BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(24)38

AND

JOHN SINGH (D-15254)

DETERMINATION OF A SUBSTANTIVE HEARING
3-7 MARCH 2025

Committee Members:	Louise Fox (Chair) Vivienne Geary (Lay) Ian Hanson (Lay) Simon Pinnington (Dispensing Optician) Ian Taylor (Dispensing Optician)
Legal adviser:	Kelly Thomas
GOC Presenting Officer:	Arthur Lo
Registrant present/represented:	Yes and represented
Registrant representative:	John Graham
Hearings Officer:	Terence Yates
Facts found proved:	Particulars 1(a), 1(b) and 2.
Misconduct:	Found
Impairment:	Impaired
Sanction:	12 months suspension – with Review
Immediate order:	No immediate order

ORIGINAL ALLEGATION

The Council alleges that you, John Singh (D-15254), a registered dispensing optician:

1. *On one or more occasion, between January 2018 and March 2022,*
    a. *you supplied the patients listed in Schedule A with spectacles with a lower value and/or inferior to the spectacles the patients had originally paid for; and/or*
    b. *You knowingly overcharged patients listed in Schedule A and processed transactions to the value of £9793.43*
2. *Your conduct as set out at 1 above was inappropriate and/or dishonest in that you knew the spectacles provided to the patients were of a cheaper and/or inferior quality to what they paid for and/or you did not refund the patients with the difference in price.*

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

Schedule A

Patient 1-145

DETERMINATION

Background to the allegations

1. The Registrant graduated as a Dispensing Optician in June 2013.
2. At the time of the allegation, he was working as a registered Dispensing Optician and Branch Manager for Leightons Insight Opticians.
3. On 25 January 2022 a 'whistle-blower' raised a concern by reporting discrepancies in the spectacle lenses and coatings being supplied to patients not matching those having been ordered and paid for by the patient.
4. The directors were notified of the concern and initiated an internal investigation which also highlighted discrepancies.
5. The Registrant was suspended on 9 February 2022 pending an internal investigation. The Registrant was reported to the GOC on 17 February 2022.
6. Following the internal investigation, it is alleged that between January 2018 and March 2022 the Registrant supplied patients with spectacle lenses and coatings that were of a lower value than they had paid for.
7. The Registrant has no other fitness to practise history.

Application to amend allegations

8. Mr Lo made an application to amend the allegations under *Rule 46(20)* of the *Fitness to Practise Rules 2013 ("the Rules).*

9. Mr Lo submitted that following a review of the calculations of the sums and patients involved, the revised value that appears in Particular 1(b) should be £7051.61. Further, that in Schedule A there should be 145 patients and not 191 as outlined in the Council's bundle.
10. Mr Graham had no objections to these amendments.
11. The Legal Adviser gave advice, namely that *Rule 46 (20) of the Fitness to Practise Rules* provides that:

    (*20) Where it appears to the Fitness to Practise Committee at any time during the hearing, either upon the application of a party or of its own volition, that—*

    a. the particulars of the allegation or the grounds upon which it is based and which have been notified under rule 28, should be amended; and

    b. the amendment can be made without injustice,

    it may, after hearing the parties and consulting with the legal adviser, amend those particulars or those grounds in appropriate terms.
12. The Committee agreed to the amendment as there was no injustice caused to the Registrant, and the revised amount was reflective of the evidence itself.

ALLEGATION (as amended)

The Council alleges that you, John Singh (D-15254), a registered dispensing optician:

1. *On one or more occasion, between January 2018 and March 2022,*
   a. *you supplied the patients listed in Schedule A with spectacles with a lower value and/or inferior to the spectacles the patients had originally paid for; and/or*
   b. *You knowingly overcharged patients listed in Schedule A and processed transactions to the value of £7051.61*
2. *Your conduct as set out at 1 above was inappropriate and/or dishonest in that you knew the spectacles provided to the patients were of a cheaper and/or inferior quality to what they paid for and/or you did not refund the patients with the difference in price.*

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

Schedule A

Patient 1-145

Admissions

13. The Registrant admitted particulars 1(a), 1(b) and 2 of the Allegation.
14. Under Rule 46(6) (6), as the facts have been admitted, the Committee therefore found Particulars 1(a), 1(b) and 2 (on the basis of inappropriate conduct) proved.

Submissions on misconduct

15. Mr Lo outlined the facts as proved and submitted that the Registrant's actions touch upon both types of misconduct as defined in *Remedy UK Ltd v General Medical Council [2010] EWHC 1245 (Admin)*. The Registrant had acted dishonestly towards the affected patients, causing them to receive products the value of which fell below what they had paid for, conduct which was morally culpable which is capable of attracting opprobrium and bringing the profession into disrepute. Such conduct took place within a clinical setting, over a period of months and caused his employer sizeable financial loss. Mr Lo stated that the Registrant's actions fell far below the standards expected of registered opticians.

16. With regards to the *Council's Standards of Practice for Optometrists and Dispensing Opticians 2016* (*'the Standards'*), Mr Lo submitted that the Registrant has breached the following provisions:

- Standard 16 – Be honest and trustworthy
- Standard 16.1 – Act with honesty and integrity to maintain public trust and confidence in your profession.
- Standard 17 – Do not damage the reputation of your profession through your conduct.
- Standard 17.1 – Ensure your conduct, whether or not connected to your professional practice, does not damage public confidence in you or your profession.

17. The Registrant accepted misconduct. Mr Graham submitted that misconduct has most recently been defined in the judgment of *Forz Khan v Bar Standards Board [2018] EWHC 2184 (Admin)* at paragraph 35 as:

"behaviour must be "seriously reprehensible" before it can amount to professional misconduct."

18. In *Meadow v General Medical Council [2007] 1 All ER 1*, the Court of Appeal made clear that the "misconduct" should not be viewed as anything less than "*serious professional misconduct*" and as to seriousness, *Nandi v General Medical Council [2004] EWHC 2317 (Admin),* rightly emphasised as "*conduct which would be regarded as deplorable by fellow practitioners*."

19. Mr Graham also outlined the case of *Remedy* which outlined two principal kinds of misconduct, misconduct in the exercise of professional practice and also conduct of a morally culpable or otherwise disgraceful kind which may prejudice the reputation of the profession. Mr Graham submitted that even on the basis of the GOC case, there do not appear to be any discrepancies which have caused a clinical issue and therefore this is not a public safety case.

20. The Legal Adviser outlined the *GOC Hearings and Indicative Sanctions Guidance ("the Guidance")* at *Paragraphs 15.5-15.9,* and the case of *Roylance v GMC [1999] Lloyd's Rep Med 139* where misconduct was described as:

21. *"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".

22. The Legal Adviser further outlined the case of *Remedy* that there were two principal kinds of misconduct, those relating to professional practice and conduct that otherwise brings the profession into disrepute.

23. The Committee were advised that only serious misconduct is taken into consideration at the impairment stage. 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

24. The Committee heard and accepted the advice of the Legal Adviser, and considered the written and oral submissions as well as the case law relating to misconduct.

25. The Committee noted that misconduct is admitted. The Committee agreed that the relevant *Standards* were *16.1 and 17.1.* The Committee also considered that *Standard 1 (Listen to patients and ensure that they are at the heart of decisions about their care)* also applied. The Committee considered the *Guidance* at *Paragraph 15.5-15.9* and the definition of misconduct in the case of *Roylance*, also applied in subsequent cases.

26. The Committee considered that this was a serious falling short of the *Standards.*

27. The Committee considered that the Registrant's fraudulent practice of overcharging patients was over a long period of time and amounted to a significant amount of money, in excess of £7000. The Committee considered that the wider public would be shocked by this, as well as the affected patients themselves, some of whom had paid a significant amount more than necessary for the lenses they received.

28. The Registrant was the branch manager and as such, held a position of trust, both for patients and for the staff that he worked with. As such, he would have been aware of the need for honesty and compliance with the *Standards*, as well as the need to demonstrate this compliance to other staff. His failure to do so would be likely to affect the culture at the branch. As branch manager, the Registrant would also have been directly aware of the improvement in profitability for the business.

29. The Committee considered the facts, that the patients had followed the advice they were given and it had later transpired that the glasses they received were not of the quality of the spectacles they had, in good faith, paid for. The Committee considered this to be a breach of trust which was deplorable.

30. Once patients were informed of these allegations, the Committee considered that even without concern of clinical harm, there was a detriment to patients due to the financial losses they suffered as a result of the Registrant's actions. The Committee considered that patients may have been supplied with a product which was not the optimum product for them. Those patients would have been concerned about all staff in that practice, which affects the reputation of

profession as well as trust in the profession itself. The Committee considered these actions to be 'seriously reprehensible.'

31. For those reasons, the Committee found that the Registrant's actions did amount to serious misconduct.

Submissions on impairment

32. The Registrant gave evidence in addition to his witness statement. The Registrant outlined that prior to 2019 he was used to dispensing branded lenses. However, following this, there was a policy which was introduced which required Dispensing Opticians to use alternative versions of branded lenses, which were 'white label' lenses, i.e. Leightons' own brand lenses. The Registrant submitted that due to the 'frosty' relationship between Leightons and Leightons Insight, there was very little training provided on how to recognise the appropriate white label lenses in comparison to the branded lenses. The Registrant admitted he was aware that he placed orders for patients which were less valuable that those they had paid for. The Registrant accepted that this was dishonest and acknowledged the detrimental impact this would have on the profession and the public confidence.

33. The Registrant accepted under cross examination that he would indirectly benefit from this practice because it increased profitability and consequently increased the likelihood of improving his own potential bonuses. The Registrant outlined the training he had completed and highlighted his insight, remediation and remorse.

34. Mr Lo on behalf of the GOC submitted that the Registrant is currently impaired. According to the principles in *CHRE v Grant [2011] EWHC 927 (Admin)* at [70] ("the *Grant* case"), when considering the issue of impairment, whilst Panels are primarily concerned with current impairment, any analysis must also involve consideration of past impairment, steps taken to remediate and the risks of recurrence. The Committee must consider the fundamental considerations of protecting the public, as well as declaring and upholding proper standards so as to maintain public confidence in the profession.

35. With regard to the Shipman criteria as set out by Dame Janet Smith in *Grant*, Mr Lo submitted that (b)-(d) are pertinent to the present case, in that the Registrant has acted in the past and/or is liable in the future to bring the profession into disrepute, has in the past breached and/or is liable in the future to breach fundamental tenets of the profession, and has in the past acted dishonestly and/or is liable to do so in the future.

36. Mr Lo accepted that the Registrant has demonstrated limited insight and remediation but submitted that dishonesty is the fundamental issue in the case. The presence of dishonesty in this case is noteworthy. In the *Guidance at 17.1,* it is noted that "dishonesty is particularly serious as it may undermine confidence in the profession". Furthermore, per the Privy Council in *Dr Shiv Prasad Dey v GMC (Privy Council Appeal No. 19 of 2019),* "*…Health Authorities must be able to place complete reliance on the integrity of practitioners; and the Committee is entitled to regard conduct which undermines that confidence as calculated to reflect on the standards and reputation of the profession as a whole*."

37. Mr Lo submitted that in addition to dishonesty, the overall high value of the sums involved and the large number of patients affected, meant that the public interest, and the need to uphold standards and maintain public confidence would be undermined if no findings of impairment are made. Mr Lo stated that as per the case of *Yeong v General Medical Council [2009] EWHC 1923 (Admin)*, a finding of impairment may be justified on the grounds that it is necessary to reaffirm clear standards of professional conduct so as to maintain public confidence.

38. Mr Lo submitted that even in his witness statement the Registrant did not accept that he received a benefit from his actions. However, in his oral evidence he did accept that he received bonuses which were tied to revenue, and that the overcharging had a direct positive effect on revenue. Further Mr Lo submitted that the Registrant gained a further benefit, namely that it meant he could show to his employers his willingness to adhere to company policy, which tied into his performance and standing within the company.

39. Mr Lo therefore invited the Committee to find that that the Registrant's fitness to practice is currently impaired.

40. Mr Graham, on behalf of the Registrant, submitted that the Registrant is not currently impaired. Mr Graham outlined the legal guidance and stated that it is generally recognised that the principle purpose of a Fitness to Practise Committee is the preservation and maintenance of public confidence in the profession rather than the administration of retributive justice. Mr Graham submitted that limb (a) of the factors in the *Grant* case was not engaged in this case and therefore remediation is more likely to be achieved than would be the case in respect of clinical deficiencies.

41. Mr Graham submitted that there has been no repetition, the Registrant is now working collaboratively in his work setting. The Registrant recognised the importance of systems and processes and the importance of putting the patient first at all times. Patient care comes first over commercial considerations which is the culture in his new practice as opposed to his previous practice, the subject of these allegations.

42. Mr Graham submitted that the risk of repetition is zero. There has been no repetition, but there is evidence of insight, including early admissions, a self-referral to the GOC and engagement with the process. There was an offer to compensate and assist in the analysis of the transactions. The Registrant has also expressed genuine remorse. The Registrant has demonstrated a desire to make a positive contribution in the work setting and rebuild his career.

43. Mr Graham submitted that the two testimonials from the Registrant's existing employers attest to the Registrant's professionalism, appropriate professional conduct with patients and colleagues, and effective practice, as well as complete trust being placed in the Registrant. The Registrant has previous exemplary character. In particular, no fitness to practice proceedings. Finally, the Registrant has completed training which includes training on:

    i. Enhanced quality control and order verification;
    ii. Improved communication and informed consent;
    iii. Competence;
    iv. Communication;
    v. Learning and improvement;

vi. Auditing at [redacted] Opticians is done monthly to check orders, collate with records;
vii. Enhanced ethical training and professional development;
viii. Financial transparency and cost management;
ix. Mentorship and supervision; and
x. Patient care.

44. The Legal Adviser outlined *Paragraphs 16.1 to 16.7,* and *17.1-17.3* of the *Hearings and Indicative Sanctions 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*.

45. The Legal Adviser also outlined the case of *CHRE v Grant 2011 EWHC 927* which indicated some questions for the Committee to ask itself:

a. *Has [the Registrant] in the past acted and/or is [he] liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
b. *Has [the Registrant] in the past and/or is [he] liable in the future to bring the medical profession into disrepute; and/or*
c. *Has [the Registrant] in the past breached and/or is [he] liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
d. *Has [the Registrant] in the past acted dishonestly and/or is liable to act dishonestly in the future*

46. 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

47. The Committee heard and accepted the legal advice. The Committee considered the evidence given by the Registrant, and the submissions from both parties.

48. The Committee also considered the *Guidance* at *Paragraphs 16.1* to *16.7, 17.1-17.3,* the four questions in the *Grant* case; and the Council's overriding objective giving 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."

49. In relation to limb (a) of the criteria in *Grant*, the Committee acknowledged that both parties had accepted there had been no clinical risk alleged and this limb was not engaged.

50. The Committee determined that the Registrant had *in the past* brought the profession into disrepute under limb (b), had breached one of the fundamental

tenets of the profession under limb (c) and had acted dishonestly under limb (d) as per the case of *Grant*.

51. The Committee noted the facts as admitted and proved. The Registrant had deliberately made fraudulent transactions and overcharged 145 patients, to the value of £7051.61 over a substantial period of four years. As branch manager, the Registrant had abused the trust of other staff members as well as the patients involved in the fraud. Members of the profession and the public would be shocked by such behaviour and this seriously undermines public confidence in the profession. This was a serious falling short of the fundamental tenets of the profession, in particular *Standards 1, 16.1 and 17.1.*

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

53. The Committee accepted that the Registrant has shown some level of remorse, given that he made early admissions, made a self-referral to the GOC and apologised to the GOC and the Committee, accepting his dishonesty. The Committee also appreciated that the Registrant had made a voluntary offer to repay and to assist his employers with the investigation.

54. With regard to insight, the Committee noted the changes the Registrant had made to avoid being in the same circumstances he found himself in at the time.

55. The Committee noted that the allegations only came to light due to a whistleblower reporting these matters, it was not the Registrant himself who voluntarily stopped these transactions.

56. Further, the Committee noted that the Registrant's witness statement asserted that he did not benefit from his actions. It was only during his oral evidence, under cross examination that the Registrant accepted that he did benefit from overcharging the patients, both by receiving bonuses linked to profitability and also being able to demonstrate good performance and willingness to adhere to policy which amounted to an indirect benefit. The Committee found this late admission to be a concern as the Registrant had only just started to appreciate his own motivations for his behaviour.

57. The Committee found that the Registrant had demonstrated only a limited understanding of his own culpability as to what he had done wrong and the impact this would have had on the 145 patients affected, as well as the wider public perception of the profession.

58. The Committee was also concerned by the Registrant's comment in his evidence that this was an 'isolated incident.' There were 145 fraudulent transactions over a substantial period of four years. The overall value was high, at £7051.61. The transactions were sustained, systematic and calculated. Some of the patients were overcharged by values in excess of £200. The Committee were concerned that the Registrant had blamed his employer's policy of promoting white label products to minimise his own behaviour. Therefore, the Committee considered that the Registrant demonstrated developing, but still limited insight.

59. The Committee considered remediation and noted that it is difficult to remediate dishonesty. The Committee noted that the Registrant had completed professional courses although was concerned that the courses selected had only

rudimentary relevance to the breaches of the *Standards* that had been identified. The Committee accepted that the Registrant has worked since leaving Leightons without further incidents, and has provided two supportive references from his current employers which attest to his integrity in the workplace.

60. The Committee noted the Registrant's previous good conduct and his engagement with the proceedings appeared to have been a salutary experience for the Registrant. The Committee determined that the risk of the of the Registrant repeating the specific proven behaviour was low. However, it was not satisfied that the Registrant fully accepted and understood the gravity of his dishonesty and the impact on patients. The Committee determined that there remains a risk of repetition of dishonesty if the Registrant was put under pressure in the future.

61. For those reasons, the Committee determined that there was a *future* risk of bringing the profession into disrepute under limb (b), of breaching one of the fundamental tenets of the profession under limb (c) and of acting dishonestly under limb (d) as per the case of *Grant*.

62. The Committee found that the Registrant had in the past, and is at risk in the future of failing to maintain public confidence in the profession and failing to maintain proper professional standards and conduct.

63. The Committee therefore found that the fitness of the Registrant to practise was currently impaired.

Submissions on sanction

64. On behalf of the GOC, Mr Lo submitted that the GOC were neutral as to sanction. Mr Lo outlined the general principles, namely that the purpose of sanctions is primarily concerned with protecting the public and to meet the Council's overarching objective in relation to the wider public interest, and not to punish practitioner wrongdoing *per se.* The Committee should at all times bear in mind the imperative of proportionality, and to impose a sanction which goes no further than necessary to achieve the relevant objective.

65. Mr Lo referred to authorities in relation to dishonesty, namely *Brennan v Health* Professions *Council [2011] EWHC 41 (Admin) at [47], Bolton v Law Society [1994] 1 W.L.R. 512, Solicitors Regulation Authority v Imran [2015] EWHC 3058 (Admin) at [29], and Solicitors Regulation Authority v James, MacGregor* and *Naylor [2018] EWHC 3058 (Admin) at [103].*

66. In respect of the aggravating and mitigating factors present in this case, Mr Lo acknowledged that the Registrant has admitted frankly to the fact that he has provided patients with products lower in value than those they paid for, and that his conduct had been dishonest. He has apologised for his actions and expressed remorse and his determination to not repeat his conduct. Juxtaposed against these matters are the aggravating factors of the case. These include the fact that there had been a persistent and prolonged course of dishonest conduct stretching over four years, the high number of patients affected, the relatively high value of the sums involved, and the fact that the Registrant had abused a position of trust (that of branch manager). The misconduct had a major impact

on his employer (owing to the need to refund clients). Mr Lo submitted that evidence of insight and remediation is relatively limited.

67. Mr Lo submitted that in the circumstances, even bearing in mind the need to start with the least restrictive sanction, it is submitted that taking no further action, a financial penalty order and conditions of practice would not be sufficient to properly address the serious and dishonest nature of the Registrant's conduct and to declare and uphold standards. In particular, in respect of a financial penalty order, the lack of evidence of means makes it inappropriate at this stage. In relation to conditions of practice, it is unclear whether any proportionate and workable conditions can be devised in light of the limited insight and remediation evinced thus far.

68. Mr Lo submitted that the least restrictive sanction which is appropriate to the present case is that of Suspension, which the Committee may impose for a maximum of twelve months. *Paragraphs 21.29-21.31* of the *Guidance* sets out the matters to be considered in respect of suspensions. Mr Lo submitted that the majority of those factors are not directly applicable. The most relevant is that of (a), in other words, the presence of a serious instance of misconduct where a lesser sanction is insufficient. In respect of (b), the Committee has limited evidence to assess whether a deep-seated personality or attitudinal problems exist. In relation to (c), there is clear evidence of repetition of the relevant behaviour between 2018-2022. In respect of (d), the Committee has limited evidence available in order to assess the risk of repetition at this stage in the absence of detailed reflective pieces, CPD certificates and references.

69. Ultimately, when considering whether a suspension order is appropriate, the Committee should determine whether a suspension is sufficient to address the public interest concerns identified, and whether it adequately marks the seriousness of the Registrant's conduct, and in terms of maintaining the public's confidence in the profession and upholding and declaring proper standards of professional conduct and behaviour.

70. Mr Lo submitted that the Committee may also consider erasure, guidelines for which are contained at *paragraphs 21.35-21.39* of the *Guidance*, which state that erasure is likely to be appropriate when the behaviour is fundamentally incompatible with remaining a registered professional. This part of the *Guidance* sets out a number of potential matters, such as serious departure from relevant professional standards, creating or contributing to a risk of harm to patients, abuse of position/trust, sexual and violent offences, dishonesty, repeated breaches of the duty of candour and persistent lack of insight into seriousness of actions or consequences. Erasure may be appropriate if it is the only means of maintaining public confidence in the profession.

71. Mr Lo submitted that some of the factors in the *Guidance* are engaged including the presence of dishonesty, serious departure from professional standards, and potentially the abuse of a position or trust (that of branch manager). It is also open to the Committee to hold that erasure is necessary in this case as the only means to maintain public confidence in the profession owing to the gravity of the Registrant's wrongdoing.

72. Mr Graham submitted that the Committee should consider that suspension is more appropriate than erasure in this case. Mr Graham distinguished the case of *Bolton* and submitted that the case of *Hassan and General Optical Council [2013] EWHC 1887 (Admin)* cautioned against the approach of cross

refencing too widely when relying on cases before the regulator of a profession operating in an entirely different field. Further, that it is not appropriate to assume the legal position in relation to one profession is necessarily the same as another.

73. Mr Graham referred to the Committee's findings so far and in particular, the following factors in mitigation, that the Registrant has:

- practised without further incident for a period of two years with no Interim Order
- shown remorse, and already paid a high price for his actions, including the loss of his employment and reputation from the finding itself
- received a wake up call from this investigation, has reflected and gone through a period of intense self-examination
- shown limited insight and demonstrated genuine reflection

74. Mr Graham directed the Committee to the *Guidance* at *Paragraphs 21* and *22* and submitted that the Committee should consider the options in ascending order, having regard to the principles of proportionality and weighing the interests of the public against those of the Registrant. Public interest considerations include protecting the public, maintaining public confidence in the profession, and maintaining proper standards of behaviour. Any sanction should be no more than is necessary to persuade a reasonable member of the public that it recognises the seriousness of the conduct alleged with the result that public confidence is not harmed or undermined.

75. Mr Graham submitted that even where there is a finding of dishonesty, it does not automatically follow that an otherwise competent professional should be erased.

76. The Legal Adviser outlined the *Guidance Paragraphs 20-23* and *13F - 13H* of the *Opticians Act 1989* in outlining the sanctions available to the Committee. Of particular importance are Paragraphs 22.4-22.6 on dishonesty. The Legal Adviser stated that the sanctions guidance is not a 'straightjacket', but if the Committee were to deviate, they must give reasons. It is not the purpose of sanctions to punish, but the Committee should consider proportionality and balance the interests of the public against those of the Registrant. That said, the interests of the profession take precedence as per *Bolton v Law Society (1994) 1 WLR 512*.

77. In relation to dishonesty, the Legal Adviser indicated that following the cases of *Bolton* and Salsbury, as well as *SRA v Sharma [2010] EWHC 2022,* the following principles applied:

> *"a) Save in exceptional circumstances, a finding of dishonesty will lead to the solicitor being struck off the roll, see Bolton and Salsbury. 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."*

78. However, the Legal Adviser indicated from the case of *Hassan v General Optical Council (2013) EWHC 1887 (Admin)* that dishonesty encompasses a very wide range of different facts and circumstances, and the right approach is to consider the facts of this particular case under *Paragraphs 22.4-22.6,* without any presumption or default rule that erasure is the appropriate sanction.

79. The Legal Adviser advised the Committee to consider whether there are any particular mitigating or aggravating features, and then to work through the sanctions starting first with the least restrictive, and having regard to the over-arching objective of protecting the public, whilst taking a proportionate approach.

Findings on sanction

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

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

82. The Committee took into account the *Guidance* at *Paragraph 14.3* and considered the aggravating factors in this case, which were found to be:

    a. the misconduct was large scale, with 145 patients affected;
    b. sustained over a long period of 4 years;
    c. calculated and deliberate;
    d. the Registrant had minimised his role prior to the proceedings, stating that he had not benefitted;
    e. the Registrant had displayed only limited insight;
    f. there was an abuse of trust, the Registrant also being in a position of authority;
    g. the dishonesty was not stopped by the Registrant but by a whistleblower.

83. In mitigation, the Committee acknowledged the following factors, the Registrant has:

    a. provided evidence of positive good character and good professional practice asserted from two optometrists who have worked with the Registrant for a period of two years;
    b. fully engaged with the GOC investigation from the beginning, including offering to compensate patients for their losses;
    c. self-referred the matter to the GOC, albeit after some delay;
    d. admitted and apologised for his behaviour at the outset and throughout the proceedings;
    e. demonstrated commitment to the profession by remaining in employment and remaining current with training;
    f. shown no clinical harm to patients, and no risk of clinical harm in the future

84. The Committee followed the *Guidance* at *8.3* and went through the possible sanctions, starting with the least severe, that being to take no further action. It determined, having regard to the *Guidance*, that there were no exceptional

circumstances to justify it doing so. Taking no action would not protect the public or be in the wider public interest, it would not reflect the seriousness of the misconduct and therefore it would be entirely inappropriate.

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

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

87. There were however no clinical concerns, this was a dishonesty case, therefore the Committee considered it was not possible to formulate appropriate and practical conditions to impose on registration and make provision as to how conditions will be monitored. Further the Committee considered that the imposition of conditions in this case did not sufficiently mark the level of misconduct, or adequately protect the public interest.

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

    a. *Serious instance of misconduct where a lesser sanction is not sufficient.*
    b. *No evidence of harmful deep-seated personality or attitudinal problems.*
    c. *No evidence of repetition of behaviour since the incident.*
    d. *The Committee is satisfied the Registrant has insight and does not pose a significant risk of repeating behaviour.*

89. The Committee found all of the above factors to be relevant.

90. The Committee considered that whilst the Registrant did receive a benefit from these transactions, that does not appear to have been his primary motivation. The Committee acknowledged that the Registrant's misconduct was at a time when he felt under significant pressure from his managers to sell the white-label lenses. The Committee considered that this context contributed to his behaviour and reflected more an inability or unwillingness to challenge the policy than a deep seated attitudinal problem relating to dishonesty. The Committee noted the steps the Registrant has taken to ensure he is now working in an environment where he can adhere to the *Standards* and where measures are in place to ensure orders are made correctly and transparently. For these reasons the Committee did not conclude that there was any evidence of harmful deep-seated personality or attitudinal problems, nor a significant risk of repetition.

91. The Committee acknowledged that there had been no repetition of the behaviour since this incident. Further, from its findings on impairment, the Committee had found that there was a low risk of repetition and there was some developing insight.

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

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

> *a. Serious departure from the relevant professional standards as set out in the Standards of Practice for registrants and the Code of Conduct for business registrants;*
> *b. Creating or contributing to a risk of harm to individuals (patients or otherwise) either deliberately, recklessly or through incompetence, and particularly where there is a continuing risk of harm to patients;*
> *c. Abuse of position/trust (particularly involving vulnerable patients) or violation of the rights of patients;*
> *d. Offences of a sexual nature, including involvement in child pornography;*
> *e. Offences involving violence;*
> *f. Dishonesty (especially where persistent and covered up);*
> *g. Repeated breach of the professional duty of candour, including preventing others from being candid, that present a serious risk to patient safety; or*
> *h. Persistent lack of insight into the seriousness of actions or consequences.*

94. The Committee considered that some of the factors were present, namely a serious departure from the *Standards,* an abuse of a position of trust and the fact that this was a dishonesty matter which had been persistent. The Committee gave weight to the fact that there was no evidence of clinical harm.

95. The Committee considered dishonesty sanctions in the case law of *Bolton* and *Hassan,* and determined, in accordance with the *GOC Guidance* at Paragraphs *22.4-22.6* on dishonesty, that there is no blanket rule or presumption that erasure is the appropriate sanction in all cases of dishonesty. The Committee considered it must 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 (*Paragraph 22.5).*

96. The Committee also noted in particular the *Guidance* at *Paragraph 22.6,* namely:

> *22.6 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 (Solicitors Regulation Authority v James; Solicitors Regulation Authority v MacGregor; Solicitors Regulation Authority v Naylor [2-18] EWHC 3058 (Admin)).*

97. The Committee applied the above factors to the Registrant's case. The Committee had already made findings in relation to the dishonesty itself at the fact finding, misconduct and impairment stage, and had concluded it was serious. The Committee found that the dishonesty did have a detrimental impact on the Registrant's character, the wider profession and public perception of the profession. The Committee gave more weight to the fact that the dishonesty occurred over a four-year period and had an impact on 145 patients, than the

workplace pressure it accepted the Registrant was under at the time. The Committee concluded that it would be open to it to consider erasure in these circumstances.

98. However, the Committee moved on to consider the Registrant's insight and did not find that there was a persistent lack of insight as described in *factor (h)* at *Paragraph 21.35* of the *Guidance*. The Committee noted here that the first time the Registrant had accepted he had benefitted from the misconduct was during the substantive hearing. The Committee considered that there was limited but developing insight. There was also evidence of remorse, the process itself had been a salutary experience, and there had been early engagement from the Registrant. The Registrant had demonstrated that he has been able to practice safely for the past two years, and the Committee concluded that the Registrant's insight is, with time, remediable. The Committee noted that the Registrant is now working as a locum and the two optometrists who had provided references had indicated a willingness to continue to work with him. In particular, the Committee noted the comments in the reference from Mr A:

> "*Based on my experience, [the Registrant] has consistently exemplified honesty, integrity, and fairness in his interactions with patients. His work ethic is exemplary, and he consistently maintains a high level of professionalism in all aspects of his approach. I have never witnessed him engage in any behaviour that would compromise patient care or ethical standards. His unwavering commitment to integrity is evident in the trust patients place in him and the consistently positive feedback he receives…I would have no hesitation in recommending [the Registrant] for his services as a Dispensing Optician. He is a respected professional with outstanding clinical abilities, a strong ethical framework, and a personable demeanor, and I believe he will continue to make a positive contribution to the optical profession.*"

99. The Committee considered that this case was finely balanced. The Committee reminded itself of its duty to have regard to the over-arching objective of protecting the public, whilst taking a proportionate approach. On balance, the Committee determined that erasure would be disproportionate in this case. The Committee were satisfied that their concerns in relation to insight could be sufficiently addressed in time, with a suspension for the Registrant to further reflect on his behaviour.

100. The Committee took into account the Registrant's personal interests and the importance of balancing those against the public interest. The Committee considered that a substantial period of suspension would have a significant impact on the Registrant but would give him an opportunity to continue the progress made so far with regard to his developing insight. The Committee considered that a suspension for the maximum period of 12 months would also be sufficient to mark the seriousness of the behaviour, to ensure public confidence in the profession and uphold proper professional standards.

101. In order to ensure public confidence in the profession and uphold proper professional standards, the Committee concluded that 12 months suspension was the lowest appropriate and proportionate sanction.

Review hearing

102. The Committee determined that a review hearing should be held between four and six weeks prior to the expiration of this order. The Review Committee will need to be satisfied that the Registrant has:

- fully appreciated the gravity of the offence;
- not repeated his misconduct;
- maintained his skills and knowledge.

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

- The Registrant's engagement at the next Review Hearing;
- Evidence the Registrant has undertaken learning and development relating to standards of behaviour, honesty, integrity and professional ethics;
- A reflective piece from the Registrant addressing his development of further insight, in particular to relating to the impact of his misconduct on patients, colleagues, the wider profession and the public;
- Further testimonials commenting on how the Registrant has demonstrated honesty, integrity and professional ethics.

Immediate order

104. Mr Lo on behalf of the GOC did not invite the Committee to exercise its discretion to impose an immediate suspension order under Section 13I of the Opticians Act 1989 as it was not necessary for the protection of members of the public, otherwise in the public interest or in the best interests of the Registrant.

105. Mr Graham on behalf of the Registrant also submitted that an immediate order was not necessary. The Registrant was not subject to an interim order and the Registrant had been practising unrestricted for three years without incident. The Committee's findings had indicated no clinical risk to patients. Mr Graham submitted that 28 days would enable time for the Registrant to adjust his practice and reduce the impact on patients. Mr Graham submitted that the public interest was satisfied by the sanction itself. Mr Graham submitted it was not therefore necessary in this case to impose an immediate order.

106. The Legal Adviser drew the Committee's attention to *Paragraph 23.2* of the *Guidance* and whether the statutory test in section 13I of the Opticians Act 1989 is met, i.e, that the making of an order is 'necessary for the protection of members of the public, otherwise in the public interest or in the best interests of the Registrant.'

107. The Committee accepted the legal advice and had regard to the statutory test. The Committee accepted that there was no risk to the public, there being no clinical safety risk in this case. The Committee accepted that the Registrant had practised unrestricted for a long period of time and considered it reasonable to allow the Registrant time to manage his affairs before the suspension started. The Committee determined that the wider public interest was satisfied by the sanction itself.

108. The Committee therefore concluded it was not necessary for the protection of members of the public, otherwise in the public interest or in the best interests of the Registrant to impose an immediate order.

Chair of the Committee: Louise Fox

Signature **Date: 5 March 2025**

Registrant: John Singh

Signature *present and received via email* **Date: 5 March 2025**

FURTHER INFORMATION
Transcript
A full transcript of the hearing will be made available for purchase in due course.
Appeal
Any appeal against an order of the Committee must be lodged with the relevant court within 28 days of the service of this notification. If no appeal is lodged, the order will take effect at the end of that period. The relevant court is shown at section 23G(4)(a)-(c) of the Opticians Act 1989 (as amended).
Professional Standards Authority
This decision will be reported to the Professional Standards Authority (PSA) under the provisions of section 29 of the NHS Reform and Healthcare Professions Act 2002. PSA may refer this case to the High Court of Justice in England and Wales, the Court of Session in Scotland or the High Court of Justice in Northern Ireland as appropriate if they decide that a decision has been insufficient to protect the public and/or should not have been made, and if they consider that referral is desirable for the protection of the public. Where a registrant can appeal against a decision, the Authority has 40 days beginning with the day which is the last day in which you can appeal. Where a registrant cannot appeal against the outcome of a hearing, the Authority's appeal period is 56 days beginning with the day in which notification of the decision was served on you. PSA will notify you promptly of a decision to refer. A letter will be sent by recorded delivery to your registered address (unless PSA has been notified by the GOC of a change of address). Further information about the PSA can be obtained from its website at www.professionalstandards.org.uk or by telephone on 020 7389 8030.
Effect of orders for suspension or erasure
To practise or carry on business as an optometrist or dispensing optician, to take or use a description which implies registration or entitlement to undertake any activity which the law restricts to a registered person, may amount to a criminal offence once an entry in the register has been suspended or erased.
Contact
If you require any further information, please contact the Council's Hearings Manager at 10 Old Bailey, London, EC4M 7NG or, by telephone, on 020 7580 3898.