BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(24)52

AND

MOHAMMAD KHAN (01-38634)

DETERMINATION OF A SUBSTANTIVE HEARING
16-19 JUNE 2025

Committee Members:	Jayne Wheat (Chair/Lay) Victoria Smith (Lay) Mark McLaren (Lay) Sarvat Fida (Optometrist) Ann Barrett (Optometrist)
Legal adviser:	Kelly Thomas
GOC Presenting Officer:	Chuba Nwokedi
Registrant present/represented:	Yes and represented
Registrant representative:	Rebecca Vanstone [Counsel] Katie Holland [AOP]
Hearings Officer:	Arjeta Shabani
Facts found proved:	Admitted and proved
Misconduct:	Found
Impairment:	Impaired
Sanction:	2 months suspension order with no review
Immediate order:	No

ALLEGATION

The Council alleges that you, Mr Mohammad Khan (01-38634), a registered optometrist:

1. *On 10th June 2023, you failed to carry out an adequate eye examination on Patient A in that you:*

    a. *Failed to obtain an accurate patient history for Patient's A symptoms in that you:*

        ii. *Did not record whether the onset of Patient A's worsening vision was sudden or gradual;*
        iii. *Did not record Patient A's presenting vision;*
        iv. *Did not record details regarding the nature of the squint in Patient A's eyes;*

    b. *Failed to maintain accurate patient records in that you:*

        i. *Recorded the results of an optic disc assessment of Patient A's eyes as 'def[ined] and flat, nrr healthy colour', despite the optic discs presenting as abnormal;*
        ii. *Recorded that an internal eye examination had been performed on Patient A, despite not performing an internal eye examination; and/or*
        iii. *Pre-populated the results for an internal eye examination on Patient A, despite not performing an internal eye examination;*

    c. *Failed to perform adequate assessments on Patient A in that you:*

        i. *Did not perform an internal eye examination on Patient A;*
        ii. *Did not review Patient A's fundus photos despite this being available to you;*

    d. *Failed to detect signs of papilledema in Patient A, despite Patient A experiencing:*

        i. *Headaches;*
        ii. *Vomiting;*
        iii. *Diplopia;*
        iv. *Abnormal optic discs;*

    e. *Failed to urgently refer Patient A to the hospital eye service for further investigation and/or urgent treatment despite Patient A presenting with signs of papilledema;*

2. *Your actions set out at b.ii and/or b.iii were dishonest in that you knew that you had not performed an internal eye examination on Patient A.*

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

1. The Registrant admitted all of the particulars of the allegation.

Background to the allegations

2. Mr Mohammad Khan ("the Registrant") has been registered with the General Optical Council ("the GOC") as a student Optometrist since 1 November 2016 and as a qualified Optometrist since 3 November 2022. The Registrant signed a locum contract with Vision Express dated 15 February 2023.
3. On 10 June 2023, Patient A, accompanied by his parents attended at Vision Express [redacted]. He was attended to by the Registrant.
4. On 12 June 2023, Patient A attended a different practice local to him [redacted]. The optometrist diagnosed him with papilloedema and immediately referred him to [redacted] Hospital for further assessment where Ophthalmology confirmed the diagnosis and sent him to paediatric A&E. Patient A underwent an urgent CT to rule out a brain tumour. Patient A was then admitted to hospital for further tests including MRI. Patient A's mother details in a letter to Vision Express: "*Due to extremely significant high pressures that staff were concerned may [have] lead to Patient A losing his sight he urgently had a lumbar drain and in the following days a lumbar shunt put in place."*
5. Patient A was eventually confirmed to have a diagnosis of bilateral optic disc swelling and a 6th nerve palsy cause by raised intra-cranial pressure. The letter also states that Patient A had undergone a CSF diversion procedure to alleviate the raised intracranial pressure at RVI [redacted] on 22 August 2023.
6. On 6 September 2023, the Council received an email notification from Vision Express advising that they would be referring the Registrant to the Council regarding concerns in respect of an eye examination that the Registrant had carried out on Patient A, who was a child.
7. On the same date, the Council received a referral from Vision Express which raised concerns regarding the Registrant's examination of Patient A on 10 June 2023 when the Registrant failed to detect and manage Patient A's symptomatic papilloedema. Vision Express had become aware of the concern following a complaint by Patient A's parents. The referral attached optical records of Patient A and correspondence between Vision Express and the Registrant.
8. Vision Express provided a response about the incident to Patient A's parents on 14 September 2023.
9. In Vision Express' referral to the Council, it explained that "*Mr Khan informs us that he is undertaking reflection and remediation following this incident. However, Mr Khan was but will no longer be engaged by Vision Express as a locum Optometrist. As a result, Vision Express do not have a procedure whereby they can work with him to reassure themselves that he has adequately reflected on the events and remediated such that they can be confident that a similar case will not arise in the future.*"

10. On 26 October 2023, the Council obtained a clinical risk assessment from Ms Denise Voon, the optometric adviser. She also prepared a Clinical Opinion Report dated 4 April 2024. Ms Voon considered that '*a failure to detect and manage a patient with symptomatic papilloedema would fall far below the standard of a reasonably competent optometrist due to the possible life threatening consequences*." Ms Voon assessed the Registrant as being 'high risk' to the public if he continues to practise unrestricted whilst the concern is investigated and concluded.

11. Ms Voon's report said that: '*Patient A attended for a sight test with the Registrant on 10 June 23 complaining about worsening distance vision. The Registrant hasn't recorded whether this was sudden or gradual or the onset of the worsening vision; this is important because a sudden change in vision would likely be more serious than a gradual worsening over time.*'

12. The Registrant had also recorded that Patient A was experiencing '*diplopia even when closing one eye*'. Ms Voon added that diplopia (double vision) would not occur when a patient has one eye closed. Ms Voon added that in this case it should have been established what Patient A was actually noticing, for example, if it was '*halos around lights*.' Ms Voon also outlined that it had been noted by the Registrant that Patient A '*squints a lot* (sic)' but the Registrant had not recorded any further information about this.

13. Ms Voon also stated that it is not clear whether the Registrant has completed a refraction or not but from the patient notes it appeared that an autorefraction has been performed.

14. Ms Voon questioned the accuracy of the Registrant's record keeping: '*The Registrant has recorded an external and internal examination, but it has been alleged that the Registrant did not perform the internal examination but had prepopulated the results. If this is the case, it calls into question the integrity of the patient records as a whole. However, according to the patient notes, the external and internal eye examination was unremarkable.'*

15. Ms Voon wrote, with reference to the retinal images: '*The retinal photos, taken at the time of the sight test have been provided and show an abnormality in both optic discs which has the appearance of a swollen optic disc.… In my opinion, the optic disc appearance from the photographs alone are suspicious enough to seriously consider papilloedema as a potential diagnosis.'*

16. Ms Voon concluded: '*In my opinion, the failure of this case is multifactorial. Firstly, it appears that the Registrant has failed to elicit (or failed to record) an accurate patient history (GOC Standard 2 Communicate effectively with you patients and GOC Standard 8 Maintain accurate patient records). It appears that Patient A had been experiencing headaches, vomiting and diplopia at the time of the sight test and this should have alerted the registrant to consider a neurological condition.* [178]

17. *Secondly, the Registrant appears to have failed to conduct an adequate examination in that they did not detect the abnormal discs (GOC Standard 7 Conduct adequate assessments, examination, treatments and referrals). In mitigation, I accept that Patient A appeared to be uncooperative and that a fundus examination may have been difficult but the appearance of the optic discs in the photographs coupled with Patient A's symptoms (including the uncooperating)*

should have been enough to warrant an emergency referral.' Lastly, if found to be true, prepopulating record is a serious failing as it can lead to inaccurate patient notes. This is particularly true if certain tests were not actually done e.g. the internal eye examination.'

Findings on the facts

18. The Registrant admitted all of the particulars of allegations 1 and 2;
19. The Committee therefore found the particulars of allegations 1 and 2 proved.

Submissions on misconduct

20. Mr Nwokedi submitted on behalf of the GOC that the Committee should consider the case of *Roylance v GMC (2000) 1 AC 311,* and submitted that the facts alleged in particulars 1 and 2 fell far short of what would be proper in the circumstances that the public would expect.
21. Mr Nwokedi submitted that the Registrant's actions involved both clinical failures, in the failure to conduct a clinical examination, and deliberate misrepresentation, in the dishonest clinical records. The fact that no urgent referral was made should be seen as unacceptable.
22. In relation to the clinical examination, the Registrant failed to conduct or record an adequate clinical assessment of an [redacted] patient presenting with symptoms consistent with papilloedema.
23. Mr Nwokedi adopted the findings of the independent clinical opinion of Ms Denise Voon, who stated:

    "*The retinal photos, taken at the time of the sight test have been provided and show an abnormality in both optic discs which has the appearance of a swollen optic disc….In my opinion, the optic disc appearance from the photographs alone are suspicious enough to seriously consider papilloedema as a potential diagnosis."*
24. Ms Voon also stated:

    "The failure to detect and manage a patient with symptomatic papilloedema would fall far below the standard of a reasonably competent optometrist due to the possible life-threatening consequences."
25. Mr Nwokedi submitted that the Registrant's omissions are not minor or technical but represent a significant departure from the standard of care one would expect from a competent optometrist and constitute serious professional misconduct where a formal finding of misconduct is necessary to reflect the gravity of his conduct.
26. In relation to the dishonest clinical records, Mr Nwokedi noted Ms Voon's report:

    "The registrant has recorded an optic disc assessment result for both eyes as 'defined and flat, nrr healthy colour' and recorded a C/D ratio of 0.25. This would suggest that the optic disc was flat and had a well defined rim which is not consistent with the appearance of the retinal photos taken at the time of the sight test."

27. Mr Nwokedi also noted the Registrant's admissions that "*I prefilled the assessment as a baseline and normally modify it from there which I forgot as we were having a discussion to cyclo or not on the day*."

28. Mr Nwokedi submitted that dishonest pre-filling of patient records, with no subsequent correction, goes beyond negligence. It undermines the integrity of clinical documentation, places patients at risk and is a clear breach of *Standard 8.* Mr Nwokedi relied on Ms Voon who states:

    "lastly ,if found to be true, pre-populating records is a serious failing as it can lead to inaccurate patient notes."

29. Finally, Mr Nwokedi submitted that despite a recent patient history of vomiting, diplopia, headaches and visible optic disc abnormality, the Registrant made no referral for urgent investigation. Ms Voon in her report states that even if Patient A was uncooperative, the combination of fundus photographs and clinical history should have warranted an emergency referral.

30. Mr Nwokedi submitted that a finding of dishonesty lies at the top end in the spectrum of gravity of misconduct.

31. Mr Nwokedi submitted that the Registrant breached *Standards of Practice for Optometrists and Dispensing Opticians ("the Standards"),* namely:

    3. *Standard 1* – Listen to patients and ensure they are at the heart of decisions made about their care;
    4. *Standard 2* – Communicate effectively with your patients
    5. *Standard 7* – Conduct appropriate assessments, examinations, treatments and referrals;
    6. *Standard 8* – Maintain adequate patient records;
    7. *Standard 16* – Be honest and trustworthy

32. Ms Vanstone, on behalf of the Registrant, accepted there was misconduct in this case and made no positive submissions against a finding, save to say that the Registrant was not aware of the existence of the photographs referred to by Ms Voon. Further, Ms Vanstone stated the allegations focus around one incident on one occasion and therefore the Committee should consider the spectrum of misconduct in their decision.

33. The Legal Adviser outlined the *Hearings and Indicative Sanctions Guidance ("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".

34. 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, conduct which relates to professional practice and 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 amount to serious misconduct. 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

35. The Committee heard and accepted the advice of the Legal Adviser and considered the written and oral submissions as well as the *Guidance* at *Paragraph 15.5-15.9* and the definition of misconduct in the case law.

36. The Committee identified that the relevant *Standards* engaged in this case were *Standards 1, 7, 8 and 16.*

37. The Committee noted that whilst the misconduct is admitted, the Committee recognised that a finding of misconduct was a matter for its own independent judgement.

38. The Committee noted that all of the admitted facts arose from one appointment with one vulnerable person, a child, Patient A. The Committee considered carefully the opinion of Ms Voon, the optometric adviser. The Committee found that whilst this was a failing on only one occasion, there were multifactorial failings within that single episode of care which carried a high risk of significant harm.

39. The Committee found that there were different types of failings found proved, there were serious clinical failings as well as matters of dishonesty.

Allegation 1(a)

40. The Committee determined that failing to carry out an adequate eye examination as outlined at particulars 1ai-1aiii is a serious failing, given that history taking and recording of symptoms is fundamental to a proper examination. The Committee noted that Patient A presented to a different optician only two days after where his signs and symptoms triggered and urgent referral. The Registrant has admitted that he did not complete a full eye examination, and the optometric adviser Ms Voon also noted that with the signs and symptoms presented there should have been enough information to make an immediate referral.

41. The Committee considered that this was in breach of *Standard 1,* in particular *1.1,* and *Standard 7,* in particular *7.1,7.2* and *7.5.* The Committee found that this amounted to serious misconduct.

Allegation 1(b)

42. The Committee also noted here that the Registrant had admitted this matter in that he accepted that he had pre-filled Patient A's record prior to the examination and had failed to amend it accurately at the end of the examination.

43. The Committee noted again the findings of the optometric adviser Ms Voon who has expressed concern that in pre-populating a clinical record before the appointment would be to assume the patient's answers in advance. The Committee considered this to be an entirely dangerous practise which amounted to a risk to patient care.

44. The Committee considered that this was in breach of *Standard 8,* in particular *8.1, 8.2.3* and *8.2.4.* The Committee found that this amounted to serious misconduct.

Allegation 1(c)

45. The Committee determined that not performing adequate assessments by not examining the internal eye was a serious failing. Whilst the Committee accepted that the Registrant may not have reviewed the fundus photos, however, it is incumbent on him as an Optometrist to understand the policy and procedures of any optical practice where he is providing locum services. Therefore, this was also a serious falling short of what was expected of a reasonably competent Optometrist.

46. The Committee considered that this was in breach of *Standard 7,* in particular *7.1, 7.2* and *7.5.* The Committee found that this amounted to serious misconduct.

Allegation 1(d)

47. The Committee considered that Patient A attended with "*red flag*" symptoms, for example headaches, vomiting and diplopia, therefore it should have been obvious to the Registrant even without sight of the fundus photographs that this warranted further investigation. The Committee determined that these were not subtle but serious symptoms presented by Patient A, which could be fatal if missed.

48. The Committee considered that this was in breach of Standard 1, in particular 1.1, and Standard 7, in particular 7.1, 7.2 and 7.5. The Committee found that this amounted to serious misconduct.

Allegation 1(e)

49. The Committee considered that the failure to refer in this case, despite the serious symptoms presented amounted to a serious breach of the *Standards.*

50. The Committee considered that this was in breach of *Standard 7,* in particular *7.2* and *7.5.* The Committee found that this amounted to serious misconduct.

Allegation 2

51. The Committee considered that the Registrant's actions in particulars b.i and b.ii in failing to maintain accurate records did amount to misconduct. The Registrant had accepted he acted dishonestly which the Committee determined was very serious, particularly as it was intrinsically linked to his professional practice and fell far below the *Standards* expected of a reasonably competent Optometrist.

52. The Committee determined that the Registrant's dishonesty had breached *Standard 16,* in particular *Standard 16.1.* The Committee found that this amounted to serious misconduct.

53. The Committee therefore concluded that both individually and collectively, the proven facts amounted to serious misconduct.

Submissions on impairment

54. The Registrant gave evidence in relation to impairment, both through his reflective statement and in oral evidence. The Registrant confirmed that the incident that

led to these proceedings occurred shortly after he qualified. The Registrant saw Patient A with his father. Patient A was later found to be suffering from papilloedema due to raised intracranial pressure. The patient was extremely photophobic, and the Registrant was unable to complete an indirect ophthalmoscopy. The Registrant made the serious error of having pre-filled the clinical record, not completing the necessary tests and therefore documented findings he had not verified. The Registrant stated that this was dishonest, and acknowledged it as a lapse in professional judgement.

55. At the time, the Registrant stated that he was under considerable personal, financial and professional stress. The Registrant stated that he had originally handed in his resignation to his previous employers in January but was pressured to stay on. The Registrant finally left the role in April 2023 and, soon after, received a demand for additional fees for supervision, which further compounded his emotional distress. The Registrant had started locum work at Vision Express in May and said he was not familiar with the systems in place. He admitted he did not demonstrate good judgement at the time of the appointment and failed to keep Patient A safe.

56. The Registrant stated that during his pre-registration training, there was no access to fundus photography, and where the Registrant initially worked, the policy was not to routinely offer fundus photography to patients under 16. He then transferred to a store where fundus photography was only provided if requested. The Registrant's experience at that time was to review photographs only if they were taken. The Registrant confirmed that at Specsavers, if fundus photography had been performed, the patient record would be stamped to indicate this. The Registrant accepted the concerns around his professional judgment in failing to access the fundus photographs at Vision Express, particularly in combination with the documentation failings.

57. The Registrant told the Committee that it was his first day as a locum at the [redacted] branch of Vision Express. He stated that it had been suggested to him that he could pre-fill records in order to speed up appointments. The Registrant confirmed that this was the first and only time he pre-filled a record. The Registrant expressed his sincere remorse and stated that this would never happen again. He gave details of three hospital eye service clinical placements with three different ophthalmologists which have provided opportunities to reflect on his decision making and communication skills and to improve his own practices as a result.

58. Upon being questioned by the Committee, the Registrant further confirmed that he felt terrible about what had happened, that it was a mistake that was always with him, and that he fully appreciated how serious it could have been for Patient A. The Registrant stated that he has tried his best to remedy to remedy his clinical failings by undertaking additional learning to prevent that situation ever occurring again.

59. The Registrant expressed his remorse to the parents and to Patient A, and articulated to the Committee that he understood the impact of his misconduct upon them and upon the reputation of the profession.

60. In his submissions in relation to impairment, Mr Nwokedi for the GOC stated that the Committee should ask itself, in accordance with *PSA v Nursing and Midwifery Council (Grant) [2011] EWHC 927*, ("*Grant*"):

"*not only whether the Registrant continued to present a risk to members of the public, but whether the need to uphold proper professional standards and public confidence in the Registrant and in the profession would be undermined if a finding of impairment of fitness to practise were not made in the circumstances*."

61. Mr Nwokedi referred to the opinion from the optometric adviser Ms Voon, who stated that the delay in the diagnosis of papilloedema could have led to loss of vision or, if prolonged, death in Patient A. This risk came from not only failing to properly assess Patient A but also failing to obtain an accurate patient history and record accurate patient data.

62. Mr Nwokedi submitted that the Registrant's actions have brought the profession into disrepute in three ways, namely the undermining of the reliability of records, (*Nicholas-Pillai v GMC (2009) EWHC 1048 (Admin));* that he failed to refer urgently presents the profession as complacent and unsafe, and that the Registrant's dishonesty related to core clinical duties of keeping accurate records.

63. Mr Nwokedi submitted that the Registrant has also breached fundamental tenets of the profession, according to the Committee's findings, those at *Standards 1, 7, 8* and *16*.

64. Mr Nwokedi acknowledged that a finding of impairment does not necessarily follow upon a finding of dishonesty (*PSA v GMC and Uppal [2015] EWHC 1304)* ("*Uppal"),* however, dishonesty would usually impair a professional person's fitness to practise. (*General Medical Council v Dr Iheanyi Chidi Nwachuku [2017] EWHC 2085(Admin; R(Hassan) v General Optical Council [2013] EWHC 1887.* Mr Nwokedi submitted that it would be unusual for a case of dishonesty not to amount to impairment, and to make no such finding would have an adverse impact on the public perception of the profession.

65. Mr Nwokedi told the Committee that the Registrant had demonstrated 'quite a bit' of remediation, and gone through great lengths to remediate, and that it was not strictly the GOC's case that a finding of impairment was necessary for the protection of the public.

66. Ms Vanstone submitted that the Committee should make a finding that the Registrant is not currently impaired, and invited the Committee to consider the clinical and dishonesty matters separately.

67. Ms Vanstone confirmed that the Registrant has been on an Interim Order with conditions since December 2023 and has provided regular positive progress reports during this time. Ms Vanstone invited the Committee to treat Ms Voon's opinion that the Registrant presented a 'high risk' with caution. When her report was written, Ms Voon did not have the benefit of seeing the Registrant's excellent progress since and this may affect her opinion of the Registrant's future risk. Further, Ms Voon had the benefit of seeing the fundus photographs, which the Registrant did not have access to, albeit that he accepts this was his failure. Ms Vanstone submitted that as soon as the photographs were presented to him, the Registrant admitted straightaway that he had failed to diagnose correctly.

68. Ms Vanstone also asked the Committee to consider that the Registrant has dealt with the concerns of Ms Voon with regard to communication with vulnerable patients. The Registrant had obtained multiple placements to ensure his training is focused on this issue, and had applied these to his own current practice. The Registrant had built a network of peers to support him.

69. Ms Vanstone submitted that the conduct is remediable, and that the Committee can be sure that the Registrant has remedied this conduct by his extensive commitment in continuing to practise under supervised conditions, and has undertaken additional training over the last 15 months. Ms Vanstone highlighted positive comments from the Registrant's training supervisors from the references provided, in particular the Registrant's 100% audit scores, and an experience where the Registrant found suspected papilloedema with another child and referred them immediately to hospital. Ms Vanstone also highlighted the significant, targeted and appropriate CPD courses the Registrant had completed.

70. For those reasons, Ms Vanstone submitted that the risk of repetition is low. Ms Vanstone submitted that there are clinical concerns and separate dishonesty elements, but the dishonesty concerns in this case are at the lower end. As this was one patient on one day, and given the stress that the Registrant was under at the time, Ms Vanstone submitted that the Committee can be satisfied that there will be no repetition of this conduct.

71. Ms Vanstone further submitted that given the above, the Committee should also consider that there is no ongoing risk which would make a finding on the basis of public interest necessary. The Registrant has taken all the reasonable steps to demonstrate remediation, has made early admissions, apologised to the patient and his family, all of which would allow the public to consider that public confidence in the profession is upheld.

72. Ms Vanstone referred to the case of *Uppal* in submitting that the duty to uphold public confidence was satisfied by the regulatory process itself, and that a finding of dishonesty did not necessarily result in a finding of impairment.

73. Ms Vanstone submitted that in a case such as this, where the Registrant has achieved remediation, has complied with supervised conditions of practise over a substantial period, where the conduct involved one appointment two years ago, with no repetition before or after, and with such positive references and current standards of practice, it would not be necessary to find impairment. Ms Vanstone submitted that the Registrant's evidence and obvious remorse, specifically on how he still feels about the incident, that he constantly second guesses himself, is evidence enough to reassure the Committee that he is a safe practitioner and the public would still have confidence in the profession in such circumstances and the Committee did not need to make a finding of current impairment.

74. The Legal Adviser outlined *Paragraphs 16.1 to 16.7* of the *Guidance.* The Legal Adviser 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***.** The Legal Adviser also highlighted the four questions in the *Grant* case.

75. As this is a case of dishonesty, the Legal Adviser also outlined the *Guidance* at *Paragraph 17.1-17.3.* However, as per the case of *Lusinga v NMC (2017) EWHC 1458 (Admin),* there is a scale of dishonesty, "...dishonest conduct can take various forms; some criminal, some not; some destroying trust instantly, others merely undermining it to a lesser or greater extent." The case of *Professional Standards Authority v Health and Care Professions Council and Ghaffar [2014] EWHC 2723 (Admin)* also confirmed that *"a finding of impairment does not, of*

course, necessarily follow upon a finding of dishonesty, although it is accepted by the Panel that it will be a frequent one." The case of *Uppal* also re-iterated that a finding of dishonesty does not mean impairment is inevitable.

76. 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

77. The Committee heard and accepted the legal advice.

78. The Committee considered all of the written evidence, the oral evidence given by the Registrant, the submissions from both parties, and the Registrant's full bundle including the Registrant's reflective piece, CPD training and references supplied.

79. The Committee also considered the *Guidance* at *Paragraphs 16.1* to *16.7,* the *Cohen* case, the four questions in the *Grant* case, as well as 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."

80. The Committee first considered the questions in the *Grant* case with regards to the Registrant's past behaviour.

81. The Committee determined that the facts found in this case did amount to the Registrant *in the past* acting so as to put a patient at unwarranted risk of harm. The Registrant had left incorrect information on Patient A's clinical records which recorded that an internal eye examination had been completed despite knowing he had not completed such an examination. The evidence of Ms Voon, as accepted, was that due to the Registrant's failings, Patient A was put at risk of severe harm, in this case potential sight loss and even risk of death. The Committee considered this to be a significant risk of harm with potentially devastating consequences.

82. The Committee determined that the Registrant had also *in the past* brought the profession in disrepute. Whilst the Committee accepted that this was one patient and one episode of care, the issues were multifactorial. The Committee found that failing to carry out an adequate eye examination, failing to maintain accurate patient records, failing to perform adequate assessments, failing to detect signs of papilloedema and failing to urgently refer Patient A, did bring the profession into disrepute. These are core clinical competencies of a reasonably competent Optometrist. The Registrant was in a trusted position to provide adequate care to a vulnerable patient. This failure undermines the reputation of the profession amongst members of the public, other colleagues in the profession and patients.

83. The Committee found that the Registrant had *in the past,* breached the fundamental tenets of the profession. In its findings the Committee had concluded that the Registrant had breached *Standards 1, 7, 8 and 16.* The Committee determined that it must be able to place complete reliance on the integrity of

practitioners, and the dishonestly element to this matter undermines that confidence which negatively affects the standards and reputation of the profession as a whole.

84. The Committee noted that the Registrant had accepted dishonesty with regards to recording that an internal eye examination has been performed on Patient A (*Particular 1.b.ii),* and pre-populating the results for an internal eye examination (*Particular 1.b.iii),* despite not performing an internal eye examination. In doing so, the Committee determined that the Registrant had *in the past* acted dishonestly.

85. The Committee therefore considered that all four limbs of the *Grant* questions were engaged in relation to the Registrant's past conduct.

86. The Committee then went on to consider the issues in the case of *Cohen* as found at *Paragraph 16.1* of the *Guidance.*

87. Firstly, the Committee considered whether the conduct which led to the allegation is remediable. The Committee considered that the clinical failings and the dishonesty in this case were interlinked, because the Registrant's dishonesty related to his clinical omissions. The Committee considered that it is possible to remediate the clinical failings with specific targeted training. The Committee considered it to be harder to remediate dishonest misconduct. However, this case involved one incident of dishonesty relating to one patient on one occasion. The Committee considered the most contemporaneous evidence from the Registrant to be his email to Vision Express on 10 July 2023 which was sent almost immediately in response to being sent the records and the fundus photographs of Patient A. The Registrant was open and honest straightaway after being made aware of this failing and has maintained that position throughout. For these reasons, the Committee concluded that in this case, despite clinical and dishonest failings, the conduct was capable of remediation.

88. Secondly, in *Cohen*, the Committee considered whether the conduct has been remedied. The Committee were reassured by the way the Registrant has reacted to the allegations from the outset. The Registrant's candid email response of 10 July 2023 gave a sincere apology and confirmed he would cancel all his shifts with immediate effect. Since then, the Registrant has engaged with the GOC process, in admitting the allegations from the beginning and engaging with the Committee in giving oral evidence, directing his remorse towards the patient and parents, as well as the public and the wider profession. The Committee were reassured by the Registrant's evidence with regard to his reflection and insight. The Registrant gave a credible account which was consistent with the email he sent immediately following the event.

89. The Registrant appeared to convey genuine remorse in his oral evidence. The Committee accepted the Registrant's evidence that whilst there were some clear gaps in his training, which took place during COVID, he took ownership of those gaps and demonstrated good insight by trying to close those gaps in the placements he sought and completed since the misconduct came to light. The Registrant outlined that this was a profession he entered in order to help people and he felt, having failed at that on this occasion, that it was a mistake he would always carry with him and took full accountability for his actions.

90. The Committee considered the steps the Registrant has taken since the incident on 10 June 2023. The Registrant has managed to continue to practise for the last two years and is doing so under strict supervision in compliance with an Interim Order of conditions. In his oral evidence, the Registrant was able to relay the content of the specific regular review meetings and discussions he undertook with his supervisor. Both his supervisor and the practice manager, at the store where the Registrant has worked for the past 18 months, have provided positive references confirming the same. The Committee attached weight to these references because they were provided by the GOC approved supervisor who is regulated by the GOC, and the practice manager with whom the Registrant works on a regular and current basis.

91. The Committee considered that the Registrant's three shadowing placements, in particular that with Professor B, have had a significant impact on the Registrant. Under questioning in oral evidence, the Committee were persuaded that the Registrant had really engaged with the input from the professionals he had shadowed during the placements, and his supervisor, which was ongoing. The Registrant had welcomed the opportunity to continue to engage with Mr C, one of the professionals he had shadowed, for further ongoing coaching and mentoring. In particular, the Committee were assisted by the insights the Registrant had gained from his work alongside Professor B, whose particular area of expertise is paediatric ophthalmology for patients with learning difficulties. The Registrant said that this helped him to learn and understand how to communicate and give appropriate care to patients who may have difficulties in communication, and the importance of engaging the parents throughout the examination process. This spoke to the concerns raised by Ms Voon.

92. The Committee considered that the CPD training the Registrant had demonstrated was targeted and went over and above what would be generally required from a reasonably competent practitioner.

93. The Committee therefore concluded that the Registrant has taken every opportunity to remedy his failings and it therefore concluded that the conduct had been remedied.

94. The Committee considered next whether the conduct is likely to be repeated. The Committee considered that the Registrant's oral evidence made clear that his failings remain with him. The Registrant also acknowledged that he may make mistakes again but is now acutely aware of this possibility. The Committee determined that the Registrant has demonstrated, in his evidence, a deeply felt remorse for what happened. Although the dishonesty was related to clinical issues, this was one episode with one patient, and the Committee determined that the risk of repetition is low.

95. The Committee then returned to the *Grant* questions with reference to the Registrant's *future* risk. Given its findings in relation to the *Cohen* questions, the Committee determined that the Registrant was not liable *in the future* to put patients at unwarranted risk of harm, to bring the medical profession into disrepute, to breach one of the fundamental tenets of the profession or to act dishonestly.

96. The Committee concluded that a finding of impairment was not necessary for the protection of the public.

97. The Committee then considered the public interest element with regard to the case of *Grant*. The Committee considered that going through the process of the GOC proceedings demonstrates that the regulator is showing how seriously they take these failings. The Committee also took into account the Registrant's substantial remorse. However, the Committee considered that this was still a serious case of clinical failings linked to dishonesty, which would usually result in a finding of impairment. Notwithstanding that the Committee has determined that there is no further risk that the profession will be brought into disrepute, the Registrant's conduct did amount to a very serious falling short of the professional *Standards.* The Committee determined that given the seriousness of the potential consequences, there was a need to uphold proper professional standards, and public confidence in the Registrant and in the profession would be undermined if a finding of impairment of fitness to practise were not made in the circumstances of this case.

98. For the above reasons, the Committee determined that an informed and fair-minded member of the public, if they were appraised of all the facts, would reasonably conclude that a finding of impairment was necessary to maintain public confidence in the profession as well as declaring and upholding proper standards of conduct and behaviour.

99. The Committee therefore found that the Registrant is currently impaired on the grounds of public interest only.

Submissions on sanction

100. Mr Nwokedi on behalf of the GOC submitted that the purpose of any sanction is to protect patients and the wider public interest. Mr Nwokedi outlined all of the sanctions available to the Committee and submitted it should start with the least severe sanction first until the most appropriate sanction is reached.

101. Mr Nwokedi submitted that a 6 month suspension order would be an appropriate sanction in this matter, as it would acknowledge the remediation from the Registrant but also marks the serious misconduct and dishonesty directly connected to patient safety. Mr Nwokedi submitted that dishonesty is treated as fundamentally incompatible with professional practice, that it seriously undermines public trust and will usually result in erasure. Mr Nwokedi stated that the Committee should consider setting a review hearing.

102. Ms Vanstone, on behalf of the Registrant submitted that the Committee should consider taking no action because this case was exceptional. Ms Vanstone submitted that the Registrant had made full admissions, has shown remorse and insight and had fully remediated. The Registrant has demonstrated positive engagement with hospital placements and CPD, and according to the Committee's findings has gone above and beyond what would be expected of him, therefore there is no risk of repetition. Further to this, the Registrant has no fitness to practice history and was newly qualified at the time of this matter, which occurred on one day with one patient, and was therefore an isolated and spontaneous incident. Ms Vanstone submitted that it was clearly in the public interest to return this competent optometrist back to practise. Ms Vanstone referred to the *Guidance* and invited the Committee to determine that this was an exceptional case and it should consider taking no further action.

103. Ms Vanstone further submitted that if the Committee were not minded to take no action, a conditions of practice order would serve no purpose given the Registrant's complete remediation. Therefore, the Committee would have to consider a suspension order. Ms Vanstone submitted that some of the points raised at *21.29* of the *Guidance* were engaged, but that a short suspension much less than 6 months was all that would be required to mark the public interest. Ms Vanstone submitted that as the Committee had found that remediation is complete, there would be no need for a review hearing.

104. The Legal Adviser referred to 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.

105. The Legal Adviser drew the Committee's attention to the *Guidance* on sanctions in dishonesty cases, at *Paragraph 22.4-22.6,*namely that "*there is no blanket rule or presumption that erasure is the appropriate sanction in all cases of dishonesty, although a failure to impose any sanction for dishonesty may be found to be unreasonable in light of the importance of maintaining public confidence in the profession."* The Legal Adviser advised that the Committee should "*first assess the particular conclusions about the act of dishonesty itself, then, it must consider the extent of the dishonesty and its impact on the Registrant's character and, most importantly, its impact on the wider reputation of the profession and public perception of the profession."*

106. The Legal Adviser also outlined the *Guidance at Paragraph 22.6 that "where the fact finding Committee has concluded that an individual was dishonest, notwithstanding mental health issues or workplace related pressure, the weight to be attached to those mental health and working environment issues in assessing the appropriate sanction will inevitably be less than is to be attached to other aspects of the dishonesty found, such as the length of time for which it was perpetrated, whether it was repeated and the harm which it caused, all of which must be of more significance."*

107. The Legal Adviser also referred to the case of *Lusinga* and stated that the Committee should consider the broad spectrum of dishonesty misconduct, as it does not automatically follow that a finding of dishonesty should lead to the most serious sanction.

108. The Legal Adviser referred to the case of *SRA v Sharma [2010] EWHC 2022 (Admin),* a case involving a solicitor and not an optical professional, but which highlighted the following three points of principle for sanctions on dishonesty:

"a) Save in exceptional circumstances, a finding of dishonesty will lead to the solicitor being struck off the roll. That is the normal and necessary penalty in cases of dishonesty.

b) There will be a small residual category where striking off will be disproportionate in all the circumstances.

c) In deciding whether a particular case falls into that category, relevant factors will include the nature, scope and extent of dishonesty itself; whether it was

momentary, or over a lengthy period of time; whether there was a benefit to the solicitor and whether it had an adverse effect on others."

109. Finally, the Legal Adviser outlined that there is no burden or standard of proof at this stage, but sanction is a matter for the Committee's own judgment. In accordance with *Paragraph 8.3* of the *Guidance*, the Committee was advised to consider the least restrictive sanction first and, if not appropriate or proportionate, to move to the next available sanction in ascending order.

110. Ms Vanstone submitted that the Committee should not place weight on the legal advice in relation to the case of *Sharma,* because the case of *Hassan and General Optical Council [2013] EWHC 1887 (Admin)* indicated that the principles which applied in regulating solicitors would not apply to those acting within the optical profession.

Findings on sanction

111. In reaching its decision on sanction the Committee took into account the submissions on behalf of the parties, the facts found proved and its previous findings on misconduct and impairment.

112. Throughout its deliberations the Committee had regard to the *Guidance*, in particular *paragraph 22.4-22.6* as set out above, and determined the level of seriousness of dishonesty on the case of *Lusinga.*

113. The Committee had regard to the overarching objective, giving equal consideration to each of its limbs as follows:

"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."

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

- Risk of significant serious harm – the Committee considered this to be found both in the clinical and the dishonesty failings. The Committee considered this risk to be heightened further by the red flag symptoms presented to the Registrant by Patient A, and the Registrant's failures could have led to sight loss or death;
- Vulnerable patient – Patient A was aged [redacted] and the Committee considered that extra care should have been taken by the Registrant;
- Breach of trust – by the Registrant leaving the clinical record to show that an internal eye examination had been completed when it had not, the Registrant had breached the trust placed in him by Patient A and his parents that proper care had been provided.

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

- Inexperience of Registrant – the Registrant had newly qualified during the COVID crisis, and had not benefitted from the same practical experience that would otherwise have been available, in particular with reduced clinical placements and less exposure to communication with vulnerable patients, like Patient A;

- Remorse and insight – the Committee determined the Registrant's insight and remediation to be complete;
- Isolated instance of dishonesty – the Committee considered this to be a spontaneous event which occurred with one patient on one day, and was far from a sophisticated pattern of behaviour. The Committee considered that whilst the dishonesty was serious, it was not at the top end of the scale of dishonest acts.
- Full admissions – the Registrant accepted his failings to Vision Express shortly after receiving an email containing Patient A's records and fundus photographs of Patient A. The Registrant had continued to accept his failings throughout the regulation process.

116. The Committee considered and weighed the aggravating and mitigating factors above when applying the *Guidance* at *8.3* and considered the possible sanctions, starting with the least severe, that being to take no further action. The Committee had found impairment on the grounds of public interest, due to serious misconduct. The Registrant failed to do what was expected of him which resulted in serious clinical failings and dishonesty. Whilst the Committee acknowledged that the Registrant has shown an unusually high level of insight and remorse, the Committee did not consider this to be 'exceptional,' and there was nothing else exceptional about the particular circumstances of the case. The Committee therefore determined, having regard to the *Guidance*, that there were no exceptional circumstances to justify taking no further action and that it would not reflect the seriousness of the misconduct and therefore it would be inappropriate.

117. The Committee decided that the imposition of a financial penalty was not appropriate or proportionate as this was not a financial matter, and it would not reflect the seriousness of the misconduct.

118. The Committee next considered a period of conditional registration. Having found that the Registrant was currently impaired on the basis of public interest, and did not pose a risk to the public on clinical grounds, the Committee did not consider that there were any conditions which would be appropriate to meet those concerns. The Committee therefore did not consider that an order of conditional registration would be appropriate. In any event, the matters were too serious to be dealt with by way of a order with conditions.

119. The Committee next considered a suspension order and the relevant sections of the Guidance contained within *paragraph 21.29* namely:

    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.*
    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.*

120. The Committee considered that *paragraphs a) to d)* were engaged in this case, *paragraph e)* not being relevant. Given its findings on misconduct and impairment, it considered this to be a serious instance of misconduct and, for the above reasons, a lesser sanction is not sufficient. There is no evidence of deep-seated personality or attitudinal problems, and there has been no evidence of repetition of behaviour since the incident. The Committee is satisfied the Registrant has insight and does not pose a significant risk of repeating this behaviour.

121. The Committee considered a suspension order to be the lowest sanction which is appropriate to mark the seriousness of this misconduct. Whilst a suspension itself is punitive to the Registrant, this sanction will allow this otherwise competent Registrant to return to the profession, which is both in his interests and in the interests of the profession. The Committee considered that this sanction would maintain public confidence in the profession and promote and maintain proper professional standards and conduct.

122. The Committee went on to test this proposition against the criteria for erasure, the most serious sanction. The Committee considered the factors in relation to erasure under *Paragraph 21.35* and it determined that this was not an appropriate sanction because the dishonesty in this case was not persistent or covered up, there was not a repeated breach of the professional duty of candour, and the Registrant did not have a 'persistent lack of insight into the seriousness of the actions or consequences.' The Committee determined that public confidence could still be maintained and whilst this case was serious, it did not consider it to be fundamentally incompatible with ongoing registration.

123. The Committee was satisfied that the seriousness of the misconduct was reflected in the imposition of a suspension order. The Committee concluded that when taking into account the Registrant's interests and balancing those against the public interest, in order to ensure public confidence and proper professional standards, a suspension order was the appropriate and proportionate sanction.

124. In considering the length of the suspension order, the Committee again weighed the aggravating and mitigating factors it had identified, and had regard to the principle of proportionality. The Committee determined that a short suspension adequately marked the misconduct and satisfied the public interest. The Committee considered the most appropriate and proportionate length of suspension to meet the need to uphold public confidence in the profession and to uphold proper standards, but to allow the Registrant to return to practise and become a valued member of the profession, would be a suspension order of two months.

Review hearing

125. The Committee had determined a finding of impairment was not necessary for the protection of the public and that the Registrant is impaired on the grounds of public interest only. The Registrant has demonstrated full insight and has remediated, and the Committee did not require further reassurance that the Registrant will be fit to resume practice unrestricted at the end of the period of suspension. Therefore, the Committee did not consider a review hearing to be necessary.

Immediate order

126. Mr Nwokedi submitted that an immediate suspension order should be made. This order would cover the appeal period, after which the substantive order will take effect if no appeal is lodged under Section 13I of the Opticians Act 1989. There is a period in which the Registrant may be able to appeal, and the order will not take effect until this matter is resolved. Mr Nwokedi sought an immediate suspension order of 18 months to maintain public confidence in the profession and to avoid the risk of reputational harm to the profession.

127. Ms Vanstone submitted that there is no need for an immediate suspension order. There is no ongoing risk to the public and therefore no risk in the Registrant continuing to practise within the next 28 days of the appeal period. Ms Vanstone referred to the case law and submitted that the gravity of the misconduct had been relevant to previous stages, and the public interest had therefore been met by the imposition of the substantive order, and therefore an immediate order is not necessary.

128. The Legal Adviser advised the Committee that according to the *Guidance* at *Paragraphs 23.1-23.5,* the Committee should impose an immediate order only if it is satisfied that to do so is necessary for the protection of members of the public, otherwise in the public interest or in the best interests of the Registrant.

129. The Committee took account of the relevant paragraphs of the *Guidance*. The Committee had made a finding that the Registrant's fitness to practise is impaired only on the basis of public interest and not on public protection grounds. The Committee determined that an immediate order was not necessary because the substantive findings have satisfied the public interest. The Committee did not consider that this case meets the high bar required to impose an immediate order in the public interest and therefore it determined not to impose one.

Revocation of interim order

130. The Committee hereby revokes the interim order for conditional registration that was imposed on 8 December 2023.

Chair of the Committee: Jayne Wheat

Signature ……Hard copy signed……. **Date: 19 June 2025**

Registrant: Mohammad Khan

Signature ……Hard copy signed……. **Date: 19 June 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.