BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(24)42

AND

HINA ATHER (01-36144)

DETERMINATION OF A SUBSTANTIVE HEARING
19 - 21 MAY 2025

Committee Members:	Gerry Wareham (Chair/Lay) Louise Fox (Lay) Kevin Connolly (Lay) Sanna Nasrullah (Optometrist) Kamlesh Gohil (Optometrist)
Legal adviser:	Kelly Thomas
GOC Presenting Officer:	Jonathan Trussler
Registrant present/represented:	Yes and represented
Registrant representative:	Alex Mills
Hearings Officer:	Natasha Bance
Facts found proved:	Admitted and proved in relation to Allegations 1, 2 (a), 2(b), 2(c) and 3.
Facts not found proved:	Previous allegation 2(a) withdrawn
Misconduct:	Admitted and found
Impairment:	Not impaired
Sanction:	Warning for 12 months, to expire on 21 May 2026

ORIGINAL ALLEGATION

The Council alleges that you, Ms Hina Ather (01-36144), a registered Optometrist, whilst employed at Boots Opticians [redacted]:

1. Between 06/06/23 -30/08/23, you booked fictitious appointments online and in store for both [redacted] and [redacted] stores for patients who then failed to attend the appointments.

2. You booked appointments using false information in that you used:

a. customer names from [redacted] clinics without the Patients requesting this appointment and/or their consent;

b. Created new customer records of patients that had not visited the stores before; and/or

c. Used false and/or incomplete telephone numbers on the records; and/or

d. Used staff and locum staff names as customers

3. Your conduct as set out at 1 and/or 2 above was dishonest.

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

Background to the allegations

1. The Registrant was a registered optometrist whose date of registration is 12 April 2022
2. At the time of the Allegations, the Registrant was employed by Boots Opticians. The Council alleges that the Registrant booked fictitious appointments online and in store, at the [redacted] store, and this took place between 6 June 2023 and 30 August 2023. (Allegation 1)

3. The Council further alleges that in the course of committing Allegation 1, the Registrant created customer records for patients who had not visited the stores, recorded false or incomplete telephone numbers and recorded the names of staff and locum staff as 'customers'(Allegation 2).

4. Finally, the Council alleges that the conduct in relation to Allegations 1 and 2, amounted to dishonesty (Allegation 3).

5. The matters came to light in the course of the Registrant's employment. An investigation was undertaken by the Registrant's employer which resulted in due course in the Registrant's dismissal.

6. An investigation was carried out by the General Optical Council (GOC) following the Registrant's own referral, resulting in the current allegations.

Application to amend and withdraw Allegations

7. Mr Trussler, on behalf of the GOC, made an application for permission to withdraw Allegation 2(a). Mr Trussler stated that there was insufficient evidence to proceed with this Allegation.

8. Mr Trussler also applied to amend the particulars of Allegation 1, namely to remove the reference to the [redacted] store. Mr Trussler outlined that the [redacted] reference was outside the scope of the dates of the Allegations and the GOC are concerned only with regard to the [redacted] dates.

9. Mr Mills on behalf of the Registrant had no objections to this application.

10. The Committee agreed that Allegation 2(a) should be withdrawn as there was insufficient evidence. Further, the Committee agreed that the amendment to remove reference to the [redacted] store in Allegation 1 could be made without injustice as per *Rule 46(20)* of the *Fitness to Practise Rules*, and agreed to the amendment.

AMENDED ALLEGATION

The Council alleges that you, Ms Hina Ather (01-36144), a registered Optometrist, whilst employed at Boots Opticians [redacted]:

1. Between 06/06/23 -30/08/23, you booked fictitious appointments online and in store for ~~both~~ [redacted] ~~[redacted]~~ for patients who then failed to attend the appointments.

2. You booked appointments using false information in that you ~~used~~:

~~WITHDRAWN a. customer names from [redacted] clinics without the Patients requesting this appointment and/or their consent;~~

a. Created new customer records of patients that had not visited the stores before; and/or

b. Used false and/or incomplete telephone numbers on the records; and/or

c. Used staff and locum staff names as customers

3. Your conduct as set out at 1 and/or 2 above was dishonest.

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

Application for hearing in private

11. Mr Mills, on behalf of the Registrant made an application for some parts of the hearing to be heard in private. There is reference in the papers and likely to be further reference in the Registrant's oral evidence to her [redacted] which, according to *Rule 25* of the *General Optical Council (Fitness to Practise) Rules Order of Council 2013 ("the Rules")* should remain private.

12. Mr Trussler on behalf of the GOC was neutral on this issue.

13. The Committee heard and accepted the advice of the Legal Adviser, who outlined the relevant guidance, which can be found in *Rule 25:*

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

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

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

(c) the interests of the registrant; and

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

14. The Committee considered that the submissions of both parties highlighted that there were clearly parts of the hearing which would relate to the [redacted]. On that basis the Committee determined that those parts of the hearing should be heard in private. The parties must go into private session during those parts of the hearing only.

DETERMINATION

Admissions in relation to the particulars of the allegation

15. The Registrant admitted all of the particulars in Allegations 1, 2 (a), 2(b), 2(c) and 3.

16. The Committee therefore found the particulars of Allegations 1, 2 (a), 2(b), 2(c) and 3 admitted and proved.

17. The parties agreed that according to the evidence, there were a total of 16 instances of fictitious appointments made by the Registrant. A Schedule of the false entries was prepared and agreed and is attached as document C5.

Submissions on misconduct

18. The Registrant was called to give evidence. The Registrant adopted the evidence of her reflective statement. In addition, the Registrant confirmed that she booked each of the 25-minute appointments, each potentially worth around £25 to her employer. She was newly qualified and this was her first substantive post and she would do this in order to catch up with administrative work and to allow herself a break as she was [redacted].

19. The Registrant confirmed that she raised her personal issues with her manager twice at the [redacted] store before she was transferred, but she did not feel she was getting the support she required and would have to [redacted]. She used the appointments as a way to [redacted]. The Registrant confirmed that she would only make the false entries to the diary

on the day or the day before when she felt unable to otherwise manage her work.

20. The Registrant made a self-referral to the GOC. [redacted]. She also has a different employer who takes an active approach to helping her [redacted] which has made a real difference. The Registrant stated if she faced a similar lack of support again, [redacted] before continuing to work with an unsupportive employer.

21. The Registrant has completed a course which has assisted her understanding of the impact her actions would have on the public perception of the profession and how to respond differently in the future. The Registrant accepted that her actions fell below the Standards expected.

22. The Registrant gave evidence that everything has changed in her life [redacted]. The one constant in her life is her career and she is very keen to look forward, as she remains committed to her profession.

23. On behalf of the GOC, Mr Trussler submitted that the Registrant's conduct meets the threshold for misconduct under section 13D (2) of the Opticians Act 1989. While there is no formal definition of "misconduct", it has been defined in case law as an act or omission which falls short of what is proper in the circumstances, whether deliberate or reckless.

24. Mr Trussler submitted that there is a minimum level of seriousness, namely "a falling short by omission or commission of the standards of conduct expected among medical practitioners, and such falling short must be serious" so that it would be "regarded as deplorable by fellow practitioners."

25. Mr Trussler submitted that while the position of the Council is that the allegations amount to misconduct in and of themselves, it is also open to the Committee in the limited circumstances envisaged in the case of *Ahmedsowida v GMC [2021] EWHC 3466* to consider the allegations cumulatively for the purposes of assessing whether there is misconduct in this case.

26. Mr Mills accepted misconduct on behalf of the Registrant. However, Mr Mills submitted that the Committee should consider that the facts demonstrate that this is a lower-level misconduct. Firstly, that there is really only one allegation, that of making fictitious bookings, and Allegation 2 does not really add anything to Allegation 1. Further, that whilst there is reference to "*patients who then failed to attend appointments"* in Allegation 1, this would of course be obvious as they were completely fictitious and there was no

evidence of any direct effect on any patients. The nature of the records entered into the diary entries were very basic, only the name, telephone number and date of birth which demonstrated a low level and unsophisticated deception.

27. Mr Mills submitted that there was no motive for the Registrant except to try to [redacted]. The Registrant's own team confirmed that she did not take longer lunches or go home early. As the Registrant was salaried there was no financial motive, and indeed there was no way to quantify the financial impact on her employer. Even with a suggested £25 value, given that the fictitious appointments were made (with one single exception) on the day or the day before, there was no evidence as to whether any real patients had tried to book during those appointment times or indeed the true failed attendance rates at the store. There is also no evidence presented of any impact these appointments had on colleagues.

28. Mr Mills submitted that there is no evidence of any adverse effect on the Registrant's clinical practice, indeed the Registrant had given evidence that she was very mindful about her ability to do her job and told her manager on some days [redacted]. The Registrant was otherwise very careful about her clinical competence.

29. Mr Mills submitted that the totality of the misconduct is that the Registrant was booking relatively limited fictitious appointments [redacted]. Considering those circumstances this is a less serious case of dishonest misconduct.

30. 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".

31. The Legal Adviser further outlined the case of *Remedy UK Ltd v General Medical Council [2010] EWHC 1245 (Admin)*, that there were two principal kinds of misconduct, in this case the alleged misconduct does not relate to professional practice but conduct that otherwise brings the profession into disrepute. The Committee were advised that only serious misconduct is taken into consideration at the impairment stage. The Committee should

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

32. Although both parties agree that misconduct is found, the Legal Adviser advised that only if the Committee concludes that that any matters are non-serious matters, it can then go on to consider whether the cumulative effect of them, taken together, might amount to misconduct as per the cases of *Schodlok v General Medical Council [2015] EWCA Civ 769* and *Ahmedsowida v GMC (2021) EWHC 3466(Admin).*

33. 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

34. 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.

35. The Committee determined that the relevant *Standard of practice for optometrists and dispensing opticians* was *Standard 16 – be honest and trustworthy.*

Allegation 1

36. The Committee noted that misconduct is admitted. The Committee considered that these actions fell seriously short of *Standard 16* as it was a matter of dishonesty.

37. The Committee considered Allegation 1 to amount to creating fictitious appointments in the course of a profession over an 11-week period. It was repeated 16 times. The Registrant had the opportunity to [redacted] but continued to work. There was a potential for a financial loss to her employer. The Committee also noted that it was not the Registrant herself who reported the fictitious appointments.

38. However, the Committee considered the facts of this particular case to demonstrate that this is a lower-level dishonesty. The Committee drew a distinction between falsification of patient records and falsification of diary entries, as occurred in this case. The Committee accepted that there was no harm or potential harm caused to patients. The records referred to were false diary entries and not patient records. Indeed, the nature of the records

entered into the diary entries were very basic, only the name, telephone number and date of birth. They were only made on the day of, or the day before the appointment was booked out. The Committee considered this to amount to a lower level and unsophisticated dishonesty. There was no evidence of impact to patients, no false records tied to a patient and no evidence of impact on her colleagues.

39. The Committee also accepted that there was no other motive for the Registrant except [redacted]. The Committee noted that the Registrant's own team confirmed that she did not take longer lunches or go home early. The Committee also did not consider that there was a financial motive, as the Registrant was salaried. Although it was inevitable that this would impact her employer, the Committee were presented with no evidence to quantify these costs.

40. The Committee accepted that there was no evidence of any adverse effect on the Registrant's clinical practice.

41. For the above reasons, the Committee determined that the totality of the misconduct is that the Registrant was booking fictitious appointments in the appointment diary as [redacted]. As this was dishonest behaviour, the Committee considered this to be serious misconduct, albeit of a less serious level of dishonesty.

Allegations 2(a), 2(b) and 2(c)

42. The Committee reached the same determination on misconduct and for the same reasons as in Allegation 1.

43. The Committee determined that the specified activities particularised in Allegations 2(a), 2(b) and 2(c) do not add any further additional 'mischief' to the facts found at Allegation 1. Indeed, they arise from the same set of fictitious appointments, and the same set of facts and evidence.

44. Therefore, for the same reasons, the Committee determined that the totality of the misconduct is that the Registrant was booking fictitious appointments in the appointment diary [redacted]. As this was dishonest behaviour, the Committee considered this to be serious misconduct, albeit of a less serious level of dishonesty.

Allegation 3

45. The Committee determined that the matters within Allegations 1 and 2 were committed dishonestly and therefore also determine that Allegation 3 amounts to misconduct.

Submissions on impairment

46. Mr Trussler submitted that the Committee should find impairment in this case. Mr Trussler submitted that the Committee must take into account the public interest and the need to uphold proper professional standards and public confidence in the profession, and should consider evidence of the Registrant's conduct demonstrated before and after the misconduct.

47. Mr Trussler submitted that a failure to find impairment is "*tantamount to an indication on behalf of the profession that conduct of the kind need not have regulatory consequences*" as per the case of *Fopma v GMC [2018] EWHC 714 (Admin), 2018 WL 01371181* and impairment should be found if the Committee considers that would be an acceptable conclusion.

48. Mr Trussler submitted that the Committee should therefore consider firstly whether the Registrant presents a risk to members of the public on a continuing basis; and secondly whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made.

49. Mr Trussler submitted that in accordance with the judgment of Silber J in *Cohen v GMC [2008 EWHC 581 (Admin)*, when determining impairment, the Committee must consider three factors:

    (i) whether the conduct is likely to be repeated;

    (ii) whether it is easily remediable; and

    (iii) whether it has been remedied.

50. Mr Trussler submitted the GOC's position is that due to the dishonesty element, there is impairment in the present case, and according to the case of *Fopma,* there is a compelling public interest in ensuring regulatory consequences following this type of misconduct.

51. Mr Mills submitted that the Committee should consider this case as 'exceptional' as per the case law outlined in the case of *PSA v Hilton [2019] EWHC 1638 (Admin), 2019 WL 02718475* and other authorities.

52. Mr Mills submitted that according to the case of *CHRE v NMC and Grant [2011] EWHC 927 ("the Grant case"),* in determining whether a practitioner's

fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances. In particular, whether the findings of fact show that the Registrant's fitness to practise is impaired in the sense that she:

a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or
b. has in the past brought and/or is liable in the future to bring the medical 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 medical profession; and/or
d. has in the past acted dishonestly and/or is liable to act dishonestly in the future.

53. Mr Mills submitted that the prime concern was to uphold the overarching objective and that this is not a case in which there is or has been a risk to the health, safety and well-being of the public. It could properly be described as a case which centres on whether current impairment should be found on public interest grounds rather than public protection.

54. In relation to insight, Mr Mills submitted that the Registrant self-referred to the GOC on 20 November 2023. The self-referral was forthright in accepting responsibility. She accepted in a hearings questionnaire last December that all but the now dropped former Allegation 2(a) would be admitted. The admissions and self-referral are indicators of insight.

55. Mr Mills submitted that the Registrant's reflective statement demonstrates an understanding of:
a. The seriousness of the misconduct;
b. An understanding of how the misconduct arose;
c. The taking of responsibility for it;
d. Reflection on how it can be avoided in the future.

56. Accordingly, it demonstrates a significant degree of insight, which reduces the risk of repetition.

57. Mr Mills submitted that the conduct of the Registrant is capable of remediation, has been remediated, and is highly unlikely to be repeated, for these reasons:

a. The misconduct occurred in the context of [redacted];
b. The misconduct has been the subject of reflection and significant insight has been demonstrated;
c. Appropriate CPD has been undertaken;
d. Ms Ather, through effort and support, has successfully returned to work [redacted]. The references, in particular from Colleague A, speak very highly of her. The ability to achieve that after the events which had occurred is demonstrative of someone who is committed to their profession in the manner Ms Ather describes in her reflective statement. That is a factor indicating reduced risk of repetition, as well as of no repetition.

58. Mr Mills submitted on behalf of the Registrant that the Committee should bear in mind its power to impose a warning if no impairment is found, as described in the *Guidance* as having an "important role in upholding standards and maintaining confidence in the profession", and amount to a "formal response". It should also be borne in mind that even if impairment is found, a committee is not bound to impose a sanction. It may take no further action. Accordingly, even a finding of impairment does not necessarily result in "regulatory consequences."

59. The Legal Adviser outlined *Paragraphs 16.1 to 16.7* of the *Hearings and Indicative Sanctions Guidance.* The Legal Adviser then advised the Committee to consider the two separate elements of impairment namely the public component, which concerns the reputation of the profession and upholding professional standards, and the personal component which concerns the risk of repetition and insight displayed on the part of the Registrant as in *Cohen v GMC 2008 EWHC 581***.** The Legal Adviser also highlighted the four questions in the *Grant* case.

60. 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 [2015] EWHC 1304*, also re-iterated that a finding of dishonesty does not mean impairment is inevitable.

61. 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

62. The Committee heard and accepted the legal advice.

63. The Committee considered all of the evidence submitted, the evidence given by the Registrant, the submissions from both parties, and the Registrant's full bundle including the reflective piece from the Registrant (undated) and the testimonials supplied.

64. 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."

65. The Committee noted that this was not case which related to clinical concerns or patient safety.

66. The Committee looked at its findings on misconduct with regard to public confidence in the profession and maintaining proper professional standards of conduct. The Committee reminded itself that the Registrant had created 16 fictitious entries in the appointments diary over an 11-week period. The Registrant had the opportunity to [redacted]. There was a potential for a financial loss to her employer. The Committee also noted that it was not the Registrant herself who reported the fictitious appointments, and that when she was confronted she did not admit the matter straightaway. The Committee considered that this may cause concern with regard to the public interest test and will return to this issue later in the determination.

67. The Committee considered the questions in the *Grant* case with regards to the Registrant's behaviour as admitted and proved. The Committee did not consider that the Registrant had *in the past* acted so as to put a patient at unwarranted risk of harm as there were no risks to patients in this case. The Committee did find that by booking of fictitious appointments, the Registrant has, *in the past,* brought the profession into disrepute, breached a

fundamental tenet of the profession and has acted dishonestly. However, in accordance with its findings on misconduct, the Committee determined that the totality of the Registrant's misconduct was that the Registrant was booking fictitious appointments in the appointment diary as [redacted], and as such was a less serious level of dishonesty as referenced in the case of *Lusinga.*

68. The Committee went on to consider the questions in *Grant* with reference to the Registrant's future risk.

69. The Committee considered the Registrant's insight to assist it with future risk of repetition. The Committee noted that the Registrant had made a candid self-referral to the GOC on 20 November 2023, had accepted the Allegations in an early hearings questionnaire and admitted the Allegations at the outset of this hearing. The Committee also considered that the Registrant's oral evidence to be an excellent demonstration of her insight, her answers reassuring the Committee that she has recognised the seriousness of the misconduct, and the impact of her actions on the reputation of the profession. Therefore the Committee concluded she had demonstrated a high level of insight.

70. The Committee was also satisfied that there would not be a repetition of this behaviour. The Registrant had taken remedial steps which mitigate against the recurrence of concerns raised in this case. The Registrant had outlined these in both her oral evidence as well as her written submissions. In particular, the Committee noted that the Registrant was now aware [redacted]. The Registrant demonstrated a commitment to returning to work safely, working initially part time and then full time. The Registrant confirmed that she could recognise when she felt unsupported, [redacted], even considering leaving an employer if she perceived that she was not able to obtain appropriate support. The Registrant gave evidence that she is now working very well with a new employer who provided her with excellent support, and this was reinforced by two positive testimonials from her current employers. The Committee considered that it was highly unlikely that [redacted] the Registrant found herself in at the time of the Allegations were likely to be repeated. If she did experience [redacted], the Committee was reassured that she was now equipped to respond appropriately. Therefore the Committee is satisfied that there is a very low risk of repetition.

71. In applying its findings on insight and repetition to the *Grant* criteria in looking forward, the Committee found the Registrant candid in her oral evidence, as she had acknowledged the impact of her actions on the profession, and assured the Committee that she would not repeat behaviour which would be liable to bring the profession into disrepute, breach a

fundamental tenet of the profession, or act dishonestly. The Committee also noted that the Registrant had taken steps to remediate by completing a Probity and Ethics course entitled "*How to Ensure a Similar Mistake or Misconduct Will Not Be Repeated in the Future,"* and the Committee were satisfied that the Registrant's oral evidence demonstrated that she had absorbed the learning points from that course. The Committee also found persuasive the testimonials provided by the Registrant's current employer and the fact that she had fully co-operated with the GOC proceedings. The Committee considered that there was a low future risk that the Registrant would bring the profession into disrepute, breach a fundamental tenet of the profession or act dishonestly.

72. The Committee also bore in mind the guidance of Sir Thomas Bingham MR in Bolton v Law Society [1994] 1 WLR 512 at 598) that "*in cases of significant professional dishonesty, mitigation has a necessarily limited role*" and its responsibility to promote and maintain public confidence in the profession and proper professional standards and conduct. However it also acknowledged case law such as *Lusinga v NMC [2017] EWHC 1458 (Admin)*; *Professional Standards Authority v Health and Care Professions Council and Ghaffar [2014] EWHC 2723 (Admin)*; *PSA v (1) GMC (2) Uppal [2015] EWHC 1304* and *PSA v Hilton [2019] EWHC 1638 (Admin), 2019 WL 02718475,* all of which underlined that a finding of impairment did not automatically follow a finding of dishonesty, but indicated that there are levels of dishonesty, and that the Committee must consider the particular circumstances of the case before it, which might lead to an 'exceptional' finding that impairment was not necessary.

73. The Committee considered this to be an exceptional case for the following reasons:

- this was a low-level dishonesty, it did not relate to clinical issues, patient safety nor indeed patient records;
- [redacted], and was inexperienced and relatively newly qualified;
- [redacted];
- the Committee accepted that the Registrant had not pursued legitimate requests for breaks because she was relatively junior and [redacted];
- the Registrant's only motivation for booking the appointments was to secure extra time [redacted];
- there is no evidence of loss or harm to her employer, patients or colleagues, indeed her own colleagues at the time confirmed the Registrant worked very hard;
- There are multiple instances of booking fictitious appointments, however they were all as a direct result of [redacted], which has not, and is not likely to be repeated;

- [redacted], which the Committee are satisfied have given her the appropriate tools to demonstrate insight;
- the Registrant self-referred to the GOC and has expressed insightful remorse;
- the testimonials supplied by her current employer are positive and demonstrate the Registrant's transparency with regard to these proceedings;
- the Registrant has managed herself admirably since the incident, considering the course of events in a short space of time: her dismissal in November 2023, [redacted] and self-referral in December 2023, and her staged return to work since February 2024, and appears to at all points during this period had high regard for the safety of the public and patients.

The Committee determined that, taken together, these factors amount to exceptional circumstances which led it find that despite the dishonest misconduct, the Registrant was not currently impaired.

74. The Committee considered that an informed and fair-minded member of the public, if they were appraised of all the facts, would not reasonably consider that a finding of impairment was necessary to maintain public confidence in the profession or to uphold proper professional standards.

75. For those reasons, the Committee found that the fitness of the Registrant to practise was not currently impaired.

Submissions on Warning

76. Mr Trussler for the GOC invited the Committee to impose a Warning. Mr Trussler pointed to the *Guidance,* and submitted that in a case such as this, where the fitness to practise of a Registrant is found not to be currently impaired, then the factors outlined at *Paragraph 20.6* were engaged as follows:

a. There has been a clear and specific breach of the *Standards;*
b. The particular conduct, behaviour, or performance approaches, but falls short of the threshold for current impairment, Mr Trussler adding that but for the substantial mitigation for the Registrant, there would have been impairment;
c. The concerns in this case, as per the Committee's findings must be considered sufficiently serious that, if there were a repetition, they would likely result in a finding of impaired fitness to practise;
d. There is a need to record formally the particular concern(s).

77. Mr Trussler also referred to the relevant case law previously outlined which established that a finding of dishonesty should be usually be appropriately marked by regulators. Whilst the circumstances of and subsequent actions by the Registrant may be such that the Committee do not find impairment in this case, the seriousness of the dishonest conduct must itself be marked. As such a Warning would be appropriate in this case.

78. Mr Mills submitted that the Registrant is neutral on the issue of the imposition of a Warning.

79. Mr Mills submitted that if the Committee did conclude that a Warning was appropriate, it should review again the significant mitigating factors in this case and consider a lower length Warning on that basis.

80. The Legal Adviser also outlined *Paragraph 20* of the *Guidance* in relation to Warnings where no impairment is found, specifically the factors when a finding of no impairment has been made and a Warning may be appropriate at *Paragraph 20.6,* as well as the range of aggravating or mitigating factors to consider when determining whether a Warning is appropriate, having regard to the public interest as part of their considerations under *Paragraph 20.7.*

81. There is no specific *Guidance* on the length of Warnings and therefore the Committee must use its own judgment as to the appropriate length, bearing in mind the proportionality principles.

Findings on Warning

82. The Committee considered the submissions, legal advice, and the relevant case law in relation to Warnings.

83. The Committee considered the *Guidance* with regard to Warnings, in particular at *Paragraph 20.6*:

    a. The Committee considered that there had been a clear and specific breach of *Standard 16* because this is an admitted and proved dishonesty matter.
    b. The Committee considered that the dishonest actions of the Registrant approached, but fell short of the threshold for current impairment for the reasons explained in its findings on impairment.
    c. The Committee considered that the concerns raised by the case are sufficiently serious that, if there were a repetition, they would likely result

in a finding of impaired fitness to practice because it would undermine the Registrant's representations as to insight and repetition.

d. The Committee considered there is a need to formally record the concerns due to this being a dishonesty matter which was repeated 16 times over an 11-week period.

84. The Committee had already made determinations as to misconduct and impairment which had set out the aggravating and mitigating factors to satisfy the considerations in *Paragraph 20.7* of the *Guidance.*

85. The Committee reviewed the aggravating factors, namely that the Registrant had created 16 fictitious entries in the appointments diary over an 11-week period. The Registrant had the opportunity [redacted]. There was a potential for a financial loss to her employer. The Committee also noted that it was not the Registrant herself who reported the fictitious appointments, and that when she was confronted, she did not admit the matter straightaway.

86. The Committee reviewed the following mitigating factors:

a. Genuine expression of regret/apology from the Registrant in the tone of her self-referral, her early admissions and her oral evidence expressing regret;
b. The Registrant's previous good Fitness to Practise history;
c. The Registrant was [redacted], which has demonstrated her clear insight;
d. The Registrant has successfully re-gained employment;
e. The Registrant's significant insight, learning and remediation since these events;
f. Testimonials from the Registrant's current employer are positive as to her current working practices.

87. The Committee determined that despite the extensive personal mitigation and relevant circumstances of the Registrant, the nature of the misconduct, involving as it did dishonesty, was such that a Warning was appropriate to highlight to the wider profession that such behaviour was unacceptable. This would also serve as a reminder to the Registrant that her misconduct represented a departure from the *Standards* expected and should not be repeated.

88. The Committee settled on the wording of the Warning as follows:

*"*Ms Ather, the Fitness to Practise Committee has concluded that your fitness to practise is not currently impaired. However, the Committee found that your conduct did fall below the *Standards*, in particular *Standard 16,*

expected of a Registrant and considers it appropriate and proportionate to issue you with a formal warning for a period of 12 months. This Warning will be placed on your registration record and may be taken into account in any future fitness to practise proceedings. While no further action is being taken at this time, the Committee reminds you of the importance of adhering to the Standards set by the General Optical Council and expects no repetition of the conduct in question. This Warning will expire on 21 May 2026."

89. The Committee therefore issued a Warning which will be recorded against the Registrant's registration for a fixed period of 12 months.

Chair of the Committee: Gerry Wareham

Signature **Date: 21 May 2025**

Registrant: Hina Ather

Signature *Present remotely and received via email* **Date: 21 May 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.
Contact
If you require any further information, please contact the Council's Hearings Manager at Level 29, One Canada Square, London, E14 5AA or by telephone, on 020 7580 3898.