BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(24)20

AND

UMAR MASOOD (01-26624)

DETERMINATION OF A SUBSTANTIVE HEARING
03 – 06 MARCH 2025

Committee Members:	Mr Andy Brennan (Chair) Mr John Vaughan (Lay) Ms Danielle Ellis (Optometrist)
Legal adviser:	Ms Jennifer Ferrario
GOC Presenting Officer:	Ms Diana Constantinide
Registrant present/represented:	Yes
Registrant representative:	Mr Trevor Archer
Hearings Officer:	Ms Latanya Gordon
Facts found proved:	1a, 1b, 1c, 1d, 1e, 1f, 1g, 1h, 1i, 1j, 1k 2ª, 2b, 2c, 2d, 2e, 2f, 2g, 2h, 2j
Facts not found proved:	2i
Misconduct:	Found
Impairment:	Found
Sanction:	Suspension Order for 4 months
Immediate order:	Yes

PRELIMINARY MATTERS

1. At the beginning of the hearing, the Chair said that the Committee comprised of three members and the parties were content with this.

ALLEGATION

The Council alleges that in relation to you, Umar Masood (01-26624) a registered Optometrist, whilst working at Store A Specsavers Limited:

(1) On or around 2 June 2023, you failed to perform an appropriate examination and/or assessment of Patient A's eyes in that you:

a. Failed to perform a visual field test despite it being clinical indicated; and/or

b. Failed to perform an external eye examination; and/or

c. Recorded entries for the following despite these external examinations not being performed:

i. 'normal as seen' for the external eye;
ii. 'clear and quiet' for the anterior chamber, and/or

d. Failed to perform an internal eye examination; and/or

e. Recorded entries for the following despite these internal examinations not being performed:

i. Lens;
ii. Vitreous;
iii. Optic disc;
iv. CD (cup to disc) ratio;
v. Vessels;
vi. AV (arterio-venous) ratio;

vii. Macula;

viii. Peripheral retina;

f. Completed Patient A's eye examination in around 9 minutes despite the patient clinically presenting as a new presbyopic patient having a history of retinal detachment;

g. Your conduct as set out at (1)c is dishonest in that you recorded findings from an external eye examination which had not been undertaken; and/or

h. Your conduct as set out at (1)e is dishonest in that you recorded findings from an internal eye examination which had not been undertaken; and/or

i. Your conduct as set out at (1)e is unprofessional and/or inappropriate in that you only documented findings from Patient A's retinal photos where neither the lens, the vitreous, or the retinal periphery, would be visible from solely looking at Patient A's retinal photos; and/or

j. Your conduct as set out at (1)e iv is unprofessional and/or inappropriate in that you recorded an entry that significantly under-estimates optic disc cupping, by falling outside the range expected of a reasonable estimate for optic discs, despite the retinal photos revealing the likely cupping; and/or

k. Your conduct as set out at (1)f is unprofessional and/or inappropriate in that you failed to allow sufficient time to conduct an adequate and/or complete examination;

(2) On or around 19 May 2023, you failed to perform an appropriate examination and/or assessment of Patient B's eyes in that you:

a. Failed to perform an external eye examination; and/or

b. Recorded entries for the following despite these external examinations not being performed:

i. 'normal as seen' for the external eye;

ii. 'clear and quiet' for the anterior chamber, and/or

c. Failed to perform an internal eye examination; and/or

d. Recorded entries for the following despite these internal examinations not being performed:

i. Lens;

ii. Vitreous;

iii. Optic disc;

iv. CD (cup to disc) ratio;

v. Vessels;

vi. AV (arterio-venous) ratio;

vii. Macula;

viii. Peripheral retina.

e. Completed Patient B's eye examination in around 11 minutes despite the patient clinically presenting as a new presbyopic patient;

f. Your conduct as set out at (2)b is dishonest in that you recorded findings from an external eye examination which had not been undertaken; and/or

g. Your conduct as set out at (2)d is dishonest in that you recorded findings from an internal eye examination which had not been undertaken; and/or

h. Your conduct as set out at (2)d is unprofessional and/or inappropriate in that you only documented findings from Patient B's retinal photos and OCT scans where neither the lens, the vitreous, or the retinal periphery, were visible from solely looking at Patient B's OCT images and/or retinal photos; and/or

i. Your conduct as set out at (2)d)iv is unprofessional and/or inappropriate in that you recorded an entry that significantly under-estimates optic disc cupping, by falling outside the range expected of a reasonable estimate for optic discs, despite the retinal photos revealing the likely cupping; and/or

j. Your conduct as set out at (2)e is unprofessional and/or inappropriate in that you failed to allow sufficient time to conduct an adequate and/or complete examination;

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

DETERMINATION

Admissions in relation to the particulars of the allegation

2. The Registrant admitted particulars (1)a – k and (2)a – h and j of the allegation.

Background to the allegation

3. The Registrant is a registered Optometrist and he first registered with the General Optical Council ('the Council') on 23 April 2012. At the material time, he was a locum worker for Specsavers as an Optometrist at its Store A and Store B stores in [redacted]. His role included carrying out eye examinations and record keeping of the examinations.

4. On the 19 May 2023 and 2 June 2023, the Registrant performed sight tests on Patient A and Patient B at the Store A Specsavers. Patient A and Patient B attended the practice as a "mystery shopper" and their interactions with the Registrant and all other staff during the visits were recorded both audio and visual.

5. Witness A, an Ophthalmic Director of the Specsavers at Store A was made aware of concerns raised by colleagues following a training exercise, during which they had observed the footage from the eye examinations carried out by the Registrant for Patients A and B. It had appeared to those observing the footage that the Registrant had not checked the back of the eyes for either patient. Witness A observed the footage for both examinations and he could not see that the Registrant had checked the back of the patients' eyes.

6. Witness A spoke with a co-Director, Witness B and they informed the Registrant that Specsavers would be carrying out an internal investigation and the matter would be referred to the Council. On the 25 August 2023, Specsavers made a referral to the Council. Since the referral, the Registrant has no longer worked as a Locum for the Specsavers stores at Store A or in Store B.

7. On the 2 September 2023, Witness B provided to the Council the clinical records relating to both eye examinations together with OCT scans and photographs.

8. The Council instructed Professor Robert Harper to prepare an expert report and to provide an opinion. In terms of Patient A and the eye examination on the 2 June 2023, Professor Harper's report included the following;

    (i) *'Patient A was 56 years of age and was attending Specsavers as a new patient with a history of moderately high myopia and left eye retinal detachment. From the retinal photos taken on the day it is clear that the optic discs are somewhat tilted and myopic in appearance and with noteworthy optic disc cupping.'* Professor Harper gave an opinion that a visual field test should have been conducted.

    (ii) The video footage showed that the Registrant did not conduct an external eye examination. Professor Harper's evidence is that in the circumstances, an external eye examination should have been carried out.

(iii) Despite not having carried out an external eye examination, the Registrant had recorded 'normal as seen' for the external eyes and 'clear and quiet' for the anterior chamber.

(iv) The video footage showed that the Registrant did not conduct an internal eye examination and in the circumstances, an internal eye examination should have been carried out.

(v) The Registrant's record card had documented entries on the pro-forma record card for the following: Lens; vitreous; optic disc; CD (cup to disc) ratio; vessels; AV (arterio-venous) ratio; macula; and peripheral retina all of which are internal eye measures. Professor Harper's report provides that whilst the retinal photographs allow for a record to be made of the status of the central retina, the optic disc and the maculae, *'an actual examination of the internal eye allows for evaluation of the lens, the vitreous and the whole of the retina.'*

(vi) The examination of nine minutes had been of *'short duration'*. Professor Harper's opinion evidence is that as a *'presbyopic patient with a history of retinal detachment'* he would have expected Patient A's examination to have taken at least twenty minutes. He said that he had consulted a guide produced by Specsavers which indicates that an eye examination of a young healthy person ought to take around twenty minutes.

(vii) When the Registrant recorded the entries for Patient B's internal and external eye examinations he did so without examination and used the patient's OCT images and/or retinal photographs.

(viii) Retinal photographs would not provide the necessary information required for an eye examination in terms of the lens, vitreous or the retinal periphery.

(ix) The entry relating to an internal eye examination and the cup to disc ratio *'significantly underestimates the optic disc cupping.'* Professor Harper's opinion is that the Registrant's assessment of Patient A's cupping fell outside of the range expected to reflect a reasonable estimate of this patient's optic disc from the retinal photographs.

9. In relation to Patient B and the eye examination on the 19 May 2023, Professor Harper's report included the following;

(i) The Registrant did not *'appear to'* conduct an external eye examination.

(ii) For the external eye, the Registrant had entered 'normal as seen' and for the anterior chamber had recorded 'clear and quiet' with no *'relevant companion examination'* having been carried out.

(iii) The Registrant did not *'appear to'* conduct an internal eye examination.

(iv) The Registrant made entries on Patient B's record card for the lens, vitreous, optic disc, CD (cup to disc) ratio, vessels, AV (arterio-venous) ratio, macula and peripheral retina all of which are internal eye measurements.

(v) The eye examination of around eleven minutes had been *'of short duration.'* Professor Harper would have expected an eye examination for a *'new presbyopic'* patient to take at least twenty minutes.

(vi) When the Registrant recorded the entries for Patient B's internal and external eye examinations he did so without performing an examination and used the patient's OCT images and/or retinal photographs.

(vii) The cup to disc ratio *'.. does appear to under-estimate the magnitude of optic disc cupping.'* Professor Harper went onto to say that the *' ..usual expected inter-observer variability in this measure may infer that the Registrant's estimate falls within an expected reasonable range for this measure in this case.'*

10. Upon receiving Professor Harper's report, the Registrant's legal representative wrote to the Council on the 10 May 2024 and responded to the allegations.

Findings in relation to the facts

11. Ms Constantinide opened the case on behalf of the Council and took the Committee through the Council's skeleton.

12. The Committee heard evidence from the Registrant in relation to particular (2)i of the allegation.

13. The Registrant told the Committee that he used the retinal photographs and professional judgement when he had estimated and recorded the optic disc cupping for Patient B. He accepted that if he had carried out an internal examination of the eye, the CD (cup to disc) ratio estimate would have been more accurate.

14. The Committee heard submissions on behalf of the Council and the Registrant in relation to particular (2)i of the allegation. Ms Constantinides referred the Committee to the Council's skeleton and submitted that during his evidence, the Registrant had told the Committee that his eye measurements would have been more accurate if he had carried out an internal examination of Patient B's eyes. Mr Archer on behalf of the Registrant submitted that for particular (2)i of the allegation, to find it proved, the Committee would need to satisfy itself on a balance of probabilities that the optic disc cupping estimated by the Registrant had been a significant under-estimation and had fallen outside of the range of reasonable estimates. Mr Archer submitted that Professor Harper does not provide this evidence in his report and he referred the Committee to paragraph 5.13.9.

15. The Committee accepted the advice of the Legal Adviser. She advised that pursuant to rule 46(6) of the Fitness to Practise Rules, the Committee must find the particulars of the allegation that have been admitted, proved. The one remaining particular is (2)i and the Legal Adviser referred the Committee to paragraph 5.13.9 of Professor Harper's report. The Committee was reminded that it is for the Council to prove the facts on a balance of probability. It was advised to refer to the evidence and use its professional judgment to decide if the facts in the allegation are made out and if so, whether the conduct is unprofessional and/or inappropriate.

16. The Committee reminded itself of the particular of the allegation that was not admitted. The Council alleged that the Registrant had recorded an entry onto Patient B's record that the CD (cup to disc) ratio had been examined when it had not. Furthermore, that the Registrant's record had significantly under-estimated the optic disc cupping and had fallen outside the range of reasonable estimates. The Registrant had admitted to not carrying out an internal eye examination. He disputed however that the Council's evidence supported a finding that there had been a significant under-estimating such that it had fallen outside of the range of reasonable estimates.

17. In reaching its decision on the facts, the Committee took into account the evidence bundle, the Registrant's evidence, the Council's skeleton and the submissions from Ms Constantinides and Mr Archer. It also bore in mind that it had no evidence to suggest that the Registrant was not of good character.

18. In terms of evidence to support its case, the Committee reminded itself that the Council relied primarily on the evidence of Professor Harper and his report dated 11 April 2024 and the video footage.

19. The Committee considered that during his submissions, Mr Archer on behalf of the Registrant had submitted that the Registrant accepted that his internal eye examinations for Patient B had been *'deficient and inadequate.'* He had told the

Committee that particular (2)i alleged that the entry recorded by the Registrant had *'significantly'* underestimated the optic disc cupping and this had not been supported by Professor Harper's evidence. Neither did it support the allegation that the estimate had fallen outside the reasonable range.

20. The Committee carefully considered the evidence. It noted that particular (1)j of the allegation was the same allegation but for Patient A. Professor Harper at paragraph 5.4.9 of his report clearly states that the optic disc cupping recorded by the Registrant had been significantly under-estimated and fallen outside of the reasonable range for estimating this measurement.

21. In relation to Patient B and particular (2)i, the Committee reminded itself of Professor Harper's evidence at paragraph 5.13.9 of his report. He states that the Registrant when recording the optic disc cupping had *'appeared to under-estimate.'* He also states that for Patient B *'this measure may infer that the Registrant's estimate falls within an expected reasonable range for this measure in this case.'*

22. The Committee found that Professor Harper's evidence at paragraph 5.13.9 did not support particular 2i of the allegation. In the absence of Professor Harper, the Committee was unable to be satisfied on the evidence that the Registrant had significantly under-estimated the optic disc cupping or that his estimate had fallen outside of the reasonable range of estimates. The Committee went on to find that it could not be satisfied that the Registrant's conduct in recording the optic disc cupping as he had, had been unprofessional and/or inappropriate.

23. The Committee, applying the balance of probability found particular (2)i of the allegation not proven.

Misconduct

24. Having found the alleged facts proved save for particular (2)i, the Committee next considered whether the facts found proved amount to the statutory ground of misconduct.

25. The Committee heard submissions on misconduct on behalf of the Council from Ms Constantinide. She referred the Council to the skeleton and submitted that the Registrant's conduct had fallen seriously short of the professional standards expected from him. She submitted that the dishonesty was not an isolated incident but a pattern of behaviour that demonstrated a complete disregard for ethical and professional standards. She said that the failures to carry out the eye examinations and record measurements to indicate that he had, exacerbated the seriousness of the Registrant's conduct and put obstacles in the way for proper continuity of care. She referred the Committee to Professor

Harper's report and submitted that the Committee should have patient care and safety at the forefront of its mind. Ms Constantinides submitted that whilst there had been no actual evidence of harm to patients, there had been a risk of harm.

26. Mr Archer on behalf of the Registrant said that misconduct is admitted in relation to some of the particulars of the allegation that have been proved. He submitted that not every falling short of a professional standard amounts to misconduct. He reminded the Committee of Professor Harper's opinion in terms of whether the Registrant's conduct had demonstrated a lack of competency. Mr Archer invited the Committee to decide whether each individual particular of the allegation amounts to misconduct and submitted that particulars (1)e (iii – vii) and (2)d (iii – vii) do not. He said that the Registrant may have considered that the review of scans and photographs ought to have been sufficient for him to provide an estimate of the measurement and the Committee should determine whether this amounts to serious conduct.

27. The Committee received and accepted advice from the Legal Adviser. The Committee was advised to remind itself of paragraphs 15.5 – 15.9 of the Council's Hearings and Indicative Sanctions Guidance which highlighted that there was no statutory definition of misconduct. For guidance on assessing misconduct, the Legal Adviser referred to the cases of ***Roylance v GMC [2000]1 AC 311*** and ***Nandi v GMC [2004] EWHC 2317 (Admin)*** as referred to in the Council's skeleton. The Legal Adviser invited the Committee to consider the Standards of Practice for Optometrists and Dispensing Opticians (2025) ('the Council's Standards') and to decide whether the Registrant's conduct had breached any of the standards and if so whether that breach had been sufficiently serious to amount to misconduct.

28. The Committee took into account the submissions and the report from Professor Harper dated 11 April 2024. It considered the Council's Standards and determined that the following standards had been breached:
1.1: Give patients your full attention and allow sufficient time to deal properly with their needs.

1.5: Where possible, modify your care and treatment based on your patient's needs and preferences without compromising their safety.

7.1: Conduct an adequate assessment for the purposes of the optical consultation, including where necessary any relevant medical, family and social history of the patient. This may include current symptoms, personal beliefs, cultural factors and vulnerabilities.

7.2: Provide or arrange any further examinations, advice, investigations or treatment if required for your patient. This should be done in a timescale that does not compromise patient safety and care.

7.5: Provide effective patient care and treatments based on current good practice.

16.1: Act with honesty and integrity to maintain public trust and confidence in your profession.

17.1: Ensure your conduct, whether or not connected to your professional practice, does not damage public confidence in you or your profession.

17.3: Be aware of and comply with the law and regulations that affect your practice, and all the requirements of the General Optical Council.

29. The Committee decided that each of these standards had been breached by the Registrant. The Committee found that in failing to carry out basic internal and external eye examinations for both patients, and recording measurements and findings on the patient's record based only on photographs and scans, the Registrant had acted in a deceptive manner.

30. During his evidence, the Registrant had accepted that at the time of the eye examinations with both patients, he had been aware that carrying out an internal and external examination of the eye would have provided a more accurate measurement. The Committee found that the measurements related to integral parts of the eye and in line with the professional standards, the Registrant should have carried out the examinations to obtain a more accurate measurement. The Committee went on to find that at the time of recording the measurements and findings onto the patients' records, the Registrant knew or ought to have known that he should have carried out the internal and external eye examinations.

31. The Committee reminded itself of Professor Harper's report. In terms of Patient A, he had provided an opinion that in failing to carry out internal and external

eye examinations, the Registrant had fallen far below the professional standards. His opinion was that for the measurements relating to the external eye, anterior chamber, lens, vitreous and peripheral retina, these could not be viewed from photographs or scans. His opinion was that for the measurements relating to the optic disc, the CD ratio, vessels, AV ratio and macula, it was possible to use photographs or scans however an examination would have obtained a more accurate result.

32. The Committee considered that the Registrant's breaches of professional standards had not been an isolated incident. The patients had been examined by the Registrant on two separate occasions, approximately two weeks apart. It was satisfied that this demonstrated a pattern of behaviour particularly as the misconduct had been of the same nature each time.

33. In relation to the failures to carry out the internal and external examinations and the inaccurate entries on the patients' record cards, the Committee determined that this was conduct that demonstrated a blatant disregard for patient safety, and the fundamental professional standards expected of an Optometrist. He had or ought to have known at the time of completing the record cards, that there had been an expectation that the full eye examinations had been carried out. The Registrant had had no regard for the onward care of the patients and had placed them at risk of harm. The Committee had no evidence to suggest that the Registrant's conduct had occurred due to incompetency. It was satisfied on the evidence that the Registrant had known of his responsibilities and had not met them.

34. The Committee considered that the dishonest conduct by the Registrant was the most serious falling short of the Council's Standards. It was satisfied that the dishonesty together with the failures of the Registrant to carry out the internal and external eye examinations was conduct that falls seriously below expected standards and amounts to misconduct. It was the Committee's view that this conduct would be regarded as deplorable by fellow practitioners.

35. The Committee had taken the opinion of Professor Harper into account and had noted that for some particulars of the allegation he had described a 'falling below' rather than a 'falling far below.'

36. However, the Committee reminded itself that Professor Harper had opined that the failures to carry out basic internal and external eye examinations could have placed the patients at risk of harm. The Committee went on to consider that as the failures to carry out the examinations underpinned the entirety of the particulars of the allegation, that whilst each individual particular of the allegation may not amount to misconduct, the Registrant's conduct in terms of the failure to carry out full examinations and the associated dishonesty, had been conduct that had fallen seriously below the standards expected.

37. It was decided by the Committee that the facts found proved amount to misconduct.

Impairment

38. Having determined that the facts found proved amounted to misconduct, the Committee went on to consider whether the Registrant's fitness to practise is currently impaired.
39. Ms Constantinide made submissions on behalf of the Council. She submitted that the Committee should make a finding of current impairment on both a personal and public interest basis. She referred the Committee to the Council's skeleton specifically the leading case authorities, and to paragraphs 5.1.5, 5.1.9 and 5.1.10 of Professor Harper's report. She said that whilst there had been no actual harm, Professor Harper had identified a risk of harm to patients in terms of continuity of care.

40. Ms Constantinide invited the Committee to find that the misconduct had *'not been a minor transgression.'* She said that dishonesty is a *'severe violation of the Council's professional standards'* and submitted that the Registrant had not demonstrated full remediation. She said that public confidence would be undermined if a finding of current impairment was not made.

41. The Committee heard evidence from the Registrant, relating to impairment. He said that he had been practising as a registered Optometrist for fourteen years and had previously experienced mystery shoppers, with no issues having arisen. He told the Committee that he did not agree with its findings that he had shown a *'blatant disregard'* for the safety of patients however he accepted that his conduct had placed patients at risk of harm. He said that he *'had not been at my best'* when examining Patients A and B because at the time he had been [redacted]. **[Private]**

42. The Registrant told the Committee that he has worked under supervision since he began his employment with Specsavers in Store C on February 12th 2024. He works Sunday to Thursday and it is a busy store inside a supermarket. He referred the Committee to the CPD work that he has undertaken since the allegations came to light, and has enhanced his clinical skills. He said that around November 2024, there were some customer complaints about his lack of communication and he was spoken to by the Directors in a formal conversation which is the 'disciplinary' referred to by his supervisor in her report dated 17 February 2025. He said that he has improved his communication skills since these complaints and no further issues have arisen. He went on to say that when he is [redacted] he tends to withdraw and he has put measures in place to try and address this. He said that he is [redacted] about these proceedings and *'[redacted]'* about giving evidence.

43. When the Committee asked the Registrant about strategies that he has in place for when he [redacted], the Registrant said that he speaks to colleagues, close family or friends; takes himself away from work; goes for a walk or to the gym. He said that if he [redacted] at work, that he would take his time with patients which he said he had communicated to his Directors. He said that he will always ensure that a full examination is carried out and there will be no repeat conduct. When the Committee took the Registrant to his personal development plan, the Registrant said that it had been written in August 2024, and he acknowledged that it did not include any reference to the management of [redacted].

44. Mr Archer made submissions on behalf of the Registrant. He said that the Registrant accepts that his current fitness to practise is impaired on a public interest level but disputes that it is impaired on a '*clinical'* level. He said that the Registrant is *'not fundamentally a dishonest person'* and he acted *'out of character by taking short cuts when he was [redacted].'* He said that the Registrant had practised for several years with no issues and since the allegations, has worked for over a year under supervision and demonstrated *'a sustained period of hard work.'*

45. Mr Archer told the Committee that that the Registrant's efforts to remediate himself are contained in the Registrant's bundle. He said that he has equipped himself with new clinical skills and upon being unable to find CPD courses designed to improve probity, he had engaged in counselling and a 'reflective process'. He said that when [redacted] the Registrant *'[redacted]'* and he has attempted to improve this. Mr Archer submitted that whilst the Registrant accepts that a finding of current impairment is appropriate to maintain public confidence in the profession, it is not appropriate on a personal level.

46. The Committee accepted the advice of the Legal Adviser which included reference to the principles established in the cases of ***CHRE v NMC and Grant EWHC 927 (Admin)*** and ***Cohen v GMC [2008] EWHC 581 (Admin)***. The Committee was advised to consider personal impairment first; specifically whether the Registrant had provided any evidence in terms of insight, reflection, remorse or remediation. The Legal Adviser advised the Committee to determine whether there was a risk of repeat conduct by the Registrant in terms of taking short cuts with his eye examinations.

47. The Committee was further advised by the Legal Adviser to consider the public interest element of impairment notwithstanding the admission made by the Registrant in this regard. It was advised to consider whether an ordinary well-informed person would expect a declaration of current impairment in order to promote and maintain public confidence in the profession. The Legal Adviser summarised for the Committee's benefit the approach formulated by Dame Janet Smith in her Fifth Report from the Shipman case, cited with approval in Grant, namely whether the Registrant:

a. *Has in the past acted and/or is liable in the future to act so as to put a patient(s) at unwarranted risk of harm: and/or,*
b. *Has in the past and/or is liable in the future to bring the profession into disrepute, and/or*
c. *Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the profession; and/or*
d. *Has in the past acted dishonestly and/or is liable to act dishonestly in the future.*

48. The Legal Adviser referred the Committee to the case of ***General Medical Council and another v Dugboyele [2024] EWHC 2651 (Admin****)* and advised it to consider the public interest element even if there is a finding of no impairment on a personal level.

49. The Committee bore in mind the Council's overarching 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.

50. The Committee first considered the questions endorsed in ***Grant*** in relation to past behaviour. It concluded that by not carrying out external and internal eye examinations and estimating measurements from retinal photographs and scans, the Registrant had in the past put patients at risk of harm. The Committee considered that in completing the patient record cards without having carried out the required eye examinations, and acting dishonestly, the Registrant had in the past brought the profession into disrepute and breached fundamental tenets of the profession. This had been demonstrated by the breaches of professional standards outlined above.

51. Following on from the consideration of past behaviour, the Committee went on to consider the questions to be asked from the case of ***Cohen*** as follows:

a. Whether the conduct leading to the allegations is easily remediable?
b. If it is, whether it has been remedied, and then,
c. Whether it is likely to be repeated?

52. The Committee considered that dishonest conduct is difficult, but not impossible to remediate. The Registrant had engaged with the hearing and provided his own bundle of documents for this stage of the hearing. The Committee had considered the content of this bundle very carefully. It also took into account the report from Professor Harper, the Registrant's oral evidence and submissions made by Ms Constantinide and Mr Archer.

53. It was noted by the Committee that there had been no concerns raised about the Registrant's clinical competency. He had answered the Committee's questions in such a way that he had satisfied the Committee that he knew how to carry out internal and external eye examinations. The concern for the Committee was whether he would take short cuts in the future, if he was experiencing [redacted] either in his personal life or in the workplace.

54. In terms of insight, the Committee determined from the evidence, that the Registrant had shown some insight. He had accepted responsibility for his actions however the Council was not satisfied that he had shown full insight into how a [redacted] situation or period of time, may impact on his work. There was a lack of recognition from the Registrant about the impact of [redacted] and how he would manage this to ensure that he did not take any short cuts. He did not provide evidence either in the bundle or during his oral evidence of a structured [redacted].

55. The Committee considered whether there was evidence of cogent measures in place to avoid repeat conduct. The Committee noted that the Registrant's supervisor makes no mention of any discussions with the Registrant about managing his workload. There was no reference to addressing [redacted] or at work, in the Registrant's PDP. The Registrant's supervisor had indicated in her reference that on average the Registrant carries out sixteen eye examinations

during the work day. The Committee found this to be at the high end of the reasonable range. The Committee noted that the Registrant had recently upskilled himself however, it was not satisfied that this would assist him in ensuring that he would not take short cuts in the future.

56. [Redacted].

57. When the Registrant gave evidence, Mr Archer asked him if he was [redacted] and the Registrant said that he was. Mr Archer went on to submit to the Committee that when the Registrant is [redacted], he will *'[redacted].'* The Committee observed that the Registrant appeared to be reserved with his evidence. It was satisfied on balance that he had appeared unable to adopt the measures that he had spoken about to [redacted]. The Committee was not reassured that the Registrant would manage [redacted] in the workplace and the risk of repeat conduct was therefore real. The Committee reminded itself that approximately four months ago, the Registrant had been spoken to formally by Directors for issues around his communication with patients. The Registrant had told the Committee that the issues had arisen due to [redacted].

58. The Committee recognised that the Registrant had carried out some CPD. It had however been accepted by Mr Archer that the Registrant had been unable to find training courses relevant to the misconduct. Mr Archer submitted that by way of an alternative, the Registrant had engaged in counselling and a *'reflective process'*. The Committee reminded itself that the Registrant had engaged in [redacted] for the period April – July 2023 and there had been no formal [redacted] or counselling since. The Committee referred itself to the Registrant's bundle and the piece of reflective writing and noted that it was not dated. The Committee concluded that it had evidence of reflection however it did not have evidence of a 'reflective process.'

59. The Committee concluded on balance, that the Registrant had demonstrated some but not full insight into his conduct. Having determined that there was a lack of evidence to demonstrate that measures were in place to address [redacted], the Committee went on to conclude that the conduct had not been remedied. The Committee then returned to the questions posed by Dame Janet

Smith above and concluded in light of the conduct not being remedied, that there was a future risk that patients would be placed at an unwarranted risk of harm. Furthermore, that the profession may be brought into disrepute, that fundamental tenets of the profession may be breached in future and that the dishonesty might re-occur. It determined in the circumstances that there was a risk of repetition.

60. On the basis that there remained a risk to the health, safety and wellbeing of patients, the Committee concluded that the Registrant's current fitness to practise is impaired on a personal and/or clinical level.

61. The Committee went on to consider the wider public interest in maintaining public confidence in the profession and in promoting and maintaining proper professional standards and conduct. It determined that in circumstances where the Registrant had acted dishonestly and potentially placed patients at a risk of harm, public confidence would be undermined if a finding of impairment was not made. The Committee concluded that all three limbs of the overarching objective were engaged.

62. The Committee accordingly concluded that the Registrant's fitness to practise is currently impaired both on a personal and public interest basis.

Sanction

63. Having determined that the Registrant's fitness to practise is currently impaired, the Committee went on to consider sanction.

64. Ms Constantinide made submissions on behalf of the Council. She referred the Committee to paragraphs 48 – 52 of the Council's skeleton and the relevant paragraphs in the Council's Guidance. She submitted that a finding of dishonesty *'should always be considered as serious because it lies at the very top of the gravity spectrum for misconduct.'* Ms Constantinide said that either erasure or a suspension order would be justified. She told the Committee that the Registrant had been subject to an interim order of conditions on his practise since 15 November 2023 and there had been no breaches of the conditions. She reminded the Committee of the customer complaints that had been raised

during the duration of the interim order however she did not submit that these had amounted to a breach of the interim conditions order.

65. Mr Archer made submissions on behalf of the Registrant. He submitted that whilst this was not a case based on the statutory ground of health, that the misconduct *'would not have occurred [redacted].'* He said that the Registrant *'has had this hanging over him for one and a half years'* and during that time, he had been met with significant periods of [redacted]. He referred the Committee to the testimonials in the Registrant's bundle and highlighted positive feedback in terms of the Registrant's work ethic and valued input.

66. Mr Archer submitted that a period of suspension will remove the Registrant from the workplace and will not assist with improving his insight or remediation. He said that the Registrant needs to work in order to [redacted]. Mr Archer referred to the relevant paragraphs in the Council's Guidance in relation to imposing a conditions order and said that the required criteria was engaged. He invited the Committee to find that this was not a case where erasure would be appropriate or proportionate.

67. The Committee accepted the advice of the Legal Adviser. She referred the Committee to the Hearings and Indicative Sanctions Guidance ('the Guidance') and reminded the Committee that it must come to its own independent view in terms of the most appropriate and proportionate sanction to impose. The Committee was advised that there was no burden or standard of proof at this stage of the hearing.

68. The Legal Adviser advised the Committee that the purpose of imposing a sanction is not to punish, but the appropriate sanction may have a punitive effect. The Committee was advised to have regard to the principle of proportionality, balancing the Registrant's interests with the public interest. In accordance with the Guidance, the Committee was advised to consider aggravating and mitigating factors together with the extent of the dishonesty. The Legal Adviser said that the impact of the dishonesty ought to be considered in terms of the overarching objective including the wider reputation of the profession and public perception of the profession.

69. The Committee was advised to consider the least restrictive sanction first and, if that was not appropriate or proportionate, to move to the next available sanction in ascending order. The Legal Adviser referenced ***Tait v Royal College of Veterinary Surgeons [2003]*** which provided that *'For all professionals, a finding of dishonesty lies at the top end of the spectrum of gravity and misconduct.'* Also ***Bolton v Law Society [1994] WLR 512*** and *'The reputation of the profession is more important than the fortunes of any individual member. Membership of a profession brings many benefits but that is part of the price.'* The Committee was advised to consider this particular case on its own facts, and apply the relevant legal principles.

70. The Committee was also advised to refer to the case of ***Dr R Muhammad Rashid Masood v The General Medical Council [2024] Scot (D) 13/9*** as it helpfully sets out the principles regarding sanction and the criteria to be taken into account.

71. In reaching its decision on sanction, the Committee took into account the content of the hearing and Registrant's bundles; the facts found proved; the submissions that it had heard, and its previous findings on misconduct and impairment.

72. Throughout its deliberations the Committee had regard to the overarching objective, giving equal consideration to each of its limbs.

73. The Committee considered the following to be aggravating factors:

a. The misconduct was not an isolated incident.

b. The Registrant had acted dishonestly on two separate occasions.

c. The Registrant had placed patients at the risk of harm on two separate occasions.

d. The conduct was identified not by the Registrant but by a person that had observed footage from the mystery shopper.

e. The Registrant had lacked full insight. He had not demonstrated that he had put specific measures in place to address [redacted] and had made use of those measures.

f. During the interim order of conditions, customer complaints had been received about the Registrant's communication which led to formal discussions with the Directors. The Registrant told the Committee that his conduct had been due to [redacted].

74. The Committee considered the following to be mitigating factors:

a. The Registrant had a previous good record.

b. He had demonstrated remorse.

c. There was no evidence of actual harm to patients.

d. The Registrant has some insight.

e. Testimonials had spoken of him as competent and conscientious.

f. No evidence of repetition of the conduct since the referral to the Council.

g. The Registrant has complied with the interim conditions order that was imposed on the 15 November 2023.

75. It was the Committee's assessment that on a scale of dishonest conduct, the Registrant's actions were at a medium level. The most serious aspect of the misconduct was failing to carry out the internal and external eye examinations and completing the patient records in such a way that another professional would consider that these examinations had been carried out. The Committee did not regard the Registrant on the evidence, as a fundamentally dishonest person. The Committee had previously determined that the Registrant had taken short cuts with Patients A and B due to the [redacted] that he had been experiencing at the time. The Committee concluded on the evidence, that his conduct had been out of character.

76. In terms of the misconduct as a whole, and having considered the aggravating and mitigating factors the Committee took the view that an informed and reasonable member of the public would be deeply concerned by the Registrant's actions. The Committee determined that this was particularly prevalent having regard to the Committee's finding that there remained a risk of repetition in terms of short cuts and to patient safety. The Committee determined that the fact that there had been no repetition to date did not preclude it from finding that repetition could occur in the future.

77. The Committee had previously found some insight from the Registrant. It was satisfied on balance that he had accepted responsibility for his actions. However the Committee reminded itself that the Registrant had not recognised the potential impact of [redacted]; had not demonstrated cogent coping mechanisms or explained how he would put them into practice. The Committee had previously concluded from this that the Registrant had not fully remediated himself and there remained a risk of repetition of the conduct.

78. The Committee first considered taking no 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.

79. The Committee decided that the imposition of a financial penalty was not appropriate or proportionate. It had regard to the financial motive that may have been behind the Registrant's dishonest conduct however it had no evidence that he had benefitted financially from his actions. The Committee's view is that in any event a financial penalty would not reflect the seriousness of the misconduct and would not protect the public against the risk of repetition.

80. The Committee next considered a period of conditional registration. The Committee took into account that since the 15 November 2023, the Registrant had been the subject of an interim conditions order and there had been no breach of the conditions. There had been complaints from customers about his communication skills however this had not been a direct breach of the conditions. The Committee concluded on the evidence, that it would be able to formulate workable and measurable conditions. This would enable the Registrant to continue working and to develop his insight and reduce the risk of repeat conduct.

81. The Committee went on to consider whether a conditions order will reflect the public protection and public interest element of the overarching objective. The Committee took into account its findings in relation to the medium level of dishonesty identified by the Committee and the relevant paragraphs of the

Council's Guidance. It reflected on the aggravating and mitigating factors and decided that the seriousness of the misconduct required a proportionate sanction. The Committee had previously found that an informed and reasonable member of the public would be deeply concerned by the Registrant's actions. The Committee concluded from this, that a conditions of practice order would be a disproportionate sanction.

82. The Committee next considered a suspension order and the relevant sections of the Guidance contained within paragraph 21.29 namely;

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

a. Serious instance of misconduct where a lesser sanction is not sufficient.

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

c. No evidence of repetition of behaviour since incident.

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

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

83. The Committee considered that paragraph 21.29 parts (a) to (d) were engaged. In relation to part (d) whilst the Committee had been satisfied that there was a risk of repeat conduct, it had not regarded the risk as 'significant.'

84. In accordance with paragraph 8.3 of the Guidance, the Committee considered whether a suspension order in the circumstances would sufficiently protect the public, promote and maintain public confidence in the profession and promote and maintain proper professional standards in line with the overarching objective.

85. The Committee, in assessing whether the sanction of a suspension order would be appropriate and proportionate, considered whether the Registrant's conduct was fundamentally incompatible with being a registered Optometrist. It decided that it was not.

86. The Committee was satisfied that a suspension order was the most appropriate and proportionate means of protecting patients and/or maintaining public confidence in the profession.

87. The Committee went on to consider the length of the suspension. Having determined that the dishonesty element of the misconduct had been of a medium level, the Committee determined that a suspension order of 4 months will be sufficient to reflect the overarching objective including the maintaining and upholding of public confidence in the profession.

88. Having decided to impose a suspension order for 4 months, the Committee went on to decide that a review hearing should take place before the suspension order expires.

89. The Committee would expect the Registrant to provide the following to the review Committee, to demonstrate that he is fit to return to unrestricted practice:

(a) Detailed specific measures that have been put in place by the Registrant to address the impact whilst at work, of any [redacted] that he may experience and how he will put these measures into practice.

(b) Evidence that he has continued with relevant CPD.

(c) Evidence that the Registrant's PDP has been amended to include [redacted] and [redacted].

(d) An up to date reflective piece of writing from the Registrant to demonstrate (1) the effectiveness of the specific measures that he has put in place to

address [redacted] and (2) learning from the CPD and how he will put that into practice when he resumes work.

Immediate Order

90. Ms Constantinide when prompted by the Committee, invited the Committee to make a decision as to whether an immediate order of suspension to cover the appeal period on behalf of the Council ought to be imposed. She said that the Council takes a neutral view. Ms Constantinide reminded the Committee that the Registrant was currently the subject of an interim conditions of practice order.

91. Mr Archer on behalf of the Registrant said that it is unnecessary for the suspension order to be imposed immediately because the Committee had found that the risk of repeat conduct *'was not significant.'* He said that the Registrant has clinics booked in for the following week and those patients will suffer if the Registrant is suspended immediately. He submitted that an immediate order of suspension will in effect be a 5 month period of suspension.

92. The Committee accepted the advice of the Legal Adviser who said that the Committee should have regard for the criteria set out in Section 13I of the Opticians Act 1989. She advised that the decision was a matter for the Committee's own professional judgement.

93. The Committee had regard for the submissions made by Mr Archer. It considered that having made a substantive decision about sanction, that it should continue to have the overarching objective at the forefront of its mind. It therefore decided to impose an immediate order of suspension having regard to its findings. It determined that it was necessary for the protection of the public and in the wider public interest.

94. The Committee revoked the current interim order and imposed an immediate suspension order.

Chair of the Committee: Andy Brennan

Signature **Date:** 06 March 2025

Registrant: Umar Masood

Signature Present via Microsoft Teams **Date:** 06 March 2025

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.