BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(24)14 and 15

AND

ADEEL IQBAL (SO-15327)

DETERMINATION OF A SUBSTANTIVE HEARING
28 OCTOBER TO 8 NOVEMBER 2024

Committee Members:	Sara Fenoughty (Chair/Lay) Miriam Karp (Lay) Alice Robertson-Richard (Lay) Caroline Clark (Optometrist) Gemma O'Rourke (Optometrist)
Legal adviser:	Kelly Thomas
GOC Presenting Officer:	Anthony James
Registrant present/represented:	Yes and represented
Registrant representative:	Nicholas Hall [Counsel] Katharine Germishuys [AOP]
Hearings Officer:	Arjeta Shabani
Facts found proved:	**Case 1 (2022-354)** Allegations 1, 2, 3a, 3b, 3bi, 3bii, 3biii, 3c, 3d (as amended), 4ai and 4aii admitted and proved. **Case 2 (2023-006)** Allegations 1a, 2, 3a, 3b, 3c, 4 and 5ai, 5aii and 5aiii.
Misconduct:	Found in relation to **Case 1 (2022-354)** Allegations 1, 2, 3a, 3b, 3bi, 3bii, 3biii, 3c, 3d (as amended), 4ai and 4aii.
Impairment:	Fitness to train currently impaired

Sanction:	9 month suspension with review
Immediate order:	Imposed

ALLEGATIONS

Allegations 2022-354 (Case 1)

The Council alleges that you, Mr Adeel Iqbal (SO-15327), a registered student optometrist:

1. On or around 13 October 2022, you failed to adhere to GDPR and/or
2. Breached data protection requirements in that you obtained Ms B's mobile number by accessing Patient A's records without her consent and texting her;
3. Between October 2022-November 2022 outside of work hours, you failed to maintain appropriate boundaries with Ms B in that you:
    a. Sent Ms B inappropriate text messages to her personal social media platforms unrelated to optical services and unrelated to Patient A's clinical care; and/or
    b. On multiple occasions contacted Ms B via "WhatsApp" without her consent;
        i. You sent messages relating to financial trades;
        ii. You sent a message saying "Hi I just realised I've added the wrong number. I must've entered one of the digits wrong. I am incredibly sorry for disturbing you. Wont (sic) happen again x" or words to that effect;
        iii. You asked numerous questions about her personal life
    c. On multiple occasions contacted Ms B via a social media platform "Instagram" without her consent and sent her multiple videos and images of footages from Syria of men wearing army uniforms holding weapons and/or
    ~~d. On multiple occasions contacted Ms B via a social media platform "Instagram" without her consent and sent her multiple inappropriate videos~~

    AMENDED TO:

    On one occasion, added Ms B as a friend on social media platform "Snapchat" without her consent

4. Your conduct at 1) and/or 2) and/or 3 above was:

    a. Unprofessional or otherwise inappropriate in that you:

        i. failed to maintain appropriate boundaries; and/or
        ii. knew or ought to have known that such conduct was not suitable in a student optician-client relationship.

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

Allegations 2023-006 (Case 2)

The Council alleges that you, Mr Adeel Iqbal (SO-15327), a registered student optometrist, whilst working at [redacted] Specsavers that:

1. Around December 2022 to April 2023, you acted inappropriately towards Ms 1, in that you:
    a. Failed to maintain appropriate boundaries in that you touched and/or rubbed Ms 1's shoulder making her feel uncomfortable.
2. On or around September 2022, you acted inappropriately towards Ms 2, in that you whispered in Ms 2's ear, '[redacted] the monarchy' or words to that affect making her feel uncomfortable.
3. On an unknown date around December 2022 to April 2023 you approached Ms 2 and had an inappropriate conversation about a patient saying words to the effect:

a. '*It's getting heated in there'*

b. In response to 3.a) above, Ms 2 replied '*why*' and you responded, '*she's horny*'

c. Your comments caused Ms 2 to feel uncomfortable

4. On 9 January 2023, you acted inappropriately towards Mr 4, in that you approached Mr 4 from behind and poked him by the waist;
5. Your conduct at 1), 2), 3) and/or 4) above was:
    a. inappropriate in that you:
        i. failed to maintain appropriate boundaries; and/or
        ii. knew or ought to have known that such conduct was not appropriate
        iii. your colleagues were made to feel uncomfortable by your actions

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

Background to the allegations

1. Mr Adeel Iqbal (SO-01-22613) registered with the Council on 9 October 2019 as a Student Optometrist.
2. At all material times, the Registrant was a Student Optometrist at Specsavers Optical Group Ltd, working at the branches in [redacted] and in [redacted].
3. The Registrant was employed by Specsavers, [redacted] ("the [redacted] Practice") on 15 August 2022.
4. 9. On 14 November 2022, the Council received an email with enclosures from Mr A, Ophthalmic Director at Specsavers, [redacted] and [redacted]. Mr A informed the GOC that the [redacted] Practice had received complaints from Ms B against the Registrant.
5. By way of background, on 13 October 2022, Ms B attended the [redacted] Practice with her daughter, Patient A to collect her glasses (MB75). After this date, Ms B alleged that the Registrant began messaging her on her personal number and her social media platforms: WhatsApp, Instagram and Snapchat about material that is unrelated to optical services.
6. On 9 November 2022, Ms B contacted Ms A, the Practice Manager and reported the Registrant's alleged conduct. Ms B also submitted a complaint about the Registrant's alleged conduct to Hampshire Constabulary.
7. After receiving Ms B's complaint, the [redacted] Practice formally notified the Registrant of an internal investigation. The Registrant was suspended from his employment pending the internal investigation. The internal investigation concluded on 23 November 2022. There was no disciplinary case against the Registrant and the suspension was lifted.
8. In around November 2022, at the request of the Registrant, he was transferred to the Specsavers practice in [redacted] ("the [redacted] Practice").
9. On 5 January 2023, Mr A informed the Council that there were new complaints against the Registrant from staff members at the [redacted] Practice. Mr A provided the Council with three statements from the staff members from the [redacted] Practice who detailed their concerns against the Registrant's conduct.
10. On a Saturday before Christmas 2022, Ms 1 who was an apprentice Optical Assistant, alleges that she was touched on the shoulder by the Registrant as he placed paracetamol and chocolates on her desk, saying "it's just for you". This made her feel uncomfortable.
11. Ms 2 was an Optical Assistant who alleges that the Registrant made two sets of inappropriate comments towards her:
    a) In September 2022, shortly after the late Queen had died, the Registrant whispered to her "[redacted] the monarchy". There were customers on the premises and Ms 2 felt uncomfortable at how close the Registrant had got to her; and

b) On another date, the Registrant left his test room and approached Ms 2 at the repairs desk and said “it’s getting heated in there”. On being asked why, he responded “she’s horny” and “she’s horny, I can tell”. Ms 2 said she hoped he was not entertaining it and he stopped smirking and replied “oh no I’m not”. He did not elaborate on this further when asked later in the day.

12. On 9 January 2023, the Registrant approached Mr 4, an optometrist who also worked at the [redacted] Practice, from behind and poked him around his waist with his hands. Mr 4 pushed the Registrant away immediately and was made to feel uncomfortable. This incident is captured on two CCTV clips (one is zoomed in). The Council submits this incident is clearly shown on the footage, including Mr 4’s reaction.
13. A local investigation about the new alleged concerns was conducted, however, it never concluded because the Registrant raised a grievance against the Directors, including Mr A. The investigation about these concerns did not reach a conclusion locally as the Registrant had resigned.
14. The Council sought to join the two cases in an application on 25 June 2024, citing a significant nexus between the two allegations in that they relate to the same Registrant, and the same broad complaint being his inappropriate behaviour towards patients and colleagues. The Registrant consented to the joinder application and it was granted on 24 July 2024.
15. There are no previous adverse regulatory findings against the Registrant.

PRELIMINARY APPLICATIONS

Application for hearing in private

16. Mr James, on behalf of the General Optical Council (“the Council”) made an application for some parts of the hearing to be heard in private.
17. Mr Hall, on behalf of the Registrant, agreed with those submissions.
18. The Committee heard and accepted the advice of the Legal Adviser, who outlined the relevant guidance, which can be found in *Rule 25* of the *General Optical Council (Fitness to Practise) Rules Order of Council 2013 (“the Rules”).*

    25.—

    (1) Substantive hearings before the Fitness to Practise Committee must be held in public. This is subject to the following provisions of this rule.

    (2) The Fitness to Practise Committee may determine that the proceedings, or any part of the proceedings, are to be a private hearing, where the Committee consider it appropriate, having regard to—

    (a) the interests of the maker of an allegation (where one has been made); (b) the interests of any patient or witness concerned;

(c) the interests of the registrant; and

(d) all the circumstances, including the public interest.

19. The Committee considered that the submissions of both parties highlighted that there were clearly parts of the hearing which would relate to the personal matters of the makers of the allegations. On that basis the Committee determined that those parts of the hearing should be heard in private. The parties must go into private session during those parts of the hearing only.

Application for witnesses to appear by video link

20. On Day 1, Mr James, on behalf of the Council, submitted that three of the witnesses, namely Ms A, Mr A and Ms B would request remote attendance by video link to give their evidence. Mr James submitted that each of the witnesses had a good reason for doing so and asked the Committee to note that all witnesses are based on the south coast. The witness Ms A is able to give evidence on Day 2 but she is a carer for her husband. Whilst she is able to arrange alternative care for him during short periods, travel to the hearing venue would cause her significant difficulties. Mr A has two young children at home because it is half term at their primary school. Again he may be able to arrange alternative care for a short period, but to travel from the Isle of Wight to the hearing venue would be very difficult to manage. The witness Ms B, whose evidence is more contentious, has been working in Mexico and is currently on a flight home. She is a single mother to two young children and has difficulties with childcare.

21. Mr James referred the Committee to *Rule 40(1)* of the *Rules* in that the Committee should '*admit any evidence it considers fair and relevant to the case before it, whether or not such evidence would be admissible in a court of law.'* Mr James submitted that there is no reason why a witness would be required to give evidence in person and invited the Committee to consider that all of the witnesses subject of this application are due to give evidence that is relevant to the proceedings.

22. Mr James further submitted that the consideration for the Committee was therefore one of whether it would be fair to the Registrant to allow the witnesses to give evidence by video link. In *R, on the application of Arman v Secretary of State for the Home Department (2021) EWHC 1217 Admin* Mr James submitted that whilst it was traditionally considered unsatisfactory for witnesses to give evidence by video link, except where the witnesses were giving evidence from abroad or were vulnerable, it is now, following the COVID pandemic, widely accepted that there should be provision to allow witnesses to give evidence by live link.

23. Mr James outlined his skeleton argument and submitted that according to the principles *in YI v AAW [2020] CSOH 76,* and *Suddock v NMC [2015] EWHC 3612 (Admin),* the Committee should not place huge weight on demeanour of a live witness as against written statements, documentary or agreed

evidence, but that in the event of oral evidence by video link, the Committee are perfectly able to assess credibility including demeanour, and that this will cause no unfairness to the Registrant.

24. Mr Hall made three points on behalf of the Registrant, in expanding his own skeleton argument. Firstly, that it has always been the default position, according to the *Remote Hearings Protocol dated 20 December 2021,* that a hearing should take place in person with live witnesses, and that any remote witnesses are almost always dealt with after obtaining consent from the Registrant. In this matter, the Registrant had stated from the outset that he would prefer all of the witnesses to give live evidence, including himself, and that the only reason that week 2 and 3 are listed to be remote, was that it was anticipated that all live evidence in relation to facts would be complete.

25. Secondly, Mr Hall submitted that case law principles that govern this area do not dispute the principle that live evidence is the best evidence.

26. Thirdly, Mr Hall submitted as the default position is that the witnesses will give live, in person evidence, it is therefore for the GOC to make the application for video links if it felt necessary. Consequently, the GOC should satisfy the Committee as to the detailed reasons, especially in a case such as this, where the Registrant does object to changing the previously agreed procedure. Mr Hall stated that the Registrant's position has been made clear since the hearing questionnaires were submitted on 7 May 2024. In those circumstances, Mr Hall submitted that it is not acceptable for the witnesses simply to indicate through the GOC that they *prefer* to give evidence by video link, but that the GOC should obtain more formal reasons, including when they made this decision and whether they can in fact give live evidence if required.

27. The Committee heard and accepted advice from the Legal Adviser, who firstly advised the Committee in relation to 'demeanour' in accordance with the principles in *Byrne v General Medical Council* [2021] EWHC 2237 (Admin) "*In assessing the reliability and credibility of witnesses, … demeanour might in an appropriate case be a significant factor and the lower court is best placed to assess demeanour,"* and *Khan v The General Medical Council [2021] EWHC 374 (Admin)* that "*Tribunals should not assess a witness's credibility exclusively on their demeanour when giving evidence."*

28. The Legal Adviser also gave some case law for the Committee when considering whether to allow the witnesses to provide video link evidence. In *Lawrence v GMC (2012) EWHC 464 (Admin)*, fitness to practise proceedings against a consultant psychiatrist of a sexual nature. The higher court concluded that there is to be a balance between the witness being adversely affected by not allowing video link evidence, and ensuring no unfair prejudice to the practitioner. In that case, the court found that there was no unfair prejudice to the practitioner when the witness was allowed to give evidence by live link.

29. Further, the case of *Schodlok v GMC (2013) EWHC 2280 (Admin)* where one witness gave evidence from London to the hearings in Manchester because his wife was undergoing chemotherapy treatment in London.

30. *Schodlok* endorsed the earlier case of *Polanski v Conde Nast Publications (2005) 1 WLR* 637 in which Lord Slynn stated that *'although evidence given in court is often the best, as well as the normal way of giving oral evidence, in view of technological developments evidence by video link is both an efficient and an effective way of providing oral evidence both in chief and cross examination*. In *Schodlok*, the witness was able to be cross examined and no prejudice to the practitioner was caused.

31. The Legal Adviser summarised that the current case law encourages the Committee to consider the balance between whether there would be prejudice to the Registrant versus the public interest in allowing a matter to be properly and fairly litigated, and ultimately this is a matter for the Committee to determine.

32. The Committee determined that they would require further information before making a final decision. As it was noted that one of the witnesses was on a plane and was unlikely to be available on Day 1, the Committee adjourned the case to the following day.

33. On Day 2 the GOC outlined further information in relation to the witnesses Mr A and Ms A, outlining specific personal and private details which amounted to the witnesses not being able to travel to the hearing given that they reside on the Isle of Wight and have childcare and caring responsibilities. Mr James stated that Ms B was still currently unavailable and the GOC were still seeking further information from her.

34. Mr Hall agreed that the Committee should make a decision in relation to Mr A and Ms B before proceeding to a decision in relation to Ms B. The Committee proceeded to consider whether the witnesses Mr A and Ms A should be allowed to give evidence by video link.

35. *The Committee considered first the GOC Remote Hearings Protocol at 3.2.1* that '*If the registrant would prefer the event to be heard in person, a physical hearing will be arranged.'* The Committee also considered the case law and considered the balance between considering unfairness to the Registrant against the public interest in allowing the matter to be properly and fairly litigated.

36. The Committee understood the Registrant's position, having requested and expected an in-person hearing with witnesses attending in the first week, that arrangement having been put in place since 7 May 2024. The Committee also considered that the GOC could have been more pro-active in making a very clear early request for live-link witnesses, a failure which is understandably frustrating for the Registrant. It is for that reason that the Committee delayed the case to obtain further information to satisfy itself that there was indeed good reason for the request for live links.

37. The Committee considered the possible unfairness to the Registrant. The Committee accepted that the best evidence is provided through live witnesses. The Committee considered the technology available, namely large screens within the tribunal hearing room which would allow for the witness to appear on screen to give evidence in chief, and to be cross examined on behalf of the Registrant. Following the case law, the Committee would approach the fact-finding stage by initially assessing credibility of witnesses against other evidence, such as contemporaneous written evidence, documentary evidence and other oral evidence, in accordance with the case of *Byrne*. If considering demeanour of any witness, the Committee determined that, as is wide and common practice, it would be perfectly able to assess demeanour on a live link without any unfairness being caused to the Registrant.

38. The Committee also considered the public interest in allowing the matter to be properly and fairly litigated. The Committee considered that the two witnesses, Mr A and Ms A, were witnesses who had engaged from the beginning of the process, and both have shown flexibility in agreeing to have their evidence moved to Day 2 instead of Days 6 and 7 as originally planned. The Committee considered, as part of their consideration of whether to allow remote attendance, that the reasons for the request are reasonable and were satisfied from the information given that the reasons related to important caring responsibilities which are very hard to delegate. The Committee noted that the case alleges unprofessional and inappropriate misconduct and dates back to October 2022.

39. On balance, the Committee determined that any unfairness caused to the Registrant by allowing witnesses to give live link evidence would be outweighed by the public interest in these matters being litigated on, and being litigated on expeditiously. The Committee would, via the live link, be capable of assessing the demeanour of any witness where appropriate, with reference firstly to other contemporaneous, oral and written evidence before it.

40. The Committee allowed the evidence of Mr A and Ms A to be given by live link.

41. Mr Hall on behalf of the Registrant outlined that the Registrant had reviewed the position overnight and the Registrant would be admitting the entirety of Case 1 and therefore the witness Ms B would not be required to attend.

Admissions in relation to the particulars of the Allegation

42. The Registrant admitted all of the particulars in Case 1 (2022-354) of the Allegations.

43. The Committee therefore found the particulars of Case 1, Allegations 1-4 admitted and proved.

DETERMINATION

44. Mr James opened the case for the GOC and adopted his written submissions. In relation to Case 2, "the [redacted] case" 2023-006, Mr James outlined that around November 2022, at the request of the Registrant, he was transferred to the Specsavers practice in [redacted] ("the [redacted] Practice"). On 5 January 2023, Mr A informed the Council that there were new complaints against the Registrant from staff members at the [redacted] Practice. The Council were provided with three statements from the staff members from the [redacted] Practice who detailed their concerns against the Registrant's conduct.

45. On a Saturday before Christmas 2022, Ms 1 was an Apprentice Optical Assistant who alleges that she was touched on the shoulder by the Registrant as he placed paracetamol and chocolates on her desk, saying "it's just for you". This made her feel uncomfortable.

46. Ms 2 was an Optical Assistant who alleges that the Registrant made two sets of inappropriate comments towards her:

    (a) In September 2022, shortly after the late Queen had died, the Registrant whispered to her "[redacted] the monarchy". There were customers on the premises and Ms 2 felt uncomfortable at how close the Registrant had got to her.

    (b) On another date, the Registrant left his test room and approached Ms 2 at the repairs desk and said "it's getting heated in there". On being asked why, he responded "she's horny" and "she's horny, I can tell". Ms 2 said she hoped he was not entertaining it and he stopped smirking and replied "oh no I'm not". He did not elaborate on this further when asked by Ms 2 later in the day.

47. On 9 January 2023, the Registrant approached Mr 4, an optometrist who also worked at the [redacted] Practice, from behind and poked him around his waist with his hands. Mr 4 pushed the Registrant away immediately and was made to feel uncomfortable. This incident is captured on two CCTV clips (one is zoomed in). The Council submits this incident is clearly shown on the footage, including Mr 4's reaction.

48. A local investigation about the alleged concerns was conducted, however, it never concluded because the Registrant raised a grievance against the Directors, including Mr A. The investigation about these concerns did not reach a conclusion locally as the Registrant had resigned.

EVIDENCE

49. On Day 2 of the hearing, Mr A was called and gave oral evidence by video link in accordance with his witness statement dated 31 July 2023. Mr A outlined the details of the first investigation (Case 1) which was reported on 9 November 2022 and referred to the GOC on 14 November 2022. Following investigation of Case 1, it was decided that there was no disciplinary case against Mr Iqbal, and the GOC were informed of the same. On his return to work, Mr Iqbal was transferred to the [redacted] branch of Specsavers, and Mr

A confirmed that to his knowledge, the staff at the [redacted] practice were not aware of the previous investigation. The second investigation (Case 2) was paused when the Registrant raised a grievance. On cross examination, Mr A confirmed that the [redacted] and the [redacted] stores were around 7-7.5 miles apart, and that sometimes there were overlaps with staff, including Ms A, although this was rare. Mr A confirmed that staff in both stores knew each other and there were often staff events such as team building or Christmas parties which would be combined. Mr A confirmed that his social interactions with all staff would be incredibly minimal and professional, but he could not account for personal relationships between his staff. Mr A stated that he was aware that when the investigation was paused there were staff members who raised concerns about why their complaints were not being dealt with. Mr A confirmed that he did not witness staff in [redacted] being "off" with the Registrant or "out to get" the Registrant, and nor did the Registrant raise any such issue with Mr A. Mr A disagreed that the staff in [redacted] were unwelcoming towards any new staff or towards any staff who joined from outside of the Isle of Wight.

50. On Day 3 of the hearing, Ms 1 gave oral evidence by video link in accordance with her witness statement dated 11 May 2023. Ms 1 stated that she met the Registrant when they both did their induction together at the [redacted] store in August 2022. She stated that the Registrant did not respect her personal space although she did not raise this with him. On a Saturday before Christmas 2022, after complaining that she had a headache, the Registrant brought her paracetamol pills and a bar of chocolate saying "this is for you" and either touched or rubbed her shoulder, which made her uncomfortable and she did not appreciate this. Ms 1 did not tell anyone of that incident until she reported it to her manager on 10 December 2022 at the work Christmas party. Upon cross examination, Ms 1 agreed that she only reported this incident after hearing of a similar report from a younger member of staff at the Christmas party. Ms 1 stated that she did hear of an incident in the [redacted] store where the Registrant had taken a lady's number from Socrates and then messaged her. Ms 1 stated that once she knew this, and then what had happened to her with the paracetamol and chocolates, she then formed the view that this was not a person she wanted to be around as she felt it was 'creepy.' From that point on Ms 1 confirmed that she did not feel comfortable working with the Registrant, and others felt the same way, she stated it was because the Registrant had put himself in that situation.

51. On Day 3 of the hearing, Ms A gave oral evidence by video link in accordance with her witness statement dated 5 August 2023. As the practice manager of the [redacted] store, Ms A only had dealings with the first investigation (Case 1) and took the initial statement from the complainant. Ms A confirmed that as far as she knew, the only staff with knowledge of that matter was herself and the three directors. Ms A had no explanation as to how any other members of staff would know the details of that investigation. Ms A confirmed that the Registrant had asked to be moved to [redacted] following that incident, where, on 9th January 2023 she conducted a welfare meeting with him. Upon cross

examination, Ms A accepted that the Registrant had raised some issues with other staff members being 'off' with him and that 'people know things they shouldn't,' however Ms A could not remember the details of the information the Registrant was referring to.

52. On Day 4 of the hearing, Mr 4 gave evidence in person at the hearing and adopted his witness statement dated 30 April 2023 as evidence. Mr 4 outlined that he had been working with the Registrant for 2-3 months, as Mr 4 was mainly based in the [redacted] store. Mr 4 confirmed that on 9 January 2023, whilst he was sitting at a desk on the shopfloor, the Registrant approached him from behind and poked him around the waist with both of his hands. Mr 4 stated that he was uncomfortable with this, and pushed the Registrant back and told him not to touch him. Mr 4 said the CCTV showed the incident as he remembered it. Upon cross examination, Mr 4 disagreed that the Registrant only leaned over and did not touch him. Mr 4 accepted that he did not raise this incident with any other staff or management until a few weeks later. Mr 4 accepted that there were negative discussions regarding the Registrant but denied knowing of the reasons for the Registrant's transfer to [redacted]. Mr 4 stated feeling uncomfortable around the Registrant was part of the reason he reported this incident and requested to transfer stores.

53. Ms 2 also gave evidence on Day 4 in person and adopted her witness statement dated 30 April 2023. Ms 2 stated that a few days after the Queen passed on 8 September 2022, she recalled an incident where the Registrant, on the shopfloor, bent down and whispered in her ear "[redacted] the monarchy." She also recalled a second incident where the Registrant had reported "it's getting heated in there" and referred to a patient as "she's horny." Ms 2 stated that she felt uncomfortable working with the Registrant following these incidents. Upon cross examination, Ms 4 accepted that she only reported these incidents when she was at the work Christmas party, on or around 10 December 2022, after she heard negative comments about the Registrant from other staff members. Ms 2 denied knowing about the reasons for the Registrant's transfer to the [redacted] store. Ms 2 stated that she handed in her resignation after she felt that her reports about the Registrant were not taken seriously.

54. The Registrant started his evidence in person on Day 4 and completed it on Day 5. The Registrant stated that he started working in the Isle of Wight [redacted] branch of Specsavers in September 2022. The Registrant stated that several members of staff were nasty to him, including one member of staff who he placed a grievance against after she told a racist joke and spoke negatively about him to customers and other staff. The grievance was upheld in relation to the racist joke and she received a warning. The Registrant admitted the facts in Case 1 (2022-354). Following this, no disciplinary action was taken but the Registrant was transferred to the [redacted] store. The Registrant stated that immediately all the staff were 'off' with him, that they were aware of the details of the Case 1 investigation, and the staff, including

the witnesses Mr A, Ms A, Ms 1, Mr 4 and Ms 2 and deliberately left him out and made him feel uncomfortable. He raised these concerns to managers at a welfare meeting on 9 January 2023. The Registrant resigned on 4 April 2023 after being told by another manager that the staff were not likely to stop making false allegations against him.

55. In relation to the "paracetamol" incident with Ms 1, the Registrant stated that he simply bought Ms 1 paracetamol and chocolate following her complaints of having a headache as a gesture of goodwill.

56. In relation to the "poke" incident with Mr 4, the Registrant stated that he was leaning over Mr 4, with his hands placed on the chair, to reach for a PD ruler, that he did not touch Mr 4 at all.

57. In relation to the "monarchy" incident with Ms 2, the Registrant denied making that comment at all, and stated that the first time he heard of this allegation was when he read the GOC papers.

58. In relation to the "horny" incident with Ms 2, the Registrant stated that the only reference he made to being heated was when he had a conversation with Ms 2 in relation to his own eczema and how his room had been too hot. The Registrant denied ever making a reference to a patient being "horny" and confirmed that the first time he read about this was when he received the GOC papers.

59. Upon cross examination, the Registrant stated that he believed that all of the staff had collectively been involved in making false allegations against him. The Registrant stated that he was not made aware of the allegations from Ms B in relation to the Case 1 (2022-354) matters during his disciplinary investigation at all. The Registrant accepted that allegation. The Registrant did not accept making a series of misguided jokes which have led to these allegations.

60. During Day 5, the Registrant stated in his evidence that he did not fully accept the facts of Case 1 (2022-354) Allegation 3d.

61. On Day 7, the Registrant withdrew his admission in relation to Allegation 3d. Mr James for the GOC, having reviewed the case, made an application to amend Case 1 (2022-354) Allegation 3d, as it did not amount to an allegation which matched the facts on the evidence.

62. Mr Hall on behalf of the Registrant raised no objections.

63. The Committee heard and accepted advice from the Legal Adviser, that under *Rule 46 (20) of the Fitness to Practise Rules* the Committee can, where it appears 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 those particulars or those grounds in appropriate terms.

64. The Legal Adviser advised that the Committee should consider the prejudice to the Registrant, and balance this against the overarching objective of protection of the public (*s. 2A of the Opticians Act 1989*).

65. The Committee agreed to the amendment of Case 1 (2022-354) Allegation 3d which now reads as follows:

    "On one occasion, added Ms B as a friend on social media platform

    "Snapchat" without her consent."

66. The Registrant admitted Allegation 3d as amended.

67. The Committee found the facts of Allegation 3d proved.

Submissions on the facts

68. Mr James on behalf of the GOC provided written submissions on the facts. Mr James summarised the evidence in relation to Case 2 and submitted that each of the witnesses has given a credible and consistent account, and it is unlikely that the witnesses have all conspired together to lie in relation to the alleged behaviour of the Registrant. Mr James submitted that it is far more likely that the Registrant, in an effort to fit in with the staff in the [redacted] store, has made a series of jokes in poor taste. Mr James submitted that this is best demonstrated on the CCTV in relation to Allegation 4. In doing so, the Registrant has failed to maintain professional boundaries. The Registrant knew or ought to have known that such conduct was inappropriate, and that his colleagues were made to feel uncomfortable by his actions.

69. Mr Hall on behalf of the Registrant also provided written submissions and submitted that the GOC have not discharged their burden to prove the Allegations on the 'balance of probabilities.' Mr Hall submitted that the witnesses are either mistaken or deliberately lying so as to remove the Registrant from being able to work at the [redacted] practice. Mr Hall submitted that the staff at the [redacted] practice had heard about the facts in relation to the Case 1 (2022-354) Allegations in the [redacted] store, and were therefore unwelcoming to the Registrant. Further, due to the Registrant's upheld grievance against another managerial staff member, the Registrant was also disliked by her. Mr Hall submitted that Ms 1 and Ms 2 only raised their concerns following a discussion about the Registrant with others at the Christmas party. Further, Mr Hall submitted that each of the witnesses' memories of the alleged incidents were tainted by both what they had learned of the Registrant's behaviour in relation to Case 1, as well as the general office impression of the Registrant.

70. The Legal Adviser provided legal advice at the fact-finding stage, outlining that the burden of proof is on the Council to the civil standard, that is, on the balance of probabilities. The Committee must consider the entirety of oral evidence heard, in the context of documentary evidence and make its own findings on reliability, accuracy and credibility. The Committee must reach a

conclusion on each Allegation separately, but it is entitled, in determining whether or not each particular is proved, to have regard to relevant evidence in relation to any other Allegation.

71. Although it does not provide a defence, previous good character is an important factor capable of assisting the Registrant in two ways: in relation to credibility as well as propensity. The Committee can also consider here the three references submitted as part of the Registrant bundle.

72. The Legal Adviser also addressed the issue of credibility and the cases of *Dutta v GMC [2020]EWHC 1974, Byrne v General Medical Council [2021] EWHC 2237 (Admin)* and *Khan v The General Medical Council [2021] EWHC 374 (Admin)* in that the Committee should start with the objective, independent, contemporaneous evidence before moving on to consider demeanour, if necessary.

Findings on the facts

73. The Committee acknowledged that the Registrant had already admitted the facts in Case 1 (2022-354) and started by considering whether the disputed allegations in Case 2 (2023-006) were proved.
74. The Committee heard and accepted the advice of the Legal Adviser. The Committee considered all of the written and oral evidence from each of the witnesses in the case, as well as the CCTV of the incident alleged on 9th January 2023 and the admissions from the Registrant in relation to Case 1.
75. Given the drafting of the Allegations, the Committee considered each allegation in turn as to whether the facts are proved, and then went on to consider each Allegation with reference to Allegation 5, as to whether the conduct, if found proved, was inappropriate in that the Registrant had i) failed to maintain appropriate boundaries; and/or, ii) knew or ought to have known that such conduct was not appropriate, iii) his colleagues were made to feel uncomfortable by his actions.

<u>Allegation 1a</u>

76. The Committee considered the evidence of Ms 1 and her witness statement dated 30 May 2023 which was the most contemporaneous record of this incident. The Committee found Ms 1's evidence consistent in that she described that the Registrant had, after giving her paracetamol and chocolates, touched her shoulder, which made her feel uncomfortable. Ms 1's account had clear reference to how the Registrant made her feel and she described his behaviour as 'creepy' and 'sleazy.' The Committee accepted Ms 1's account that this behaviour made her uncomfortable.
77. Despite the acknowledgement that she was aware of the other Allegation made in the [redacted] store, the Committee considered that Ms 1 had no other motivation to report this incident other than that it was true, and it believed her account that she finally reported this at the Christmas party because she learned of a similar pattern of behaviour with other staff.

78. The Committee noted that the Registrant had stated that he had not become aware of this Allegation until he received the GOC bundle several months later, and had given his first account to the Committee almost two years after the event. The Committee did not find it credible that the Registrant had such a detailed recollection of, on his account, such an unmemorable event.
79. In considering the credibility of the witnesses, the Committee did not initially take into account the admitted facts of Case 1, or the findings in relation to the other Allegations in Case 2. However, having formed a view of the evidence in relation to each separate particular, it considered the extent to which its view was consistent with the evidence relating to Case 1, and with the other allegations in Case 2. It found that its initial views were consistent with the conclusion that the Registrant had not established that his evidence was credible. The Committee refers to this below when making its findings in relation to Allegation 5.
80. The Committee therefore found, on the balance of probabilities, that the facts were proved.
81. In relation to Allegation 5, the Committee found that this behaviour did amount to inappropriate behaviour in that 5ai the Registrant failed to maintain appropriate boundaries in placing his hand on her shoulder and that in 5aiii, the Registrant made Ms 1 feel uncomfortable, which was clear from her evidence. The Committee was not satisfied on balance that the Registrant, in 5aii knew, or ought to have known that such conduct was inappropriate. Taking the evidence in the round, it appeared that the Registrant may have had some difficulty recognising appropriate professional behavioural boundaries.

Allegation 2

82. The Committee considered the evidence from Ms 2 and her witness statement dated 30 April 2023 which was the most contemporaneous record of this incident. The Committee considered Ms 2's evidence to be consistent with her witness statement. Ms 2 had described a lack of awareness of personal boundaries in that the Registrant came very close to her in making the comment. The Committee considered Ms 2's evidence to be credible in this regard.
83. The Committee noted that according to Ms 2 herself, it was not the words "[redacted] the monarchy" that she found so uncomfortable, but the fact the Registrant had got very close to her and whispered it into her ear. Ms 2 described feeling uncomfortable and leaving the store after she had reported the allegation and did not feel it was taken seriously by managers.
84. The Committee noted that the Registrant had stated that he had not become aware of this Allegation until he received the GOC bundle several months later, and had given his first account to the Committee more than two years after the event. The Committee did not find it credible that the Registrant had such a detailed recollection of, on his account, such an unmemorable event.
85. The Committee therefore found, on the balance of probabilities, that the facts were proved.

86. In relation to Allegation 5, the Committee found that this behaviour did amount to inappropriate behaviour in that 5ai the Registrant failed to maintain appropriate boundaries in getting close to Ms 2 and whispering in her ear, and that in 5aiii, the Registrant made Ms 2 feel uncomfortable by being too close to her, which was clear from her evidence. The Committee was not satisfied on balance that the Registrant, in 5aii knew, or ought to have known that such conduct was inappropriate. Taking the evidence in the round, it appeared that the Registrant may have had some difficulty recognising appropriate professional behavioural boundaries.

Allegation 3a, 3b and 3c

87. The Committee considered the evidence from Ms 2 and her witness statement dated 30 April 2023 which was the most contemporaneous record of this incident. The Committee considered Ms 2's evidence to be consistent with her witness statement. Ms 2 had described the Registrant referring to a patient as "she's horny." Ms 2 described challenging the Registrant, who had been smiling, and upon Ms 2 saying "I hope you are not entertaining it" the Registrant stopped smiling. The Committee found her evidence in this regard credible.
88. The Committee also considered the fact that Ms 2 had not reported it at the time, and considered her explanation of allowing the Registrant more time to settle in at the store to be believable. Despite the acknowledgement that she was aware of the other Allegations made in the [redacted] store, the Committee considered that Ms 2 had no other motivation to report this incident other than that it was true, and accepted her account that she finally reported this at the Christmas party once she learned of similar behaviours of the Registrant towards other staff.
89. The Committee noted that the Registrant had stated that he had not become aware of this Allegation until he received the GOC bundle several months later, and had given his first account to the Committee almost two years after the event. The Committee did not find it credible that the Registrant had such a detailed recollection of, on his account, such an unmemorable event.
90. The Committee therefore found, on the balance of probabilities, that the facts were proved.
91. In relation to Allegation 5, the Committee found that this behaviour did amount to inappropriate behaviour in that 5ai the Registrant failed to maintain appropriate boundaries in making inappropriate comments in relation to a patient. The Committee also considered that 5aii was made out in that the Registrant knew, or ought to have known that these comments were inappropriate. It found that the Registrant ought to have known that it was highly inappropriate to make lewd comments about a patient. The Committee also found in 5aiii that Ms 2 was made to feel uncomfortable, which was clear from her evidence.

Allegation 4

92. The Committee considered the evidence from Mr 4 and his witness statement dated 30 April 2023. The Committee considered Mr 4's evidence to be consistent with his witness statement. Further, in this Allegation, the Committee were provided with two CCTV clips showing the incident. The Committee considered the CCTV to be the most contemporaneous evidence of this incident. The Committee did consider that the Registrant approached Mr 4 from behind and poked him by the waist, as was evident in the CCTV. Mr 4 clearly reacts immediately and his evidence was that he told the Registrant "I don't like being touched." Mr 4 also stated that the Registrant apologised later, which the Committee also found credible.
93. The Committee considered carefully the Registrant's version of the CCTV and found it implausible that he was simply reaching around Mr 4 to get a PD ruler from the lowest shelf below the desk. The incident is clear from the CCTV. Mr 4 reported this incident only weeks later, giving details consistent with the subsequent CCTV evidence, before even being aware that CCTV footage was available.
94. The Committee also considered the Registrant's version of events that Mr 4 may have either lied or misremembered this incident due to becoming aware of the other incidents involving the Registrant. The Committee considered the CCTV to undermine the Registrant's account. Further, it considered that as a witness who is also regulated by the GOC, it is unlikely that Mr 4 would have made the statement, without knowledge of the existence of CCTV evidence, and travelled to give evidence in London from the Isle of Wight, and lied to the Committee under oath, unless his evidence was true.
95. The Committee noted that the Registrant had stated that he had not become aware of this Allegation until he received the GOC bundle several months later, and had given his first account to the Committee almost two years after the event. The Committee did not find it credible that the Registrant had such a detailed recollection of, on his account, such an unmemorable event.
96. The Committee therefore found, on the balance of probabilities, that the facts were proved.
97. In relation to Allegation 5, the Committee found that this behaviour did amount to inappropriate behaviour in that 5ai the Registrant failed to maintain appropriate boundaries in poking Mr 4 by the waist, and in 5aiii that Mr 4 was made to feel uncomfortable, which was clear from his evidence and the CCTV. The Committee was not satisfied on balance that the Registrant, in 5aii knew, or ought to have known that such conduct was inappropriate. Taking the evidence in the round, it appeared that the Registrant may have had some difficulty recognising appropriate professional behavioural boundaries.

Allegations 5ai, 5aii and 5aiii

98. The Committee found for the above reasons that the Registrant's conduct was inappropriate in relation to allegations 1, 2, 3 and 4.
99. The Committee went on to consider Case 1 (2022-354) and the cross admissibility of evidence. The Committee noted the Registrant's assertion that he was not asked about the facts of Case 1 at his disciplinary meeting,

despite the fact that the written evidence is clear that the Registrant was asked about this and denied it at the time. He was specifically asked whether he had ever taken information from the database for his own personal use and he replied "never." Further, during his welfare meeting he stated that he was shocked at being suspended over the incident as "it was all hearsay." In fact, the Committee noted that the Registrant had not admitted the facts of Case 1 until as late as Day 2 of this substantive hearing, when he admitted the facts of Case 1. The Committee considered this to undermine the Registrant's overall credibility.

100. The Committee, when taking together the admitted facts of Case 1, the witness evidence in Case 2, and in particular the independent CCTV evidence, did not accept the Registrant's version of events that the witnesses were either mistaken or were lying about their accounts due to being aware of the details of the Allegations in Case 1. The Committee considered that when considering the case as a whole, there was, on the evidence, a credible pattern of the Registrant failing to understand boundaries of personal space and appropriate behaviour at work.
101. The Committee therefore found in Allegation 5 of Case 2 that the Registrant failed to maintain appropriate boundaries, that he knew or ought to have known that his conduct was not appropriate (in relation to Allegation 3) and that his colleagues were made to feel uncomfortable by his actions.
102. The Committee therefore found the facts proved in relation to Case 2 (2023-006) Allegations 1a, 2, 3a, 3b, 3c, 4, 5ai, 5aii and 5aiii.

Submissions on misconduct

103. Mr James, on behalf of the Council, submitted that in Case 1 misconduct is admitted by the Registrant. This case demonstrates a clear and serious breach of data protection and professional boundaries. The behaviour also breaches the reputation of the profession as the public rightly expects their data to be protected.
104. In relation to Case 2 Mr James submitted that the facts proved amount to misconduct. Mr James referred to the definition of misconduct in *Roylance v General Medical Council (No 2) [2001] 1 AC 311* and outlined that the "*rules and standards ordinarily required to be followed*" in this case would be the General Optical Council Standards for Optical Students ("*the Standards*"). Mr James argued that the Committee has found in respect of each Allegation that the Registrant has failed to maintain appropriate boundaries in breach of *Standard 14.* The Committee has also found that the Registrant's conduct made his colleagues feel uncomfortable, underlying the seriousness of the breach. Mr James submitted that the Allegations in relation to Ms B, Ms 1 and Ms 2 all involve "sleazy" behaviour with women and this is a clear pattern of behaviour that taken together amounts to serious breaches of *Standard 14.*
105. Mr James submitted that the Registrant has displayed a repeated lack of judgement and abuse of position, and that the seriousness of the misconduct is also spoken to by a member of the public in Ms B. Mr James submitted

that the Allegations proved breach *Standards 13 (maintain confidentiality and respect patients' privacy), 14 (maintain appropriate boundaries with others) and 16 (do not damage the reputation of your profession through your conduct).* Mr James also submitted that the Committee can take into account the cumulative effect of the individual instances of misconduct (*Ahmedsowida v GMC [2021] EWHC 3466 (Admin*)).

106. Mr Hall, on behalf of the Registrant, submitted that the facts found proven at Case 2 (1-5) are not "*serious professional misconduct*" but at most constitute *inappropriate* behaviour by the Registrant. Mr Hall submitted that the Registrant's actions, at most, were thoughtless and stemmed from a desire to make friends with his colleagues, having recently moved to the Isle of Wight. They have never been put higher than "*inappropriate*"; they are not charged or presented as flirtatious or sexually motivated. The Registrant's actions did not put patients at risk, nor fall seriously below what would have been proper in the circumstances. His actions should be contextualised with the reality of working in a small-knit optometry practice on the Isle of Wight, where its staff members frequently socialised together outside of work.
107. Further, Mr Hall submitted that the Registrant's actions were not wilfully malicious. It is of note that for paragraphs 1, 2, and 4 of the Allegation, the Committee has not found that the Registrant "*knew*" that such conduct was not appropriate and therefore it is hard to see how the unintended consequences of whispering, touching, buying gifts, and poking could ever constitute misconduct in a Regulatory setting.
108. Mr Hall outlined the cases of *Schodlok v General Medical Council [2015] EWCA Civ 769* and *Ahmedsowida v GMC (2021) EWHC 3466(Admin)* and submitted that this is not an exceptional case with many failings to satisfy the legal test for looking at the findings cumulatively. Mr Hall submitted that although the Committee may have found that the Registrant's conduct showed "*a credible pattern of the Registrant failing to understand boundaries of personal space and appropriate behaviour at work,"* the Registrant's conduct is not severe enough, nor endemic enough, exceptionally, to elevate it to misconduct.
109. The Legal Adviser outlined the *Guidance* at *Paragraphs 15.6-15.9,* and the case of *Roylance v GMC [1999] Lloyd's Rep Med 139* where misconduct was described as:
"A falling short by omission or commission of the standards to be expected among [medical practitioners] and such falling short must be serious… It is of course possible for negligent conduct to amount to serious professional conduct, but the negligence must be to a high degree".
110. The Legal Adviser further outlined the case of *Remedy UK Ltd v General Medical Council [2010] EWHC 1245 (Admin)*, that there were two principal kinds of misconduct, in this case the alleged misconduct does not relate to professional practice but conduct that otherwise brings the profession into disrepute. The Committee were advised that only serious misconduct is taken into consideration at the impairment stage. The Committee should therefore

consider each of the proven allegations in turn, and first decide on whether each amounts to serious misconduct.

111. The Legal Adviser then advised that if the Committee concludes that any matters are non-serious matters, it can then go on to consider whether the cumulative effect of them, taken together, might amount to misconduct. The Legal Adviser outlined the cases of *Schodlok v General Medical Council [2015] EWCA Civ 769* and *Ahmedsowida v GMC (2021) EWHC 3466(Admin). Schodlok* has set a high bar for cumulation; unless the numbers are large and the case exceptional.

112. The Legal Adviser reminded the Committee that misconduct was a matter for its own independent judgement and no burden or standard of proof applied.

Findings on misconduct

113. The Committee heard and accepted the advice of the Legal Adviser, and considered the written and oral submissions.

Case 1 (2022-354)

114. The Committee noted that misconduct in relation to Case 1 (2022-354) has been admitted. The Committee considered the unchallenged written evidence of Ms B. The Registrant, between October 2022 and November 2022, obtained personal details of a patient, Ms B, and contacted her multiple times on various social media platforms, including sending multiple videos and images. This included footage of somewhere that resembled Syria of a man in army uniform holding a weapon. The Registrant continued to contact her and send her unsolicited and highly inappropriate messages. This behaviour had a significant impact on Ms B, she described “freaking out” and being scared of repercussions, and she felt it serious enough to report the matter to the Registrant’s employer and the police.

115. The Committee considered this to be a very serious falling short of the *Standards,* in particular *Standards 13, 14* and *16.* The Committee found this matter to be serious misconduct.

Case 2 (2023-006)

Allegation 1a

116. The Committee had found the facts proved in relation to this Allegation and had determined that Allegations 5ai and 5aiii applied. The Committee found that the Registrant’s behaviour was unwelcome and made Ms 1 uncomfortable. Ms 1 was understandably frustrated that when she reported this, she felt that the management did not take appropriate action. However, the Committee did not consider that the Registrant was aware, or was made

aware, of this at the time of the incident. Whilst the Registrant had some difficulty recognising appropriate professional boundaries, and the touching of Ms 1's shoulder was ill-judged and unwise, it did not amount to serious misconduct in accordance with the description in *Roylance v GMC [1999] Lloyd's Rep Med 139.*

Allegation 2

117. The Committee had found the facts proved in relation to this Allegation and had determined that Allegations 5ai and 5aiii applied. The Committee found that the Registrant's comment, but more crucially the fact the Registrant had got very close to Ms 2's ear and whispered it into her ear, had made her uncomfortable. The Committee did not consider that the Registrant was aware, or was made aware, of this at the time of the incident. Whilst the Registrant had some difficulty recognising appropriate professional boundaries, and his behaviour was ill-judged and unwise, it did not amount to serious misconduct in accordance with the description in *Roylance v GMC [1999] Lloyd's Rep Med 139.*

Allegations 3a, 3b and 3c

118. The Committee found the decision as to misconduct in this Allegation more finely balanced. The Committee considered this to be a lewd comment about a patient which was wholly inappropriate and made Ms 2 feel uncomfortable. In this Allegation, the Committee had found that Allegations 5ai, 5aii and 5aiii applied. The Committee considered, given the professional environment the Registrant was in, that he ought to have known this was an inappropriate comment, especially in relation to a patient. The Committee considered that the Registrant appeared to have recognised that himself at the time as, when challenged by Ms 2, he stopped smiling and changed his behaviour.
119. However, when considering the test in *Roylance v GMC [1999] Lloyd's Rep Med 139*, the Committee did not consider that this behaviour, when taken alone, reached the level of serious misconduct. Whilst the Registrant had some difficulty recognising appropriate professional boundaries, and the comments regarding a patient were ill-judged and unwise, it did not amount to serious misconduct in accordance with the description in *Roylance v GMC [1999] Lloyd's Rep Med 139.*

Allegation 4

120. The Committee had found the facts proved in relation to this Allegation and had determined that Allegations 5ai and 5aiii applied. The Committee found that the poking of Mr 4 by the Registrant appeared to be an ill-judged joke and made Mr 4 feel uncomfortable. The Committee did consider this to demonstrate the Registrant's difficulty in recognising appropriate professional

boundaries. Whilst the behaviour was ill-judged and unwise, the Committee did not find that it amounted to serious misconduct in accordance with the description in *Roylance v GMC [1999] Lloyd's Rep Med 139.*

121. The Committee therefore found that each of the Allegations in Case 2 (2023-006) did not individually amount to serious misconduct.
122. The Committee then considered the cases of *Schodlok v General Medical Council [2015] EWCA Civ 769* and *Ahmedsowida v GMC (2021) EWHC 3466(Admin)* and determined that the facts found proved, taken cumulatively, could potentially amount to misconduct in this case, in so far as the GOC had opened their case on that basis, and the matters were of a similar nature. However, in the Registrant's case, although the Committee had found four instances of inappropriate conduct which fell short of misconduct, it did not consider that this was an 'exceptional' or 'unusual' case or even a large number of instances. For those reasons it did not consider it appropriate to take the matters cumulatively to find misconduct.

Submissions on impairment

123. The Registrant gave oral evidence in relation to impairment, which, following the Committee's findings on misconduct, was now only relevant to the facts of Case 1. The Registrant admitted he was currently impaired, and had admitted this from the outset of this hearing. The Registrant accepted that his actions would have had a significant negative impact on patients, his colleagues and the profession as a whole, and was a significant failure of the duty to uphold the *Standards.* The Registrant stated that he would never engage in any form of patient contact again outside of work. The Registrant described feeling lonely at the time, being so far from home and family, which resulted in a moment of madness. The Registrant stated that he did not seek to justify his actions, has always regretted his actions, and has never repeated the same action again in practice. The Registrant accepted that the videos he sent to Ms B would have caused her to be scared and anxious and wished to apologise to Ms B.
124. Since leaving the Isle of Wight, the Registrant completed a second pre-registration placement in Sheffield which was a short-term contract to try and complete his stage 2 in time to sit OSCEs. As the time has expired for the Registrant to complete his pre-registration qualification, the Registrant is currently working in schools through a teaching agency, teaching mainly maths and science between age groups 11-16. During his time at the Sheffield store the Registrant completed courses on 'iLearn' in relation to GDPR, safeguarding and professionalism, although had not brought certificates or evidence of this to the hearing. The Registrant stated that he hoped to complete his pre-registration and pursue his desired career to become an optometrist.
125. Upon questioning, the Registrant accepted that his contact with Ms B was over a period of at least two weeks, and he stated that at the time, he lacked the discipline and moral character to stop himself from making contact with Ms B. The Registrant indicated that the video sent to Ms B containing a reel

of somewhere that resembled Syria, of a man in army uniform holding a weapon, was taken out of context and was just a normal video. The Registrant stated that he had sent this to a number of people and had not meant to cause any concern to Ms B, although accepted that she may have been distressed by this.

126. The Registrant was referred to the evidence bundle and the signed notes of the disciplinary meeting which took place on 23 November 2022. The Registrant was taken through the GOC bundle at pages 125 (questions) and page 112-113 (answers – **in bold below**):

"T [reference to Manager] – Reads out Allegations 4 & 5:
Inappropriate use of customer details- including accessing customer records to obtain a personal phone number
Inappropriate and unwanted contact with customers via social media
GDPR training is present throughout your induction, and we have records to show you have completed this. You will also have had strict guidance through your professional training and GOC membership.
I refer to page 59 in the staff handbook and GOC standards -
14.6 Only use the patient information you collect for the purposes it was given, or where you are required to share it by law
Q22. Have you ever taken information from the database for your own personal use?
ANSWER: Never

Q23. How many mobile phone numbers do you have? If more than one what is your other mobile number?
ANSWER: Just 1

T READS OUT
The police have informed us that because the young lady did not wish to be named at this stage that they could not take further action, but had informed you by letter that there had been a report raised. We received the below update from the police on Weds 16/11. I have sent a letter out to the male informing him of his behaviour and the offences he may commit if he continues. I have only told him that the police received a report of his conduct regarding his employment at Specsavers. No personal details were given of any person. I will now submit this incident for filing with no further action but it will remain recorded on our systems.
Q24. Did you receive this letter?
ANSWER: No

Q24. Can you think of any reason somebody would file a complaint against you?
ANSWER: No

Q25. Do you have anything you would like to add?

ANSWER: No"

127. In his evidence the Registrant remembered that he had been asked questions 22 and 23, but said the Allegations had not been read to him nor was he asked about contacting Ms B. He acknowledged his signature on each page of the meeting notes and recalled that he had been asked about a letter from the police but denied having any knowledge of the details of the Allegation in relation to Patient B at the stage of the disciplinary hearing, maintaining that he had always accepted that he was wrong to have contacted her.
128. In his submissions on impairment, Mr James, on behalf of the GOC, outlined the *Guidance Paragraph 16.4,* and submitted that the Registrant is currently impaired firstly in that his behaviour undermines the trust and confidence that the public places in the profession. The public expects their personal details to be kept private and this was a clear misuse of confidential patient information. Mr James outlined that there is a clear risk to the public because Ms B was caused genuine emotional distress by the Registrant's actions, so much so that she reported it to his employer and the police. Further, Mr James submitted that a well-informed member of the public would be shocked if such a serious breach of a fundamental tenet of profession were to go unrecognised and therefore it was in the public interest that action should be taken. Finally Mr James submitted that the Registrant continues to give a false account in relation to his recollection of the disciplinary proceedings, and maintains that this undermines the Registrant's insight in that despite his evidence, he did not acknowledge his behaviour towards Ms B until the beginning of these proceedings.
129. Mr Hall, on behalf of the Registrant, submitted that the Registrant had already accepted he was currently impaired in relation to the public interest and public protection. The Registrant had gone through a difficult period and had demonstrated stupidity and thoughtlessness in his exchanges with Ms B. The Registrant had demonstrated insight in his evidence and his reflective statement dated 7 November 2024, and should be given credit for his level of remorse and regret expressed. Mr Hall submitted that the Registrant should also be credited for his level of engagement with the proceedings.
130. The Legal Adviser outlined *Paragraphs 16.1 to 16.7* of the *Hearings and Indicative Sanctions Guidance.* The Legal Adviser then advised the Committee to consider the two separate elements of impairment namely the public component, which concerns the reputation of the profession and upholding professional standards, and the personal component which concerns the risk of repetition and insight displayed on the part of the registrant as in *Cohen v GMC 2008 EWHC 581***.**
131. The Legal Adviser also outlined the case of *CHRE v Grant 2011 EWHC 927* which indicated some questions for the Committee to ask itself:

a. Has [the Registrant] in the past acted and/or is [he] liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or

b. Has [the Registrant] in the past and/or is [he] liable in the future to bring the medical profession into disrepute; and/or
c. Has [the Registrant] in the past breached and/or is [he] liable in the future to breach one of the fundamental tenets of the medical profession; and/or
d. [not applicable] Has [the Registrant] in the past acted dishonestly and/or is liable to act dishonestly in the future.

132. The Legal Adviser further advised the Committee that at the impairment stage, there is also no burden or standard of proof, but ultimately it is a question of judgement for the Committee alone.

Findings on impairment

133. The Committee heard and accepted the legal advice.
134. The Committee considered the evidence given by the Registrant, the submissions from both parties, and the reflective piece from the Registrant dated 7 November 2024.
135. The Committee also considered the *Guidance* at *Paragraphs 16.1* to *16.7,* the four questions in the *Grant* case and the Council's overriding objective and gave equal consideration to each of its limbs as set out below:

"To protect, promote and maintain the health, safety and well-being of the public, the protection of the public by promoting and maintaining public confidence in the profession and promoting and maintaining proper professional standards and conduct."

136. The Committee noted that the Registrant had admitted he was currently impaired in relation to Case 1. The Committee also found that he had in the past acted so as to put a patient at unwarranted risk of harm, had brought the profession into disrepute, and had breached one of the fundamental tenets of the profession as per the case of *Grant*. The Committee went on to consider the questions in *Grant* with reference to the Registrant's future risk.
137. The Committee considered insight to assist it with the Registrant's future risk of repetition. The Registrant had given evidence that he had always admitted these Allegations. The Committee considered the handwritten notes of the Specsavers disciplinary meeting on 23 November 2022, the denials the Registrant had purportedly made, and the Registrant's response that these allegations were not put to him at that stage. The Committee found the Registrant's response in relation to this unconvincing. The Committee also noted that as late as Day 1 of the hearing, the Registrant had required Ms B's attendance in person to give evidence. The Committee found the Registrant's evidence unconvincing in this regard. The Committee considered that this undermined the Registrant's account that he had admitted the allegations early enough to demonstrate sincere remorse for, and insight into his actions. The Committee acknowledged that since his admissions on the second day of this hearing, the Registrant had expressed remorse and apologised to Ms B.

138. In relation to placing a patient at unwarranted risk of harm, the Committee had already concluded that the Registrant's actions were serious and caused Ms B psychological harm. Ms B had been "freaking out" and was scared of repercussions, and had felt it serious enough to report the matter to the Registrant's employer and the police, as well as installing CCTV at her address.
139. Despite the fact that the Registrant himself had referred to Ms B as 'ghosting' him and 'airing' him, as well as blocking him on some media platforms, he continued to contact her on other social media platforms. The Committee considered that the Registrant would have, or should have been aware at that point that his messages were unwanted. The Committee considered that this showed a clear lack of respect for boundaries.
140. Looking forward, the Committee acknowledged that the Registrant had admitted the Allegations and shown some insight, but it considered his insight into the seriousness of his behaviour, and the reasons for his behaviour, to be limited. The Committee was not therefore satisfied that there would not be a repetition of this behaviour. The Registrant had, in his evidence on impairment, repeatedly placed himself at the forefront when listing people who had been negatively affected by his behaviour, and appeared to minimise his actions and the consequences of his behaviour.
141. In particular, in relation to the video reel sent to Ms B of what looked like Syria with a man dressed in an army uniform holding a weapon, the Registrant still did not appear to have fully grasped himself why he sent this to Ms B, nor how seriously this would have affected her, stating only that he was lonely at the time, that it was a 'normal' video which she had taken 'out of context.' The Committee considered that the Registrant minimised his actions, and that the public would be very concerned were these actions not to be taken sufficiently seriously. The Committee concluded that the Registrant's insight in this regard was severely lacking and therefore there was a risk in the future of patients being placed at unwarranted risk of harm.
142. The Committee found that the Registrant had, as admitted, brought the profession into disrepute in that the public' confidence in the profession would be undermined by his behaviour. Looking forward, the Committee noted that the Registrant had acknowledged the impact of his actions on the profession, and assured the Committee that he would not repeat the same behaviour. The Committee considered the three testimonials provided by the Registrant and the fact that he had fully co-operated with the GOC proceedings. However, for the above reasons, the Committee considered that there remains a risk of repetition and the Registrant was liable in the future to bring the profession into disrepute.
143. The Registrant also accepted a breach of the fundamental tenets of the profession, given that he fell short of *Standards 13, 14* and *16.* Looking forward, the Committee acknowledged that the Registrant had taken some steps to remediate by completing a brief period of employment at Specsavers in Sheffield, as well as completing various 'iLearn' training courses. The Committee would have been assisted further by certificates confirming the

Registrant's training, particularly in relation to courses regarding maintaining professional boundaries. The Committee considered that there was further work the Registrant could have undertaken and demonstrated to remedy this gap in his training, and therefore there still remained a risk of repetition.

144. The Committee returned to the overarching objective and for the reasons above, considered that all three limbs of the test were engaged, namely that the Registrant had in the past, and is at risk in the future, of failing to protect, promote and maintain the health, safety and well-being of the public, failing to maintain public confidence in the profession and failing to maintain proper professional standards and conduct.
145. The Committee therefore found that the fitness of the Registrant to undertake training was currently impaired.

Submissions on sanction

146. Mr James on behalf of the GOC submitted that a sanction of 6 months' suspension with review would be appropriate in this case. Whilst the Committee must consider all sanctions, the risk of harm and the public interest considerations are such that action needs to be taken. Mr James submitted that, this is not an exceptional case, nor one where there is an identifiable clinical deficiency. Further, Mr James submitted that due to the nature of the particular misconduct, it would be a very difficult issue to supervise and deal with through workable conditions. Mr James submitted that when left with suspension or erasure, this case is not necessarily so serious as to fulfil the requirements of erasure. For those reasons, Mr James submitted that suspension is appropriate. There was clearly an impact on Ms B and this distress had been recognised in the Committee's findings. However, there is a degree of insight from the Registrant, some remorse, some remediation, and no repetition since the incident. Given those circumstances, a 6-month suspension with review will give the Registrant the opportunity to develop insight, remediate and show a future Committee that he will not repeat this behaviour.
147. Mr Hall on behalf of the Registrant submitted that the appropriate sanction for the allegations before the Committee (Case 1) is one of a period of 6 months' suspension. That suspension order will strike the correct balance between protecting the public, upholding professional standards, and enabling the Registrant to develop further insight, remediate and return to practice. It is submitted that to erase the Registrant from the register is not necessary and would be disproportionate and punitive. The conduct is a serious instance of misconduct where a lesser sanction is not sufficient.
148. Mr Hall submitted that there was no evidence of harmful deep-seated personality or attitudinal problems, nor of any repeated behaviour since the incident. The Registrant has demonstrated some insight (albeit limited) and does not pose a significant risk of repeating the behaviour.
149. Mr Hall submitted that erasure would be disproportionate and punitive because the conduct of the Registrant was not "fundamentally incompatible" with him remaining on the Register. Mr Hall stated that although a departure

from professional standards, the Registrant's conduct was not so serious as to cross the erasure threshold on the spectrum of allegations. Mr Hall stated that there was no abuse of position, it was not an allegation of sexual, violent or dishonest conduct, and there has been no breach of the professional duty of candour. Further, Mr Hall stated that there has not been a persistent lack of insight. The Registrant admitted the allegations. Ms B did not have to give evidence. The Registrant provided a reflective statement, demonstrated insight, and gave evidence to the Committee and clearly understands the consequences of his actions towards Ms B, his colleagues, and the profession.

150. Mr Hall further submitted that there has been no evidence of a longstanding impact on Ms B, that there was evidence of the Registrant's insight and remorse, and that the Committee may consider the stage of the Registrant's career when making decisions, as he may have done things differently with the benefit of experience. Finally Mr Hall drew the Committee's attention to the personal mitigation in the form of the Registrant's circumstances at the time and his accompanying testimonials.
151. The Legal Adviser outlined the *Guidance Paragraphs 20-23* and *13F - 13H* of the *Opticians Act 1989* in outlining the sanctions available to the Committee. The Legal Adviser stated that the sanctions guidance is not a 'straightjacket', but if the Committee were to deviate, they must give reasons. It is not the purpose of sanctions to punish, but the Committee should consider proportionality and balance the interests of the public against those of the Registrant. That said, the interests of the profession take precedence as per *Bolton v Law Society (1994) 1 WLR 512*.
152. The Legal Adviser advised the Committee to consider whether there are any particular mitigating or aggravating features, and then to work through the sanctions starting first with the least restrictive, and having regard to the over-arching objective of protecting the public, whilst taking a proportionate approach.

Findings on sanction

153. In reaching its decision on sanction, the Committee took into account the submissions on behalf of all parties, the facts found proved and its previous findings on misconduct and impairment.
154. Throughout its deliberations the Committee had regard to the overarching objective, giving equal consideration to each of its limbs.
155. The Committee took into account the *Guidance* at *Paragraph 14.3* and considered the following to be aggravating factors in this case:

    a. There was an abuse of trust, Ms B being the mother of a patient and the Registrant having taken advantage of his position in order to access the notes and obtain her phone number;

    b. Ms B suffered actual psychological harm, impactful enough that she contacted the Registrant's employer and the police, and installed CCTV;

c. This was not one isolated incident; the Registrant contacted Ms B on multiple occasions albeit over a period of weeks;

d. The Registrant has tried to minimise his behaviour and the Committee has concerns about his candour during the hearing;

e. The Registrant's insight was not timely, his admissions to the Allegations only being entered at the start of this hearing, (arrangements having been made for Ms B to attend to give evidence) and his reflective statement only being dated 7 November 2024.

156. In mitigation, the Committee acknowledged the following factors:

a. The Registrant did not appear to have a harmful or deep seated attitudinal problem;

b. There has been no repetition of this behaviour;

c. The Registrant has apologised and shown some remorse, albeit late;
d. The Registrant has shown some insight, albeit still developing;
e. The Registrant has provided positive testimonials from those he has worked with after the misconduct occurred.

157. The Committee followed the *Guidance* at *8.3* and went through the possible sanctions, starting with the least severe, that being to take no further action. It determined, having regard to the *Guidance*, that there were no exceptional circumstances to justify it doing so. Taking no action would not protect the public or be in the wider public interest, it would not reflect the seriousness of the misconduct and therefore it would be entirely inappropriate.

158. The Committee decided that the imposition of a financial penalty was not appropriate or proportionate and would not reflect the seriousness of the misconduct, or protect the public against the risk of repetition.

159. The Committee next considered a period of conditional registration. It took into account *Paragraph 21.25* of the *Guidance* which indicates the circumstances where this sanction may be appropriate:

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

b. Identifiable areas of the registrant's practice in need of assessment or retraining.

c. Evidence that the 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.

160. The Committee found that there was no evidence of harmful deep-seated personality or attitudinal problems, nor evidence of repetition. However there were also no clinical concerns which would make the imposition of conditions appropriate. The Committee considered it would be difficult to supervise or manage this type of misconduct with conditions. Further the Committee considered that the imposition of conditions in this case did not sufficiently mark the level of misconduct, or adequately protect the public interest.

161. The Committee next considered a suspension order and the relevant sections of the Guidance contained within *Paragraph 21.29* which indicates the circumstances where this sanction may be appropriate:

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 the incident.*

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

162. The Committee found all of the above factors to be relevant. The Committee considered that a period of suspension would mark the seriousness of the misconduct, and would give the Registrant the time he would need to develop insight and show further remediation. The Committee still had remaining concerns with regard to the Registrant's insight and risk of repetition and therefore went on to test this proposition against the criteria for erasure, the most serious sanction.

163. The Committee considered the factors in relation to erasure under *Paragraph 21.35* which indicates the circumstances where this sanction may be appropriate:

a. Serious departure from the relevant professional standards as set out in the Standards of Practice for registrants and the Code of Conduct for business registrants;

b. Creating or contributing to a risk of harm to individuals (patients or otherwise) either deliberately, recklessly or through incompetence, and particularly where there is a continuing risk of harm to patients;

c. Abuse of position/trust (particularly involving vulnerable patients) or violation of the rights of patients;

d. Offences of a sexual nature, including involvement in child pornography;

e. Offences involving violence;

f. Dishonesty (especially where persistent and covered up);

g. Repeated breach of the professional duty of candour, including preventing others from being candid, that present a serious risk to patient safety; or

h. Persistent lack of insight into the seriousness of actions or consequences.

164. The Committee considered that some of the factors were present, namely a serious departure from the *Standards* and an abuse of a position of trust. The Committee considered carefully the issue of insight and concluded, on balance, that there was not a persistent lack of insight from the Registrant, although there was much further development to follow, not least because his first demonstration of insight was during the hearing, two years after the misconduct. The Committee considered however that the behaviour of the Registrant was not 'fundamentally incompatible with being a registered professional in accordance with *paragraph 21.35* of the *Guidance.*
165. The Committee were further reassured by the Registrant's engagement with this Committee, and the testimonials and reflection he has produced which have demonstrated that he has some developing insight. On balance, the Committee considered that erasure would be disproportionate in this case. The Committee were satisfied that their concerns in relation to insight could be sufficiently addressed by allowing time, with a suspension for the Registrant to further reflect on his behaviour.
166. The Committee took into account the Registrant's personal interests and the importance of balancing those against the public interest. In order to ensure public confidence in the profession and uphold proper professional standards, the Committee concluded that suspension was the appropriate and proportionate sanction.
167. The Committee understood that both the GOC and the Registrant agreed that the appropriate length of suspension should be one of 6 months. However, given that the Registrant has only just started to be able to demonstrate insight, despite this matter being two years old, the Committee did not feel that a 6-month suspension would mark the seriousness of the misconduct, or give the Registrant sufficient time to reflect on his behaviour. The Committee considered the lowest possible length of suspension appropriate to be one of 9 months.
168. The Committee therefore found the most appropriate sanction, to ensure public confidence in the profession and to uphold proper standards, but also to allow the Registrant to further develop his insight and to continue to become a valued member of the profession would be one of 9 months.
169. The Committee also determined that a review hearing should be held between four and six weeks prior to the expiration of this order. The Review Committee will need to be satisfied that the Registrant:

- has fully appreciated the gravity of the misconduct,
- that the Registrant's patients will not be placed at risk by resumption of practice or by the imposition of conditional registration
- has not repeated his misconduct and
- has maintained his skills and knowledge

170. A Reviewing Committee may be further assisted by the following:

- The Registrant's engagement at the next Review Hearing
- Evidence of the Registrant having undertaken targeted courses relating to professional boundaries and GDPR
- A reflective piece from the Registrant dealing with his development of further insight, in particular to address an understanding of his behaviour towards Ms B.

Reduction of Committee members

171. One Committee member had personal difficulties and needed to leave the hearing. This Committee member was an optometrist member and had taken part in all of the deliberations on sanction, the decision on sanction therefore had been made as a five person Committee.
172. The Committee invited submissions from the parties as to whether they had any objections to proceeding in the absence of the optometrist member.
173. Neither Mr James or Mr Hall raised any objections.
174. The Legal Adviser gave legal advice and referred to the *The General Optical Council (Committee Constitution Rules) Order of Council 2005 Rule 25:*
"The quorum of the Fitness to Practise Committee shall be—
(a)one registered optometrist or registered dispensing optician; and
(b)two lay persons."
175. The Committee therefore decided to proceed in the absence of the optometrist member.

Immediate order

176. Mr James on behalf of the GOC invited the Committee to exercise its discretion to impose an immediate suspension order under Section 13I of the Opticians Act 1989. He reminded the Committee that if the Registrant appealed, the order for erasure would not come into effect for several months whilst the appeal was pending. Mr James stated that the Committee may consider that there are grounds to do so based upon the risks it had already identified in its earlier findings.
177. Mr Hall on behalf of the Registrant submitted that an immediate order was not necessary. The Registrant was not subject to an Interim Order and the Registrant is not able to train at the moment regardless. In these circumstances Mr Hall submitted it was not therefore appropriate in this case to impose an immediate order.
178. The Legal Adviser drew the Committee's attention to *Paragraph 23.2* of the *Guidance* and whether 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.

179. The Committee accepted the legal advice and had regard to the statutory test. The Committee bore in mind that it had found that the misconduct was serious, the Registrant lacked developed insight and there remained a risk of repetition. The Committee was therefore concerned that if no immediate order was made, the Registrant could seek to return to training during the appeal process. The Committee therefore concluded it was in the public interest that an immediate order be imposed, in order to protect the public and the wider public interest and maintain confidence in the profession and the Regulator. Accordingly, the Committee imposed an immediate order of suspension.

Chair of the Committee: Sara Fenoughty

Signature **Date: 08 November 2024**

Registrant: Adeel Iqbal

Signature …present via videoconference……. **Date: 08 November 2024**

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.