BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(25)09

AND

ABDUL KHAN (01-30126)

DETERMINATION OF A SUBSTANTIVE HEARING
20-22 JULY 2026

Committee Members:	Mr Adrian Smith (Chair/Lay) Ms Victoria Smith (Lay) Ms Diane Roskilly (Lay) Ms Denise Connor (Optometrist) Ms Gaynor Kirk (Optometrist)
Legal adviser:	Mr Graeme Dalgleish
GOC Presenting Officer:	Ms Holly Huxtable
Registrant present/represented:	Yes and represented
Registrant representative:	Ms Elisabeth Acker
Hearings Officer:	Ms Natasha Bance
Facts found proved:	All
Facts not found proved:	None
Misconduct:	Found
Impairment:	Not found
Sanction:	N/A
Immediate order:	N/A

General Optical Council

DETERMINATION

ALLEGATION

1. The Council applied to amend the allegation. Prior to amendment the allegation stated the following:-

   The Council alleges that you, Mr Abdul Shakoor Khan (01-30126), a registered Optometrist:

   1) On 10 June 2022 you performed a sight test on Patient A, and you:

   a) Failed to recognise signs of suspicious optic discs in Patient A's right eye and/or left eye, despite there being photographic evidence to clinically support;

   b) Failed to accurately assess Patient A's optic disc status, namely: (i) Recorded "healthy colour margins" despite there being clinical evidence of significant neuro-retinal rim thinning in Patient A's right eye and/or left eye;

   c) Failed to perform a visual fields assessment on Patient A, despite this test being clinically indicated;

   d) Wrongly recorded that a visual fields assessment was "not required" for Patient A, despite this test being clinically indicated;

   e) Failed to measure and/or record Patient A's intra-ocular pressures, despite this test being clinically indicated;

   f) Failed to routinely refer Patient A to the Hospital Eye Service for suspected glaucoma, despite this being clinically indicated;

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

2. Ms Huxtable for the Council applied to amend the allegation pursuant to rule 46(20) of the Rules submitting :- *"Where it appears to 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 prejudice".*

3. The Council further submitted as follows :- *"In essence, the proposed amendment better particularises the allegation and reflects the standards of*

practice. The amended allegation does not materially differ from the allegation that was referred to the Committee."

4. The amended allegation was sent to the Registrant on 22 April 2025 in accordance with the standard procedural directions set out in rule 29 of the Rules. Ms Acker for the Registrant confirmed that the Registrant had no objection and the amendment was not opposed.

5. The Council proposed the following amended allegation:-

   The Council alleges that you, Mr Abdul Khan (01-30126), a registered Optometrist:

   1) On 10 June 2022 you performed a sight test on Patient A, and you failed to undertake appropriate assessments in that you:

   a) did not recognise signs of suspicious optic discs in Patient A's right eye and/or left eye, despite there being photographic evidence to clinically support;

   b) did not perform a visual fields assessment on Patient A, despite this test being clinically indicated;

   c) did not measure and/or record Patient A's intra-ocular pressures, despite this test being clinically indicated;

   2) On 10 June 2022 you failed to provide adequate patient care in that you:

   a) recorded "healthy colour margins" for Patient A despite there being clinical evidence of significant neuro-retinal rim thinning in Patient A's right eye and/or left eye;

   b) recorded that a visual fields assessment was "not required" for Patient A, despite this test being clinically indicated;

   3) On 10 June 2022 you failed to routinely refer Patient A to the Hospital Eye Service for suspected glaucoma, despite this being clinically indicated.

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

6. Having accepted legal advice as to the rules and fairness, the Committee decided that there was no material change in the proposed amendment which essentially reformatted and made clearer the existing allegation. There is nothing new, no change in the nature or gravity of the allegation and no prejudice to the Registrant arises. The Committee noted that the Registrant has

not opposed the proposed amendment and it therefore decided to allow the proposed amendment.

Admissions in relation to the particulars of the allegation

7. The Allegation (as amended) was read and the Registrant admitted all the factual particulars of the Allegation.

Background to the allegations

8. The Registrant first registered with the Council as a student optometrist on 16 October 2012. He registered as a fully qualified optometrist on 13 April 2017. Patient A was examined by the Practice on 13 June 2016, 10 June 2022 and 22 December 2023.

9. The Council received a referral from [redacted] ("the Practice") on 2 May 2024 stating that: *"Patient A attended for a sight test on 22 December 2023. Having reviewed the previous records the examining optometrist … was concerned that when Patient A was previously examined, on 10 June 2022, there was evidence of optic nerve head changes which were potentially indicative of glaucoma. The June 2022 test had been performed by Mr Khan who had failed to identify the presence of these changes".*

10. Following the eye examination on 22 December 2023, Patient A was duly referred to the Hospital Eye Service (HES) by the Practice. He was examined on 15 January 2024, and it was found that his intraocular pressures were markedly raised, with glaucomatous optic discs being noted and a left eye optic disc pit/central serous retinopathy was suspected.

11. The Council opened an investigation and obtained an expert opinion from Professor Robert Harper. In his report dated 25 November 2024, Professor Harper concluded at para 5.9.1 and 5.9.2 that :- *"the Registrant's actions were not in accordance with the standards expected of a reasonably competent optometrist. In summary, there was a failure to recognise at least the suspicion of glaucoma based upon Patient A's optic disc appearance, compounded by a companion failure to undertake tonometry, a failure to undertake visual field testing, and a failure to refer routinely for secondary care glaucoma assessment".*

Findings in relation to the facts

12. The Committee accepted the full admissions by the Registrant and it accordingly found all the facts as alleged proved.

Submissions and Evidence in relation to misconduct

13. The Committee heard submissions on behalf of the Council and the Registrant. Ms Huxtable invited the Committee to find that the facts found proved amounted to misconduct and she referred to her Skeleton argument and the relevant case law. She referred to GOC standards 7 and 17 and submitted that the conduct found proved was serious and would be considered "*deplorable*" by fellow practitioners.

14. Ms Acker for the Registrant submitted that the Registrant fully accepted the allegation and the expert report of Prof. Harper. There was no evidence of any harm caused, but the Registrant accepted that there was a risk of harm. She posed the question - Does the mistake made reach the high standard to be misconduct? She told the Committee that the Registrant was embarrassed, regretful and he was concerned about the risk of harm to the patient.

15. Ms Acker submitted that this was a single instance of deficient professional performance and it was isolated. The act was not done purposefully but related to a single patient on a single date. The Registrant had failed to recognise signs of suspicious optic discs, and as a result, then failed to take the steps that should have been taken.

16. Ms Acker referred to the GOC guidance on misconduct (June 2026) at paragraph 12.9 which states:-

    "Where a Registrant may have been negligent, misconduct may be constituted by a series of acts, unless the one act in question was particularly serious; see R (on the application of Vali) v General Optical Council [2011] EWHC 310 (Admin):

    "Mere negligence does not of itself show that the act was misconduct. A higher degree of gravity than mere carelessness is required. I also note and agree that a single act is less likely to cross the threshold of misconduct but that depends of course on the gravity of the act."

17. Ms Acker submitted that the *Vali* case was relevant here as there had been a single failure on one day with one patient. It was the initial mistake of failing to identify the suspicious optic disc that then led to the subsequent failings regarding tests and referral. She said that the facts were not of a gravity and seriousness such that this single incident amounted to misconduct, and she submitted that there was not a fair sample of the Registrant's work for the Council to try to prove deficient professional performance. She submitted that the Registrant had fully accepted his failings and that his conduct did not amount to misconduct.

18. The Committee enquired further with Professor Harper. He affirmed and he told the Committee in his live evidence that, in relation to Allegation 1 a), a key part of the examination is observing the appearance of the optic nerve or disc. That was central to an adequate eye examination. In June 2022 he considered that on observation alone there was at least a "*highly suspicious"* optic nerve and

evidence of glaucoma damage, and that should have been detected by a reasonably competent optometrist.

19. Prof. Harper said that missing the observation was significant given the potential for disease indicated by the appearance of the optic nerve. He said that in this case it was not a borderline judgement on which different clinicians may disagree, it was something that a reasonably competent optometrist should have identified, and it was potentially a very significant finding. The observation in June 2022 had followed an earlier sight test and retinal photos from 2016, and Prof. Harper stated that it was a serious observational deficiency.

20. Ms Huxtable referred Prof. Harper to paragraph 5 of his report, and he confirmed that the failure to observe and/or report the features as alleged at 1a) was serious and in his opinion fell far below the expected standard.

21. Ms Acker asked Prof. Harper to consider paragraph 5.3 of his report. He accepted that the steps the Registrant had failed to take were a *"stepping up"* and had followed on from the failure in not detecting the issue as alleged in Allegation 1 a). He accepted that there was an unusual ophthalmic history along with a family history of glaucoma in this case, and the patient was in his thirties and may not therefore have been someone that might be expected to be at risk.

22. Prof. Harper was referred to paragraph 5.3.3 of his report. He stated in his live evidence that an ophthalmic history had been properly taken and "*flagged"* by the Registrant, as one would expect. Prof. Harper said that the routine tests and steps undertaken were adequate, other than the failure in Allegation 1 a). He said that the risk to the patient was an important aspect to consider, and his "*far below*" opinion arose given the risk to this particular patient.

23. Ms Acker submitted that Prof Harper had said the failing to detect the suspicion as alleged was not addressed in his report where he largely addressed the concomitant failings that flowed from that failure. She submitted that he had for the first time today expressed his view on the seriousness of that initial failing at Allegation 1a).

Findings in relation to misconduct

24. The Committee accepted the advice of the Legal Adviser. He advised the Committee that misconduct was a matter for its own professional judgment and there was no burden of proof. He referred to the GOC guidance and to *Roylance v GMC* (no 2) [2000] 1 AC 311 where misconduct was described as: *"a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular* circumstances." He

emphasised the need for the Committee to carefully consider seriousness and referred to *Remedy UK Ltd v GMC* [2010] EWHC 1245 (Admin) where it is stated misconduct must be "*…sufficiently serious misconduct in the exercise of professional practice that it can be properly described as misconduct going to fitness to practise...".* He reminded the Committee of the *Vali* case as set out in the GOC guidance on misconduct at paragraph 12.9.

25. The Committee considered all the evidence and submissions it had heard. It was mindful that the decision on misconduct is one for its own professional judgement, and whilst it has some expert evidence to assist, it is not the role of the expert to make the decision about misconduct.

26. The Committee considered the whole allegation as admitted and found proved. It took account of Prof. Harper's live evidence specifically regarding the failure at Allegation 1a), but it was of the view that it was not appropriate, and it would be artificial, to overly compartmentalise the allegation. Whilst parts of the allegation flowed from the proved failing at Allegation 1a), the Committee decided it was fair and appropriate to consider the whole allegation in the round and not to risk diminishing the proved and admitted consequential factual findings.

27. It is a fundamental aspect of an eye examination to assess the optic nerve, and the Committee was of the view that the examination on 10 June 2022 raised an obvious and suspicious issue with the optic nerve that was not a borderline case. There was a clear abnormality apparent in the photographs taken during the examination when viewed in isolation and when compared with previous photos. The patient ought to have had further investigations including intra-ocular pressure and visual fields and been referred, if needed. The Registrant admits these failings as stated in the Allegation. The Committee also took into account, that this patient presented a number of risk factors given the family history and the "*tilted*" optic nerve which made observation more difficult.

28. The Committee considered the guidance and the case law including the *Vali* case. This was a single, non-deliberate incident on one day with the one patient. There was, however, a risk of harm and a number of interlinked failings have been proved. The failings cover several important areas of professional practice – failings in observation, clinical judgement, recording and patient care all contributing to an increased potential for patient harm.

29. The Committee found that the findings were also a breach of paragraphs 6.2, 7 and 17 of the *GOC Standards of Practice for optometrists and dispensing opticians*:-

- *Standard 6.2 Be able to identify when you need to refer a patient in the interests of the patient's health and safety and make appropriate referrals.*

- *Standard 7 – conduct appropriate assessments, examinations, treatments and referrals.*
- *Standard 17 - do not damage the reputation of your profession through your conduct.*

30. A number of failings are proved and these essentially result in a failure in patient care and a consequent risk of harm. Considered as a whole, the Committee decided that the failings fall far short of the standards expected and go to fitness to practise and they are serious.

31. Accordingly, on balance, and taking all of the evidence into account as well as the guidance and case law, the Committee decided that the conduct was serious, despite being a single act, and that it amounted to misconduct.

Submissions and Findings regarding impairment of fitness to practise

32. Ms Huxtable referred the Committee to the Skeleton Argument, the relevant law and GOC guidance on impairment of fitness to practise. She submitted that the allegations demonstrate serious failings, breached a fundamental tenet of the profession and involved a risk of harm. Ms Huxtable acknowledged the reflective statement from the Registrant and submitted that the Committee should consider whether the conduct is likely to be repeated. She submitted that the Registrant's fitness to practise remained impaired on public protection grounds, and that a finding of impairment was also required to maintain public confidence in the profession. She referred to the option of imposing a warning if impairment was not found.

33. Ms Acker submitted that the Registrant's fitness to practise was not currently impaired. She invited the Committee to consider 13.1 of the GOC guidance, as follows: "*Relevant factors for the Committee to consider when determining impairment include: whether the conduct which led to the allegation is remediable; whether it has been remedied; and whether it is likely to be repeated. Certain types of misconduct (for example, cases involving clinical issues) may be more capable of being remedied than others.*"

34. Ms Acker submitted this case was a one off clinical issue and the misconduct was not attitudinal in nature. She submitted that the conduct was remediable, as the Council appeared to accept, and that it had been remedied. The Registrant had undertaken targeted and long term CPD, and in addition the Committee has his reflective statement and several positive references.

35. Ms Acker submitted that the conduct emphatically would not be repeated. The incident occurred in 2022 and has not been repeated in the four years since. Ms

Acker submitted that the Registrant has admitted and accepted the seriousness of his conduct, and he has serious and ongoing insight. She submitted that means he will not repeat the error as to glaucoma.

36. Ms Acker referred to the "*glowing*" references in support of the Registrant's current practice, including from his supervisor who refers to the Registrant's "*exceptional glaucoma referrals"* and the "*lasting and positive*" change in the Registrant's professional practice. The Registrant is said to be open to feedback and learning and is described as having made substantial efforts to improve his practice.

37. Ms Acker submitted that the conduct had been remedied and that is demonstrated by the reflective piece, the testimonials and the CPD undertaken as well as the absence of any repetition of the misconduct. She submitted that it was unsustainable to take the view that there remained a risk of repetition, and that the conduct was "*incredibly unlikely"* to be repeated.

38. Ms Acker submitted that the public, properly informed in this case, would not consider that a finding of impairment was required. Public confidence did not require a finding of impairment. She referred to the GOC guidance on issuing a warning where there is no finding of impairment.

39. The Committee accepted the advice of the Legal Adviser. He referred the Committee to the GOC guidance on current impairment of fitness to practise and the relevant case law, including the guidance in *CHRE v NMC and Grant* [2011] EWHC 927 (Admin). He reminded the Committee to consider the central issues of the Registrant's insight, remediation of his practice and the risk of repetition, as well as considering the crucial public interest element. He referred the Committee to the GOC guidance on issuing a warning where there is no finding of impairment.

40. The Committee considered the GOC guidance, the case law and all the information before it. It was mindful that impairment is a matter for the professional judgement of the Committee.

41. The Committee was of the view that the conduct is remediable. It took account of the relevant and significant level of CPD undertaken by the Registrant, as well as his detailed reflective piece. The Committee found that the feedback about the Registrant's referrals to the hospital was strong and reassuring as to the Registrant's current practice on glaucoma referrals. The Registrant's professional supervisor has provided a supportive and positive testimonial and he speaks highly of the Registrant's practice and professional attitude.

42. The Committee was of the view that the Registrant has demonstrated and developed mature insight and his reflective piece is impressive. At no point does he seek to deflect or minimise his conduct. He demonstrates a good understanding of his conduct and he accepts full responsibility for his failings.

43. The Committee concluded that the Registrant has fully remediated and strengthened his practice. He has demonstrated good insight and there is consequently a low risk of repetition of the misconduct. The Committee concluded that the Registrant's fitness to practise was not currently impaired on public protection grounds.

44. As regards the public interest, the Committee was mindful that this is an important aspect of impairment. This case involves a single incident four years ago. The Registrant has subsequently taken all reasonable steps to remedy his practice and he has demonstrated good insight and there is evidence of current, good clinical practice.

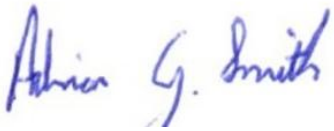
45. The Committee was satisfied that the Registrant has clearly "learned his lesson" and that there is a low risk of repetition. The Committee considered that a reasonable and well informed member of the public would be sufficiently reassured by these factors and by the positive and meaningful steps taken by the Registrant in relation to his professional practice.

46. The Committee concluded that in all these circumstances there was no need to make a finding of impairment on public interest grounds, and that to find no impairment would not undermine public confidence in the profession.

47. Accordingly, the Committee decided that the Registrant's fitness to practise is not currently impaired on either public protection or public interest grounds.

48. The Committee decided that in the circumstances of this particular case a warning was not justified. That concludes this case.

Chair of the Committee: Adrian Smith

Signature  **Date:** 22 July 2026

Registrant: Abdul Khan

Signature *Present remotely and received via email* **Date:** 22 July 2026

FURTHER INFORMATION
Transcript
A full transcript of the hearing will be made available for purchase in due course.
Appeal
Any appeal against an order of the Committee must be lodged with the relevant court within 28 days of the service of this notification. If no appeal is lodged, the order will take effect at the end of that period. The relevant court is shown at section 23G(4)(a)-(c) of the Opticians Act 1989 (as amended).
Professional Standards Authority
This decision will be reported to the Professional Standards Authority (PSA) under the provisions of section 29 of the NHS Reform and Healthcare Professions Act 2002. PSA may refer this case to the High Court of Justice in England and Wales, the Court of Session in Scotland or the High Court of Justice in Northern Ireland as appropriate if they decide that a decision has been insufficient to protect the public and/or should not have been made, and if they consider that referral is desirable for the protection of the public.

Where a registrant can appeal against a decision, the Authority has 40 days beginning with the day which is the last day in which you can appeal. Where a registrant cannot appeal against the outcome of a hearing, the Authority's appeal period is 56 days beginning with the day in which notification of the decision was served on you. PSA will notify you promptly of a decision to refer. A letter will be sent by recorded delivery to your registered address (unless PSA has been notified by the GOC of a change of address). Further information about the PSA can be obtained from its website at www.professionalstandards.org.uk or by telephone on 020 7389 8030.
Contact
If you require any further information, please contact the Council's Hearings Manager at Level 29, One Canada Square, London, E14 5AA or by telephone, on 020 7580 3898.