evidence and submissions it had heard, as well as its previous findings at the misconduct and impairment stage. The Committee noted the background of the attempted APD process, and how the GOC had at one stage proposed that conditions could be an appropriate and proportionate sanction. However, the Committee noted that both parties were in agreement that this was not in any way binding on the Committee, who had to form their own independent judgment of what was the appropriate and proportionate sanction, if any, to impose, based upon the evidence it had heard.

111. Further, the Committee noted that the evidence before this Committee was wider and fuller than what had previously been available at the earlier stage in the proceedings when APD was being considered, and included the Registrant's evidence (both written and oral), her reflective statement and evidence of the remediation that she had more recently undertaken.

112. The Committee considered the aggravating and mitigating factors. In the Committee's view, the aggravating factors in this case are as follows:

1) The lack of full insight, in that there was in the Committee's view a lack of timely remediation and reflection on that remediation (what reflection and remediation had occurred appeared to have been undertaken shortly before the hearing);

2) The abuse of the trust placed in the Registrant by her employer;

3) There was a potential risk of patient harm as a result of the cancelled appointments (if eye conditions were to be missed), albeit there is no evidence of direct harm;

4) The Registrant initially denied responsibility in the early stages of the local investigation, on more than one occasion (in two interviews on 6 and 12 November 2000), only making admissions some weeks later at the disciplinary hearing on 19 November 2000).

113. The Committee considered that the following were mitigating factors:

1) There has been no repetition;
2) This was an isolated episode, which took place in the early years of the Registrant's career;
3) There is no evidence of direct harm to patients;
4) The dishonesty was not for financial benefit;
5) The Registrant has sincerely apologised to the profession, public and her employer;
6) The Registrant is developing insight; she has shown remorse and made full admissions during the GOC process. In addition, she has now developed a greater understanding of the GOC Standards expected and her duty of care;
7) The Registrant has undertaken some relevant remediation, completing a webinar on dishonesty, albeit one day before the hearing started.

114. The Committee next considered the sanctions available to it from the least restrictive to the most severe, starting with no further action.

115. The Committee considered taking no further action as set out in paragraphs 21.3 to 21.8 of the Guidance. It concluded that there were no exceptional circumstances present that could justify taking no action in this case. It further considered that taking no further action was not proportionate, nor a sufficient outcome, given the seriousness of the case, which involved dishonesty on two occasions, and the public interest concerns.

116. The Committee considered the issue of a financial penalty order, however it was of the view that such an order was not appropriate, given that the Registrant's conduct was not financially motivated and had not resulted in financial gain.

117. The Committee carefully considered the GOC Indicative Sanctions Guidance in relation to the imposition of conditions. It noted in particular that at paragraph 21.17 of the guidance it states,

"*Conditions might be most appropriate in cases involving a registrant's health, performance, or where there is evidence of shortcomings in a specific area or areas of the registrant's practice.*"

118. However, the Committee considered that this paragraph did not necessarily limit the imposition of conditions to such cases.

119. The Committee considered the factors in the Guidance set out at paragraph 21.25, which indicated when conditions may be appropriate:

**Conditional registration may be appropriate when most, or all, of the following factors are apparent (this list is not exhaustive):**

*a. No evidence of harmful deep-seated personality or attitudinal problems.*

*b. Identifiable areas of registrant's practise in need of assessment or retraining.*

*c. Evidence that registrant has insight into any health problems and is prepared to agree to abide by conditions regarding medical condition, treatment, and supervision.*

*d. Potential and willingness to respond positively to retraining.*

*e. Patients will not be put in danger either directly or indirectly as a result of conditional registration itself.*

*f. The conditions will protect patients during the period they are in force.*

*g. It is possible to formulate appropriate and practical conditions to impose on registration and make provision as to how conditions will be monitored.*

120. The Committee did not consider that the Registrant held deep-seated personality or attitudinal problems and noted that the Registrant had indicated in her oral evidence to the Committee that she was willing to comply with any conditions imposed. However, the Committee was of the view that identifiable areas in the Registrant's practice in need of assessment or retraining were relatively limited given the nature of the misconduct being dishonesty.

121. The Committee considered whether it would be possible to formulate appropriate and practical conditions in this case. The Committee noted that at paragraph 21.19 of the Guidance, it states that,

"*The objectives of any conditions placed on the registrant must be relevant to the conduct in question and any risk it presents*."

122. The Committee was of the view that if conditions were placed on the Registrant they would need to be relevant to the dishonesty and the risk of repetition, which the Committee had found remained present, given that there had not yet been the development of full insight and remediation. Any conditions imposed would need to focus upon the Registrant carrying out further training to develop her insight

further, however the Committee were concerned that such limited conditions, even considering the mitigation in this case, would not sufficiently meet the public interest.

123. The Committee balanced the aggravating and mitigating factors, as set out above. Whilst it did not assess the seriousness of the misconduct as being at the higher end of the scale of dishonesty, the Committee did not consider that it was at the very lowest end of the scale either. Whilst there had been no financial gain, the Registrant had cancelled patient appointments, during the pandemic, without authorisation and activated an expired PIN of a colleague for the purpose of cancelling appointments; the cancellation of the appointments involved a potential risk to patients (albeit there was no evidence of harm). The Registrant's conduct was pre-meditated and repeated on two separate occasions. Although the Registrant had made admissions and had not repeated the misconduct, the Committee considered that she had further work to do in order to demonstrate more comprehensive remediation and develop her insight further.

124. Considering all of the above, the Committee determined that a conditions of practice order would not sufficiently mark the serious nature of the misconduct, nor address the public interest concerns identified, which were a significant consideration in relation to the Committee's finding of impairment (which was both on personal and public interest grounds). The Committee was also not satisfied that adequate conditions could be devised which would be appropriate, proportionate, workable or measurable in this case.

125. The Committee next considered suspension and had regard to paragraphs 21.29 to 21.31 of the Guidance. In particular, the Committee considered the list of factors contained within paragraph 21.29, which indicate that a suspension may be appropriate, as follows:

**Suspension (maximum 12 months)**

*21.29 This sanction may be appropriate when some, or all, of the following factors are apparent (this list is not exhaustive):*

*a. A serious instance of misconduct where a lesser sanction is not sufficient.*

*b. No evidence of harmful deep-seated personality or attitudinal problems.*

*c. No evidence of repetition of behaviour since incident.*

*d. The Committee is satisfied the registrant has insight and does not pose a significant risk of repeating behaviour.*

*e. In cases where the only issue relates to the registrant's health, there is a risk to patient safety if the registrant continued to practise, even under conditions*.

126. The Committee was of the view that all of the factors listed in paragraph 21.29 were applicable, apart from factor e) which was not relevant in this case. In relation

to factor a), this was serious misconduct, where a lesser sanction was not sufficient, as set out above.

127. In relation to b), the Committee was of the view that there was no evidence of harmful deep-seated personality or attitudinal problems. In relation to c), there was no evidence of repetition of the behaviour since the incidents in 2020.

128. In relation to d), the Committee was satisfied that the Registrant has developed some insight and, although there remains a risk of repetition until there has been further remediation and full development of insight, the Committee did not consider that the Registrant posed a *significant* risk of repeating the misconduct, particularly as there had been no repetition in the past three years. Factor e) was not applicable to the facts of this case.

129. The Committee balanced the mitigating and aggravating factors in the case, and considered the principle of proportionality. It concluded that a suspension order was appropriate in order to address the public interest concerns that it had identified. A period of suspension would send a signal to the public and profession that such conduct was not acceptable. The Committee concluded that a suspension order would adequately mark the seriousness of the Registrant's conduct, maintain confidence in the profession and declare and uphold proper standards of professional conduct and behaviour.

130. The Committee was satisfied that a reasonable member of the public and fellow members of the profession, in possession of all the facts, would consider that a suspension order was a proportionate sanction in this case.

131. The Committee did not go on to consider the relevant part of the Guidance in relation to erasure, as it was satisfied that an order of suspension was the appropriate and proportionate sanction to impose in this case and given the extent of the mitigation, erasure would be a disproportionate outcome.

132. In relation to the length of suspension, the Committee gave consideration to the appropriate length of the order of suspension and determined that, having balanced the mitigating and aggravating factors against the public interest, it would be proportionate to suspend the Registrant for a period of three months. The Committee was of the view that three months was an appropriate and proportionate period of suspension to sufficiently mark the seriousness of the Registrant's conduct, to send a signal to the public and the profession that such conduct was not acceptable and to address the public interest concerns it had identified.

133. The Committee considered whether to direct that a review hearing should take place before the end of the period of suspension. The Committee noted that at paragraph 21.32 of the Guidance, it states that a review should normally be directed before an order of suspension is lifted, because the Committee will need to be reassured that the registrant is fit to resume unrestricted practice.

134. The Committee bore in mind that it had found that there remained a risk of repetition, as the Registrant's insight was still developing, and that the finding of impairment had been made both on the personal component and to maintain public confidence in the profession and uphold proper standards. The Committee had

found that the Registrant still has further reflection and remediation to undertake, in order to develop full insight.

135. In the above circumstances, the Committee was of the view that it was appropriate to direct that a review take place in order that a future Committee could consider what steps the Registrant has taken to remediate and develop insight further and the effectiveness of the same. The Committee considered that a future review Committee may be assisted by the Registrant:

    1) Attending the future review hearing;

    2) Submitting evidence of relevant and targeted CPD successfully completed;

    3) Submitting a reflective piece relating to the misconduct found and detailing any learning from further remediation undertaken, such piece to be limited to 500 words.

136. The Committee therefore imposed a suspension order for a period of three months, with a review hearing to take place before the order expires.

**Immediate Order**

137. The Committee invited representations from the parties on the issue of whether an immediate order ought to be made in this case.

138. Ms Nelson, on behalf of the Council, invited the Committee to impose an immediate order of suspension under Section 13I of the Opticians Act 1989. Ms Nelson submitted that it was necessary to make an immediate order to protect the public and such an order would be in the public interest. Ms Nelson submitted that it was necessary to protect the public in light of the Committee's finding that there was an existing risk of repetition until the Registrant had developed full insight. An immediate order of suspension would address the risk to the public that flows from that risk of repetition.

139. Mr Hamlet, on behalf of the Registrant, opposed the imposition of an immediate suspension order. He referred the Committee to paragraph 23.3 of the GOC's Guidance and submitted that such orders should be reserved for those cases where there was a necessity for an immediate order, rather than simply being desirable. He reminded the Committee that the Allegations in this case were almost three years ago and the Registrant had not repeated the misconduct.

140. Mr Hamlet highlighted that the Committee had not found a significant risk of repetition and that the rationale of the sanction appeared to be predominantly on public confidence grounds. Imposing an immediate order on public interest grounds alone would be very rare and there was no necessity for an immediate order to be imposed on public protection grounds. Mr Hamlet confirmed that the Registrant had not been made subject to any interim restrictions.

141. The Committee accepted the advice of the Legal Adviser, which was that to make an immediate order, the Committee must be satisfied that the statutory test in

section 13I of the Opticians Act 1989 is met, i.e., that the making of an order is necessary for the protection of members of the public, otherwise in the public interest or in the best interests of the Registrant.

142. The Committee had regard to the statutory test, which required that an immediate order had to be necessary to protect members of the public, otherwise in the public interest or in the best interests of the Registrant. The Committee had found in this case that although there was a risk of repetition, as the Registrant had not yet developed full insight, there was not in the Committee's view a significant risk of repetition, as set out in its determination on sanction.

143. Further, the Committee noted that the Registrant had been in practice for the past almost three years with no repetition of her misconduct. In addition, no interim order had been made in respect of the Registrant throughout the proceedings. This case did not concern clinical concerns. The Committee was mindful that on public protection grounds the requirement of necessity was a high bar, and that being desirable to make an order was not sufficient.

144. Accordingly, the Committee was not satisfied that there was any necessity for an immediate order, nor would an order be appropriate solely in the public interest. It considered that the public interest had been adequately marked by the three month suspension order itself. There was no basis for an immediate order to be made in the best interests of the Registrant. Therefore, the Committee was not satisfied that the statutory test had been met and decided in the circumstances not to impose an immediate suspension order.

**Revocation of an interim order**

145. There was no interim order to revoke.

**Chair of the Committee: Rachel O'Connell**

**Signature**  . **Date: 11 August 2023**

NOTICE TO REGISTRANT:

- The GOC will enter these conditions against your name in the register save for any conditions that disclose information about your health.
- In accordance with Section 13C(3) of the Opticians Act 1989, the GOC may disclose to any person any information relating to your fitness to practise in the public interest.
- In accordance with Section 13B(1) of the Opticians Act 1989, the GOC may require any person, including your learning/workplace supervisor or professional colleague, to supply any information or document relevant to its statutory functions.

| **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.

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